An Interdisciplinary Evaluation Report of
Michigan's Childcare Expulsion Prevention (CCEP) Initiative

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EXECUTIVE SUMMARY

Rates of expulsion in preschool children (27.4 per 1,000 students) are far higher than rates among school-aged children (0.8 per 1,000 students), highlighting the need for interventions aimed at reducing expulsion rates among very young children (Gilliam, 2005). The Childcare Expulsion Prevention (CCEP) Program was developed by the Michigan Department of Community Health (MDCH) with funding from the Michigan Department of Human Services (MDHS) to address these needs. Michigan's CCEP program was evaluated by an interdisciplinary research team from Michigan State University between 2007 and 2010. During the evaluation period, CCEP delivered Early Childhood Mental Health Consultation (ECMHC) services to children (birth to age five years) who attended childcare that was licensed, registered, or provided by relative care providers and day care aides enrolled with MDHS. Priority for service was given to infants and toddlers who were receiving MDHS Child Development and Care subsidy.

A mixed method evaluation design was employed utilizing: **(1) a longitudinal outcome study**, measuring the extent of improvement over time in children, families and providers involved in CCEP services; **(2) a quasi-experimental outcome study**, comparing outcomes between children and families who participated in CCEP services and those who experienced challenging behaviors in children but resided in counties not served by CCEP; and, **(3) case studies**, illustrating the experiences of a sub-group of CCEP child/family participants. Also, a number of CCEP processes were examined using **(4) an online cross-sectional survey** of all consultants with active cases.

Major findings regarding child outcomes, parent outcomes, provider outcomes, and fidelity of the intervention are summarized below in the order in which the original evaluation questions were proposed. Findings that provide support for CCEP processes as a promising practice appear in *italics* and are <u>underlined</u> below. Specific case study presentations illustrating the effects on CCEP process on outcomes are provided in the Appendix.

1. Child Outcomes

Children were assessed to document change in their problem and positive behaviors as reported by providers and parents. Parents reported at the beginning and end of CCEP services and 6 months after services ended. Providers reported at the beginning and end of CCEP services. Comparison parents and a small group of comparison providers reported at baseline and 6 months later. Evaluation questions 1 through 4 address child outcomes:

1. **Does the severity of children's challenging behavior decrease from the onset of CCEP services to the conclusion of services?**

- *Parents of CCEP children reported greater improvements in hyperactivity and attention problems, and social skills than parents of comparison children. Providers of CCEP children reported greater improvements in hyperactivity than providers of comparison children. All were small- to medium-sized effects.*

- *Children in both CCEP and comparison groups showed significant declines on other measures of problem behavior over time. We are unable to determine if this was due to CCEP services as families in the comparison group were not restricted from receiving services and supports within their communities. It is possible that these improvements in problem behavior were due to maturation and future research involving stronger research methods including the use of randomization to treatment could help to address these unknowns. Most declines in problem behavior were medium to large sized effects, indicating considerable improvement across time.*

- More hours of consultation did not predict greater improvement in behavior problems at the end of services. More consultation with parents was associated with a small effect for higher levels of parent-reported behavior concerns at follow-up. It is possible that parents who received CCEP services became more sensitive to their children's behavior and the implications of those behaviors.

2. **Does children's social and emotional health increase from the onset of CCEP services to the conclusion of services?**

- *Parents of CCEP children reported greater improvements in their children's social skills than did parents of comparison children.*

- *Children in both CCEP and comparison groups showed significant increases on other measures of positive behavior over time. All effects were large. Research methods employed in our evaluation create uncertainty regarding the reasons for these improvements as maturational changes cannot be ruled out.*

- *More hours of consultation with providers were associated with a small effect for improvements in children's functional communication skills.*

3. **Does the impact of services on children's behavior last past services?**

- *In the CCEP group, most behaviors continued to show small to moderate improvements past services* except for attention problems, which returned to previous levels.

- More hours of consultation with parents were associated with parent reports of small effects denoting higher levels of behavior problems and lower levels of positive behaviors past services. It is possible that parents who received CCEP services became more sensitive to their children's behavior and the implications of those behaviors.

4. **Do children receiving CCEP services successfully stay in childcare vs. being expelled?**

- No significant differences in retention vs. removal were evident between the CCEP and comparison group, although comparison group children tended to be more likely to be retained. However, we have strong concerns about the validity of the comparison data for assessing differences in retention and removal and future studies should address those methodological weaknesses.

- Removal of children from the original childcare setting was associated with lower income, non-center-based care, less consultation, and provider-parent relationships that parents saw as

worsening and providers saw as poorer from the start. Perceptions of the consultant and the CCEP process did not differ for providers and parents of children retained vs. removed.

2. Parental Outcomes

Parents completed self-report questionnaires concerning their parenting stress and feelings of empowerment in advocating for their children's needs at the beginning and end of services and at 6 months follow-up. They also reported on the number of work and/or school absences that occurred due to their children's challenging behaviors. Comparison parents reported similar information at baseline and 6 months later. Evaluation questions 5 and 6 address parent outcomes.

5. **Do subjective feelings of parental competence in dealing with their child's challenging behaviors increase as a result of CCEP services?**

   - *By end of services, parents in the CCEP group showed significant, moderate decreases in parenting stress and significant, moderate increases in empowerment in advocating for their children. These improvements were maintained through follow-up.*

   - Parents in the CCEP and comparison groups did not differ in improvements in parenting stress; both groups decreased between Time 1 and Time 2. *CCEP parents, however, showed a small significant advantage in increased empowerment for advocating for their children relative to the comparison group.*

   - More hours of consultation was not associated with greater improvement in parenting stress and empowerment.

6. **Are families able to consistently attend work or school?**

   - *At Time 1, almost a third of CCEP parents had missed or been late to work due to childcare issues. By Time 2, the majority (63%) of these parents had not lost work/school time in the past month.*

   - *More hours of consultation with CCEP parents tended to be associated with better work/school productivity by end of services.*

   - *The CCEP and comparison groups did not initially differ in work/school productivity loss (28% and 24%, respectively). However, by Time 2, only 18% of parents in the CCEP group had work/school problems, while 100% of comparison parents did.*

3. Provider Outcomes

Providers were assessed in three areas. First, at the onset of the evaluation study, providers' knowledge of early warning signs of social-emotional challenges in infants, toddlers, and preschoolers was measured. Providers were also asked to report on the extent to which they felt they had room to improve their abilities to recognize early warning signs. Second, providers completed a questionnaire regarding their feelings of competencies in managing challenges in the classroom. Finally, providers were assessed on their general feelings of efficacy related to caring for children. Provider data were available at the beginning and end of services in the CCEP group and at baseline and 6 months later in the comparison group. Evaluation questions 7-9 address provider outcomes.

7. **Is the childcare provider better able to recognize early warning signs of social and emotional challenges in infants, toddlers, and preschoolers?**

- *The majority of CCEP providers (65%) felt they had room to improve their ability to recognize early warning signs. By the end of services, they reported better being able to do so, particularly those who felt they had the most room to improve.*

- *More hours of dosage were linked to better recognition of early warning signs.* Comparison group data were not available for this measure.

8. **Is the childcare provider better able to manage challenging behavior in the childcare setting with all children?**

- *CCEP providers and administrators reported significant improvements in Goal Achievement Scale (GAS) competence (i.e., a measure of one's feelings about managing children's challenging behaviors, working with families, and changing the center climate). Provider effects were large, and administrator effects were moderate.* Providers did not report change in efficacy as measured by the Teacher Opinion Survey (TOS) (i.e., a measure of provider's feelings of efficacy related to caring for children).

- Hours of consultation were not associated with more improvement in provider-reported competence on the GAS. However, *administrators indicated that providers increased in GAS competence when parents received more consultation.*

- *CCEP providers reported greater improvements in GAS competence than did comparison providers; this was a medium-sized effect.* The CCEP and comparison groups did not differ in changes in efficacy as measured by the TOS over time.

9. **Has the social and emotional quality of the childcare setting receiving CCEP services improved?**

- *Most case study respondents discussed the potential for change in the context of new skills, knowledge, and changed attitudes, and were influenced by the relationship between the provider and consultant*.

- *Case study respondents also discussed improvements in the social-emotional climate as occurring over time as opposed to an immediate improvement after CCEP consultation*.

4. CCEP Program and Processes

An important element of the evaluation plan involved assessing the fidelity of the CCEP consultation processes. Evaluation questions 10 and 11 address CCEP programmatic processes.

10. **What is the fidelity of the child and family consultation process among CCEP programs?**

- *On average all CCEP services provided, services lasted 4.7 months, with child-centered cases receiving an average of 11 hours of face-to-face service (not including phone and email contacts). However, there was substantial variation across cases for all measures of dosage.*

- *Cases associated with childcare centers tended to receive more hours of observation than did cases associated with group home or relative childcare.*

- *Most (91%) cases went through a formal intake and included observations in the childcare setting (92%); observation also occurred in the home in many cases (54%). Baseline assessment occurred in most cases (89%), primarily using the DECA rating scales (i.e., a measure of risk and protective factors) and less frequently other measures, such as the ITERS/ECERS (i.e., an observational measure of the environment).*

- *72% of cases developed a written, jointly agreed Positive Child Guidance Plan and subsequently participated in activities that included provider and parent coaching and informal training. Relatively few cases (27%) had a later review of the guidance plan.*

- *Nearly half (49%) of the cases received some type of referral. The most common referral type was for child mental health services, followed by early intervention and special education services.*

- *Consultants provided some type of resource in 56% of cases. These were most likely to take the form of articles and/or books.*

- *Programs provided different average amounts of service. For example, while the programs delivered an average of 12 hours of face-to-face consultation to the clients within their agency, one program delivered an average of 6 hours per client while another delivered an average of 27.6 hours per client.*

11. **What is the fidelity of the programmatic consultation process among CCEP programs?**

- *58% of cases received some degree of programmatic consultation, most commonly in the areas of Supportive Relationships (51%) and Activities and Experiences (50%). This was followed by strategies targeting Understanding and Using Strategies to Promote Socioemotional Development and Prevent Challenging Behavior (44% & 45% respectively), Partnerships with Families (43%), Daily Routine (39%) and Understanding the Importance of Child-caregiver Relationship (33%). Targeted less often were Environment/Program and Resources, reported in 27% and 22% of cases, respectively.*

- *The degree to which programmatic consultation was delivered varied substantially across consultants. Only three consultants (13%) provided no programmatic consultation.*

5. Perceptions of Consultation Process, Effectiveness, and Acceptability

The CCEP evaluation also reflected the collection of information regarding parents' and providers' perceptions about the CCEP consultation model and consultation processes. Parents and providers reported on relationships with each other at the beginning and end of services. These additional questions are described below.

12. **Did consultation improve the provider-parent relationship?**

- For the most part, the overall relationship between providers and parents did not change after CCEP services, although *providers did indicate some improvements in communicating with parents about children's behavior at the end of consultation*.

13. **How was the consultation process viewed by those involved?**

- *CCEP services were viewed very positively by all of those involved as all ratings reflected "strong agreement" with the benefits of this consultation approach*.

14. **Was consultation seen as beneficial?**

- *Parents, providers, and consultants all indicated high ratings pertaining to the benefits of CCEP services. Parents were most positive of the three about the effectiveness of CCEP services.*

Parents reported significant improvements to providers' competence in working with their child, although providers did not report that parents' competence had grown.

6. Implications

Because of the realities inherent in community program delivery, evaluation of such programs is a complicated business—a relatively small group of children, providers, and families are able to receive consultation in the optimal way as the CCEP designers intended. As with many community programs, provision of CCEP services varied considerably from case to case. These variations result from, among other things, differences in the extent to which providers and families are willing or able to engage fully, external factors unrelated to consultation such as exiting from the childcare setting for financial reasons or relocation, great variation in the type and extent of child problems from relatively normal defiance to developmental delays necessitating additional supports, the need to individualize the types of interventions provided to the specific issues presented rather than using a standard, common set of practices, and the full range of complications in delivering services in communities encountered by any program. These factors are likely to make the effects of an evaluation smaller than they would be if the same set of practices were delivered to all participants in the same way. Going to scale with any early intervention and prevention approach is a challenging endeavor. Nonetheless**, the pattern of results of this evaluation strongly suggests that CCEP is associated with benefits to participants in many areas. In sum, CCEP holds considerable promise as an effective Early Childhood Mental Health Consultation approach.** These results suggest the following implications:

- **Early intervention efforts call for sustained involvement over time.** Early interventions such as CCEP may yield small to moderate effects, suggesting the need for intensive and ongoing services as well as more seamless transitions as children move between early childhood programs or transition to school. In the current evaluation, positive outcomes for children (particularly reductions in hyperactivity and attention problems) and for parents (particularly regarding increased feelings of empowerment and reduced absences from school or work due to behavior challenges) suggest benefits of providing direct consultation to parents and providers.

- **Increasing providers' competence in managing their classrooms may be a strategy to combat high provider turnover rates in early child care settings.** The CCEP evaluation indicated significant improvement in providers' feelings of competence in managing early challenging behaviors. This finding has important implications for strategies regarding the support and retention of early childcare providers. Given the high turnover rates in employment in early childhood, often linked to stress and dissatisfaction, strategies for boosting childcare providers' competence in managing the classroom are needed as a means to reduce stress.

- **Non-center-based childcare programs need additional support in engaging in consultation processes.** Evaluation findings indicated that childcare programs not housed within formal childcare center-based frameworks were less likely to follow outlined consultation processes, such as creation of a Positive Child Guidance Plan. The more informal nature and fewer staff may make adherence to consultation processes more difficult. Non-center-based providers may benefit from additional support regarding how to manage time and resource to achieve more optimal fidelity to programmatic processes.

CHAPTER 1. INTRODUCTION

1.1. Early Childhood Mental Health Consultation

For many young children between birth and five years of age, challenging behavior is common. It can be most intense and frequent in mid-toddlerhood and decline as children develop and move towards school age (Degnan et al., 2008). It is estimated that between 9% and 14% of children five years of age or younger experience social-emotional difficulties severe enough to negatively impact their social and cognitive abilities (Brauner et al., 2008). Challenging behaviors may be too much for childcare providers resulting in rates of expulsion in preschool children (27.4 per 1000 students) that are far higher than rates among school-aged children (0.8 per 1000 students) (Gilliam, 2005).

In addition to potential school readiness and academic achievement problems that children may experience, parents of children with behavior problems contend with a variety of challenging circumstances such as children's expulsion from childcare, strained relationships with childcare providers, rejection from other parents, and limited childcare options at home to provide time away for the parents (Webster-Stratton, 1990). Often, parental stress and children's behavior problems transact over time such that severe behavior problems contribute to elevated parenting stress, and high parenting stress contributes to increasing behavior problems (Baker et al., 2003). For parents of children expelled from childcare, the spillover of family issues to the workplace exacerbates rates of absenteeism and job loss. Such loss of productivity has significant economic implications for employers and certainly for parents who leave or are dismissed from their jobs because of impending family-life issues. Without intervention, opportunities may be lost to support the child and their family, make environmental changes or train staff and improve the quality of care. Interventions directly addressing parenting stress and children's aggressive behaviors are related to reductions in children's problematic behaviors and in parenting stress, as well as reduced parental perceptions of barriers to services (Kazdin & Whitley, 2003). Moreover, interventions aimed at reducing children's aggression and supporting parents can enhance the parent-teacher relationship (Webster-Stratton, Reid, & Hammond, 1991), promoting more open communication and support for the child.

Early childhood mental health consultation (ECMHC) programs focus on helping parents and providers meet the developmental needs of young children who are at-risk for later challenges. ECMHC has been identified as a potentially cost-effective preventive approach to managing challenging child behaviors (Upshur, Wenz-Gross, & Reed, 2009). These services primarily comprise an indirect, collaborative problem-solving approach between parents, providers and qualified, skilled mental health consultants to systemically prevent, identify and treat challenging behaviors among children up to 6 years of age (Hepburn & Kaufmann, 2005). The single most important ingredient of ECMHC is reported to be the

ability of the consultant to develop positive collaborative relationships through effective interpersonal communication with program staff (Green, Everhart, Gordon, & Gettman, 2006). A recent study reported that the likelihood of expulsion from early childhood education and care services decreased as access to behavioral consultation increased and was lowest in centers where there was a regular, ongoing relationship with a consultant (Gilliam & Shahar, 2006).

1.2. Michigan's Childcare Expulsion Prevention Program

In Michigan, the Childcare Expulsion Prevention Program (CCEP), an approach to ECMHC, was established by the Michigan Department of Community Health (MDCH) with the support of funding from the Michigan Department of Human Services (MDHS) in the late '90s and has since expanded and diversified. Implementation changes, such as the target age group for children, the number of sites and the development of a specific Michigan model of service delivery, have further evolved in response to ongoing internal and external evaluations and funder requirements. During the MSU evaluation period, the program delivered ECMHC services to children (birth to age five years) who attended childcare that was licensed, registered, or provided by relative care providers and day care aides enrolled with MDHS. Priority for service was given to infants and toddlers who were receiving the MDHS Child Development and Care subsidy.

During the past decade, MDCH developed a common approach to CCEP centering on six explicit cornerstones to support quality ECMHC services. These cornerstones of practice required that projects offer (1) both programmatic and child-centered consultation (2) in collaboration with other local early childhood agencies and providers (3) provided by highly qualified consultants who are required to participate in ongoing professional development and (4) state-level technical assistance. Emphasis is placed on using (5) evidence-based practices supported by (6) mandatory reflective supervision for CCEP consultants.

In 2008, the Michigan CCEP program was identified as one of the national leaders in the ECMHC field by the Center for Early Childhood Mental Health Consultation, Georgetown University, Washington, D.C. The MI program received funding in 2009 of $1,852,992 from the Childcare Development Fund through DHS. The CCEP program covered 31 of Michigan's 83 counties including urban, suburban, and rural communities. To give a sense of CCEP's scope, it was reported that in 2008, 572 children received child and family-centered consultation; programmatic consultation was provided to 306 childcare settings serving 6,884 children; 957 parents and providers participated in state developed social-emotional modules; and 2,151 parents and providers participated in specialized social-emotional trainings.

The initiative was organized and managed by MDCH, including the provision of state-level administrative and budgetary oversight for 16 CCEP projects operated by local Community Mental Health Service Programs (CMHSP). MDCH contracted with three state-level Technical Assistance (TA) Consultants responsible for TA support to local-level CCEP supervisors and consultants and for coordination of intensive state-level collaboration with other early childhood entities. CCEP's State Administrator was responsible for negotiating and managing contracts with local CMHSPs and providing oversight and direction to the three CCEP state-level Technical Assistance (TA) Consultants that equaled 1.4 full-time equivalent support. The 16 local CCEP project sites employed 30 mental health consultants (16 full-time, 7 half-time, and 7 part-time with a combined average total of a 1.6 FTE consultant per site).

CCEP programs were staffed by mental health professionals, most of whom had a master's degree in social work, psychology or a related field and the Michigan Association for Infant Mental Health Endorsement (minimum Level II). CCEP Consultants were also expected to have a wide range of

experience, including at least two years as a mental health clinician specializing in relationship-based work with young children and their families, familiarity with social and emotional assessment, and experience providing training and facilitating groups. CCEP consultants were also required to have experience working in childcare settings, knowledge of infant and early childhood development (0-5 years), particularly social-emotional development, and personal and professional qualities that included being culturally competent and having a warm, empathic personality, as well as having excellent communication skills.

A standardized approach to the delivery of CCEP services was shared with consultants as a part of orientation. This included dissemination of the CCEP program binder, which included program information pertinent to the consultation process, such as the local contract, chapters outlining best-practice consultation processes and cornerstones of practice, and data reporting forms. Consultants also had access to regular on-site quarterly meetings and participated in statewide monthly technical assistance calls involving state- and local-level CCEP staff. In line with regular practice, state-level TA consultants facilitated four on-site technical assistance meetings each year. These were open to CCEP project staff and others working in or attempting to promote early childhood mental health services in Michigan. Regular administrative and reflective supervision of consultants was viewed as an essential component of CCEP and was a requirement made of sub-contractors. Reflective supervision had to be provided by individuals that were knowledgeable about ECMHC, infant mental health, and childcare practices. Table 1.1 shows a summary of these program characteristics, including the six cornerstones of CCEP practice in Michigan.

1.3. Evaluation of CCEP in Michigan

Many lessons for the ECMHC field and the Michigan program have been learned throughout the past decade of developing, implementing, and evaluating CCEP in Michigan. National research on ECMHC has developed over this time and has been informed by the work of CCEP in Michigan. Research on ECMHC in early education and care settings provides wide evidence of positive program outcomes (e.g., reductions in program expulsions, improvements in classroom climate), teacher outcomes (e.g., improvements in teachers' self-reported competence, attitudes, skills) and child outcomes (e.g., reduction in externalizing and internalizing behaviors, increased social skill development) (Brennan, Bradley, Allen, & Perry, 2008; Perry, Allen, Brennan, & Bradley, in press) but less information about the benefit of ECMHC to families. However, much has yet to be learned about how and why ECMHC works (Upshur et al., 2009).

A comprehensive evaluative approach was taken by an interdisciplinary team at Michigan State University (MSU; see Appendix 2 for details of team membership) to explore the effectiveness of CCEP. This report outlines the key approaches, methods and findings from this evaluation, conducted over nearly four years, from planning in early 2007, data collection from late 2007 to early 2010, to dissemination of final results in October of 2010. In Chapter 2, the specific research questions identified by MDCH in collaboration with CCEP consultants, their supervisors, and technical assistance providers across the state are detailed along with the mixed methods used to collect data to answer these questions. Key findings are outlined in subsequent chapters and the Appendices. Chapters include an outline of the Michigan CCEP process and fidelity of consultants to the prescribed model (Chapter 3); child outcomes (Chapter 4); parent outcomes (chapter 5); and provider and program outcomes (chapter 6). The report concludes with a chapter on perceptions of the consultation process according to key participants – the consultant, parent and provider (Chapter 7). In the Appendices, more detail can be

found from case study material that highlights the key themes that emerged on the CCEP consultation process as well as the individual stories and outcomes data of case study children and their families.

Table 1.1 Features of the CCEP Program in Michigan in 2009

Feature	*Description*
Program Type	One model, statewide
Program Scope	GEOGRAPHIC AREA SERVED • 31 of Michigan's 83 counties, including urban, suburban, and rural communities. SETTINGS SERVED • Licensed child care centers and group day care homes, registered family day care homes, enrolled relative care providers, and enrolled day care aides. AGES SERVED • Birth to age 5. ANNUAL NUMBERS SERVED (FY2008) • 572 children received child and family-centered consultation; 6,884 children received programmatic consultation in 306 childcare settings; 957 parents and providers participated in state developed social-emotional modules; and 2,151 participated in specialized social-emotional trainings.
Organizational/ Management Structure	The Michigan Department of Community Health (MDCH), Mental Health Services to Children and Families provides state-level administrative and budgetary oversight for 16 CCEP projects that are operated by local Community Mental Health Service Programs (CMHSP). MDCH contracts with the 1.4 FTE state-level Technical Assistance (TA) consultants who are responsible for TA support to local-level CCEP supervisors and consultants and for coordination of intensive state-level collaboration with other early childhood entities.
Staff Composition	CCEP's State Administrator is responsible for negotiating and managing contracts with local CMHSPs and providing oversight and direction to the three CCEP state-level TA Consultants. The 16 local CCEP project sites employ 30 mental health consultants (16 full-time, 7 halftime, and 7 part-time).
Consultant Supervision and Support	SUPERVISION • Administrative and clinical supervision within own agency. • Reflective supervision, one-on-one twice a month with a Michigan Association for Infant Mental Health (MI-AIMH) qualified professional. SUPPORT • Ongoing support by state-level TA consultants: Monthly conference calls, quarterly TA meetings, documents and resources, email listserv, quarterly newsletter, regular on-site visits to programs and phone support.
Consultant Caseload	Caseload of 8-15 children and families at any one time—about 30 cases per year. Caseload of between 15-20 childcare programs per year.
Service Array, Frequency and Duration	• Child/family-centered consultation varies considerably across cases due to the diversity of challenges address. On average, this may involve 1-3 hours weekly, for a period of 3-6 months with no set number of visits as flexibility is essential. • Programmatic consultation, on average, 1-3 hours weekly, duration of 3-6 months. • Standardized CORE Training Modules, two series of four, 3-hour modules

Feature	Description
	for parents, childcare providers, and other early childhood services community members
Funding	AMOUNT AND SOURCES (FY2009) • Annual program budget: $1,852,9928 • Funds provided by the Department of Human Services, Childcare Development Fund
Notable Program Features	• Consultant qualifications, supervision, and MI-AIMH endorsement • CORE Training Modules and training coordination • Technical assistance support to consultants • Emphasis on birth to three • Require reflective supervision support for all consultants • Require MI-AIMh endorsement for all consultants
Cornerstones of CCEP Practice	• Both programmatic and child-centered consultation • Collaboration with other local early childhood agencies and providers • Highly qualified consultants who are required to participate in ongoing professional development • State-level technical assistance • Evidence-based practices • Mandatory reflective supervision for CCEP consultants.

Adapted from Duran et al., 2009.

CHAPTER 2. EVALUATION METHODOLOGY

This chapter outlines the research questions and the mixed methods design used to answer these questions. Appendix A provides a simple logic model that describes the CCEP model. Appendix B summarizes the evaluation plan that includes research questions, measurement instruments, raters, and time of data collection. Descriptions of measures are presented in the chapters to which they apply.

2.1. Research Questions

Research questions were collaboratively identified by MDCH, CCEP consultants from all active programs across the state, their supervisors and state-level TA consultants. These covered child, family and provider outcomes resulting from CCEP consultations and the extent to which consultants worked to the prescribed CCEP model. Target outcomes were defined as follows:

Child Outcomes

1. Does the severity of children's challenging behavior decrease from the onset of CCEP services to the conclusion of services?

2. Does children's social and emotional health increase from the onset of CCEP services to the conclusion of services?

3. Does the impact of services on children's behavior last past services?

4. Do children receiving CCEP services successfully stay in childcare vs being expelled?

Family Outcomes

5. Do subjective feelings of parental competence in dealing with their child's challenging behavior increase as a result of CCEP services?

6. Are families able to consistently attend work or school?

Childcare Provider Outcomes

7. Is the childcare provider better able to recognize early warning signs of social and emotional challenges in infants, toddlers, and preschoolers?

8. Is the childcare provider better able to manage challenging behavior in the childcare setting with all children?

Childcare Program Outcomes

9. Has the social and emotional quality of the childcare setting receiving CCEP services improved?

Fidelity

10. What is the fidelity of the child and family consultation process among CCEP programs?

11. What is the fidelity of the programmatic consultation process among CCEP programs?

2.2. Collaborative Approach

To ensure that the evaluation team understood the context in which CCEP operated and to maximize successful data collection, the evaluation team, state-level TA consultants, and local-level CCEP consultants used a highly collaborative approach to implement the evaluation. Relationships were built as CCEP staff and consultants played an integral part in the conceptualization, decision-making, interpretation, and dissemination of study findings.

The evaluation research team recognized the additional work that the evaluation plan would impose on the consultants and the impact that might have had on developing a trusting relationship with families, providers, and programs. Where possible, the proposed plan incorporated measures in which consultants were already trained as well as a limited number of additional measures to address each of the evaluation questions. The majority of measures selected demonstrated potential usefulness within the development of the Positive Child Guidance Plan and/or as a part of a consultant-based progress monitoring approach to determine whether prevention-based service goals were being met.

To maximize consistency of data collection, the evaluation team frequently connected by phone and email with state-level TA consultants and CCEP consultants to clarify questions as they arose. In addition, the evaluation research team met monthly with state-level TA consultants in order to be transparent about recruitment efforts and adjust these as warranted so that target recruitment goals were met. As a result of these meetings, CCEP state-level staff regularly communicated with local programs and, when needed, developed individualized plans to ensure that the evaluation recruitment goals were met. Evaluation team members also met regularly with CCEP consultants and administrators at their monthly meetings to provide updates, field questions, and solicit interpretation of findings.

2.3. Design

A mixed-method evaluation design was used that incorporated three overall strategies to address these research questions.

-   **A longitudinal outcome study** measuring the extent of improvement over time (pre-, post-, and 6 month follow-up) on the key outcomes in all participating children, families, and providers. Characteristics of services (including dosage), participants and consultants were also examined to explore association with successful outcomes.

-   **A quasi-experimental outcome study** to enable comparison between outcomes of children and families who participated in CCEP services and those who reported challenging behaviors in their children but lived in counties where no CCEP or similar services were available.

- **Case studies** of a selected sub-group of CCEP child and family participants to illustrate findings and assist with understanding processes, successes, and challenges.

In addition to these three approaches, a number of CCEP processes were examined. Data were collected using an online cross-sectional survey of all consultants who were actively working with cases. Findings from this part of the evaluation are described in Appendix D: Research Briefs: CCEP Program in Michigan.

2.4. Longitudinal Outcome Study

CCEP provided ECMHC services to children (birth to age five years) who attended childcare that was licensed, registered, or provided by relative care providers and day care aides enrolled with MDHS. Participants in these services were consultants, parents (especially mothers), providers and on occasion, administrators of childcare programs. All 16 CCEP programs in Michigan, covering 31 counties and all consultants (ranged from 30 at any single point and a total of 44 different CCEP consultants over the course of the study due to expansion of services in some counties, consultants job sharing, and some turnover). All consultants were expected to participate in the evaluation. To examine improvements in participants over the course of CCEP services, a longitudinal study was conducted that used pre- and post-assessments of children, parents, and providers and 6-month follow-up assessments with parents. CCEP services were individualized to meet the needs of a specific program, provider, child or family. Services were targeted to one of three different consultation approaches: to the individual child and family, to the program, or to a combination of both.

2.4.1. Child and Family Sample

2.4.1.1. Procedure

Recruitment. The evaluation was open to all (a) eligible individual child and family cases that received CCEP services and (b) all referrals for programmatic intervention only. An eligible child and family case was defined as one in which a referral from October 1, 2007 to September 30, 2009 was made to CCEP for consultation services. Cases were excluded that resulted in an external referral after a very brief assessment or were foster children or other children whose legal situation made authority for informed consent by a parent or guardian complex. The percent of potential cases that declined to participate was unavailable from the state, though we estimate it to be between 10-15% of cases.

Data collection. As part of the CCEP consultation process, all consultants, parents and providers who agreed to participate completed a set of measures that included existing CCEP materials and measures added for the purpose of this evaluation. Measures assessed child development and behavior and parent and provider perceptions at the start (Time 1: T1) and end of services (Time 2: T2). Six months after exit, the evaluation team contacted parents by phone and gathered follow-up (Time 3: T3) data on the same measures for the child and parent outcomes. An incentive of $25 was paid for T3 data since it required participation after the case was closed. This pre-post design with follow-up enabled assessment of change and sustainability in the outcomes over at least 6 months.

2.4.1.2. Data Cleaning

Final data set. Ultimately, data were available from 432 child-family consultation cases at T1, 394 cases at T2, and 177 cases at T3. Twenty-three cases were removed because their consultant changed during the course of services, and 49 cases were removed because no information on services provided was available. This resulted in a final sample of 361 cases. Within this sample, 11 cases had a different parent reporter at one of the time points. Parent report data for these cases were recoded to missing. Finally, in 208 cases, the provider, classroom, and/or center had changed (164 cases) or it was not reported whether they had changed (55 cases); provider report data for these cases were recoded to missing to insure that inconsistency in provider raters across time was eliminated.

Imputation. Even when data were available, the parent or provider did not always fill out measures completely. When data were available from a reporter (i.e., parent or provider) in a certain area (e.g., child outcomes, parent outcomes, provider outcomes, consultation process), missing data for that reporter in that area were imputed from the data that the reporter had completed and from child age, type of childcare setting, and a family low-income variable (yes/no) based on whether the family received federal assistance for food, child health care, or childcare at any time point. Table 2.1 presents the maximum sample size used in analyses by reporter and time point after imputation. Because some analyses include only cases where data from both providers and parents were available, the sample size used in analyses varied according to the specific question**.**

Table 2.1 CCEP Group Maximum Sample Sizes

Reporter	Time 1	Time 2	Time 3
Provider			
Child outcomes	190	190	NA
Provider outcomes	189	189	NA
Provider-parent relationship	179	179	NA
Perceptions of consultation	NA	179	NA
Parent			
Child outcomes	256	256	136
Parent outcomes	253	253	138
Provider-parent relationship	230	230	119
Perceptions of consultation	NA	230	NA
Consultant—perceptions of consultation	NA	334	NA
Service utilization		361	

Note. NA = Not applicable.

Differences in datasets with and without Time 3 data. The data set used to analyze parent-reported change from Time 1 to Time 2 were examined to see if it was demographically different from the data set that included Time 3, which was smaller. Child age, race, and gender, parent age and education, and provider type (center vs not center-based) did not differ. The group that had Time 3 data tended to be less likely to be low-income; but this was not significantly significant (χ^2=2.23, df = 1, p = .09). There were no significant differences between parents with and without Time 3 data on initial child behavior problems on the DECA or BASC.

2.4.1.3. Sample Description

Table 2.2 describes the demographic characteristics of the 361 cases for whom dosage data were available. A very diverse group of children and families received CCEP services, though children were predominantly 36 months or older, male, white, and attending childcare centers. Sixty percent resided in two-parent families (not necessarily two-biological parents), and the majority of parents had at least a high school diploma or GED. Slightly over a third of families were categorized as low-income.

Ten percent of children had previously been expelled from childcare. According to both providers and parents, over half of the children presented with aggression (e.g., biting, hitting, kicking), regulatory issues (e.g., difficulty adjusting to transitions, tantrums, sleep/feeding/toileting difficulties), and/or developmental issues (e.g., clingy, withdrawn, crying for parent, poor social skills, impulsive, cognitive delay). One quarter or less of children presented with problems around sensory integration (e.g., perseveration, sensitivity to noise/touch, repetitive speech), physical development (e.g., hearing/language issues, gross/fine motor), and/or other behaviors (e.g., sexual acting out, fearful, bizarre behaviors, sad affect, oppositional/defiance).

Table 2.2 CCEP Sample Description

Characteristic	%
Child's mean (SD) age (in months)	42.8 (13.2)
• 0-11 months	1%
• 12-23 months	9%
• 24-35 months	15%
• 36-47 months	30%
• 48-59 months	32%
• Over 59 months	13%
Male	75%
Race	
• African American	15%
• White	77%
• Other	8%
Hispanic	8%
Primary language in home is English	98%
Two-parent family (includes biological, adoptive, same-sex, and families with step-parents)	60%
Previously expelled from childcare	10%
Primary caregiver education	
• Less than high school	8%
• High school/GED	17%
• Some college or associate's degree	34%
• Bachelor's or advanced degree	42%
Household income	
• Less than $15,000	20%
• $15,000 - $34,999	23%
• $35,000 - $54,999	21%
• $55,000 - $74,999	12%
• $75,000 - $99,999	15%

Characteristic	%	
• More than $100,000	9%	
Low-income (federal or state assistance)	35%	
• Childcare subsidy	29%	
• Family Independence Program	14%	
• Food Assistance Program	23%	
• Medical Assistance	31%	
Type of childcare provider		
• Childcare center	86%	
• Family home	5%	
• Group home	7%	
• Relative care	1%	
• In-home care	1%	
Presenting problems	Provider	Parent
• Aggression	64%	57%
• Developmental	72%	67%
• Regulatory	61%	57%
• Physical	12%	10%
• Sensory integration	24%	22%
• Externalized behavior Not Otherwise Specified	18%	16%

Note. Descriptives are for final sample included in analysis, *N* = 361. Percents are based on data available; data were missing for some variables.

2.4.2. Programmatic Intervention Sample

As part of the CCEP consultation process, consultants and providers completed a set of measures in a comprehensive case programmatic binder that included evaluation measures and existing CCEP materials. Measures assessed perceptions of a target provider and the center administrator (all were centers) at the start (T1) and end of services (T2) on provider outcomes. Fifty-five programmatic cases were included in the evaluation. Outcomes for this section are reported in the chapter on provider outcomes.

2.5. Quasi-Experimental Outcome Study: Comparison Study

To supplement the longitudinal analyses, a comparison group was identified. These were children attending childcare in counties without CCEP or similar services who were reported by parents as exhibiting challenging behavior in childcare.

2.5.1. Recruitment

Comparison group recruitment initially targeted four counties, (Jackson, Barry, Gratiot and Ionia); this was extended later to all counties in Michigan without a CCEP or other ECMHC program (47 counties) after insufficient numbers were identified. Recruitment included the use of incentives; partnerships with a state-wide not-for-profit childcare collaborative agency with local offices in target counties (Michigan

4C), talking to state-wide coordinators and other representatives from Early Childhood and Community Mental Health Collaboratives (e.g., Great Start); five waves of targeted mailing and in-person distribution of posters and flyers to providers, childcare centers, doctor and other local offices; and insertion of a recruitment flier distributed to all providers within a statewide provider newsletter in 117 target zip codes. Partner agencies and providers received a $20 recruitment bonus. Recruitment spanned the period from July 1, 2007 to January 31, 2010.

Approximately 200 families or providers expressed interest in participating in the comparison study, but many declined to participate after contacting the research team or were not eligible. Reasons for non-eligibility that were included in an attempt to more closely approximate families who were receiving CCEP services included attendance at Head Start or Early Head Start, which already provide ECMHC services; screening results that indicated children did not have sufficiently challenging behaviors (i.e., two or more of these challenging behaviors based on a screening instrument from the CCEP program materials); residence in a county that had access to CCEP or similar services; and foster care.

A final group of 86 eligible families were recruited along with 71 associated providers. At follow-up approximately 6-8 months later, 76 parents and 25 providers who had not changed since Time 1 completed follow-up measures. Attrition among comparison families was relatively small (83% were retained) and would have reached an even higher percentage had it been possible to extend the agreed data collection time-frame necessary for the evaluation. Attrition among providers was more substantial due to the exclusion of providers who no longer cared for comparison children.

2.5.2. Procedure

The evaluation team collected measures of child, provider, and parent outcomes from the parents of comparison children by phone and from their providers by mail at baseline (T1) and approximately 6 months later (T2). Only 25 providers (35%) were consistent between T1 and T2. Comparison families received $40 at each time point and their providers received $20 for each eligible child on whom they reported.

2.5.3. Data Cleaning

The same procedures were used to clean and impute the data set as were used for the longitudinal outcomes sample.

2.5.4. Sample Description

The CCEP group and the comparison group differed substantially in sample size. Additionally, inspection of the samples revealed that the two groups had some demographic differences, most notably in the type of childcare, where the comparison sample was less likely to use childcare centers and more likely to use family day care homes, and the distribution of child gender, where the comparison group had a greater proportion of girls. To compensate, a matched comparison sample was developed in which cases in the CCEP group that matched the comparison sample on child age (under/over 36 months), child gender, family low-income status, and type of childcare setting were identified. Sample characteristics for the two samples are provided in Table 2.3 for cases that had data available on these characteristics. Although the two samples continued to have some differences, specifically in race, the distribution of childcare setting, and the distribution of parent education, the similarity of the groups

had increased. Race (white vs not white) and setting (childcare center vs not) were used as covariates in group analyses. Parent education was not included as a covariate because one-third of cases were missing this data.

Table 2.3 Matched-Comparison Sample Description

Characteristic	Comparison	CCEP
Child's mean (SD) age (in months)	38.2 (13.7)	40.1 (14.3)
• 0-11 months	1%	9%
• 12-23 months	9%	15%
• 24-35 months	15%	30%
• 36-47 months	30%	32%
• 48-59 months	32%	13%
• Over 59 months	13%	
Male	65%	69%
Race		
• African American	2%	23%
• White	82%	71%
• Other	16%	6%
Hispanic	2%	4%
Primary language in home is English	98%	96%
Two-parent family (includes biological, adoptive, same-sex, and families with step-parents)	63%	46%
Previously expelled from childcare	6%	12%
Primary caregiver education		
• Less than high school	0%	10%
• High school/GED	16%	21%
• Some college or associate's degree	55%	29%
• Bachelor's or advanced degree	28%	39%
Household income		
• Less than $15,000	25%	24%
• $15,000 - $34,999	20%	17%
• $35,000 - $54,999	19%	31%
• $55,000 - $74,999	11%	12%
• $75,000 - $99,999	16%	12%
• More than $100,000	9%	5%
Low-income (federal or state assistance)	52%	51%
• Childcare subsidy	26%	44%
• Family Independence Program	12%	21%
• Food Assistance Program	30%	34%
• Medical Assistance	45%	46%
Type of childcare provider		
• Childcare center	43%	55%
• Family home	31%	17%
• Group home	22%	21%
• Relative care	0%	5%
• In-home care	4%	2%

Note. Descriptives are for final sample included in analysis. *N* = 86 in each group. Percents are based on data available; data were missing for some variables.

2.6. Case Studies

Although a wide range of standardized quantitative measures were used to frame this evaluation, the limitations of relying on this method alone are identified in the evaluation literature (Fitzpatrick et al., 2004). A more holistic, qualitative appreciation of the process and experience of this type of consultation contributed to this study in order to:

- Illustrate the variation and unique relevance for individual children and families existing within the quantitative results

- Add depth to the understanding of the processes that underpin consultation

- Highlight the importance of context and relationships for intervention delivery

Quotes from parents, providers and administrators involved in CCEP services are included in parallel with quantitative evaluation results in this report. The words of these individuals provide concrete examples in support of the quantitative data analyzed and reported in the study.

2.6.1. Recruitment

To provide organizational and geographic diversity two established CCEP programs, one rural (employing one full-time administrator/consultant) and one urban (employing one part-time administrator/consultant and a second part-time consultant) were selected for participation in case studies. Nine active cases participating in the wider evaluation were identified and invited to share their experiences about CCEP. All non-CCEP interviewees were rewarded with a $10 gift card and a gift of a small, decorative notepad for personal use.

2.6.2. Procedure

In-person semi-structured interviews were initially conducted with each of the CCEP program administrators. Both were also consultants. These interviews were recorded for review and transcription later. Interviews primarily focused on program organization, local context, collaboration and relationships. Data were collected on administrator experience and background, job satisfaction, program goals and role, program strengths, challenges, overall program success, program decision-making, balancing programmatic and child/family-centered consultations in the program, perceptions of local need, collaboration with other local early childhood agencies, other CCEP programs and understanding of the cornerstones of CCEP practice.

After these two contextual interviews, case-focused semi-structured interviews (27) were conducted in-person or by telephone with the consultant, parent, provider(s) and center administrator, if applicable. Interviews explored perceptions of the consultation process, outcomes, and fidelity to the process with respect to the target cases.

2.6.3. Analyses

The content of interviews was coded and thematically organized. Interviews were also structured to provide a profile of the key characteristics in each case, including individual child, mother and provider quantitative outcome scores from the wider evaluation (Appendix C, Case Studies). The purpose of including individual scores was to demonstrate the diversity of cases served and to provide a sense of varying outcomes that were associated with each case. These child profiles and a table outlining key themes from interviews are included in Appendix C. Quotes from the case study component of the evaluation are used throughout this report to illustrate key points.

2.6.4. Sample

Table 2.4 presents a brief summary of the characteristics of the case studies (names associated with each case are pseudonyms). Eight were from childcare centers, and the ninth was from a family day care provider.

Table 2.4 Characteristics of Case Studies

Name	Child Gender	Age in months	Behavior challenges	Household	Involvement with Other agencies	Interview	Outcome
Dylan	M	60	Listless, withdrawn. Mom leaving for army for 3- month absence.	Mother, stepfather	No	5 (C, M, D, P[2])	Adjusted, moved on to kindergarten.
Sophia	F	40	Defiant, aggressive. Mother depressed, self-harm witnessed by Sophia	Single mother, boyfriend, younger sibling.	No Insurance. Offered but did not receive services for sibling from not-for profit agency	2 (C, P)	Mom lost job. Child withdrawn from daycare, went to Head Start.
Jason	M	71	Head-banging, tantrums.	Single mother	School district services daily, Wraparound services, Psychiatrist. History of Child Protective Services (CPS)	3 (C, M, P)	Reduced intensity.
Ryan	M	51	Tantrums, screaming.	2 bio parents, Twin brother (fraternal) also in day care center	No	3 (C, M, P)	Reduced intensity, went to elementary school.
Kayla	F	41	Age-inappropriate defiance, hyperactive, adjustment to transitions.	2 Adoptive parents, older brother	No	3 (C, M, P)	Changed parent/provider behavior.

Name	Child Gender	Age in months	Behavior challenges	Household	Involvement with Other agencies	Interview	Outcome
Nathan	M	49	Biting, hitting, inappropriate physicality, developmental delay	2 Bio parents, brother	ISD, psychiatric assessment	3 (C, M, P)	Changed parent/provider behavior. Child matured.
Madison	F	60	Tantrums, disruptive.	2 Bio parents	No	1 (C)	Kindergarten.
Hannah	F	42	Aggression.	Single mom	Play therapist, Psychologist	3 (C, M, P)	Moved.
Daniel	M	48	Aggression, sexualized behavior, self- destructive.	Single mom	Wraparound services. History of CPS while receiving CCEP services	4 (C, M, P, D)	Expelled.

Note. C = Consultant, M = Mother, P = Provider, D = Center Director.

2.7. Analytic Approach

For most chapters, analyses are presented as follows:

- **Descriptives.** Means, standard deviations, and frequencies are presented for the CCEP group.

- **Change in the CCEP group.** Results of dependent paired-t-tests or chi-square analyses are presented for (a) change from Time 1 to Time 2 and (b) Time 1 to Time 3 for the subsample that had Time 3 data. Statistical significance tests permit assessment of the likelihood of whether a result can be considered "true," but findings sometimes can be statistically significant when they are very small and effectively meaningless. For that reason, we also present effect sizes (Cohen's *d*). Effect sizes measure the strength of the relationship between two variables—here, change between one time and another. Typically, the effect size measure used here is interpreted as small if around .20 or .30, medium if around .50, and large if around .80 or higher.

- **Change in the CCEP group associated with dosage.** Because eligible children could not be assigned randomly to the CCEP group or no service, we are unable to attribute any changes to the CCEP program directly. The changes evident over time may be due to maturation or other factors. One approach to address this problem is to examine links between dosage of CCEP services and change over time. This approach is based on the assumption that more services will lead to greater impacts. To assess this question, multiple regression analyses were conducted in which hours of face-to-face consultation with providers and parents were examined to see if they predicted outcomes after controlling for (taking out the effect of) scores at previous time points and child age, child sex, center vs non-center-based care, and family low-income status. The effect size measure used in these analyses is the standardized beta (*β*). The interpretation is that for every hour of dosage, the outcome will change by beta. A general rule of thumb of this effect size for social science data such as presented here is that .10 to .23 is small, .24 to .36 is medium, and .37 and above is large.

- **Comparison of CCEP and comparison group.** Another approach to clarifying whether any changes were attributable to CCEP was to examine whether children receiving CCEP services improved more than children in the comparison group. Using the matched-comparison sample,

repeated measures analysis of covariance (ANCOVAs) were conducted with child age, child sex, center vs non-center-based care, and family low-income included as covariates to equalize the effect of differences between groups. Although equal numbers of CCEP and comparison cases were in this data set as a whole, not all parents and providers reported data for all measures. Sample sizes therefore vary. For these analyses, the effect size is the partial eta-squared (partial η^2) for the time x group effect. This type of effect size is interpreted as .01 is small, .06 is medium, and .14 is large.

- **Case studies.** Case study quotes are inserted to illustrate findings. Full case studies are found in Appendix C.

2.8. Limitations

A number of study limitations are important to consider when interpreting the findings of this evaluation. First, the lack of a randomized control group prevents firm conclusions about the role CCEP services play in improving the lives of those children who are at-risk for preschool expulsion. Without random assignment to a 'no treatment' or a 'control' condition, which was deemed not to be feasible for ethical and practice-based reasons, it is impossible to know if results are due to extraneous variables unrelated to CCEP services. While a matched comparison group was utilized in an effort to rule out maturational changes in this age group and other differences, the size of the sample limits the generalizability of findings. Additionally, because the matched comparison samples were somewhat different than the CCEP group as a whole, the results of the longitudinal CCEP analyses and the comparison analyses are generalizable to different populations. Differences in communities or counties in which our comparison group was recruited could also help to explain the changes found in this study, when compared to children from counties in which CCEP services exist.

The inclusion of multiple raters was a strength, reflecting the different contexts within which children act and the varied pressures that those contexts place upon them. At the same time, reports from multiple raters means that it can sometimes be difficult to make sense of the findings when disparate perceptions emerge between parents and providers. Moreover, the lack of provider data over three time points, and changes in providers, classrooms, and settings over time limited our ability to assess longer-term changes in provider perceptions and outcomes, although providers were the primary point of contact. In general, a considerable amount of data was missing across both CCEP and comparison cases, highlighting challenges in conducting applied research within communities.

Although observational data of provider-child interactions and childcare setting processes and procedures is an important tool for understanding process and change in outcomes, it was not financially feasible to collect such data outside of the case studies. Without having collected this objective CCEP intervention fidelity and implementation data, uncertainties remain as to what exactly led to the improvements and changes reported. Although case studies aimed to contribute somewhat to this understanding and provided triangulation of many results, by necessity the scope of this evaluation focused primarily on measurable results with only limited, supporting qualitative material.

CHAPTER 3. CHILD OUTCOMES

3.1. Summary of Findings

This section describes the measures and results used to understand how CCEP services impact child outcomes, specifically reduction of behavioral problems and promotion of children's strengths and competencies both immediately after services are provided and after a period of time following services. The questions addressed in Chapter 3 correspond to specific questions from the evaluation and findings are summarized below:

1. Does the severity of children's challenging behavior decrease from the onset of CCEP services to the conclusion of services?

- Parents of CCEP children reported greater improvements in hyperactivity, attention problems, and social skills than parents of comparison children. Providers of CCEP children reported greater improvements in hyperactivity than providers of comparison children. All were small- to medium-sized effects.

- Children in both CCEP and comparison groups showed significant declines in problem behavior over time, most likely due to maturation. Most effects were medium to large.

- More hours of consultation did not predict greater improvement in behavior problems at the end of services. More consultation with parents was associated with a small effect for higher levels of parent-reported behavior concerns at follow-up. It is possible that parents who received CCEP services became more sensitive to their children's behavior and the implications of those behaviors.

2. Does children's social and emotional health increase from the onset of CCEP services to the conclusion of services?

- Parents of CCEP children reported greater improvements in social skills than parents of comparison children. No differences emerged for CCEP and comparison group provider reports of positive behaviors.

- Children in both CCEP and comparison groups showed significant increases on other measures of positive behavior over time. All effects were large.

- More hours of consultation with providers were associated with a small effect for improvements in functional communication skills. Dosage was not linked to improvements in other positive behaviors.

3. Does the impact of services on children's behavior last past services?

- In the CCEP group (the comparison group did not have Time 3 data), most of the behaviors continued to show small to moderate improvements except for attention problems, which returned to previous levels.

- More hours of consultation with parents (providers did not have follow-up data) were associated with parent reports of small effects denoting higher levels of behavior problems and lower levels of positive behaviors. It is possible that parents who received CCEP services became more sensitive to their children's behavior and the implications of those behaviors.

4. Do children receiving CCEP services successfully stay in childcare vs being expelled?

- Removal of children from the original childcare setting was associated with lower income, non-center-based care, less consultation, and provider-parent relationships that parents saw as worsening and providers saw as poorer from the start. Perceptions of the consultant and the CCEP process did not differ for providers and parents of children retained vs removed.

- No significant differences in retention vs removal were evident between the CCEP and comparison group, although comparison group children tended to be more likely to be retained. However, we have strong concerns about the validity of the comparison data for assessing differences in retention and removal.

3.2. Measures

In order to evaluate both the short and long term behavioral outcomes associated with interventions carried out within the CCEP model, multiple measures of child-level behavioral change were targeted within the evaluation plan. In addition, these measures were collected from both providers and parents in order to obtain the perspectives of both the child's primary caregiving settings.

To avoid overburdening the CCEP consultants, measures in which consultants were trained and regularly used as part of their everyday evidence-based assessment procedures were included as evaluation measures. This included the *Devereux Early Childhood Assessment* (DECA), *DECA-Infant-Toddler Version* (*DECA-IT; Mackrain, Powell, & LeBuffe, 2007*) and a *Problem Description Key* developed by Michigan CMH. In addition, subscales from the *Behavior Assessment System for Children-Second Edition* (BASC-2) were utilized to garner a greater level of treatment sensitivity with respect to changes in both adaptive and maladaptive behaviors. Finally, questions about retention, placement, and expulsion were asked to determine whether CCEP services helped retain children within their childcare setting.

Devereux Early Childhood Assessment (DECA; LeBuffe & Naglieri, 1999). The DECA is a nationally-normed behavior rating scale that evaluates within-child protective and risk factors in preschool children, ages 2-5 years. The DECA is especially well suited to target and monitor the promotion of positive behaviors. Comprised of 37 items, this instrument was completed by parents and providers. The DECA evaluates the frequency of 27 positive behaviors (i.e., strengths) across three subscales (i.e., Initiative, Self-Control, Attachment). It also contains a 10-item problem behavior screen. The DECA has strong psychometric properties and the standardization sample consists of 2,000 preschool children which accurately reflect the diversity of preschool children in the United States (LeBuffe & Naglieri, 1999; LeBuffe & Shapiro, 2004). The DECA has been found to link well with Head Start Standards and state guidelines (e.g., WA, MO, AZ, TX) for school readiness (S. Damico, personal communication, Dec. 27, 2006). The DECA-IT (Infant-Toddler: Mackrain, Powell, & LeBuffe, 2007) versions (Infant: ages 4 weeks to 18 months; Toddler: ages 18 to 24 months for this evaluation) were used with children under 2 years of

age. Both of those versions have at least two protective subscales (Initiative and Attachment) and an overall Total Protective Factor scale. Neither of the early age versions of the DECA have a Behavior Concern scale. The Infant version does not have items pertaining to a Self-Regulation subscale.

Behavior Assessment System for Children-2 (BASC-2; Reynolds & Kamphaus, 2004). Because the small number of behavior problem items on the DECA had the potential to limit sensitivity to treatment effects on challenging behavior, the BASC-2 was also completed by teachers and parents. The BASC 2 is a norm-referenced rating scale and four subscales from this measure were used to measure two problem behaviors (attention problems, hyperactivity) and two adaptive or protective behaviors (social skills, functional communication). Teacher and parent versions of the BASC-2 indicate these subscales to have strong reliability and validity (Bergeron, Floyd, McCormack, Farmer, 2008; Myers, Bour, Sidebottom, Murphy, & Hakman, 2010; Reynolds & Kamphaus, 2004)

Problem Description Key (CCEP Program Form). The Problem Description Key was a regular part of consultant reporting and was completed by consultants at intake and exit. It was comprised of five categories of problematic behavior: Aggression (e.g., biting, hitting, kicking); Regulatory (e.g., difficulty adjusting to transitions, tantrums, sleep/feeding/toileting difficulties); Developmental (e.g., clingy, withdrawn, crying for parent, poor social skills, impulsive, cognitive delay); Sensory Integration (e.g., perseveration, sensitivity to noise/touch, repetitive speech); and Physical (e.g., hearing/language issues, gross/fine motor); and other behaviors (e.g., sexual acting out, fearful, bizarre behaviors, sad affect, oppositional/defiance). A sixth category, Externalized Behavior Not Otherwise Specified, was not used in analyses because it had a mix of both internalizing and externalizing behaviors and only three children had no other categories rated.

Each behavior category had several behaviors listed within the category. After discussions with providers and parents, consultants circled the behaviors within the categories identified as reasons for referral and indicated the intensity of the behavior for the provider and parent on a scale of 1 (mild) to 5 (extreme). For these analyses, the highest intensity rating for a behavior within a category was used as the category score. For example, for the Aggression category, if a child was rated as having an intensity score of 5 for biting, 1 for spitting, and 3 for scratching, he/she received a score of 5 for Aggression.

Summary of Services Form (CCEP Initiative). To measure retention success, one item on the CCEP Summary of Services Form, an instrument completed by consultants as part of their regular CCEP procedures, was used to collect information on the status of the child's childcare placement.

3.3. Results

3.3.1. Descriptives

Descriptive data for key child outcome measures in the CCEP group are summarized below. Table 3.1 presents means and standard deviations for providers and parents with Time 1 and Time 2 data; Table 3.2 presents the means and standard deviations for the parent group that had Time 3 (follow-up) data; and Table 3.3 outlines the childcare status of children following CCEP services.

Table 3.1 Means (SD) for Problem Behaviors in CCEP Group, Time 1 and Time 2 (Provider and Parent Report)

| | Mean (SD) | | | |
| | Provider | | Parent | |
Behavior scale	T1	T2	T1	T2
Behavior problems				
DECA behavior concerns	64.1 (7.7)	61.0 (8.6)	65.8 (8.3)	62.1 (9.0)
BASC hyperactivity	14.7 (6.0)	12.2 (6.2)	16.7 (6.1)	13.6 (5.6)
BASC attention problems	11.8 (3.2)	10.3 (3.8)	9.8 (3.3)	8.4 (3.2)
Problem grid				
Aggression	2.7 (2.1)	1.6 (1.8)	1.9 (1.9)	1.0 (1.4)
Developmental	3.0 (2.0)	1.9 (1.8)	2.5 (2.0)	1.5 (1.6)
Regulatory	2.6 (2.2)	1.6 (1.8)	2.2 (2.1)	1.2 (1.6)
Physical	.5 (1.3)	.4 (1.1)	.4 (1.1)	.2 (1.1)
Sensory integration	1.0 (1.8)	.8 (1.5)	.8 (1.6)	.5 (1.1)
Positive behaviors				
DECA total protective factors	39.5 (8.6)	44.5 (10.8)	41.0 (9.9)	46.1 (10.7)
BASC functional communication skills	10.5 (6.0)	13.1 (5.9)	16.7 (7.4)	19.3 (6.8)
BASC social skills	5.6 (3.9)	7.8 (4.4)	14.7 (5.3)	16.6 (5.3)

Note. Provider N = 190, parent N = 256.

Table 3.2 Means (SD) for Problem Behaviors in CCEP Group, Time 1, Time 2, and Time 3 (Parent Report)

| | Mean (SD) | | |
Behavior scale	T1	T2	T3
Behavior problems			
DECA behavior concerns	65.7 (8.7)	61.2 (9.8)	60.1 (9.3)
BASC hyperactivity	16.6 (6.0)	13.9 (5.8)	12.8 (5.5)
BASC attention problems	9.6 (3.3)	8.2 (3.2)	9.5 (3.5)
Positive behaviors			
DECA total protective factors	40.6 (8.9)	46.2 (10.7)	47.9 (11.0)
BASC functional communication skills	16.8 (7.4)	19.8 (6.8)	21.5 (7.0)
BASC social skills	14.6 (5.2)	16.5 (5.3)	17.2 (5.5)

Note. Problem grid data were not available for most children at Time 3. N = 136.

Childcare status. Data about childcare status at the end of CCEP services was available for 297 children (82%). The percent of children according to childcare status are presented in Table 3.3.

Table 3.3 Childcare Status Following CCEP Services

Placement	%
Same provider	60%
Educational setting for special needs	1%
New provider by parent choice	10%
Expelled	7%
Graduated to preschool or kindergarten	11%
Home with parent (quit/lost job, financial reasons)	3%
Moved	1%
Other	7%

Note. N = 297.

3.3.2. Change in the CCEP Group

This section addresses evaluation questions 1, 2, and 3: Do child behaviors improve by the end of CCEP services and are they maintained 6 months later?

Time 1 to Time 2. Paired t-tests assessed change in child behavior problems pre- and post-CCEP services for the mean scores shown above. Effect sizes are presented in Table 3.4. The results indicate that all changes were statistically significant. Both providers and parents reported significant moderate to large decreases from T1 to T2 on each challenging behavior scale and large increases on each positive behavior scale. The only exceptions were for Physical and Sensory Integration problems; providers reported small decreases for both, and parents reported small to moderate decreases in Physical problems and moderate decreases in Sensory Integration problems.

Table 3.4 Effect Sizes (*d)* for Provider and Parent Reports of Change in Child Outcomes from Time 1 to Time 2

Behavior scale	d	
	Provider	Parent
Behavior problems		
DECA behavior concerns	-.57***	-.67***
BASC hyperactivity	-.66***	-.82***
BASC attention problems	-.70***	-.67***
Problem grid		
Aggression	-.89***	-.80***
Developmental	-.96***	-.88***
Regulatory	-.93***	-.93***
Physical	-.20**	-.42**
Sensory integration	-.27**	-.63***
Positive behaviors		
DECA total protective factors	.86***	.79***
BASC functional communication skills	.87***	.92***
BASC social skills	.85***	.65***

Time 1 to Time 3. Paired t-tests assessed change between all time points in the parent sample that had follow-up data. Effect sizes are presented in Table 3.6. As above, parents reported moderate to large improvements on all scales. By follow-up, further small improvements were reported on most scales, and BASC functional communication skills showed a moderate increase. However, BASC attention problems showed a small rise by follow-up. Ultimately, DECA behavior concerns, BASC hyperactivity, and all positive behavior scores evidenced large improvements from the beginning of CCEP services to follow-up, while BASC attention problems ended up level with the initial score.

Table 3.5 Effect Sizes (*d)* for Parent Reports of Change in Child Outcomes from Time 1 to Time 3

	d		
Behavior scale	*T1 to T2*	*T2 to T3*	*T1 to T3*
Behavior problems			
DECA behavior concerns	-.81***	-.19*	-.94***
BASC hyperactivity	-.70***	-.28*	-1.17***
BASC attention problems	-.61***	.30*	-.02
Positive behaviors			
DECA total protective factors	.85***	.25*	1.11***
BASC functional communication skills	1.09***	.58***	1.46***
BASC social skills	.65***	.21	.83***

Note. Problem grid data were not available for most children at Time 3. Effect size Cohen's *d* interpretation: .30 = small, .50 = medium, .80 = large. *d* is corrected for dependence. Negative numbers indicate score decreased over time. N = 136.
*$p < .05$. ***$p < .001$.

Conclusions. These results appear to indicate that the majority of changes reported at the conclusion of CCEP services were maintained or indicated further improvement at the follow-up phase of data collection. The study design and the limitations of these analyses, however, do not allow us to conclude that these changes can be attributed to CCEP services. Instead, issues related to maturation, regression to the mean, or other threats to the validity of the results must be considered as an alternative interpretation of study results. To address this limitation, two approaches were used: (a) assessment of whether children with higher dosage (i.e., more service) showed greater improvements than children with lower levels of service; and (b) whether children in the CCEP group showed greater improvements than children in the comparison group.

3.3.3. Change Related to Dosage in the CCEP Group

Time 1 to Time 2. As shown in Table 3.6, the effect of dosage was non-significant for nearly all child outcomes. Only BASC functional communication demonstrated a significant and small effect, indicating that each hour of consultation with providers increased providers' ratings of the child's functional communication by .14 point.

Table 3.6 Effect Sizes (β) for Dosage Predicting Provider and Parent Reports of Change in Child Outcomes from Time 1 to Time 2

	β			
	Provider		*Parent*	
Behavior scale	*Hours with provider*	*Hours with parent*	*Hours with provider*	*Hours with parent*
Behavior problems				
DECA behavior concerns	-.08	-.00	-.03	.09[t]
BASC hyperactivity	-.01	-.07	.01	-.01
BASC attention problems	-.06	.05	.02	.04
Problem grid				
Aggression	.05	-.06	.05	.02
Developmental	.03	.02	.04	.08[t]
Regulatory	.02	.03	.01	.07
Physical	-.06	-.07	-.01	-.05
Sensory integration	.01	.03	.05	.00
Positive behaviors				
DECA total protective factors	.02	.01	.05	.00
BASC functional communication skills	.14**	.04	.05	-.07[t]
BASC social skills	.07	.00	.08	-.08[t]

Note. β interpretation: 10 to .23 = small, .24 to .36 = medium, .37 and above = large. Provider N = 190, parent N = 256.
[t]$p < .10$. **$p < .01$.

Time 1 to Time 3. Table 3.7 shows the findings for dosage predicting change in child outcomes, but whereas the section above gives results for Time 1 to Time 2, Table 3.7 gives results from Time 1 to Time 3 with the smaller sample of parents who had Time 3 data. Results for the smaller sample were similar to those of the larger sample from Time 1 to Time 2; significant small effects emerged for linkages between hours of consultation with parent on DECA behavior concerns, DECA total protective factors, and BASC social skills. However, the findings were the reverse of those expected by Time 3; parents who received more hours of consultation reported more behavior concerns and less positive behavior at follow-up.

Conclusions. Hours of consultation were not directly related to most provider reports of child behaviors, while hours of consultation with parents were associated with parent reports of more behavior problems at follow-up. It seems unlikely that more consultation produces more challenging behavior; one interpretation of the findings is that parents who participate more in consultation are more aware of and sensitive to their children's behavioral needs and rate them more accurately than parents who receive less consultation. In addition, children receiving more dosage typically had more behavioral

challenges; it is possible that this affected parents' perceptions, especially following exit from services and subsequent lack of ongoing consultant support.

Table 3.7 Effect Sizes (β) for Dosage Predicting Parent Reports of Change in Child Outcomes from Time 1 to Time 2 and Time 3

	β			
	Predicting Time 2		*Predicting Time 3*	
Behavior scale	Hours with provider	Hours with parent	Hours with provider	Hours with parent
Behavior problems				
DECA behavior concerns	-.07	-.00	.12	.16*
BASC hyperactivity	-.05	-.01	.07	.07
BASC attention problems	-.03	.07	-.14[t]	-.06
Positive behaviors				
DECA total protective factors	.11	-.04	-.07	-.15*
BASC functional communication skills	.06	-.03	-.06	-.06
BASC social skills	.11	-.09	.04	-.16*

Note. β interpretation: 10 to .23 = small, .24 to .36 = medium, .37 and above = large. N = 136.
**$p < .01$. ***$p < .001$.

3.3.4. CCEP Group vs Comparison Group

Descriptives. Means and standard deviations for the CCEP and comparison cases in the matched comparison data set are presented in Table 3.8, where we can see that the pattern of scores is such that both CCEP and comparison children improved over time on most measures. These data, however, do not take into account differences in demographic characteristics or test whether the degree of change over time differs. The next section addresses whether group differences were statistically significant.

Tests for group differences. As shown above, children in both groups generally improved in behavior over time, most likely due to maturation. However, Table 3.9 shows that parents in the CCEP group reported larger improvements over time than parents in the comparison group in hyperactivity, attention problems, and social skills. Additionally, providers in the CCEP group reported greater improvements in hyperactivity over time than providers in the comparison group. All were small to medium-sized effects.

Conclusions. Overall, the results suggest that CCEP effects are linked more to reduction in problem behavior than increases in positive behavior. While only one result for providers emerged as significant, the sample size of comparison group providers was very small (N = 20); a larger sample is desired to get a better understanding of differences in provider perceptions of behavior change.

Table 3.8 Means (SD) for Problem Behaviors in CCEP and Comparison Group, Time 1 and Time 2 (Provider and Parent Report)

	Mean (SD)							
	Provider				Parent			
	CCEP		Comparison		CCEP		Comparison	
Behavior scale	T1	T2	T1	T2	T1	T2	T1	T2
Behavior problems								
DECA behavior concerns	65.2 (7.6)	59.1 (10.1)	62.1 (10.4)	55.5 (7.9)	64.8 (8.4)	61.3 (8.7)	66.2 (7.9)	62.2 (8.8)
BASC hyperactivity	14.8 (6.8)	11.7 (7.1)	9.0 (6.9)	9.7 (6.4)	16.7 (6.4)	12.9 (6.0)	15.5 (6.0)	14.2 (5.7)
BASC attention problems	11.6 (4.1)	10.1 (4.3)	7.8 (5.6)	7.2 (4.4)	10.0 (3.6)	8.5 (3.3)	8.0 (3.9)	8.2 (3.2)
Positive behaviors								
DECA total protective factors	38.7 (8.9)	45.0 (12.4)	47.5 (11.1)	51.9 (10.7)	39.8 (10.9)	44.8 (9.7)	41.1 (9.8)	44.0 (8.4)
BASC functional communication skills	10.5 (7.0)	13.8 (6.8)	12.0 (8.3)	16.2 (8.2)	15.1 (7.7)	18.2 (8.2)	16.2 (7.1)	18.6 (7.3)
BASC social skills	5.1 (4.7)	13.4 (5.7)	9.0 (6.3)	10.7 (4.6)	13.4 (5.7)	15.9 (5.7)	15.5 (4.1)	16.3 (4.8)

Note. CCEP group: Provider N = 48, parent N = 60; Comparison group: Provider N = 20, parent N = 72.

Table 3.9 Effect Sizes (partial η^2) for Differences in CCEP and Comparison Group Provider and Parent Reports of Change in Child Outcomes from Time 1 to Time 2

| | η^2 | |
Behavior scale	Provider	Parent
Behavior problems		
DECA behavior concerns	.00	.00
BASC hyperactivity	.08*	.06**
BASC attention problems	.01	.05*
Positive behaviors		
DECA total protective factors	.01	.01
BASC functional communication skills	-.02	.00
BASC social skills	.01	.04*

Note. Effect size partial η^2 interpretation: .01 = small, .06 = medium, .14 = large. Negative numbers indicate comparison group improved more than CCEP group. Provider reports: CCEP group N = 48, comparison group N = 20. Parent reports: CCEP group N = 60, comparison group N = 72.
*$p < .05$. **$p < .01$.

> **Case study.** The following quotes illustrate two parents' perceptions of how behaviors have changed in children targeted for CCEP services.
>
> *"Ryan's whole attitude has improved. I mean, he doesn't have the tantrums he used to have. We had a problem with screaming. He still does it once in a while, but not like he did. But everything that he was doing, where I would say it would be at a 10, where it was really terrible, I would say had come right on down to a 3 or 4. He has his days but for the most part, it's vastly improved."*
>
> Ryan's mother talks about the decrease in the severity of his challenging behaviors. As described by his mother, Ryan was aggressive and frequently throwing tantrums. CCEP worked with the family and provider to encourage cooperation between them, promote consistency across settings, set up clearer boundaries and have a better understanding of his developmental needs for less stimulation in particular spaces.
>
> *"He is back to Dylan. That's as far as I can put it. He's very talkative. Loves to come up and talk to you as soon as you walk into the room and let you know that he did something or went somewhere, so he's basically back to himself."*
>
> Dylan's mother reported that Dylan was suddenly very withdrawn and listless when he heard that she was due to go on 6-month active army duty away from home and his biological father was no longer in the home (Dylan stayed with his step-father). In this quote, the director at Dylan's childcare center talks about the social emotional readjustments he has made since CCEP involvement.

3.3.5. Retention in Childcare Setting

This section addresses evaluation question 4, whether the CCEP program reduced child expulsions. In the CCEP group, data were available about childcare status, as reported by consultants, at the end of services for 297 children. Of these 22% exited the childcare setting for non-behavioral reasons (e.g., moved, financial reasons, graduated). Of the remaining children, 78% stayed with the same provider, 1% moved to an educational setting for special needs, 13% moved to a new provider by parent choice, and 9% were expelled.

 "Success" is difficult to define with regard to childcare status. Placement in a different setting can be an appropriate outcome in some circumstances, and the reality of the decisions going into placement are often far more complex than can be represented in a single statement. Nonetheless, in order to conduct analyses about CCEP effects on reduction of expulsion, we created three categories for childcare status among the 78% of children who did not exit for non-behavioral reasons: (a) retention (same provider/move to educational setting for special needs; 79%); (b) new provider by parent choice (13%); and (c) expulsion (9%). The few cases placed in educational settings for special needs were included in retention because these placements were into more appropriate settings for these children and were facilitated by the CCEP process.

3.3.5.1. Differences by Exit Status in the CCEP Group

Demographics. The three groups were examined for differences on a variety of characteristics. The groups did not differ in age or gender. However, children moved to other providers or expelled were more likely to have families participating in low-income assistance programs (18% of lower-income children were removed by parent choice to other providers vs 10% of children in higher-income families; 14% of lower-income children were expelled vs 6% of higher-income children, $p < .05$). Additionally, children removed by parents to other providers tended to be more likely to attend non-center-based care (21% of children in non-center-based care vs 11% of children attending centers). Center providers expelled 8% of children, while non-center providers expelled 12% of children.

Dosage. No significant differences in dosage were evident among the three groups.

Provider-parent relationships. Parents of children in all three groups reported similar relationships with providers at the beginning of CCEP services. By Time 2, however, parents of expelled children showed small, significant declines in their reports of shared expectations with providers ($p < .05$) and tended to report declines in overall positive feelings about providers and in perceptions of the dependability of providers. At the same time, parents of expelled children reported significant medium-sized increases in the providers' sharing of emotions about the child; parents of retained children did not change over time, and parents who removed their children tended to report less sharing of emotions from providers over time. Parents of retained children and parents who moved their children to other providers did not differ in their feelings about the provider on other scales.

Providers' reports of their relationship with parents, including parents of children who were expelled, did not change in most ways, but providers did report small significant declines in positive feelings overall about parents who ultimately moved their children to other providers ($p < .05$).

Consultation process. Consultants, but not providers or parents, reported that consultation was a significantly less appropriate mode of intervention for children who were expelled than for those children who had switched providers or been retained. This may indicate that consultants at some point in the process realize that children who are at greatest risk for expulsion are in need of a more intensive level of direct service care than what can be provided through consultation to the provider and parent. Consultants and providers, but not parents, showed significant differences in their perceptions of the effectiveness of the consultation, with consultation seen as most effective for retained children, somewhat effective for children who were removed to other providers, and not very effective for children who were expelled. This finding provides further evidence for providers and consultants' recognition of the progress or lack of progress evidenced within the consultation process.

3.3.5.2. Exit Status in CCEP and Comparison Groups

In the matched comparison data set, information on exit status was available for 84% of comparison group children and 66% of CCEP group children. In the CCEP group consultants' reports, 73% of children were retained, 7% moved to another provider by parent choice, and 20% were expelled. In the comparison group's parent reports, 89% of children were retained, 12% were moved to a new provider by parent choice, and none were expelled. These differences were statistically significant, $\chi^2 = 10.98$, df = 1, $p < .01$, with fewer expulsions in the comparison group.

Conclusions. Although the pattern suggests that children tended to be retained more in the comparison group, we believe that this data should be considered with great caution. Even more than with

assessments of levels of behavior problems, random assignment is needed to equalize the various factors that contribute to a child being removed from the childcare setting. Comparison cases did not have consultants' reports; instead, parents reported on the child's placement at Time 2. In the full CCEP data set, consultants, providers, and parents differed on their reports of whether the child had been retained or removed, and we chose to use consultant reports as an outside observer. This difference raises substantial questions as to the validity of these results and calls for further investigation of this question.

Case Study. The case of Kayla provides an example of a child at risk of imminent expulsion and the contribution of CCEP services to her retention.

"Her teacher was just finished with her; finished with my daughter. Finished with trying to solve the problem. .. I was going to research other daycare places 'cause I didn't know if it was the environment or me or what but now it is much better and I'm not needing to do that".

Kayla's mother articulates her previous concerns about expulsion. She described her daughter as bright and active but also defiant, disruptive and aggressive with adults and children. Kayla's mother was a teacher and thought that it was a discipline problem, but the CCEP consultant worked with the parents and provider to help them reframe Kayla's behaviors and see them in terms of Kayla as an active child with high energy.

CHAPTER 4. PARENTAL OUTCOMES

4.1. Summary of Findings

This section describes the measures and results used to understand how CCEP services impact parent outcomes both immediately after services are provided and after a period of time following services. The questions addressed in Chapter 4 correspond to specific questions from the evaluation and findings are summarized below:

5. Do subjective feelings of parental competence in dealing with their child's challenging behaviors increase as a result of CCEP services?

- By end of services, parents in the CCEP group showed significant, moderate decreases in parenting stress and significant, moderate increases in empowerment in advocating for their children. These improvements were maintained through follow-up.

- More hours of consultation was not associated with greater improvement in parenting stress and empowerment.

- Parents in the CCEP and comparison groups did not differ in improvements in parenting stress; both groups decreased between Time 1 and Time 2. CCEP parents, however, showed a small significant advantage in increased empowerment for advocating for their children relative to the comparison group.

6. Are families able to consistently attend work or school?

- At Time 1, almost a third of CCEP parents had missed or been late to work due to childcare issues. By Time 2, the majority (63%) of these parents had not lost work/school time in the past month.

- More hours of consultation with CCEP parents tended to be associated with better work/school productivity by end of services.

- The CCEP and comparison groups did not initially differ in work/school productivity loss (28% and 24%, respectively). However, by Time 2, only 18% of parents in the CCEP group had work/school problems, while 100% of comparison parents did.

4.2. Measures

Feelings of parental competence were assessed via two measures, reflecting parenting stress and feelings of empowerment, as described next.

Parenting Stress Index/Short Form (PSI/SF). The PSI/SF (Abidin, 1990), used to assess parenting stress, contains 36 items divided into three 12-item subscales: Parental Distress (PD), Parent-Child Dysfunctional Interaction (P-CDI), and Difficult Child (DC). The Parental Distress (PD) subscale is designed to quantify the distress a person experiences, as a function of individual personal characteristics, in his/her role as a parent. The Parent-Child Dysfunctional Interaction (P-CDI) subscale taps the parent's perceptions that the child did not meet his or her expectations. Reliability estimates are high with Cronbach alpha coefficients of .83 for Parental Distress, .80 for Parent-Child Dysfunctional Interaction and .86 for the combined scales. The Difficult Child subscale was not used in the current evaluation. A total parenting stress score was derived from the PD and P-CDI subscales.

Skills and Knowledge subscale of the Psychological Empowerment Scale (PES). The PES measures dimensions of psychological empowerment of parents in advocating for their children and their children's needs. Parents completed the 8-item Attitudes and Knowledge subscales, which address parents' abilities to advocate for their children and work with child-serving professionals. Estimates of internal consistency reliability for the four subscales ranged from .84 to .94 in the original Akey (1996) study. Furthermore, this instrument has demonstrated convergent and discriminant validity through direct comparison with other measures of family empowerment (Akey et al., 2000). A total empowerment score was derived from the skills and knowledge subscales.

Work productivity. Loss of work/school productivity was measured by asking parents at pre- and post- to estimate the days of work/school lost or for which they had been late due to childcare issues in the past month. The majority of parents reported no days of work/school lost or late, with a range of 0 to 30 days. The variable was coded into 0 (none) or 1 (any). Data were not available on this variable for Time 3.

4.3. Results

4.3.1. Descriptives

Descriptive data for key parent outcome measures in the CCEP group are summarized below. Table 4.1 presents means and standard deviations for parents with Time 1 and Time 2 data; Table 4.2 presents the means and standard deviations for the parent group that had Time 3 (follow-up) data.

Table 4.1 Means (SD) for Parent Outcomes in CCEP Group, Time 1 and Time 2

	Mean (SD)	
Scale	T1	T2
Parenting stress	46.7 (13.4)	42.7 (13.0)
Empowerment	66.4 (7.6)	69.1 (7.4)

Note. N = 253.

Table 4.2 Means (SD) for Parent Outcomes in CCEP Group, Time 1, Time 2, and Time 3 (Parent Report)

	Mean (SD)		
Scale	*T1*	*T2*	*T3*
Parenting stress	46.5 (13.8)	42.5 (13.1)	43.0 (14.2)
Empowerment	66.1 (7.5)	68.7 (7.4)	68.7 (8.0)

Note. N = 138.

At Time 1, 31% had lost work/school productivity due to childcare issues; at Time 2, 21% of parents had lost work/school productivity (*N* = 253).

4.3.2. Change in the CCEP Group

Time 1 to Time 2. Paired t-tests assessed change in parent outcomes pre- and post-CCEP services for the mean scores shown above. The effect size *d* was .52, *p* < .001, for parenting stress was -.54, *p* < .001, for empowerment (*N* = 253). Both indicated a significant moderate improvement by the end of CCEP services.

For work/school productivity, among parents who reported missing or being late to work/school due to childcare issues prior to CCEP services, the majority (63%) no longer had these issues at Time 2; among parents who did not report productivity loss at Time 1, a small group (14%) did by Time 2. Differences from Time 1 to Time 2 were significant, χ^2 = 17.94, *df* = 1, *p* < .001.

Time 1 to Time 3. Paired t-tests assessed change between all time points in the parent sample that had follow-up data. Effect sizes are presented in Table 4.3. The results replicate those in the larger sample, with significant moderate improvements from Time 1 to Time 2. From end of services to follow-up, parent outcomes remained stable.

Table 4.3 Effect Sizes (*d*) for Change in Parent Outcomes from Time 1 to Time 3

	d		
Scale	*T1 to T2*	*T2 to T3*	*T1 to T3*
Parenting stress	-.51***	.06	-.42***
Empowerment	.57***	.00	.57***

Note. Effect size Cohen's *d* interpretation: .30 = small, .50 = medium, .80 = large. *d* is corrected for dependence. Negative numbers indicate score decreased over time. N = 138.
p < .05. ***p* < .001.

Conclusions. Parent stress and empowerment around advocating for children improved significantly from the beginning to the end of CCEP services and stayed stable through follow-up. Work/school productivity increased significantly among parents who reported problems at Time 1, while relatively few parents who reported no issues at Time 1 had problems at Time 2.

4.3.3. Change Related to Dosage in the CCEP Group

Time 1 to Time 2. Dosage was not significantly associated with change in parenting stress (β = -.03 for consultation with provider, β = .07 for consultation with parent) or empowerment (β = -.03 for consultation with provider, β = -.08 for consultation with parent, *N* = 253).

For work/school productivity, independent *t*-tests on the dosage scores of the 78 parents reporting productivity loss at Time 1 revealed no significant effect for hours of consultation with providers (*d* = .09, *p* = .67) and a small positive trend for hours of consultation with parents (*d* = .39, *p* = .09).

Time 1 to Time 3. As shown in Table 4.4, dosage did not predict changes in parent outcomes in the group of parents with follow-up data.

Table 4.4 Effect Sizes (β) for Dosage Predicting Parent Outcomes at Time 2 and Time 3

	β			
	Predicting Time 2		Predicting Time 3	
Scale	Hours with provider	Hours with parent	Hours with provider	Hours with parent
Parenting stress	.07	.03	-.06	.03
Empowerment	.00	-.10	.07	-.06

Note. β interpretation: 10 to .23 = small, .24 to .36 = medium, .37 and above = large. N = 138. **p < .01. ***p < .001.

Conclusions. More hours of consultation, on average, did not produce greater change in parent outcomes. The observed improvements in parenting stress and empowerment in advocating for their children were evident regardless of how much consultation took place. However, parents who had experienced the impacts of children's challenging behavior on work/school and who had more consultation showed a pattern of less impact on productivity by end of services. This trend toward dosage effects might have moved toward statistical significance had the sample been larger. Interestingly, as we describe in the following section, program effects were found such that parents who participated in CCEP reported greater improvements with regard to the effects of challenging behaviors on work/school productivity as compared to parents in the comparison group. In light of this finding, the positive trend for the relationship between increased hours of consultation and reductions in lost productivity is particularly encouraging and supports the interpretation that a small sample size may explain the lack of a significant dosage finding.

The lack of dosage effects on parenting stress and empowerment is puzzling. On the one hand, the slight improvements in parenting stress and empowerment may reflect change as a function of children's increasing age. As children mature, parents may feel less stress and greater feelings of empowerment in their roles as parents. Aside from these likely maturational changes in parent outcomes, it may be that large changes in parenting stress and empowerment involve processes that exceed and cannot be detected in the average 4.7 months of services and 11 hours of consultation that parents in the study received. This may be particularly true given that 45% of children in the CCEP program were aged four years or older and an additional 30% of children were three years of age. Hence, patterns of parental stress (which were measured as distress in the parenting role and perceptions that the child did not meet the parent' expectations) were likely years in the making. In general, parents of children with challenging behaviors may benefit from longer intervention efforts.

4.3.4. CCEP Group vs Comparison Group

Descriptives. Means and standard deviations for the CCEP and comparison cases in the matched comparison data set are presented in Table 4.5.

Table 4.5 Means (SD) for Parent Outcomes in CCEP and Comparison Group, Time 1 and Time 2

	Mean (SD)			
	CCEP		Comparison	
Scale	T1	T2	T1	T2
Parenting stress	48.7 (14.2)	44.4 (12.3)	51.9 (12.7)	47.6 (11.6)
Empowerment	65.3 (8.7)	67.8 (7.6)	67.0 (7.3)	67.0 (6.7)

Note. CCEP group: N = 61; Comparison group: N = 72.

Table 4.6 shows the percent of parents reporting missing or being late to work/school as a result of childcare issues. Notably, all comparison parents reported issues by Time 2. Most parents in both groups indicated that one day of work/school was affected.

Table 4.6 Percent of Parents Reporting Work/School Productivity Loss in CCEP and Comparison Group, Time 1 and Time 2

	%			
	CCEP		Comparison	
	T1	T2	T1	T2
Work/school productivity loss	28%	18%	24%	100%

Note. CCEP group: N = 61; Comparison group: N = 72.

Tests for group differences. There was no difference between the CCEP and comparison groups in change in parenting stress over time, η^2 = .00, p = 1.00. However, the CCEP group demonstrated a small effect[1] for significantly greater empowerment by Time 2 than did the comparison group, η^2 = .04, p < .05.

While the CCEP and comparison groups did not differ at Time 1 in work/school productivity loss (p = .64), by Time 2, the CCEP group reported significantly less work/school loss than the comparison group (p < .001).

Conclusions. Overall, the results suggest that CCEP effects are associated with improvements in parents' confidence and ability to advocate for their children and in reduced loss of time at work and school. Study findings also indicate that parenting stress associated with their child's challenging behaviors appears to naturally abate from high points. This is evident as reductions in parenting stress were found in both the group who received CCEP services and also within the group of parents involved as Comparison families.

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[1] Effect size partial η^2 interpretation: . 01 = small, .06 = medium, .14 = large.

Case study. The case of Kayla describes how CCEP consultants provided parents with strategies for managing challenging behavior.

"She (the consultant) just suggested heavy work; vacuuming, picking up big baskets and moving them, anything that would give that deep joint stretching. And now that I've learned a lot about her little sensory input and output, I can see how necessary they are for Kayla. I can take her out and ride her bike with her or run her around for a half an hour - our whole dinner time is so much better."

Kayla's mother gives an example of the ways in which CCEP services helped her manage her daughter's high energy and sometimes challenging behavior. Kayla did not focus long on any activities and did not rest at any time during the day. The consultant worked with Kayla's mother and provider to help them think about the ways in which Kayla's temperament, particularly her high energy level and short attention span, might contribute to her behaviors. Kayla's parents and her provider found new ways to involve Kayla in physical activities.

CHAPTER 5. PROVIDER OUTCOMES

Although the child and family are one of the primary targets of CCEP, CCEP consultants primarily work through childcare providers to support children who demonstrate a need for services. The impact of CCEP services on childcare provider competence, skills, and knowledge are consequently also of critical importance. Research has demonstrated that a number of childcare provider qualifications and characteristics are associated with program quality. For example, level of staff training is associated with the quality of interactions between practitioners and children in childcare settings (Elfer and Wedge, 1996). To promote healthy social-emotional development, relationships with young children should be characterized by 'consistency, sensitivity and responsiveness' (Mooney and Munton, 1997). Many providers have had little opportunity or resources to develop their skills and knowledge in childcare and are often ill-equipped to respond or manage children who may display disruptive behavior. In a Massachusetts study on the rates and predictors of preschool expulsion and suspension, program-level variables, such as program location, class size and having a higher proportion of 3-year-olds in the class, were identified as having a significant impact on outcomes (Gilliam & Shahar, 2006). Other characteristics such as improvements in job satisfaction, teacher stress and turnover are also associated with the ability of teachers to better manage challenging behavior in the childcare setting (Green et al., 2006).

5.1. Summary of Findings

Questions addressed in this section and findings are summarized below.

7. Is the childcare provider better able to recognize early warning signs of social and emotional challenges in infants, toddlers, and preschoolers?

- The majority of CCEP providers (65%) felt that they had room to improve their ability to recognize early warning signs. By the end of services, they reported better being able to do so, particularly those who felt they had the most room to improve.

- More hours of dosage was linked to better recognition of early warning signs. Comparison group data were not available for this measure.

8. Is the childcare provider better able to manage challenging behavior in the childcare setting, with all children?

- CCEP providers and administrators reported significant improvements in competence on the Goal Achievement Scale (GAS). Provider effects were large, and administrator effects were moderate. Providers did not report change in efficacy as measured by the Teacher Opinion Survey (TOS).

- Hours of consultation were not associated with more improvement in provider-reported competence on the GAS. However, administrators indicated that the providers increased in competence when *parents* received more consultation. Dosage did not predict improvement in TOS efficacy.

- CCEP providers reported greater improvements in GAS scores than did comparison providers; this was a medium-sized effect. The CCEP and comparison groups did not differ in changes in the TOS over time.

9. Has the social and emotional quality of the childcare setting receiving CCEP services improved?

- Most case study respondents discussed the potential for change in the context of new skills, knowledge, changed attitudes, and were influenced by the relationship between the provider and consultant.

- Case study respondents also discussed improvements in the social-emotional climate as occurring over time as opposed to an immediate improvement after CCEP consultation.

5.2. Measures

Early Warning Signs. A measure was developed for this evaluation to assess change in providers' perceptions of their skills and knowledge of social-emotional development in babies, infants and toddlers. At the end of consultation, providers were asked to rate 8 items regarding the extent to which their knowledge had changed after CCEP on a 3-point scale of *Same, Little More,* and *Lot More.* They also indicated how much knowledge they had before CCEP on a 3-point scale of *Little, Some,* and *Lots*; this scale was used as a covariate when appropriate. The mean score of all items was computed for analysis. The comparison group did not receive this measure because it specifically asked about change linked to CCEP.

Goal Achievement Scale (GAS; Alkon, Ramler, & MacLennon, 2003). The GAS was developed specifically to assess changes in teachers' competence as a result of interventions like CCEP. Provider and, if applicable, center administrators reported on behavioral changes in teachers' ability to manage children and work with families and assesses changes in center climate as well. Previous work found improvements in retrospective reports on the GAS after providers participated in a CCEP-type intervention. The GAS was used here as a pre-post measure, with providers completing it at the beginning and end of consultation. Thirteen items were rated on a 3-point scale of *Not at all*, *Somewhat*, and *Very much.* When administrators of the program were available, they also rated change in the provider's competence in working with children's challenging behavior on the GAS. Comparison providers also completed the GAS. The GAS was completed by providers and administrators as part of programmatic consultation as well.

Teacher Opinion Survey (TOS; Geller & Lynch, 1999). The TOS assesses the provider's feelings of efficacy related to caring for children in general, which are likely to affect her/his actual ability to manage children effectively. A few items specifically relate to efficacy in managing challenging behavior. Previous work assessing child mental health consultation interventions have shown significant improvements on the TOS (Bowman & Kagan, 2003). The TOS has two versions, one for providers serving children 0-2 years, 11 months (12 items), and one for providers serving children aged 3 years and older (11 items). Both asked providers to rate each item on a 5-point scale from *strongly disagree* to *strongly agree* at the beginning and end of consultation. Because items were conceptually the same on

both scales apart from one item, the versions were standardized to the same scale and analyzed together. Providers participating in programmatic consultation also reported on the TOS.

Case study interviews. Within the scope of this evaluation, it did not prove feasible to quantitatively measure quality of the day care settings at pre- and post. Instead case study interviews with consultants, providers and parents included specific questions about perceived changes in the quality of the childcare environment resulting from CCEP services. Data from these interviews is included.

5.3. Results

5.3.1. Descriptives

Descriptive data for key provider outcome measures in the CCEP group are summarized below. Table 5.1 presents means and standard deviations for providers with Time 1 and Time 2 data; Table 4.2 presents the means and standard deviations for the provider group that had Time 3 (follow-up) data.

Prior to CCEP services, the average provider score on knowledge of early warning signs was 2.33 (*SD* = .04). To put this into perspective, scores indicated that 29% of providers felt they had quite a bit of room for improvement prior to CCEP services, 36% felt they had a little room for improvement, and 35% felt they did not have much room for improvement.

Table 5.1 Means (SD) for Provider Outcomes in CCEP Group, Time 1 and Time 2 (Child-Family Consultation)

	Mean (SD)	
Scale	T1	T2
Knowledge of early warning signs	--	1.3 (.5)
Goal Achievement Scale – provider report	22.5 (2.7)	25.2 (2.5)
Goal Achievement Scale – administrator report	22.1 (3.2)	23.3 (2.8)
Teacher Opinion Scale	47.8 (4.4)	48.0 (4.6)

Note. N = 103 providers reporting room for improvement on knowledge of early warning signs, N = 189 providers for GAS and TOS, N = 194 administrators for GAS.

GAS and TOS data were also available for providers and administrators participating in programmatic consultation. Table 5.2 presents means and standard deviations.

Table 5.2 Means (SD) for Provider Outcomes for Programmatic Consultation

	Mean (SD)	
Scale	T1	T2
Goal Achievement Scale – provider report	21.6 (2.5)	25.0 (2.6)
Goal Achievement Scale – administrator report	22.0 (3.2)	23.6 (2.5)
Teacher Opinion Scale	46.6 (4.4)	47.6 (4.6)

Note. N = 44 providers for GAS, 43 providers for TOS, 42 administrators for GAS.

5.3.2. Change in the CCEP Group

Time 1 to Time 2. In the child-family consultation group, among those with room to improve on knowledge of early warning signs, the average score at end of services was equivalent to providers reporting that they had gained somewhat more knowledge. Providers who indicated that they were less knowledgeable about early warning signs at the beginning of CCEP services reported the greatest improvements in knowledge (β = .18, p < .05).

On the GAS, both providers and administrators reported significant increases in provider competence. The effect size d for providers' self-reports was large (d = 1.45, p < .001). Results for administrators' reports of change in provider competence was .57 (p < .001), a moderate effect. No significant differences were evident on the TOS (d = .06, p = .60).

Results for the programmatic consultation group generally replicated those of the child-family consultation group, but were stronger. Large significant effects emerged on GAS competence for providers (d = 1.89, p < .001) and administrators (d = .81, p < .001). TOS efficacy showed a small, nonsignificant effect (d = .29, p = .22), although this was larger than for providers receiving child-family consultation.

Conclusions. CCEP providers showed significant improvements in knowledge of early warning signs and competence, but not feelings of efficacy. This may be because providers were already fairly high in efficacy and had less room to improve.

5.3.3. Change Related to Dosage in the CCEP Group

Time 1 to Time 2. Providers who received more hours of consultation reported greater improvements in knowledge of early warning signs (β = .20, p < .05); more hours of consultation with parents, as expected, did not make a difference in providers' knowledge of early warning signs (β = -.02, p = .82). More hours of consultation with either providers or parents was not linked to more provider-reported competence on the GAS (β = .00 for consultation with providers, p = .98; β = -.08 for consultation with parents, p = .22). However, administrators reported that providers had gained more competence when parents (not providers) received more hours of consultation (β = -.03 for consultation with providers, p = .63; β = .18 for consultation with parents, p < .01). Dosage was not associated with improvement on the TOS. Dosage was not associated with change in any programmatic consultation provider outcomes (GAS provider report β = .02, p = .92, GAS administrator report β = .06, p = .60, TOS provider report = -.19, p = .22), but analyses were limited by the small sample size.

Conclusions. Providers who received more hours of consultation had greater knowledge of early warning signs for challenging behavior than those who received fewer hours. Administrators were more likely to view their providers as improving in competence when *parents* received more hours of consultation. The reasons behind this are not clear, but could be that administrators were more likely to get feedback from parents about provider improvements when parents were exposed to more consultation.

5.3.4. CCEP Group vs Comparison Group

Descriptives. Means and standard deviations for the CCEP and comparison cases in the matched comparison data set are presented in Table 5.3. Reports were available from only 20 providers in the comparison group. These results must, therefore, be reviewed with caution.

Table 5.3 Means (SD) for Provider Outcomes in CCEP and Comparison Group, Time 1 and Time 2

| | Mean (SD) | | | |
| | CCEP | | Comparison | |
Scale	T1	T2	T1	T2
Goal Achievement Scale – provider report	22.4 (3.0)	25.5 (2.5)	23.3 (2.1)	24.5 (3.1)
Teacher Opinion Scale	47.9 (4.4)	48.0 (4.5)	47.8 (4.4)	48.1 (4.2)

Note. CCEP group N = 67, comparison group N = 20.

Tests for group differences. The results showed a medium-sized effect for more improvement in provider reports of GAS competence (η^2 = .07, p = .05) in the CCEP group relative to the comparison group. Improvement in TOS efficacy scores did not differ over time for the two groups.

Conclusions. Provider reports of increased competence were more likely in the CCEP group.

Case Studies. Nathan's childcare provider talked about the impact of CCEP services on the way she managed challenging situations on a day-to-day basis.

"It has really helped us a lot, and [the consultant] has definitely helped us here deal with different situations, not necessarily ones where the CCEP would be involved but other ones where we ask ourselves, 'Does it need to go to that point or can it be handled this alternative way?', so it's really helped us a lot".

A family childcare provider who received CCEP services notes that she is more aware of "red flags" in behaviors that may indicate the need for additional support for the child.

"It's helped me—enlightened me that in some situations there are red flags with kids. Where before I probably would have thought, I hate to say this, but they're 'just being difficult,' but now that I know that [the red flags might mean that the] behavior could be an issue. Before I wouldn't have thought that there's more going on when children behave badly, but now I think more about what's behind it—whether it's their parents getting divorced—and they're struggling with a bad, hard time with it, so the consultant really helped me with things to recognize."

5.3.5. Changes in the Childcare Setting

This section uses case study data to address evaluation question 9 about improvements in the social and emotional quality of the childcare setting due to CCEP. Interviewees were asked direct questions about perceived changes in the quality of care as a result of CCEP intervention.

We found that responses were always framed within the context of applying new skills, knowledge and changed attitudes garnered from CCEP consultation about managing a particular child's behavior to future similar child cases or generalizing what was learned to changed classroom practices or organization. Interviewees often stressed the importance of the relationship between the consultant and provider in effecting classroom change. Consultants sometimes viewed broader changes to improve the general social and emotional quality of the childcare setting as a possible longer-term impact; they did not tend to see overall childcare quality as an immediate impact of their work, as it was far more common for them to work with a specific provider or teacher rather than across the full program, even in programmatic consultation. Table 5.4 illustrates some of the perceived changes reported by interviewees.

Table 5.4 Perceived Social-Emotional Classroom Changes Reported by Interviewees

Outcome	Example	Illustrative quote
More positive provider attitudes	Improved individualization	*"Because of what the consultant said, we also had Kayla be used a lot as a helper at school, and that really gave her that leadership role and she loved to help. So that kind of helped the classroom to help manage just her active style and that kind of thing."* -- Teacher talking about how classroom practice improved once they had changed their perceptions of Kayla as a 'disruptive' child to one of a very bright, active child with particular needs that they could help meet in the classroom.
Improved provider knowledge, skills & behavior leading to improved practice	Use of new positive guidance practices	*"I really did feel that providing for children and her interactions and everything definitely grew a lot, because providing childcare was a new experience to her, She had come from, I think , working in an office for several years and then made this shift when the company was struggling somewhat. And plus she wanted to be home with her daughter. So the whole arena of childcare was very new to her so some of her techniques were a little 'old-school' - like having the children stand in the corner or if she was gonna give them a 'time-out', it would just be maybe unreasonably long. And all that changed. I think that just, being able to get information sharing, a little coaching and guidance or whatever."* —Consultant talking about working with Sophia's childcare provider.
	Improved adult-child interactions	*"I've done some of the CCEP trainings and even just team building types of things with them as well. So I'm really connected with that staff and I definitely see changes with them—more listening to children as individuals, a higher level of patience with children. They're much more mindful of consistency in their care giving and also in their ability and willingness to*

Outcome	Example	Illustrative quote
		persevere and work with children and really kind of hang in there with them, rather than say, making comments like, 'The director just needs to get this kid out of here.' I mean, that's the kind of stuff that you would hear originally.... I've really seen a big difference in terms of bonding."— Consultant talking about the quality changes she perceives in the center since her involvement. This was despite one CCEP child's expulsion as his behaviors became increasingly sexualized and dangerous to others.
Longer-term changes to classroom environment	Integration of learning	*"it's always possible that at a later date, that some of the suggestions that I made get taken on board when they're seen as their own ideas or have become integrated into their way of thinking."*—Hannah's consultant talking about the potential longer term impact of her work.

CHAPTER 6. CCEP PROGRAM AND PROCESSES

Detailed responses to the following questions were presented in 2009 to MDCH in a set of Research Briefs (Appendix D). This section provides supplementary material to address the following questions:

10. What is the fidelity of the child and family consultation process among CCEP programs?

- On average, services lasted 4.7 months, with cases receiving an average of 11 hours of face-to-face service (not including phone and email contacts). However, there was substantial variation across cases for all measures of dosage.

- Cases associated with childcare centers tended to receive more hours of observation by consultants than did cases associated with group home or relative childcare.

- Most (91%) of the cases went through a formal intake and had observations completed by consultants in the childcare setting (92%); observation also occurred in the home in many cases (54%). Baseline assessment occurred in most cases (89%) primarily using the DECA surveys and less frequently other measures, such as the ITERS/ECERS.

- 72% of cases developed a written, jointly agreed Positive Child Guidance Plan and subsequently participated in activities that included provider and parent coaching and informal training. Relatively few cases (27%) had a later review of the guidance plan.

- Nearly half (49%) of cases received some type of referral. As shown in Table 6.3, the most common referral type was for child mental health services, followed by early intervention and special education services.

- Consultants provided some type of resource in 56% of cases. These were most likely to take the form of articles and/or books, which were provided to a quarter to nearly a third of parents and providers. Books were more likely to be recommended for parents than providers.

- Programs provided different average amounts of service. For example, while the programs delivered an average of 12 hours of face-to-face consultation to clients, one program delivered an average of 6 hours per client while another delivered an average of 27.6 hours per client.

11. What is the fidelity of the programmatic consultation process among CCEP programs?

- 58% of cases received some degree of programmatic consultation, most commonly in the areas of *Supportive Relationships* (51%) and *Activities and Experiences* (50%). This was followed by strategies targeting *Understanding* and *Using Strategies to Promote Socioemotional Development and Prevent Challenging Behavior* (44% & 45% respectively), *Partnerships with Families* (43%), *Daily Routine* (39%) and *Understanding the Importance of Child-caregiver*

Relationship (33%). Targeted less often were *Environment/Program* and *Resources*, reported in 27% and 22% of cases, respectively.

- The degree to which programmatic consultation was delivered varied substantially across consultants. Only three consultants (13%) provided no programmatic consultation.

A key component of confirming that the effectiveness of an intervention is due to the intervention itself, and not to other processes that might be occurring, is to assess the fidelity of the intervention—that is, to ensure that the intervention is being conducted as specified. Thus, a critical part of the proposed evaluation of the CCEP program was to assess the fidelity of the two consultation processes: child and family consultation and programmatic consultation. While the two types of consultation are conceptually different, in practice, other programs have noted that they frequently overlap significantly (Bowman & Kagan, 2003). The evaluation assesses fidelity from two perspectives:

- Service utilization, which allows examination of populations served and of "dosage"—types of services used and amount and duration of services provided for both the child and family consultation process and the programmatic consultation process.

- Process fidelity, which evaluates the degree to which CCEP consultants follow the principles and procedures outlined in the CCEP process chapters (5 & 6) for the child and family consultation process and the programmatic consultation process. Detailed findings on fidelity were derived from a 2007 survey of CCEP consultants and published in 2008 as a series of Research Briefs to MDCH (Appendix D).

The following questions were addressed relative to service utilization:

- What types of services were provided?

- What dosage, overall and of each service type, did children/families and providers/programs typically receive?

- How did service utilization vary across children/families and providers/programs?

- How did service provision vary across consultants/sites?

6.1. Measures

Consultants documented the minutes of services provided to each case on a Time Log form, indicated the types of services provided during the child and family consultation process using the Child-Family Consultation Codes Form and the Service Summary Form sheet, and reported services provided for programmatic consultation on the Programmatic Consultation Activity Codes form.

Time Log. Dosage was calculated through time logs employed for the evaluation. Consultants reported each contact with the case on the time log sheet and indicated the amount of time spent in 15-minute increments. Contacts were coded as face-to-face contacts or telephone contacts, and records noted the recipient of the contact (provider or parent). Minutes devoted to each contact were summed, resulting in the total hours of face-to-face dosage for total (provider and family combined), provider only and parent only. In addition, duration, hours of observation and the presence of a Positive Child Guidance Plan were documented.

Consultants also reported on the total number of hours they devoted to each case; however, correlations between the consultant-reported number of hours and the hours generated from the time log were not significantly associated. On the Summary of Services Form, consultants reported an

average of 24.7 (*SD = 74.5)* hours of "child-family consultation activity" per case. On the time log, consultants recorded an average of 19.3 (*SD =12.0)* hours of consultation, coded as face-to-face and phone consultation with providers and families as well as observation. While the reason is not clear for the difference in summary reports by consultants in comparison to the time logs, consultants may include travel time in their estimates on the summary of services form. Because the time log was maintained on an ongoing basis throughout the course of services, we expected that it provided a more accurate estimation of time than the consultant-reported total number of hours and used the time log data in analyses.

Child-Family Consultation Codes Form. Service use was measured through the CCEP Child-Family Centered Consultation Codes Form, in which consultants indicated which specific services that they provided for each child/family-centered consultation case. The form had four categories: (a) Referrals, which were coded into Early Care and Education, Early Intervention and Special Education, Children's Mental Health Services, Adult Mental Health and Substance Abuse Services, Physician/Public Health, and Other Services and Supports; (b) Positive Guidance Services, which encompassed most of the child-family consultation process, including Intake, Assessment, Positive Child Guidance Plan Development and Implementation, and Follow-Up/Conclusion; (c) Resources, such as toys, articles, and books provided to providers and parents; and (d) Written Reports to service providers, parents, or childcare providers.

Programmatic Consultation Codes Form. The Programmatic Consultation Codes Form, a standard part of the CCEP program, was used to report focal areas targeted during programmatic consultation as part of each case. The six categories of programmatic consultation included (a) Supportive Relationships, which addressed the ways that adults interacted with children to develop trust and security as well as ways that adults were supported around work relationships and personal issues that could impact care giving; (b) Partnerships with Families, comprised of strategies that childcare providers use with families to support children; (c) Activities and Experiences, or strategies for building opportunities for children to develop developmentally appropriate skills; (d) Daily Routine, addressing strategies to improve schedules, routines, and transitions; (e) Environment/Program, targeting physical space as well as overall policies and procedures; and (f) Resources, including strategies to support childcare programs by linking them to resources that could enhance quality and encourage sustainability. Each category outlined specific activities and strategies.

Summary of Service Form. CCEP Consultants used the Summary of Service Form to report on service activity for each case as part of the CCEP program. The form provided additional information on the frequency and focus of consultation and was used to supplement the above forms.

Consultant Survey. In spring 2008, an online survey of all consultants and supervisors was conducted to measure service use, fidelity and components of the consultation process and program organization. The survey was based on the content of chapters 5 and 6 of the CCEP manual describing required and recommended practices and was collaboratively developed by the research team and CCEP state-level TA consultants. This comprehensive survey addressed consultant demographics, experience, education and training; patterns of child-family and programmatic consultation activities; best methods for providing information to providers; consultants' roles and responsibilities and consultation process, including the use of evidence-based practices; access to and frequency of reflective supervision; collaboration with other early childhood organizations; job satisfaction, and the effectiveness of state-level training and technical assistance. The CCEP program subsequently experienced some turnover among consultants; therefore, not all consultants who reported cases were hired at the time of the survey. Consequently, the survey does not include responses from every consultant who contributed to

the child/family/provider dataset. Data are available for 29 consultants across the 16 programs, a response rate of 97%, with one consultant abstaining due to illness.

6.2. Results

6.2.1. Child/Family Centered Consultation Services Provided

Dosage. On average, services lasted 4.7 months, with cases receiving an average of 11 hours of face-to-face service (not including phone and email contacts). On average, providers received 6.7 hours of face-to-face consultation, while parents received less, 4.3 hours. Cases were observed, on average, for 5.8 hours. However, there was substantial variation across cases for all measures of dosage.

Table 6.1 Dosage of CCEP Services Received

Dosage type	M	SD	Range
Duration (months)	4.7	2.8	.5 – 18.1
Face-to-face contact (hours)			
Total	11.1	9.1	0 – 66.0
Provider	6.7	6.9	0 – 49.5
Parent	4.3	3.8	0 – 28.5
Observation (hours)	5.8	5.2	0 – 41.5

N = 361 children/families.

Positive Child Guidance Services. Positive guidance services constituted the main processes that constitute the CCEP program. Most (91%) of the cases went through a formal intake and had observation in the childcare setting (92%); observation also occurred in the home in many cases (54%). Assessment using the DECA surveys and occasionally other measures also occurred in most cases (89%).

Following this preliminary phase, 72% of cases moved into development and implementation of the Positive Child Guidance Plan. The remaining cases were referred to other services or had dropped out of services by this point. Cases with whom the Positive Child Guidance Plan was developed participated in provider and parent coaching and informal training. Relatively few cases (27%) had a later review of the guidance plan. Consultants attributed the low levels of review to satisfactory conclusion of services, drop out, or challenges in getting providers and parents together to discuss the plan. Fifty-eight percent of cases eventually participated in a formal conclusion of services.

Table 6.2 Percent of Cases by Positive Guidance Process

Positive guidance process	%
Intake	91%
Assessment	
Observation in childcare setting	92%
Observation in home	54%
Baseline surveys from provider and/or parent	89%
Positive Child Guidance Plan	
Development	72%
Coaching with provider	56%
Coaching with parent	49%
Informal training with provider	40%
Informal training with parent	37%
Team progress review and revision of plan	27%
Conclusion and follow-up	
Follow-up assessment	61%
Conclusion of services	58%

N = 337. Data were missing for 24 cases.

Case Studies. A family childcare provider described her CCEP consultant as an important resource for her:

"I could pick up that phone and call her [Consultant], and say, 'You know what, I don't know if this is something that is a concern or shouldn't be a concern or if I'm overanalyzing it,' so I could call her and ask her any questions, and she was very informative and very helpful and a great support."

A childcare center director reflected on the use of a Positive Child Guidance Plan to support the development of Jason, a young child with autism and complex emotional issues:

"I think what happened with Jason is that we finally have had enough time to spend with him, and people really devoted time trying to just kind of make his day successful and trying to figure out what we needed to put in place for him to be successful and also put in place for the staff so they felt successful with him, because there were days where I knew that they just wanted to look at me and say 'I'm not going to deal with him anymore.'"

The CCEP consultant brought the mother, provider and intermediate school district teacher together to exchange information and reframe the challenges they experienced. A Positive Child Guidance Plan was drawn up by provider, mother, and consultant together that identified specific tasks including helping the child manage transitions more smoothly, use language more effectively, and respond appropriately to interactions with peers. The mother and provider implemented the plan, but were unable to complete it when the mother received a salary increase with a promotion. The mother was no longer eligible for the childcare subsidy and could not afford the center. Jason was placed in the care of his aunt who had two young children of her own.

Referrals. Nearly half (49%) of the cases received some type of referral. As shown in Table 6.3, the most common referral type was for child mental health services, followed by early intervention and special education services.

Table 6.3 Percent of Cases by Types of Referrals Received

Referral type	%
• Child mental health services (assessment, home-based services, infant mental health, wraparound, child case management, play therapy, family therapy, special services, other)	26%
• Early intervention and special education services (Early On, early special education, Early Childhood Developmental Delay Program, other)	18%
• Early care and education services (Early Head Start, Head Start, MI School Readiness Program, other)	8%
• Therapeutic services (occupational therapist, physical therapist, speech/language therapist)	8%
• Adult mental health and substance abuse services (assessment, individual counseling)	5%
• Physician/medical services (Primary health care provider, developmental pediatrician, neurologist, public health)	5%
• Other services (Childcare resource and referral, MSU Extension, DHS--e.g., cash assistance, childcare subsidy, etc, domestic violence program, parent education and support services, infant massage, national and state associations/resource centers, other)	18%

N = 337. Data were missing for 24 cases.

Resources. Consultants provided some type of resource in 56% of cases. These were most likely to take the form of articles and/or books, which were provided to a quarter to nearly a third of parents and providers. Books were more likely to be recommended for parents than providers.

Table 6.4 Percent of Cases by Resources Provided

Resource	Providers	Parents
Toys	4%	4%
Articles	27%	29%
Books	23%	31%
Other	14%	13%

N = 337. Data were missing for 24 cases.

Written Reports. Consultants provided written reports in 20% of cases. Most of these were provided to the parent or childcare provider.

Table 6.5 Percent of Cases by Written Report Provided

Report target	Percent of cases
Parent	15%
Childcare	13%
Psychologist	2%
Head Start	2%
Early On	1%
Other	3%

N = 337. Data were missing for 24 cases. In a few cases, more than one report was provided.

Programmatic Consultation. Fifty-eight percent of cases received some degree of programmatic consultation. The most common programmatic consultation activities were in the areas of *Supportive Relationships* and *Activities and Experiences*, occurring in about half of cases. Across both, the most common strategies targeted were around understanding and using strategies to promote socioemotional development and prevent challenging behavior and to understand the importance of child-caregiver relationship. Consultants worked on *Partnerships with Families* in 43% of cases, helping to build and sustain strong partnerships between providers and family members. *Daily Routine* was targeted in 39% of cases, helping providers build in visual supports and use best practice during transitions. Targeted less often were *Environment/Program* and *Resources*, reported in 27% and 22% of cases, respectively, and which addressed policy modification and obtaining external resources.

Table 6.6 Percent of Cases by Programmatic Consultation Area

Activity	%
Supportive relationships	51%
• Coach to understand socioemotional development and challenging behavior	44%
• Coach to understand importance of child-caregiver relationship	33%
• Coach to support parent-child relationship	23%
• Coach to interact with children consistently in nurturing ways	20%
• Help caregivers with personal concerns that may affect relationships with children and adults	17%
• Coach to implement primary caregiving practices	13%
• Help strengthen work relationships	11%
Partnerships with families	43%
• Coach to build and sustain strong partnerships with family members	38%
• Coach to build ongoing system for exchanging info with parents	20%
• Coach to use culturally and linguistically competent practices with children and families	3%
Activities and experiences	50%
• Coach to use strategies that promote socioemotional development and prevent challenging behavior during activities and experiences	45%
• Coach to use strategies to address challenging behavior during activities and experiences	40%
• Coach to use curricula to promote socioemotional development	23%

Activity	%
• Coach to understand link between literacy and socioemotional development and help children understand language, use language, and use books	18%
Daily routine	39%
• Coach to use visual supports throughout care setting	26%
• Coach to use best practice re: transitions through the day (e.g., song to indicate clean-up time)	25%
• Coach to create a flexible, dependable schedule that supports the various needs of young children	20%
• Coach to promote socioemotional development by nurturing children during personal care routines	14%
Environment/program	27%
• Coach to make modifications to the physical environment	18%
• Help assess socioemotional environment using assessment scales or checklists	10%
• Coach to strengthen programs' caregiving policies	8%
• Coach to assess program policies and practices relative to rules and standards pertaining to socioemotional development	6%
• Coach to administer child socioemotional screening and assessment tools	4%
• Coach to strengthen programs' personnel policies	3%
Resources	22%
• Help access resource materials	14%
• Help access professional development opportunities	10%
• Help access community activities to broaden children's experiences	2%
• Help access funds	1%

N = 328. Data were missing for 33 cases.

6.2.2. Differences in Services Received by Child Age

To examine how service utilization differed among children and families, we examined dosage and service use by child age. Children were classified in two ways: (a) up to 36 months and over 36 months because the CCEP program was recently refocused to serve children 0-36 months, and (b) up to 24 months and over 24 months, because the developmental needs are likely to be quite different for children under 2 years.

Dosage, positive guidance services, resources, written reports, and programmatic consultation. These services did not differ by child age.

Referrals. Children over 36 months and their families were significantly more likely to receive child mental health referrals compared to children up to 36 months (30% of older children, 18% of younger children, *p* < .05). Children 24 months and under showed a pattern of fewer referrals overall (34% of children up to 24 months vs 50% for children over 24 months) and significantly fewer child mental health referrals. However, they tended to receive more referrals for medical assistance—physicians and public health.

6.2.3. Differences in Services Received by Centers and Non-Center Settings

Although the majority of providers served came from childcare centers, some (14%) came from family day care, group homes, or relative care. We investigated whether cases based in non-center childcare settings received services differently compared to those based in childcare centers. Because the number of non-center cases with data available was small (n = 49) compared to the number of center-based cases (n = 288), consistent patterns and trends of findings are reported even if not statistically significant.

Dosage. For the most part, duration and the amount of face-to-face consultation did not differ significantly for center and non-center-based childcare. However, cases at centers received more than twice as much observation (M = 6.2 hours, SD = 5.3 hours) than did cases at non-center settings (M = 3.1 hours, SD = 3.2 hours, p < .001).

Positive Guidance Services. As part of the positive guidance services, compared to non-center cases, cases based in centers were more likely to go through all assessment processes. Specifically, they were more likely to be observed (94% for centers, 82% for non-centers, p < .01) and obtain baseline provider DECA assessments (87% for centers, 74% for non-centers, p < .05). Center cases also tended to be more likely to have a positive child guidance plan completed (73% vs 60%, p < .10).

Referrals. Physician/medical referrals were significantly more prevalent for cases in non-center care (12% for non-center, 4% for centers, p < .05)

Resources. Resources provided did not differ for center and non-center-based settings.

Written Reports. Reports tended to be provided more for cases in centers (22%) than in non-center care (12%), although this was not statistically significant.

Programmatic Consultation. Programmatic consultation showed a pattern (not statistically significant) where most areas were a little more likely to be addressed in centers, especially *Activities and Experiences* (45% for centers, 33% for non-centers, p < .10). The exception was *Resources,* which were slightly more likely to be targeted in non-center care (21% in centers and 26% in non-centers).

6.2.4. Consultant Differences in Services Provided

One evaluation question was whether consultants differed in the amount or type of services they provided. Forty-four consultants each provided between 1 and 29 cases to the dataset (average = 8.2 cases per consultant). Data from consultants who provided less than 4 cases to the dataset were removed from this analysis to get a better estimate of average service per consultant. This resulted in a final sample of 32 consultants.

Dosage. On average, these consultants reported 10 hours of face-to-face consultation with providers and parents. However, this varied substantially; while the majority of consultants provided an average of 5 to 15 hours of consultation per case, one consultant averaged less than four hours per case and another averaged more than 27 hours per case. These differences are likely to occur as a result of variations in consultant practices or employment status (e.g., full- or part-time), policies and procedures endorsed by the sites, and differences in the populations served.

Table 6.7 Differences Among Consultants in the Average Dosage of CCEP Services Provided

Dosage type	M	SD	Range
Face-to-face contact (hours)			
Total	10.0	5.4	3.7 – 27.6
Provider	5.9	3.9	1.7 – 18.9
Parent	4.1	2.3	1.2 – 10.9
Duration (months)	4.5	1.4	2.3 – 10.7
Observation (hours)	5.7	3.6	0 – 20.3
% of cases with Positive Child Guidance Plan	68%	23%	0% - 100%

n = 32 consultants; all had at least four cases in the dataset.

Positive Child Guidance Services. All consultants with at least 4 cases in the dataset were included in data related to intake and assessment (n = 32). Because not all cases moved to the positive child guidance phase, only cases with a Positive Child Guidance Plan were included in analyses of the Positive Child Guidance Plan and Conclusion and Follow-Up (n = 25). Overall, fidelity to the model was high for intake and assessment, although a small number of consultants did not report using the intake or home observation process for most or all of their cases in this dataset. These cases may have gone directly to referral for other services, or consultants may have been recently hired and in the process of learning CCEP procedures.

Processes associated with developing and implementing the Positive Child Guidance Plan showed more variation among consultants than intake and assessment. The development of the Positive Child Guidance Plan showed the highest fidelity, with more variation emerging among consultants in how the Plan was implemented (e.g., coaching, informal training, focus on provider or parent). Because a Positive Child Guidance Plan was available for all these cases, it is unclear whether consultants who did not report development of the Plan on the form simply forgot or whether the full development process as outlined by CCEP state administrators was not able to be implemented, but a plan was nonetheless created.

Table 6.8 Percent of Cases Per Consultant by Positive Guidance Services Provided

Positive guidance process	M	SD	Range
Intake	87%	23%	0% – 100%
Assessment			
Observation in childcare setting	91%	15%	33% – 100%
Observation in home	52%	31%	0% – 100%
Baseline surveys from provider and/or parent	88%	21%	0% – 100%
Positive Child Guidance Plan			
Development	84%	19%	33%– 100%
Coaching with provider	62%	34%	0% – 100%
Coaching with parent	58%	35%	0% – 100%
Informal training with provider	48%	36%	0% – 100%
Informal training with parent	45%	33%	0% – 100%
Team progress review and revision of plan	29%	26%	0% – 80%
Conclusion and follow-up			
Follow-up assessment	66%	28%	0% – 100%
Conclusion of services	62%	28%	0% – 100%

n = 32 consultants with at least four cases for Intake and Assessment. For Positive Child Guidance Plan and Conclusion and Follow-up, *n* = 25 consultants with at least four cases who had Positive Child Guidance Plans.

Referrals. Referrals provided by consultants depend on the availability of services in the area. We therefore do not report differences among consultants in their provision of specific types of referrals. The average consultant provided referrals to 48% of his/her cases (*SD* = 29%), with some consultants giving referrals to none of their cases and others who provided referrals to most of their cases.

Resources. Consultants showed much variation in provision of resources, although only two consultants (6%) did not report any resources at all. Consultants were most consistent in the degree to which they provided toys, which was not often, but differed quite a bit in whether they provided articles or books; some provided these resources to all of their cases and some did not provide these resources to any of their cases.

Table 6.9 Percent of Cases Per Consultant by Resources Provided

Resource	M	SD	Range
Providers			
Toys	5%	11%	0% – 43%
Articles	30%	27%	0% – 100%
Books	24%	30%	0% – 100%
Other	18%	22%	0% - 80%
Parents			
Toys	6%	13%	0% – 60%
Articles	31%	26%	0% – 100%
Books	29%	29%	0% – 100%
Other	12%	16%	0% - 54%

n = 32 consultants; all had at least four cases in the dataset.

Written Reports. The average consultant provided a written report on 23% of his/her cases. However, this may be misleading, as 12 consultants (38%) provided no written reports for any of their cases in this dataset.

Table 6.10 Percent of Cases Per Consultant by Written Report Provided

Report target	M	SD	Range
Parent	18%	25%	0% – 86%
Childcare	15%	23%	0% – 86%
Psychologist	1%	5%	0% – 25%
Head Start	2%	6%	0% – 26%
Early On	1%	5%	0% – 25%

n = 32 consultants; all had at least four cases in the dataset.

Programmatic Consultation. The degree to which programmatic consultation was delivered varied substantially across consultants. Only three consultants (13%) provided no programmatic consultation to any of the cases in the dataset.

Table 6.11 Differences Among Consultants in Programmatic Consultation Provided

Activity	M	SD	Range
Supportive relationships	53%	41%	0% - 100%
Partnerships with families	45%	36%	0% - 100%
Activities and experiences	55%	40%	0% - 100%
Daily routine	45%	39%	0% - 100%
Environment/program	31%	32%	0% - 100%
Resources	27%	31%	0% - 100%

n = 25. Consultants were included if they had at least four cases that had Positive Child Guidance Plans.

6.2.5. Program Differences in Services Provided

To investigate whether different programs provided different levels of service, we examined the amount of each service type per program and report the average, standard deviation, and range across all 16 programs. The number of consultants per program averaged 2.8 (*SD* = 1.4), and ranged from 1 to 6. Given the findings above about variability among consultants, it can be concluded that CCEP programs differ in the extent to which they provide various services. Degree and type of service provision depends on multiple factors, including the local population, agency policies, and consultant caseload, part- or full-time status, and approach to service. Because it is likely to be repetitive to present specific differences in service delivery by program, we outline only differences in dosage provided as an example of the kinds of variation found among programs. Programs each provided between 11 and 45 cases to the dataset (average = 22.6 cases per program).

Dosage. Programs provided different average amounts of service. For example, while the programs delivered an average of 12 hours of face-to-face consultation to clients, one program delivered an average of 6 hours per client while another delivered an average of 27.6 hours per client.

Table 6.12 Differences Among Programs in the Average Dosage of CCEP Services Provided

Dosage type	*M*	*SD*	*Range*
Face-to-face contact (hours)			
Total	11.6	6.2	6.0 – 27.6
Provider	7.1	4.7	2.6 – 18.9
Parent	4.5	1.8	2.1 – 8.9
Duration (months)	4.7	1.4	3.0 – 8.2
Observation (hours)	6.1	3.4	1.8 – 16.4
% of cases with Positive Child Guidance Plan	71%	15%	43% - 93%

N = 16 programs.

CHAPTER 7. PERCEPTIONS OF CONSULTATION PROCESS, EFFECTIVENESS, AND ACCEPTABILITY

This section describes the methods and results used to further understand the consultation process and benefits of the CCEP consultation services. The questions addressed in Chapter 7 do not correspond to specific questions from the evaluation, yet are important to consider in the larger context of understanding how CCEP impacted (a) participants' perceptions of changes in relationships, (b) the process of consultation via CCEP, and (c) overall perceptions of the effectiveness and benefit of CCEP services. To examine effects of the consultation process itself, at the end of CCEP services, providers, parents, and consultants reported on their perceptions of consultation services in a variety of areas. Providers and parents also reported on their relationships with each other at the beginning and end of consultation and estimated the effectiveness of the consultation process. These measures and results are described in detail below.

A. Did consultation improve the provider-parent relationship?

- Relationships between providers and parents generally did not change significantly over the course of CCEP services, although providers did indicate some improvements in communicating with parents about the child's behavior at the end of consultation.

B. How was the consultation process viewed by those involved?

- CCEP services were viewed very positively by all of those involved, with all ratings reflecting "strong agreement" with the benefits of this consultation approach.

C. Was consultation seen as beneficial?

- Parents, providers, and consultants all indicated that CCEP services were beneficial, especially parents. Parents reported that providers had gained significant competence in working with their children, although providers did not report the same of parents.

7.1. Measures

Adapted versions of three instruments used within the behavioral consultation literature (Sheridan, 1998, 2000a, 2000b) were included in this evaluation to collect information from consultants, providers, and parents pertaining to the consultation process, effectiveness, and acceptability. These three instruments include questions that have come from a number of different instruments used previously within the consultation research literature (e.g., Sheridan, Clarke, Knoche, & Edwards, 2006). A description of these questions and the instruments from which they were derived are presented below.

Parent-Provider Relationship: One important focus of CCEP service delivery is to improve the relationship between parents and providers. Change in this relationship was measured with a 24-item questionnaire (adapted from the Parent-Teacher Relationship Scale, PTRS; Vickers & Minke, 1995) completed by both the parent and provider at pre- and post-CCEP. Six subscales comprise this measure and include the following: Feelings of Affiliation and Support (8 items pertaining to mutual trust, respect, and cooperation), Dependability and Availability of Parties (4 items pertaining to perceptions of the other's follow-through and commitment), Shared Expectations and Beliefs (5 items pertaining to mutual expectations and understanding for one another and related to the child), Communication from the Other (2 items pertaining to positive and negative communication from the other), Sharing of Emotions to the Other (3 items pertaining to communication, when pleased, concerned and worried), and Requests for Information to the Other (2 items pertaining to asking each other for opinions about progress or regarding suggestions). Ratings on these items (9 items are reverse coded) were done on a 5-point scale, with 1 indicating "almost never" or negative perception of the relationship and a 5 indicating "almost always" or a positive perception of the relationship.

Consultation Process and Acceptability: Another important area to assess when evaluating CCEP services is providers' and parents' perceptions of satisfaction and acceptability of the consultation process (i.e., social validity). Satisfaction with the consultation process was measured by the 12-item Consultation Evaluation Form (CEF; Erchul, 1987). The CEF measures the degree to which consultees find consultants to be helpful (e.g., "The consultant offered useful information," "The consultant was a good listener"). Items are rated on a 7-point scale, with 1 indicating strong disagreement (reflecting low satisfaction/ helpfulness), and 7 indicating strong agreement (reflecting high satisfaction/ helpfulness). Scores on this scale resulted in a mean average rating per item and was used to evaluate perceptions of CCEP processes.

Acceptability. Acceptability measured the degree to which consultation was viewed as an appropriate way to intervene. It was measured by 6 items (e.g., "I like what we did as a part of consultation," "I would suggest consultation to other providers dealing with this kind of problem") derived and adapted from the Behavioral Intervention Rating Scale (BIRS; Von Brock & Elliott, 1987). A 7-point likert rating scale was used with 1 indicating strong disagreement (reflecting low acceptability), and 7 indicating strong agreement (reflecting high acceptability). For the purposes of this evaluation report, we used the mean across all items to reflect the overall acceptability (BIRS subscale) of CCEP.

Benefits of Consultation (Sheridan, 1998, 2000a, 2000b). At the beginning and end of consultation, providers and parents rated a number of additional items from Sheridan's questionnaires that focused on the benefits of consultation for changing children's behavior. These included questions from additional subscales of the BIRS (Von Brock & Elliott, 1987) including the following: Effectiveness (6 items, such as "Consultation improved my child's behavior in other places besides childcare") and Perception of Child Behavior Improvement Subscales (2 items, such as "My child's behavior improved as a result of consultation").

Competence of Other (Sheridan 1998, 2000a, 2000b). Three items rated on a 5-point scale (1 "negative perception of competence" to 5 "positive perception of competence") asked providers and parents to report on changes in the skill of the other—that is, providers reported about parents and parents reported about providers, with consultants reporting about the "consultee," who was likely to be interpreted as the provider (i.e., "After completing this consultation, how skilled do you think your child's provider/parent is to work with your/this child on his/her main difficulties), the interest of the other in working with the child around the behavior issue (i.e., After completing this consultation, how interested do you think your child's provider/parent is in working with you/your child on his/her main

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difficulty) and the awareness of the child's social-emotional needs (i.e., "In general, how are do you think your child's provider/parent is of the social-emotional needs of this/your child").

7.1.1. Change in Provider-Parent Relationships

Descriptives. Means and standard deviations for provider and parent reports about change in their relationship are presented in Table 7.1.

Table 7.1 Mean (SD) Perceptions of Provider-Parent Relationship at T1 and T2

	Provider		Parent	
Perception of relationship	Time 1	Time 2	Time 1	Time 2
Affiliation and support	34.8 (5.1)	34.6 (5.2)	36.6 (4.3)	36.7 (5.1)
Dependability and availability	16.0 (3.7)	16.2 (4.0)	18.5 (2.4)	18.4 (2.9)
Shared expectations and beliefs	19.4 (4.3)	19.6 (4.5)	21.6 (3.6)	21.6 (3.8)
Communication from the other	8.3 (1.8)	8.5 (1.2)	8.9 (1.5)	9.1 (1.3)
Sharing of emotions to the other	12.9 (2.2)	13.3 (2.1)	12.5 (2.6)	12.6 (2.7)
Requests for information to the other	7.3 (2.1)	8.0 (1.8)	8.5 (1.8)	8.5 (1.6)

Note. Provider N = , Parent N = 230.
***$p < .001$. *$p < .05$. $^{t}p < .10$.

Change in the CCEP Group. Paired t-tests examined change in provider and parent perceptions of their relationship. As shown in Table 7.2, while perceptions of overall relationship, such as support and dependability, did not change, improvements were evident among providers' levels of communication. Specifically, providers reported that they were more likely to let parents know when they were pleased with or concerned about the child and to ask for the parent's opinion or suggestions. Parents confirmed this with a near-significant increase in perceptions of communication from providers.

Table 7.2 Effect Size *d* for Change in Provider-Parent Relationship, Time 1 to Time 2

	d	
Perception of relationship	Provider (about parent)	Parent (about provider)
Affiliation and support	-.05	.03
Dependability and availability	.07	.05
Shared expectations and beliefs	.07	.00
Communication from the other	.17	.18^{t}
Sharing of emotions to the other	.23*	.06
Requests for information to the other	.46***	.00

Note. Effect size *d* interpretation: .20 = small, .50 = medium, .80 = large. *d* is corrected for dependence. Negative numbers indicate score decreased over time. Provider N = 179 , Parent N = 230.
***$p < .001$. *$p < .05$. $^{t}p < .10$.

Change and dosage. To assess whether provider-parent relationships improved to a greater extent with more consultation dosage, multiple regression analyses were conducted predicting relationships at the end of consultation from hours of face-to-face consultation with providers and parents separately, after controlling for child age, type of childcare setting, family income, and initial relationship score.

The results indicated that while more consultation was not associated with providers' perceptions, it was related to parents' perceptions. Moreover, it was primarily the hours of consultation with the

provider that predicted whether parents felt the relationship had improved. These findings were not strong; provider dosage was significantly related to parent perceptions of Shared Expectations and Beliefs (β = .14, p < .03), and all other findings were trends at p < .10 (Communication from Other β = .11, Sharing of Emotions to Other β = .12, Requests for Information to Other β = .13). A trend also emerged for more hours of consultation with parents to predict parents' ratings of Communication from Other (β = .13, p < .10), perhaps because consultation provided a forum for providers to communicate more in depth with parents. Overall, greater dosage of consultation appears to have potential for building communication between providers and parents.

> **Case Study.** Sophia's CCEP consultant described why she focuses on helping change relationships between parents and providers.
>
> *"The process of what you're actually doing is not just about giving people guidance on behavior and how to manage it. It's about changing the relationship between the parent and the provider and thereby with the child, too".*

CCEP vs comparison group. To examine differences between the CCEP group and the comparison group, repeated measure ANCOVAs were conducted with the matched comparison dataset with group (CCEP or comparison) as a between group variable and childcare type, child age, and family low-income status as covariates. For parent reports, N = 110 (55 in each group). For provider reports, N = 63 (19 comparison reports).

Results indicated only one significant difference in change over time between the CCEP group and the comparison group. Whereas the comparison group providers decreased in Sharing of Emotions over time (14.5 at Time 1, 13.4 at Time 2), the CCEP group providers increased slightly (13.3 at Time 1, 13.8 at Time 2), $F(1,58)$ = 3.82, p = .055. However, the number of providers was small and the results need to be considered with caution.

7.1.2. Perceptions of the Consultation Process

At the end of consultation, providers, parents, and consultants were asked to provide their perceptions of the consultation process. Cases were analyzed for which data from all three reporters were available in order to make comparisons across reporters. The consultation process and acceptability of consultation as an appropriate intervention were both highly rated by providers, parents, and consultants.

Differences in perceptions among providers, parents, and consultants. As shown in Table 7.3, comparisons among reporters indicated no differences in ratings of the overall consultation process. However, both providers and consultants rated the acceptability of consultation more positively than did parents.

Table 7.3 Perceptions of Consultation Process

Consultation dimension	*Providers*	*Parents*	*Consultants*
Consultation Process	6.5 (.8) [a]	6.4 (.9) [a]	6.4 (.5) [a]
Acceptability	6.5 (.7) [a]	6.1 (1.0) [b]	6.4 (.8) [a]

> **Case Study.** A director of a childcare center articulated the value of CCEP in supporting parent-provider relationships.
>
> *"I think what CCEP does for us is that it actually helps us build that partnership with the parent, which is not always an easy thing to do because parents don't really look at childcare staff as professionals and for me to say 'There's something going on with your kid's development here, let me help you with it,' still doesn't work. Parents still don't look at us in that light and it's easier for [the consultant] to come in and build that bridge for us than it is for us trying to build it on our own, but we're trying. So it really is about changing the way that the parents see us as well and the fact that we've got an important role to play with helping them manage their children when they're difficult, too. CCEP's not just working directly with children and parents, but it's that relationship between us and the childcare providers which will now forever be changed."*

7.1.3. Perceived Benefit of Consultation

Perceptions of consultation benefit and effectiveness were assessed by asking providers, parents, and consultants to report at the end of consultation on effectiveness, which here means the degree to which the reporter believes that changes in the child's behavior were evident in other settings and could be sustained, changes in one's own competence, and improvement in the child's behavior. Additionally, parents and providers reported on their perceptions of each other's competence in working with the child before and after consultation, and the same data were collected from the comparison group.

Differences in perceptions among providers, parents, and consultants. As shown in Table 7.4, differences emerged across all three reporters for ratings of consultation effectiveness, with parents rating it most effective and providers rating it less so. While providers perceived greater improvements in competence in themselves than consultants reported, parents were more likely to report greater improvement in child behavior than either providers or consultants.

Table 7.4 Perceptions of Consultation Benefits

Consultation dimension	Providers	Parents	Consultants
Effectiveness	4.9 (1.6)[a]	5.6 (1.1)[b]	5.3 (1.2)[c]
Improvement in competence*	6.3 (1.2)[a]	6.0 (1.3)[ab]	5.9 (1.2)[b]
Improvement in child behavior	5.6 (1.6)[a]	5.9 (1.3)[b]	5.5 (1.3)[a]

Notes. Includes only those with all reporters, N = 136. Differences in superscripts across a row indicate that the pair of scores is significantly different at a minimum $p < .05$.
*Provider and parent report on own competence, and consultant reports on "consultee's" competence.

Changes in perceptions of the other's competence. Results of provider and parent pre-post assessments of the other's competence (skill, interest) in working with the child indicated that parents perceived a small but significant increase in providers' competence in working with their children (Time 1 M = 4.3, SD = .8, Time 2 M = 4.4, SD = .8, t = 2.07, $p < .05$). Providers did not report a significant increase in parents' competence (Time 1 M = 3.8, SD = .8, Time 2 M = 3.9, SD = .9, t = 1.00, ns).

Differences in CCEP and comparison group on perceptions of other's competence. No significant differences emerged for parent reports of provider competence between the CCEP and comparison group. Unexpectedly, comparison providers reported significantly more improvement among parents than did CCEP providers, $F(1,58) = 10.45$, $p > .01$. However, due to the small number of comparison providers ($N = 19$), these results may be unstable.

Case Study. A family childcare provider talked about the benefits of consultation.

"There are children that are a little more difficult— that you do need someone with expertise come in and say, 'Hey, you know what, here's another way to approach this.' And I'm always like open to stuff like that 'cause the more you learn, the better off you are and the better off the children are."

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APPENDICES

APPENDIX A

LOGIC MODEL FOR EVALUATION & PROGRAM IMPROVEMENT: CHILDCARE EXPULSION PREVENTION INITIATIVE

INPUT → **ACTIVITIES** → **OUTPUTS** → **OUTCOMES**

RESOURCES
Examples:

Experienced, qualified IMH consultants:
-Consultant salaries, premises, travel, phone, conferences, training, supervision -office space, supplies and support, copying, mailing,
-DECA, other printed standardized measures
State-wide CCEP T/A & coordination: --
-Staffing, training, technical assistance and monitoring meetings, phone, cable, office supplies, travel, conferences

CCEP SERVICES
Examples:

-Mental health consultation to 0-5 year old children with challenging behavior and their families who use formal childcare providers - childcare centers, family homes and registered informal providers – relatives, day care aides.
-Provider training
-Referrals to other agencies
-Participation in local and state-wide CCEP collaboration and early childhood planning

NUMBER OF PRODUCTS
Examples:

- Number of child and family cases
- Number of programmatic cases
- Number of training sessions
 - Number of positive satisfaction surveys
-Number of children not expelled
- Number of children appropriately referred to other agencies

BENEFITS
-Reduction in severity of children's challenging behavior
-Increase in children's social-emotional health
- Sustainability of positive child outcomes
-Expulsion prevention
-Increased feelings of parental competence in dealing with their child's challenging behavior
- Consistent attendance by parents at work or school?
-Improved recognition of early warning signs of social and emotional challenges in infants, toddlers, and preschoolers
-Improved management of challenging behavior in the childcare setting

Theory of Change: Early mental health intervention delivered by consultants who maintain fidelity with the CCEP child and family and programmatic processes, improves child, family and program outcomes and protects children from developing chronic and more severe problems in later childhood

Context *examples:* Economic and social environment, grantors requirements (national and state level (ECIC), state and agency policies and practices, legislation and regulation

APPENDIX B. Summary of CCEP Evaluation Plan

How will this be studied?	Measure	Target group	Reporters	Timing
	Child Specific			
1. Does the severity of children's challenging behavior decrease from the onset of CCEP services to the conclusion of services?				
• Change in DECA/BASC-2 scores in intervention group from T1 to T2 • Comparison between intervention (sub-sample) and matched comparison group on change in DECA/BASC-2 scores from T1 to T2	• DECA • BASC-2	• Intervention group • Comparison group	• Parent • Provider (DECA only) *Administered by consultant for intervention group; by evaluation team for comparison group*	• Pre (T1) • Post (T2)
• Change in intervention group on problem grid from T1 to T2 • Comparison between intervention (sub-sample) and matched comparison group on problem grid from T1 to T2	• Problem grid • Goal Attainment Scale	• Intervention group • Comparison group	• Consultant • Comparison parents and providers *Administered by evaluation team for comparison group*	• Pre (T1) • Post (T2)
2. Does children's social and emotional health increase from the onset of CCEP services to the conclusion of services?				
• Change on DECA/BASC 2 in intervention group from T1 to T2 • Comparison between intervention (sub-sample) and matched comparison group on change in DECA/BASC-2 scores from T1 to T2	• DECA	• Intervention group • Comparison group	• Parent • Provider *Administered by consultant for intervention group; by evaluation team for comparison group*	• Pre (T1) • Post (T2)

How will this be studied?	Measure	Target group	Reporters	Timing
Child Specific				
3. Does the impact of services on children's behavior last post services?				
• Change in DECA/BASC-2 scores in intervention group across T1, T2, and T3 • Comparison between intervention (sub-sample) and matched comparison group on change in DECA BASC-2 scores at end of consultation (T2) and follow-up (T3) for intervention group and comparison group at T1 and follow-up (T2)	• DECA • BASC-2	• Intervention group • Comparison group	• Parent • Provider *Administered by evaluation team*	• Pre (T1) • Post (T2) • 6-month follow-up (T3 for intervention group & T2 for comparison group)
• Change in intervention group on problem grid across T1, T2, and T3 • Comparison between intervention (sub-sample) and matched comparison group on problem grid across T1, and T2	• Problem grid	• Intervention group • Comparison group	• Consultant • Comparison parents and providers *Administered by evaluation team*	• Pre (T1) • Post (T2)
4. Do children receiving CCEP services successfully stay in child care vs. being expelled?				
• Percent of intervention group that stays in child care as of T2 • Comparison between intervention (sub-sample) and matched comparison group of percent that stays in child care as of T2	• Service form	• Intervention group • Comparison group	• Consultant	• Post (T2)
• Percent of intervention group that stays in child care as of T3	• Interview	• Intervention group • Comparison group	• Evaluation team	• 6-month follow-up (T3)

How will this be studied?	Measure	Target group	Reporters	Timing
Family Impacts				
5. Do subjective feelings of parental competence in dealing with their child's challenging behavior increase as a result of CCEP services?				
• Change in parent competence and stress scores in intervention group (full sample) from T1 to T2 • Comparison between intervention (sub-sample) and matched comparison group on change in parental competence and stress scores from T1 to T2 • Maintenance of changes/differences through T3	• Parent Empowerment Measure • Parenting Stress index	• Intervention group • Comparison group	• Parent *Administered by consultant for intervention group at T1 and T2; by evaluation team for comparison group*	• Pre (T1) • Post (T2) • 6-month follow-up (T3)
• Stories of impacts of intervention on feelings of parental competence and stress	• Interview	• Intervention group case studies	• Parents *Administered by evaluation team*	• 6-month follow-up (T3)
6. Are families able to consistently attend work or school (due to the decrease in challenging behavior)?				
• Change in parental ability to attend work or school in intervention group from T1 to T2 • Comparison between intervention (sub-sample) and matched comparison group on ability to attend work or school from T1 to T2 • Maintenance of changes/differences through T3 (intervention group)	• Measure of work/school attendance	• Intervention group • Comparison group	• Parent *Administered by consultant for intervention group at T1 and T2; by evaluation team for comparison group*	• Pre (T1) • Post (T2) • 6-month follow-up (T3)
• Stories of impacts of intervention on ability to meet work/school demands	• Interview	• Intervention group case studies	• Parents *Administered by evaluation team*	• 6-month follow-up (T3)

How will this be studied?	Measure	Target group	Reporters	Timing
Child Care Provider				
7. Are child care providers better able to recognize early warning signs of social and emotional challenges in infants, toddlers, and preschoolers?				
• Change in perceived knowledge scores in intervention group across T1 and T2	• Knowledge measure	• Intervention group	• Provider *Administered by consultant*	• Pre (T1) • Post (T2)
8. Are child care providers better able to manage challenging behavior in the child care setting, with all children?				
• Change in perceived practice scores in intervention group from T1 and T2	• Child care practices measure	• Intervention group	• Provider *Administered by consultant*	• Pre (T1) • Post (T2)
• Change in perceived competence scores from T1 to T2	• Competence measure • Parent perception of provider competence	• Intervention group	• Parent • Provider *Administered by consultant*	• Pre (T1) • Post (T2)
• Stories of change in ability to manage challenging behavior	• Interview	• Intervention group case studies	• Provider • Consultant *Administered by evaluation team*	• Post (T2)
Child Care Program				
9. Has the social and emotional quality of the child care setting receiving CCEP services improved?				
• Qualitative data on changes in the child care setting	• Interview	• Intervention group case studies	• Provider • Center administrators (when applicable) *Administered by evaluation team*	• Post (T2)

How will this be studied?	Measure	Target group	Reporters	Timing
CCEP Model				
10. What is the fidelity of the child and family consultation process among CCEP programs?				
Descriptive statistics for e.g.: • Average number of visits per referral • Length of visits • Duration of services • Intensity • Service components	• Service form (revised) • Intervention grid (revised) • Consultant Log • Survey	• Intervention group	• Consultants *Administered by consultant*	• Post (T2)
• Qualitative data on consultation process	• Interview	• Intervention group case studies	• Consultants • Parents • Providers *Administered by evaluation team*	• Post (T2)
11. What is the fidelity of the programmatic consultation process among CCEP programs?				
• Percent of consultants following recommended consultation process • Degree to which consultants follow recommended consultation processes on average	• Program process survey	• Intervention group	• Consultants *Administered by evaluation team*	• Year 1
• Qualitative data on consultation process	• Interview	• Intervention group case studies	• Consultants • Administrators *Administered by evaluation team*	• Year 1

APPENDIX C: CASE STUDIES

APPENDIX C: CASE STUDIES

1.   Explanation of Case Studies

Nine case studies of children and their families who received CCEP services were conducted. Case studies included in-depth interviews with parents, providers, program directors, CCEP consultants, and CCEP administrators. The inclusion of case studies was designed to:

- Document CCEP processes as experienced by parents, providers, consultants and administrators
- Illustrate the variation and unique relevance of CCEP for individual children and families
- Enhance understanding of the processes that underpin CCEP consultation

A summary of the primary and secondary CCEP process themes that emerged from the data are summarized in Table 1. These themes reflect CCEP processes such as intake into CCEP services, building partnerships between parents, providers and consultants, issues in evaluation, goal planning, and case closures. Next, individual child and family case studies are summarized in Table 2. Finally, each of the nine case studies is summarized using one of the following three methods. The first two case studies - Daniel and Hannah - are presented with detailed information about experiences and processes in CCEP. The assessment scores for each child, his/her parent, and the provider, relative to the CCEP group's average score in the evaluation study, are included as well. The next four case studies- Kayla, Madison, Nathan, Ryan and Sophia- provide a brief background information for each child and the assessment scores for each child, his/her parent, and the provider, relative to the CCEP group's average score in the evaluation study. The final two cases studies- Dylan and Jason- provide only the assessment scores for each child, his/her parent, and the provider, relative to the CCEP group's average score in the evaluation study.

The inclusion of the case studies provides a rich context from which to better understand CCEP experiences and processes. Most importantly, the case studies demonstrate the wide variability in children's needs within this challenged population, describe key intervention strategies, highlight the role of collaborative relationships between parents, providers, consultant and administrators, and prompt reflection and discussion about young children's needs and strategies for supporting young children with challenging behaviors.

2. Summary of CCEP Process Themes from Case Studies Via Interviews with CCEP Administrators, Consultants, Providers and Parents

In addition to data collected from case studies conducted with the 9 families, which included interviews with consultants, providers and parents, the two CCEP Program Administrators from the programs who managed these cases were also interviewed about general program processes. There were 27 interviewees in all. Key themes emerged from these interviews and are illustrated in the table below.

PRIMARY THEME	SECONDARY THEME	DESCRIPTION/INTERPRETATION	EXAMPLE QUOTE
INTERVENTION AS CATALYST FOR CHANGE: TIMING	**1. CURRENT RESPONSIVENESS OF PROVIDER OR PARENT TO CHANGE**	Provider and parents both need to be open to change at the time of intervention.	*"They didn't really believe that Madison had a problem so I just kind of accepted where they were, and thought about listening to them and their perception and was very respectful in saying, you know, 'yeah I can see that you see that there's not really any problem with her here. Sounds like the schools have problems with her and as she progresses throughout her school career, there may be others that are gonna see problems with her because of the way she's put together, her temperament and her style. So this experience now may be useful for you in that you're gonna hear those discrepancies between what you believe and what the school believes. And, and some of the things that the school in this situation has learned that were helpful to them, you may be able to use as you advocate for Madison in the future.'"*-- Madison's consultant talks about how she responded to parents when they do not share concerns that are apparent at child care.
		When the parent or provider (or both) do not appear open to change, exposure to the idea of consultation may be beneficial later. Exposure to the idea of consultation may "plant the seeds of change" that will later develop.	*"It's always possible that at a later date, that some of the suggestions that I made get taken on board when they're seen as their own ideas or have become integrated into their way of thinking".* --Hannah's consultant talks about her view that the success of a case cannot always be measured by behavior change in the short-term. Benefits may become apparent at a later

PRIMARY THEME	SECONDARY THEME	DESCRIPTION/INTERPRETATION	EXAMPLE QUOTE
			date or perhaps for other children as providers and parents gain skills over time. *"The director had even said to me before, she's like,' I'm really grateful that we brought her (the consultant) in not just for Hannah but just in general because she really taught them (the staff) a lot of stuff on how to handle all the kids', not just, my daughter."* -- Hannah's mother notes the benefit of the CEP consultation process for her child but also for other children in the future.
PRINCIPLES UNDERPINNING CONSULTANT'S APPROACH	**1. RELATIONSHIP, STRENGTH -BASED APPROACH** **2. HOLISTIC APPROACH** **3. INTER-ACTIVE AND RESPONSIVE APPROACH** **4. APPLICATION OF KNOWLEDGE ABOUT THE IMPORTANCE OF EARLY EXPERIENCES TO HEALTHY SOCIAL – EMOTIONAL DEVELOPMENT**	Consultants approach cases and programs by initially identifying and emphasizing positive characteristics in the child, family and classroom and with the intention to consider multiple contexts of the child's development. Interactive - management of cases is responsive to the perceptions of all consultants, providers and parents. Consultants hold and promote the belief that early social-emotional development lays a foundation for later growth and development.	*"I just got this vibe from her that she was a really good person, you know, she cares what she does, she cares about what she does…One thing I love about her (consultant) is that when you have a problem and you need to talk to her about something, she just listens. She don't give an opinion, she don't like interrupt and say 'oh well, I think this is better, or why don't you do this, she just listens. …and that's what I liked about it 'cause you know, that's one thing I don't like when you want to vent, it's really just to vent to somebody and then they can listen, not to criticize you or say 'oh no, I don't think that's right' or 'you should do it like this', or maybe we should do this'. And so then it kind of frustrates you."* Daniel's mother talks about how she valued the consultant's listening and non-judgmental approach. This made her more open to the reception of services *"I really do think that the infant mental health positive approach definitely supports the strengths-based focus, yes, absolutely. You know, as I try to remind people, that's the point that we use and look for to build on, because, as with any structure, whether we're talking about ourselves or our physical structure, it's not easy if you're trying to build on the 'weakest' point. –Dylan's*

PRIMARY THEME	SECONDARY THEME	DESCRIPTION/INTERPRETATION	EXAMPLE QUOTE
			consultant explains the importance of a strengths-based approach. *"It's important to get to know how a child acts in different settings, with different caregivers, with and without peers or family, so links between home and school are very important. That is something special about CCEP. We go to the home and to the center. It helps build up a better picture of what's going on. "* –A CCEP administrator articulates strengths of the CCEP approach. *"I kind of used the concept that is used in mental health called 'motivational interview' and kind of thinking about where the family was at this time..,"*—Madison's consultant describes how she approaches parents in her work
	4. INDIVIDUALIZED APPROACH	Consultants recognize and promote the understanding that children develop at different rates and that typical development encompasses a wide range. Given unique differences in development, adaptations to the environment may need to be made to accommodate the child's needs.	*"We also had Kayla be used a lot as a helper at home and at school and that really gave her that leadership role and she loved to help. So that kind of helped the classroom to manage her active style... This was a child who was not gonna nap, and usually most of the kids I work with, up to 4, require naps, but we have those few kids that you know, they are out of nap by 3 ½ and you are not gonna make them nap, particularly these active-style, body styles, they have a hard time settling down. Also, when I went to the home and all, bedtime was a huge issue in the house, and so we focused on that. Mother and dad were just real tuned in to any suggestions and any discussion and they did alter their bedtime routine and became much more consistent and that improved greatly 'cause I am noticing that a lot of these kids are sleep-deprived"* – Kayla's consultant describes adaptations to the environment to match Kayla's needs. Kayla's high energy was channeled by

PRIMARY THEME	SECONDARY THEME	DESCRIPTION/INTERPRETATION	EXAMPLE QUOTE
			giving her meaningful roles as a helper at school and at home and by maintaining consistency of routines.
CONSULTATION PROCESS: PROVIDING A SUPPORTIVE MODEL TO BOOST SELF-EFFICACY AND USE IN FUTURE INTERACTIONS WITH OTHER INSTITUTIONS, SUCH AS SCHOOL	**1. ONGOING BUILDING AND STRENGTHENING OF RELATIONSHIPS**	Strong relationships form the foundations of successful consultation and act as a catalyst for change. Relationships target key individuals in consultation but extend beyond this and build a potentially transferable network of support for the child. Relationship building occurs between: (1) consultant & parent(s); (2) consultant and child; (3) consultant & provider; (4) provider & parent(s); (5) provider & child; (6) parent (s) & child; (7) consultant, provider and parent(s) with other agencies. Relationships are built through listening, demonstrating that partners are approachable, dependable, non-judgmental and respectful.	*"The process of what you're actually doing is not just about giving people guidance on behavior and how to manage it. It's about changing the relationship between the parent and the provider and thereby with the child, too".* –Sophia's consultant notes the ways in which strong partnerships benefit the child. *"We all met together at that very first meeting and had wonderful dialogue and to see them (director and teacher) interact with Ashley (mother); they had such a wonderful and positive interaction with her so, you know, even though maybe they were feeling all those negative pains, they didn't really seem to spill over."* --Hannah's consultant talks about the value of bringing parents and providers together in building and strengthening relationships between them.
	2. ASSESSMENT	Assessment is approached from a multi-method perspective (including the use of observation in multiple contexts, standardized scores, and joint and individual discussions with parent(s) and provider regarding observations of the child)	*"My plan is always 3 observations within 3 weeks and then to schedule a parent-teacher meeting within the next week and write up a positive guidance plan based on that parent-teacher meeting. I'm not sure that it came at that frequency but that was my plan. And in this situation I did, I believe, go back and do another contact with the staff and sent a copy of the positive guidance plan to parents and staff".* --Madison's consultant described her approach to the assessment process.
	3. JOINT PLANNING	Development of the positive guidance plan is based on jointly agreed assessment, goals, activities, time	*"I just ask them (parents and providers) what their concerns are. And kind of keep trying to have the teachers and the parents feel as much on common ground as possible so that there's like an immediate*

PRIMARY THEME	SECONDARY THEME	DESCRIPTION/INTERPRETATION	EXAMPLE QUOTE
		lines.	*sense of partnership- and working together it's kind of the spirit in the tone of the meeting and then we sort of get to more specifics at that point."*—Hannah's consultant explains her process for developing a guidance plan.
	4. INTERVENTION: **a. Mediation/** **facilitation**	The goals of intervention include bridging gaps between key participants and extending support networks for the child to include other resources and services.	*"…..the challenge of connecting parents and caregivers. That's always to me such a predominating theme because they're two relationships that are so profoundly important to children and when those aren't solidly intact, that's always concerning for me. .."* –Jason's consultant notes the challenges in supporting an emerging parent-provider relationship. *"I believe the parents need to be consistent. They need to be able to be accountable to someone and I think that's what Kathy (the consultant) was doing with them and maybe it wasn't even that many times. I think that's just a really good thing that I can't do as a teacher at Ryan's home. It's just bringing in a third party- somebody else that can say some things that you really might think but you can't really say without damaging the relationship that you have with parents".* --Ryan's teacher talks about the perceived benefit of the mediating role of the consultant working with parents in their home as well as with teaching staff in the classroom. *"I made sure that the center Director was connected with the professional development person at the ISD so that she could always be informed of trainings that would be coming up that her staff could access."* –Dylan's consultant discusses the importance of program-community partnerships.

PRIMARY THEME	SECONDARY THEME	DESCRIPTION/INTERPRETATION	EXAMPLE QUOTE
	b. Supporting partners	Consultants often provide support to parents and to providers (e.g. emotional, instrumental, informational support) with the emphasis of on parenting and caregiving.	*"I could pick up that phone and call her and say, 'Julie (consultant), you know what, I don't know if this is something that is a concern or shouldn't be a concern or if I'm overanalyzing it' so I could call her and ask her any questions and she was very informative and very helpful and a great support"*---Sophia's child care provider talks about the support she receives from her CCEP consultant. *"..we had a couple close calls early on in this case, of just you know, phone calls from the director saying 'I don't think we can do this'…you kind of have to have a little bit of background with a center …to be able to say 'could you just hang in there a little bit longer - let's try this'."* Daniel's consultant talked about the importance of having an established relationship with the provider when managinbg a very challenging case.
	c. Changing perceptions of behavior	Consultants work to support providers and parents in reframing children's behaviors to reflect the child's unique developmental context.	*"I think so much of our work, to be honest with you, is not so much that we're totally changing the behavior of the child but that we're impacting the perceptions of the teacher because sometimes when we get involved with these kids, there's already such a negative reaction, understandably so, and negative attitude toward the child that they don't see the child's strengths or they feel, like, 'This is just hopeless. It's taking too much time and energy and I got all these other children' ".* --Nathan's consultant discusses the importance to developing new perceptions of child behavior. *"The provider was just much more tolerant of her behavior, - sometimes it'd be a little bit amusing because I'd come out and it didn't seem like the change in her behavior was that dramatic, but the provider would think that she was adorable."* --Sophia's consultant describes how changes in behavioral perceptions impact the provider's interactions with the child. *"The way I work with people. I say, 'let's look at who this*

PRIMARY THEME	SECONDARY THEME	DESCRIPTION/INTERPRETATION	EXAMPLE QUOTE
			kid looks like and what he is. He looks like a 5-year-old. So you're already seeing him as a 5-year-old. Your expectations are for a 5-year-old. He's 3 ½ and he's delayed'." --Nathan's consultant explains how she supports parents and providers in reframing behaviors within a developmental context.
	d. Coaching	Coaching and supporting learning occurs both directly (e.g. Coaching providers in the classroom) and indirectly (e.g. working through a key person such as Child Program Director).	*"But it took a lot of coaching because the teacher was getting frustrated because Jason was getting frustrated and it was like, 'you just need to bring him back' and it was kind of difficult for her to do that, and so it was a lot of one-on-one coaching between me and the teacher here at the center and even having conversations between Julie (the consultant), the teacher and me. You know, we can't be successful if we don't move him along this process, and once the teacher got hold of that, it became pretty much like second nature. He's not a kid that just all of a sudden explodes. He's a kid that you can see there are actually signs and so she would just move him back over and say, 'here we are, here is what's gonna happen and we're gonna do this and then we'll get to do this'. And so he's been able to do that and Jason has been able to focus his attention on that schedule".* – Jason's child care program director talks about the coaching she was able to give to Jason's teacher to identify early warning signs of a tantrum and manage his challenging behavior as a result of the coaching and support she was receiving from the CCEP consultant, Julie.

"..is there a way to spend some one-on-one time during free play with this child sitting on the floor doing something with him that he has control of and he wants to do?. And so I usually build this into a lot of these cases where these kids are really. It's kind of an automatic for me. And sometimes teachers can't do it because they're too overwhelmed, but sometimes they do. They move |

PRIMARY THEME	SECONDARY THEME	DESCRIPTION/INTERPRETATION	EXAMPLE QUOTE
			from group to group as kids are in free play and they can sit in the group where this child is and maybe do some more relationship-building, so then they begin to feel a little more positive about the child also, so that's really important." Nathan's consultant talked about the way she routinely made suggestions that build relationships between provider and the child. *"A lot of it was making sure that the classroom setting was more accommodating for this particular child and that the providers recognize triggers for some of her challenging behaviors, rather than an emphasis on actually changing her behaviors."* --Madison's consultant talks about her role in managing Madison's behavior in the classroom.
	e. Collaboration	Collaborations are characterized not only by partnerships in individual cases but also by partnerships in the larger community. Building collaborations in the larger community, particularly in regard to garnering services for families, is sometimes challenging.	*"We now have the ISD wraparound services. I went with her (Jason's mother) to a psychiatric evaluation at community mental health as well, so a lot of work to kind of fortify that family. I'm a beautiful spokesperson for her child. Pervasive developmental disorder is what they said in the psychiatric evaluation, but the ISD is going to further evaluate him in the fall when the program starts up again. I will say this. I had to do a lot a lot of advocating to get her wraparound services…. And that meant going through two different people and talking to the supervisor to get services initiated for her because sometimes when she gets a little bit shy … she won't express her needs well".* –Jason's consultant describes the process in establishing contacts with other existing community services.
	5. CASE CLOSURE	1. Closure may be influenced by external events (e.g. summer vacation, family move) or maturation (e.g. age of child) or initiated by the consultant or parent.	*"So the question is you know, 'is behavior so extreme now that it's not manageable?'. And when people say 'it's manageable' is when I pretty much move on unless I have a totally different viewpoint. Plus circumstances like the child is gonna be home all summer with mother"* --

PRIMARY THEME	SECONDARY THEME	DESCRIPTION/INTERPRETATION	EXAMPLE QUOTE
		2. There is generally not a formal review process prior to closure.	Madison's consultant explains what events might facilitate case closure. *"Well, it was a difficult decision to close the case. And I do want to say too, in all honesty, I've told the mother if at any point she needs to reopen or maintain contact, you know, then that is perfectly fine. But you know, looking at the progress that they've made and looking at her support system being more extended and broadened and now that they also have that caregiver in place that he is so bonded with and that the mother's bonded with as well, frankly, I've looked at the way that I do my work a little bit more closely. And including that sometimes I think I need to step out quicker than I do, although some people would say that wasn't very quick, But leaving the door open for a return."* –Jason's consultant describes processes around case closure.

3. Summary of Each Child and Family Case Study

Name	Child Gender	Age in months	Behavior challenges	Household	Involvement with Other agencies	Interviews	Outcome
Dylan	M	60	Listless, withdrawn. Mom leaving for army for 3- month absence.	Mother, stepfather	No	5 (C, M, D, P[2])	Adjusted, moved on to kindergarten.
Sophia	F	40	Defiant, aggressive. Mother depressed, self-harm witnessed by Sophia	Single mother, boyfriend, younger sibling.	No Insurance. Offered but did not receive services for sibling from not-for-profit agency	2 (C, P)	Mom lost job. Child withdrawn from daycare, went to Head Start.
Jason	M	71	Head-banging, tantrums.	Single mother	School district services daily, Wraparound services, Psychiatrist. History of Child Protective Services (CPS)	3 (C, M, P)	Reduced intensity.
Ryan	M	51	Tantrums, screaming.	2 natural parents Twin brother (fraternal) also in day care center	No	3 (C, M, P)	Reduced intensity, went to elementary school.
Kayla	F	41	Age-inappropriate defiance, hyperactive, adjustment to transitions.	2 Adoptive parents, older brother	No	3 (C, M, P)	Changed parent/provider behavior.

Name	Child Gender	Age in months	Behavior challenges	Household	Involvement with Other agencies	Interviews	Outcome
Nathan	M	49	Biting, hitting, inappropriate physicality, developmental delay	2 Bio parents, brother	ISD, psychiatric assessment	3 (C, M, P)	Changed parent/provider behavior. Child matured.
Madison	F	60	Tantrums, disruptive.	2 Bio parents	No	1 (C)	Kindergarten.
Hannah	F	42	Aggression.	Single mom	Play therapist, Psychologist	3 (C, M, P)	Moved.
Daniel	M	48	Aggression, sexualized behavior, self- destructive.	Single mom	Wraparound services. History of CPS while receiving CCEP services	4 (C, M, P, D)	Expelled.

4. Case Studies

4.1 DANIEL

Age: 48 months	Gender: Male	Race: White	Household: Single parent	Income <$15,000	Type of child care: Center	Interviewees: Consultant Mother Provider (2)	Status at closure: **Expelled**

BACKGROUND

Daniel was 4 years old and living with his mother (31 years). He had 2 older half sisters (8 and 10 years) with whom he had little contact because they lived with their biological father who had grown increasingly concerned about the mother's parenting and the negative influence Daniel was having on his daughters. Daniel and his mother had moved 5 months previously from a large urban county where he attended Head Start to the current center located in a more rural setting. He came to the new program with a referral for psychiatric services. According to the consultant, his providers and his mother, Daniel was already demonstrating challenging behavior and was known to be aggressive with other children and adults. The mother was open to help, but she had her own psychological difficulties and was also very anxious. She seemed to have limited abilities and struggled to manage Daniel's behavior. The consultant said:

> "Another little added challenge, if you will, is the mother's comprehension level. Sometimes you would think that kind of a conversation was sort of understood and I think she genuinely has a difficult time understanding and comprehending so just kind of communicating in a way can be a challenge - remembering that she needs to hear things several times and that even her anxiety kind of blocks her thinking somewhat".

Daniel and his mother seemed fairly isolated in this new community with family who might have helped living some distance away and neighbors with young children also on the move in the near future. Daniel's mother worked 12-hour days for 3 or 4 days each week so he was at the center from early morning until 8pm each evening. This schedule placed a lot of demand on center staff who were keen to help but were also concerned for the safety of other children. The mother described the difficulties she was also experiencing while remaining open to help:

> "He had a lot of behavior problems like with him hitting himself, throwing things, hitting myself, verbal like - cussing and stuff - it was a lot of behavior problems; it was just really hard to control

him and he started counseling (before we moved) - that seemed to help a little bit and then he started seeing a psychiatrist and they put him on Aderol and it seemed to work for a while and then he had the adverse effect of it and then his behaviors got worse. And at that time, I had already moved so he went to a program (here). It was like very intensive therapy because his behaviors got so bad where he was like a danger to himself and to me and so they tried him on Resperidol .25 mg and that medicine seemed to work really good ."

REFERRAL

Daniel's aggressive behavior continued at his new center. It was described by the teacher in the following way:

> *"When he first joined us his behaviors were very self-destructive. He would hit himself in the head, he would pull on his ears very hard, screaming and then when it came to the other children, he would go up and he would single out children and he'd go up and punch them or he'd do that to teachers too. I watched him one day go running across the room and just throw himself fist first into one of the teachers that was sitting in a chair. So there were some very physical behaviors and things that he would say, he hated himself, he hated everybody else, nobody loved him."*

The Center Director already knew Jasmine, the consultant, and had previously worked with her. She trusted her and found her to be responsive, professional and supportive[i]. She did not hesitate to get her involved[ii] and soon made a referral. Center staff with the support of the consultant held onto Daniel as long as they could, encouraging attendance and giving support to the mother. The consultant highlighted the underlying importance of having a longstanding, positive relationship with the provider when a child continues to be very disruptive:

> *"..we had a couple close calls early on in this case, of just you know, phone calls from the director saying 'I don't think we can do this'...you kind of have to have a little bit of background with a center ...to be able to say 'could you just hang in there a little bit longer - let's try this'." [iii]*

Together center staff tried working with Daniel and the mother[iv] and although he was diagnosed as 'bipolar' and medication was initially helpful, he spiraled out of control and his behaviors became increasingly sexualized.

PROCESS

Underpinning approach: building relationships

Throughout the consultation process, the consultant developed and strengthened her relationships with the mother and with center staff through her abilities to communicate openly and helpfully, frequent contact (either in-person or by phone,) and her non-judgmental attitudes and accessibility[v]. She also supported the mother to build and extend her support network with and between the professionals who were helping her. The mother describes her interactions with her consultant below:

> *"I just got this vibe from her that she was a really good person, you know, she cares what she does, she cares about what she does…One thing I love about her (consultant) is that when you have a problem and you need to talk to her about something, she just listens. She don't give an opinion, she don't like interrupt and say 'oh well, I think this is better, or why don't you do this, she just listens. …and that's what I liked about it 'cause you know, that's one thing I don't like when you want to vent, it's really just to vent to somebody and then they can listen, not to criticize you or say 'oh no, I don't think that's right' or 'you should do it like this', or maybe we should do this'. And so then it kind of frustrates you."[vi]*

About her accessibility, the teacher at the center said:

> *"Jasmine (the consultant) opened up. I mean all of us had her cell phone number - all of us and I know Tracy (director) has called her many times. I know Shirley (teacher) has called her to bounce things off of her. I guess one of the pieces of the CCEP program that I was impressed with is it wasn't just for in-classroom, classroom management and the child, it was also for us - a sounding board for us to make sure that we were healthy. No agency I've worked for has taken such care of their caregiver."[vii]*

Despite groundwork and following individualized procedures (assessment, observation, joint planning (including drawing up a written Positive Guidance Plan)[viii] Daniel was expelled. The plan included the involvement of other services, including Child Protective Services, and the steps of the plan were followed through until a network of supportive agencies was in place.

Collaboration with other professionals[ix]

Due to the extreme nature of Daniel's challenging behaviors and the involvement of other services in the recent past, collaboration with other agencies featured significantly in this case.

The consultant attributed her involvement with the family as helping prevent Daniel from slipping through the system. The consultant described some of this work in the following way:

> *"Daniel had 'wraparound' services - to initiate the 'wraparound' program - you present the family's case to a community team - that's through CMH and then the family did get accepted for services and what that means is that the 'wraparound staff person', in essence, tries to just find every type of thing that seems imaginable - that you could think of. Right now she's helping the mother find more affordable housing - just some kinds of basic services that families need - not those intended to be therapeutic. …and just the degree and how extreme his behaviors were and his mother feeling so overwhelmed, I thought it might not be a bad idea to have therapeutic services for him too - home-based therapeutic services so that the mother could actively benefit too…. again the sexualized behaviors just ended up becoming more, more, more. When the 'wraparound' person was at their home, Daniel was touching her breasts and then wanting to like lick her toes….. there was no redirecting or stopping or helping him understand the inappropriateness. He just wasn't grasping that. And then at school, it just became more and more excessive. What ended up eventually leading to his expulsion was that one of the teachers on the playground with the children turned around and he had a little girl's head pushed to his penis with his pants down…..So I'll just say, Protective Services were called with the mother's full knowledge, supporting her in the process as well. She's felt very linked to the whole process of even the Protective Services piece. .. so, what we've done now at CMH as well is that they have someone actually come to her home 4 days a week to kind of offer her additional support and guidance. So, I guess the thing that I'm grateful for in all of this too is that if this child were just expelled and there were no CCEP kind of situation perhaps he and his mother would be just lost".*

CASE CLOSURE[x]

The consultant closed the case after 5 months (166 days) following supporting and advocating on behalf of Daniel and his mother and when she was assured that all appropriate professional support services were in place.

OUTCOMES

Expulsion[xi]

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Although medication seemed to help in this extreme case, it did not prevent expulsion. The mother, center staff and consultant all agreed that it had become impossible to maintain Daniel at the center without putting other children at risk, as explained by Daniel's consultant:

> *"What ended up eventually leading to his expulsion was that one*
> *of the teachers on the playground with the children turned around*
> *and he had a little girl's head pushed to his penis with his pants*
> *down. So the director just sort of felt maxed out at that point".*

Child outcomes[xii,xiii]

Although consultation lasted just over 5 months, and there were a number of agencies involved as well as medication, the DECA was completed by mother and the provider at pre- and post- and showed some interesting patterns. Daniel was clearly a child at high risk in terms of his behavior, hyperactivity and attention problems. Further, he displayed few protective factors. According to the mother and the provider, there was practically no change in the level of his risk factors from the start to end of consultation services but both saw some positive movement in the growth of his protective factors. Although other agencies were actively involved by the time CCEP services ended and gains cannot be attributed to CCEP alone, his social skills were perceived to have improved and he showed small gains in functional communication. A table of Daniel's' scores on the measures used in the evaluation follow this qualitative summary.

Family outcomes[xiv]

In this evaluation parental competence was assessed from sub-scales of 2 standardized measures (Parenting Stress Index and Parent Psychological Empowerment Scale). In addition, information was collected on the number of times parents were unable to attend work or school or remain undisrupted while there due to challenging child behavior reported by the provider

Daniel's mother reported that she had to leave her job because of Daniel's expulsion; therefore, one of the evaluation goals [xv] was not met. However, she said that she felt supported through the process and was pleased that she could return to the center if Daniel improved [xvi.] When Daniel's mother first began CCEP consultation, she noted, and her evaluation measures on stress indicated, that she felt a lot of anxiety and worry and did not feel in control as a parent. By the time CCEP closed the cases, her empowerment scores were similar to other parents in the CCEP group after services and her levels of parenting stress were reduced considerably.

Provider and program outcomes

The consultant spent time with providers in the classroom as well as with the mother. A number of quantitative measures were used to gauge the extent of positive change in child care knowledge and competence (GAS, TOS and Early Warning Signs). Provider measures stayed

about the same although an increase in perceived knowledge about challenging behavior was higher than average for this group. The class teacher was helped to cope with the support of the consultant and as a consequence, the social emotional classroom environment for all the other kids was also better[xvii]. The teacher said:

> *"There were days where I probably shouldn't be admitting this, but I had no clue and I didn't know where to turn next and I didn't know how to get a handle on the situation. And just talking to Jasmine (consultant) and being validated in that my feelings were a normal thing and, you know, that not everybody can deal with every situation every time. It made me feel more confident as a teacher. That it wasn't me lacking in things necessarily, it was just being a human so the support Jasmine gave me personally allowed me to go back into that classroom every day or every time I walked back in that door into a new situation and kind of let what had happened go and start over".*

Center staff reported that the consultant had given them new ideas for managing challenging behavior with children like Daniel. However, the consultant had some reservations about the ability of staff to use some of the management skills she suggested and that might have also helped with all children[xviii].

After consultation: Expulsion

As noted, as Daniel's behavior became increasingly sexualized and he became a danger to others, he was expelled. This case was not considered by the consultant as a 'failure' although it might ostensibly have looked that way. The consultant had been instrumental in coordinating and setting up a comprehensive package of new early intervention mental health services that could potentially benefit mother and Daniel. She had used her personal and professional skills to advocate successfully and to model how to build trusting networks with formal caring agencies. This modeling laid the groundwork for potentially helping mother in the future to access a range of services and improve her own advocacy skills. As the consultant emphasized:

> *"I know that it probably sounds pretty ironic 'cause it ended in an expulsion but it still feels like a successful case. I just feel like there's so much in place that we have going for this mother that really could be conducive to real true solid healing and plus there were no bitter partings. Even right now, the director who ended up expelling Daniel is in the process of trying to help that mother find affordable housing. So, and she has said too, that once he kind of gets a little bit more on solid ground, she would welcome him back."*

i CCEP Cornerstone: Appropriate qualifications and characteristics of consultants

ii Theme: Current responsiveness of consultee (provider)

iii Theme: Relationship, strength-based approach

iv Themes: Ongoing building and strengthening of relationships, Supporting, Collaboration,

v Theme: Ongoing building and strengthening of relationships

vi Theme: Supporting (mother)

vii Theme: Supporting (provider)

viii Themes: Assessment, Joint planning.

ix CCEP Cornerstone: Collaboration

x Theme: Case closure

xi Research question 4: Do children receiving CCEP services successfully stay in child care vs. being expelled?

xii Research question 1: Does the severity of children's challenging behavior decrease from the onset of CCEP services to the conclusion of services?

xiii Research question 2: Does children's social and emotional health increase from the onset of CCEP services to the conclusion of services?

xiv Research question 5: Do subjective feelings of parental competence in dealing with their child's challenging behavior increase as a result of CCEP services?

xv Research question 6: Are families able to consistently attend work or school?

xvi Theme: Ongoing building and strengthening of relationships

xvii Research question 9: Has the social and emotional quality of the child care setting receiving CCEP services improved?

xviii Research question 8: Is the child care provider better able to manage challenging behavior in the child care setting, with all children?

DANIEL'S PROFILE

The tables below describe how Daniel's profile appears relative to other children in the CCEP group.

Table 1 Demographic Characteristics for Daniel's Case

Characteristics –(T1)	Daniel	CCEP Group mean (SD) (N=432)
Age (months)	48	42.7 (13.2)
Gender	Male	72.6% male
Race	White	75.3% white
Previous expulsions	0	0.12
Length of consultation (days)	166	142.3 (85.3)
Type of provider	Child Care Center	86.6% child care center
Status of child at conclusion of services (T2)	Child Expelled	59.8% same provider

Household at T1	Daniel	CCEP Group mean (SD) (N=432)
# Adults in household	1	1.84 (0.7)
# Children in household	1	1.92 (1.0)
Living arrangements	Full time with mother only	52.6% 2 biological parents
Primary language spoken in home	English	97.6% English
Household income	Less than $15,000	19.6% less than $15,000
Parent's (respondent) highest level of ed. attainment	HS Diploma/GED	30.1% Bachelor's Degree

Table 2 Daniel's Parent's Scores in the Context of the Group

Parenting Measure	T1 Daniel	T1 CCEP Group Mean (SD) (N = 333)	T2 Daniel	T2 CCEP Group Mean (SD) (N = 237)
Empowerment	59	66.40 (7.60)	67	69.06 (7.35)
Parenting Stress	71	46.70 (13.42)	51	42.72 (12.97)
Number of Work/ School Absences due to Daniel's Behavior	Not provided	1.32 (3.57)	Not provided	.63 (2.67)

Table 3 Daniel's Provider's Scores in the Context of the Group

Provider Measure (N = 189)	T1 Daniel	T1 CCEP Group Mean (SD)	T2 Daniel	T2 CCEP Group Mean (SD)
Goal Attainment Scale	22	22.5 (2.7)	25	25.2 (2.5)
Teacher Opinion Survey	47	47.8 (4.4)	47	48.00 (4.6)

Table 4 Daniel's Scores in the Context of the Group

Child Measure (N =256)	T1 Daniel	T1 CCEP Group Mean (SD)	T2 Daniel	T2 CCEP Group Mean (SD)
Risk Factors				
DECA Behavior Concern-Parent	72	65.04 (7.80	72	**61.33 (9.05)
DECA Behavior Concern-Provider	72	65.36 (7.27)	70	**60.90 (8.63)
BASC Hyperactivity-Parent	22	16.68 (5.97)	22	**13.53 (5.68)
BASC Hyperactivity-Provider	25	14.67 (6.12)	23	**12.13 (6.18)
BASC Attention-Parent	10	9.75 (3.36)	10	**8.36 (3.33)
BASC-Attention-Provider	14	11.81 (3.15)	14	**10.19 (3.74)
Protective Factors				
DECA Total Protective Factors-Parent	34	41.04 (9.85)	44	**46.21 (10.66)
DECA Total Protective Factors-Provider	31	39.53 (8.70)	42	**44.54 (10.77)

BASC Functional Communication-Parent	17	16.45 (7.46)	21	**19.23 (7.03)
BASC Functional Communication-Provider	13	10.51 (6.04)	14	**12.99 (5.85)
BASC Social Skills-Parent	9	14.75 (5.19)	15	**16.62 (5.35)
BASC Social Skills-Provider	2	5.47 (3.95)	10	**7.67 (4.35)

4.2 HANNAH

Age: 42months	Gender: Female	Race: White	Household: Single parent	Income $15,000- $34,999	Type of child care: Center	Interviewees: Consultant, Mother, Provider (3)	Status at closure: Moved out of area

BACKGROUND

The Director of *Jill's Learning Center* was considering expelling Hannah who was 4 years old when she talked about it with the Director of her child care course at the Community College.

The Director, Jill, and the mother, Ashley, lived locally in a rural community and had attended high school together. Hannah (3 years) lived alone with her mother and had attended Jill's Learning Center from the time she was a baby. Recently staff had reported her behavior as increasingly unacceptable and unmanageable. She was perceived as not listening, being aggressive and spitting and exhibiting extreme mood swings. The childcare program director described Hannah's behavior:

> *"She (Hannah) didn't listen and she hit not only children but the*
> *adults as well and spit at them and we had just not found any way*
> *to control her behavior."*

Hannah's mother shared similar challenging behaviors with Hannah at home. Ashley was young, a single parent and although she was bringing up Hannah on her own, relatives sometimes lived with them as did some boyfriends. Hannah's biological father was no longer a presence in the household or involved with Hannah's current or future care. He was in jail but Hannah did not know where he was or what was going to happen with her relationship to him in the future. Hannah had been told he was going to play darts but he had never returned. Hannah's CCEP consultant explains Hannah's observations about her father:

> *"Hannah's father was in jail, but Ashley never wanted to have*
> *contact with him again and Hannah also recently started asking*
> *Ashley 'is my dad still playing darts?' because he told Hannah that*
> *he was going to play darts and he never came back."*

REFERRAL

Hannah's teacher was enrolled in a college course on early childhood development. In sharing anecdotal descriptions with the course professor, a suggestion was made to contact Jasmine, a consultant with CCEP, for additional support for Hannah. Hannah's behavior was of great

concern to the child care program administrator, and expulsion from the program was a possible outcome given these concerns. The course professor knew the CCEP consultant professionally and noted that she had relevant social work and infant mental health qualifications as well as relevant experience with 0 to 5 year olds, their families and child care providers. Jasmine was perceived as viewing people and situations from a positive perspective. She was described as non-judgmental and approachable, and the consensus was that Jasmine could offer much needed support to Ashley and Hannah and to the child care program. As her quote below articulates, Hannah's mother agreed to the consultation, although she was worried that it might not yield the desired results.

> *"Hannah had seen several, different professionals. She had been to a psychologist, to a clinical therapist and nothing really seemed to get any results so at that point when we first started working with Jasmine (the consultant), I tried not to get my hopes up".*

PROCESS

Initial planning meeting

The consultant visited the center for a joint meeting with the director, the director's mother who was very actively involved in the running of the center, and Hannah's mother. The consultant reflected on the meeting as follows:

> *"I asked them (teacher, Director, mother) what their concerns are and kind of keep trying to have the teachers and parents kind of feel as much on common ground as possible so that there's an immediate sense of partnership and working together. It's kind of in the spirit and tone of the meeting. Then we sort of get to more specifics at that point. What would we like to see happen for Hannah; you know what type of dialogue? What are we hoping for and then and explaining the program too as well… making sure that everybody understands how CCEP works and functions and have their questions answered."*

It was at this meeting that some of the initial paperwork began. The consultant set about collecting information about Hannah's development using formal (e.g. DECA, PSI) and informal measures (discussion with provider and mother) for her assessment. Before embarking on a series of observations, the consultant wanted to gather information from a variety of sources.

> *"I could really, really, really tell that she (mother) just had a lot more to say about her child and her experience with her child and*

*a lot more discomfort; I gave her a call immediately after that first
meeting and then the observations began."*

Observation

A period of classroom observation and, sometimes, home observation are part of the usual consultation process. Due to the frequency and intensity of Hannah's challenging behaviors, the consultant followed up with weekly observations and discussions with staff that lasted approximately two hours and with frequent (several times a week) phone discussions with mother to try to build and maintain an effective relationship and help her build a more structured environment for Hannah at home. Following these initial observations and discussions, a positive Positive Guidance Plan (PGP) was developed.

OUTCOMES

Child outcomes

Despite some challenges with follow through on the PGP and the premature ending of the consultancy after 6.7 months when the family moved, there were a number of important changes which were demonstrated in both qualitative and quantitative data on child, family and programmatic outcomes. A table of Hannah's scores on the measures used in the evaluation follows this summary.

The DECA and BASC that were completed by mother and provider when the consultation began showed Hannah to have a number of high risk factors in terms of behavior concerns, hyperactivity and attention problems and lower than average protective factors. After consultation, all the scores had moved in the correct direction showing improvements but only 'functional communication' was now perceived by the provider as close to the average scores found among other children in the CCEP group after receiving consultation.
The provider and mother both found the severity of Hannah's behavior had decreased although it was not clear whether this was due to actual or perceived behavior or management changes. As the mother said:

> *"We weren't necessarily able to stop her from kind of 'exploding'
> but once we could see when it was gonna' happen or if it had
> already happened, we knew how to get her to calm down a lot
> quicker without her being so violent and hurting people"*

The mother also felt that Hannah's self-regulation had improved and that she had a better understanding of herself. She commented:

> *"I definitely feel she helped Hannah progress a lot even just kind of learn some stuff about herself because I think it was really hard for Hannah to process her emotions and after working with Jasmine (the consultant) she definitely did a lot better job with that, which in turn made everybody's life a little bit easier."*

> And *"she (the consultant) taught Hannah how if (she) felt herself getting really angry, she should blow on her fingers and that really helped."*

Mother and provider felt that Hannah had benefited from the consultation whether or not this was due to maturation and that had she stayed living in Michigan they would have continued with CCEP support.

After consultation

Hannah was not expelled as was originally intended. After 7 months Hannah and her mother moved out of state to Illinois to live with Grandma and an aunt. The consultant reflects on her work with Hannah and her provider.

> *"Sometimes I wish that they (center) could have sustained empathy, a higher empathy level for her (mother); it's hard to pull people out of the domain of blame...I am at least grateful that they did maintain their care for her (Hannah) and did you know, as frustrated as they were, at a pretty high empathy level for the child and literally cried when she left."*

Work with Hannah and her mother was therefore cut short but the consultant maintained regular phone contact with her after her move. She soon got a job at "Target" after her move and reported Hannah's behavior as improved.

Hannah's Profile

The tables below describe how Hannah's profiles appear relative to other children in the CCEP group.

Table 1 Demographic Characteristics for Hannah's Case

Characteristics –(T1)	**Hannah**	CCEP Group mean (SD) (N=432)
Age (months)	42	42.7 (13.2)
Gender	Female	72.6% male
Race	White	75.3% white
Previous expulsions	0	0.12
Length of consultation (days)	207	142.3 (85.3)
Type of provider	Child Care Center	86.6% child care center
Status of child at conclusion of services (T2)	Moved out of state	59.8% same provider

Household at T1	**Hannah**	CCEP Group mean (SD) (N=432)
# Adults in household	1	1.84 (0.7)
# Children in household	1	1.92 (1.0)
Living arrangements	Full time with mother only	52.6% 2 biological parents
Primary language spoken in home	English	97.6% English
Household income	Less than $15,000	19.6% less than $15,000
Parent's (respondent) highest level of ed. attainment	HS Diploma/GED	30.1% Bachelor's Degree

Table 2 Hannah's Parent's Scores in the Context of the Group

Parenting Measure	T1 Hannah	T1 CCEP Group Mean (SD) (N = 333)	T2 Hannah	T2 CCEP Group Mean (SD) (N = 237)
Empowerment	59	66.40 (7.60)	72	69.06 (7.35)
Parenting Stress	63	46.70 (13.42)	45	42.72 (12.97)
Number of Work/ School Absences due to Hannah's Behavior	5	1.32 (3.57)	6	.63 (2.67)

Table 3 Hannah's Provider's Scores in the Context of the Group

Provider Measure (N = 189)	T1 Hannah	T1 CCEP Group Mean (SD)	T2 Hannah	T2 CCEP Group Mean (SD)
Goal Attainment Scale	15	22.5 (2.7)	26	25.2 (2.5)
Teacher Opinion Survey	45	47.8 (4.4)	51	48.00 (4.6)

Table 4 Hannah's Scores in the Context of the Group

Child Measure (N = 256)	T1 Hannah	T1 CCEP Group Mean (SD)	T2 Hannah	T2 CCEP Group Mean (SD)
Risk Factors				
DECA Behavior Concern-Parent	72	65.04 (7.80	70	**61.33 (9.05)
DECA Behavior Concern-Provider	72	65.36 (7.27)	72	**60.90 (8.63)
BASC Hyperactivity-Parent	26	16.68 (5.97)	25	**13.53 (5.68)
BASC Hyperactivity-Provider	25	14.67 (6.12)	27	**12.13 (6.18)
BASC Attention-Parent	11	9.75 (3.36)	10	**8.36 (3.33)
BASC-Attention-Provider	16	11.81 (3.15)	18	**10.19 (3.74)
Protective Factors				
DECA Total Protective Factors-Parent	34	41.04 (9.85)	41	**46.21 (10.66)
DECA Total Protective Factors-Provider	31	39.53 (8.70)	33	**44.54 (10.77)

BASC Functional Communication- Parent	23	16.45 (7.46)	21	**19.23 (7.03)
BASC Functional Communication- Provider	9	10.51 (6.04)	12	**12.99 (5.85)
BASC Social Skills- Parent	15	14.75 (5.19)	16	**16.62 (5.35)
BASC Social Skills- Provider	6	5.47 (3.95)	7	**7.67 (4.35)

4.3 KAYLA

The George family had recently moved from South Carolina and had settled into their new life in a busy Michigan city. They were happy with the move but were now without the support of nearby family and had not yet developed a network of friends who lived locally. When CCEP consultation began Kayla was a lively, chatty three-year-old who was tall for her age and had become familiar with spending time in her new child care center while her mother was employed nearby as a teacher. Kayla's father was working to establish himself as an insurance agent. Her older brother by 18 months had settled well into his elementary school. Despite Kayla's many positive characteristics, her behaviors could be challenging. Kayla's teacher complained that Kayla "had to be in charge" and challenged adults whenever she was asked to do something. Kayla found transitions particularly difficult and during transitions, such as movement to a new activity or mealtime, Kayla often resisted and fussed. She had a very difficult time focusing on activities or settling for a nap in the afternoon. As a teacher, Kayla's mother noted that she felt embarrassed and distressed by her daughter's behavior and empathized with Kayla's teacher. Kayla's mother and father were very enthusiastic about the idea of support from a CCEP consultant and remained actively committed throughout the 6 month intervention. The parents and provider learned to view Kayla differently through the course of CCEP intervention. For example, because Kayla was tall for her age, her provider and parents realized they sometimes held expectations for Kayla that would be more appropriate for an older child. Although she looked older, Kayla was only 3 years old and her self-regulation skills were more characteristic of a two year old. Through reframing Kayla's behaviors to reflect her age and her individual level of development, the provider and parents began to think about how to best support Kayla. Through consultation, they realized that a formal nap might not be an appropriate expectation for Kayla. They also considered how to use increased physical activities to help channel Kayla's energy and need for mastery. As the consultant shared more about possible reasons for Kayla's behavior, she encouraged Kayla's parents to see Kayla's temperament as a potential strength rather than a constant personal challenge to parental authority. This shift in thinking promoted feelings of parental competence. The consultant also gave the parents practical management ideas such as channeling some of Kayla's energy on riding her bike or jumping on her trampoline so that a family time together was more enjoyable.

The provider opted not to share the evaluation measure scores with the MSU evaluation team, although was happy to discuss the benefits and challenges they had perceived related to the consultation. The provider felt that they (the program) were better able to manage Kayla and other very active children. They also noted the benefit of getting to know Kayla's parents through the CCEP intervention, explaining that the relationship and information yielded by the collaboration prompted the creation of better intervention strategies for Kayla. Kayla's mother talked positively about her CCEP experiences. However, evaluation measures showed fairly mixed results about change in Kayla or in her mother. The consultant made some interesting

comments about this. Consultancy is often not about changing behavior but realigning perceptions of the child and accepting individual temperamental differences that may, in the long term, be very helpful in the future. The consultant explains:

> "The interesting part on some of these behavioral checklists and also on the DECA I noticed is there are not significant improvements - on the post and pre. However, part of that I think is 'cause we have a child with a very quick temperament and a very active style who's always gonna be a little quick to react - always gonna have to have some help with her impulsivity, yet very, very bright and so when you score her, you still see those traits and so, it was kind of interesting to me. But I think the perception from the parent's point of view has changed a bit and how she copes with it and so she may not look like she has made big-time progress on the DECA, but I believe she has progressed. In general, the experience, I think, kind of helped the relationship between the mother and Kayla become a little more positive. It was getting really dug into a negative interaction. Kayla is a challenge, but she is absolutely, she is just gonna go far. She's absolutely a really bright kid and this is the kind of child that maybe down the road in the school they'll say 'oh, this kid might need a med. here 'cause she's really too hyper'. Maybe so, maybe not. I think, mother is seeing that Kayla's maturing a little bit and is able to better control herself - more so than 6 months ago and that's part of just maturing. You know, she was only 3 ½ so you got that, you always got the nature of just plain old maturing, you know".

Table 1 Demographic Characteristics for Kayla's Case

Characteristics –(T1)	Kayla	CCEP Group mean (SD) (N=432)
Age (months)	41	42.7 (13.2)
Gender	Female	72.6% male
Race	White	75.3% white
Previous expulsions	0	0.12
Length of consultation (days)	186	142.3 (85.3)
Type of provider	Child Care Center	86.6% child care center
Status of child at conclusion of services (T2)	Moved on to school	59.8% same provider

Household at T1	Kayla	CCEP Group mean (SD) (N=432)
# Adults in household	2	1.84 (0.7)
# Children in household	2	1.92 (1.0)
Living arrangements	2 adoptive parents	52.6% 2 biological parents
Primary language spoken in home	English	97.6% English
Household income	Not provided	19.6% less than $15,000
Parent's (respondent) highest level of ed. attainment	Not provided	30.1% Bachelor's Degree

Table 2 Kayla's Parent's Scores in the Context of the Group

Parenting Measure	T1 Kayla	T1 CCEP Group Mean (SD) (N = 333)	T2 Kayla	T2 CCEP Group Mean (SD) (N = 237)
Empowerment	68	66.40 (7.60)	79	69.06 (7.35)
Parenting Stress	57	46.70 (13.42)	Not provided	42.72 (12.97)
Number of Work/ School Absences due to Kayla's Behavior	0	1.32 (3.57)	0	.63 (2.67)

Table 3 Kayla's Scores in the Context of the Group

Child Measure (N = 256)	T1 Kayla	T1 CCEP Group Mean (SD)	T2 Kayla	T2 CCEP Group Mean (SD)
Risk Factors				
DECA Behavior Concern-Parent	65	65.04 (7.80	70	**61.33 (9.05)
DECA Behavior Concern-Provider	Not provided	65.36 (7.27)	Not provided	**60.90 (8.63)
BASC Hyperactivity-Parent	25	16.68 (5.97)	21	**13.53 (5.68)
BASC Hyperactivity-Provider	Not provided	14.67 (6.12)	Not provided	**12.13 (6.18)
BASC Attention-Parent	14	9.75 (3.36)	13	**8.36 (3.33)

BASC-Attention-Provider	Not provided	11.81 (3.15)	Not provided	**10.19 (3.74)
Protective Factors				
DECA Total Protective Factors-Parent	57	41.04 (9.85)	52	**46.21 (10.66)
DECA Total Protective Factors-Provider	Not provided	39.53 (8.70)	Not provided	**44.54 (10.77)
BASC Functional Communication-Parent	12	16.45 (7.46)	16	**19.23 (7.03)
BASC Functional Communication-Provider	Not provided	10.51 (6.04)	Not provided	**12.99 (5.85)
BASC Social Skills-Parent	23	14.75 (5.19)	18	**16.62 (5.35)
BASC Social Skills-Provider	Not provided	5.47 (3.95)	Not provided	**7.67 (4.35)

4.4 MADISON

Madison was a bright, active little girl who had just turned five years old. She had a sister who was two years younger. In her private child care class, located in a public school, Madison was viewed by staff as often very challenging and disruptive. Her providers felt drained and that they were spending an inordinate amount of time trying to manage her behavior. Madison's provider felt that Madison wanted to be in control and threw frequent tantrums when thwarted by other children or adults. The Director, who had never before been in direct contact but had heard positive things about CCEP, made a referral.

Lizbeth, the consultant, visited the center, talked to staff and observed Madison in class. She also visited Madison's home and talked to the parents who recognized that she was very strong-willed. Madison's parents, however, reported that they did not see the same challenging behaviors at home that she displayed at the center. They had heard frequently about her difficult behavior from the Director. Despite their reservations about the need for this intervention, both the mother and father were willing to participate. They wanted to understand why Madison behaved so differently at the center as compared to her behaviors at home. The contrasting views of the center staff and the parents did not appear to change over the 3 month consultation and CCEP intervention. Lizbeth described her attempts to engage Madison's family as follows:

> *"..they didn't really believe that Madison had a problem so I just kind of accepted where they were and thought about listening to them and their perception and was very respectful in saying, you know, 'yeah I can see that you see that there's not really any problem with her here. Sounds like the schools have problems with her and as she progresses throughout her school career, there may be others that are gonna see problems with her because of the way she's put together - her temperament and her style. So this experience now may be useful for you in that you're gonna hear those discrepancies between what you believe and what the school believes. And some of the things that the school in this situation has learned that were helpful to them, you may be able to use as you advocate for Madison in the future'."*

The provider had concerns about Madison's behavior and the extent of hyperactivity in class so Lizbeth channeled the primary efforts of intervention to support the provider. She thought it useful because it affirmed their views of dealing with a very gifted and challenging little girl while recognizing their skills, giving them positive feedback, and giving them a chance to process their frustrations. Lizbeth also provided ideas for restructuring the classroom to avoid power struggles and for handling Madison's temperament and encouraging motivation.

Provider outcome scores indicated that the teacher felt a bit more competent after intervention but feelings of efficacy decreased at the same time. The provider reported her perceived high levels of existing knowledge about the early warning signs of social-emotional development and perceived that she had learned a little more as a result of CCEP services. Lizbeth engaged with the parents and this was welcomed by center staff who learned to reframe their perception of Madison as 'disruptive' to focus on her strengths.

Although intervention lasted approximately three months, according to the consultant, the records indicate that intervention was twice as long, possibly due to some of the difficulties in reaching the point of official case closure since the center moved premises and parents who were less motivated may also have been reluctant to complete paperwork in a timely way. While the consultant saw this as moderately successful case, the parents continued to feel intervention was unnecessary. As the consultant herself noted:

> *"And Dad was pretty direct about saying when I did the interview*
> *last week, well, 'yeah I don't think, no offense, but I don't think*
> *you really helped' and I said 'that's okay'."*

The center indicated their approval of the service by referring another child with similar issues to Madison to the CCEP program. The evaluation measures supported the perceptions of this case.

Table 1 Demographic Characteristics for Madison's Case

Characteristics –(T1)	Madison	CCEP Group mean (SD) (N=432)
Age (months)	60	42.7 (13.2)
Gender	Female	72.6% male
Race	White	75.3% white
Previous expulsions	0	0.12
Length of consultation (days)	186	142.3 (85.3)
Type of provider	Child Care Center	86.6% child care center
Status of child at conclusion of services (T2)	Moved on to school	59.8% same provider

Household at T1	Madison	CCEP Group mean (SD) (N=432)
# Adults in household	2	1.84 (0.7)
# Children in household	2	1.92 (1.0)
Living arrangements	2 biological parents	52.6% 2 biological parents
Primary language spoken in home	English	97.6% English
Household income	Not provided	19.6% less than $15,000

Parent's (respondent) highest level of ed. attainment	Not provided	30.1% Bachelor's Degree

Table 2 Madison's Parent's Scores in the Context of the Group

Parenting Measure	T1 Madison	T1 CCEP Group Mean (SD) (N = 333)	T2 Madison	T2 CCEP Group Mean (SD) (N = 237)
Empowerment	64	66.40 (7.60)	67	69.06 (7.35)
Parenting Stress	46	46.70 (13.42)	44	42.72 (12.97)
Number of Work/ School Absences due to Madison's Behavior	0	1.32 (3.57)	0	.63 (2.67)

Table 3 Madison's Provider's Scores in the Context of the Group

Provider Measure (N = 189)	T1 Madison	T1 CCEP Group Mean (SD)	T2 Madison	T2 CCEP Group Mean (SD)
Goal Attainment Scale	20	22.5 (2.7)	25	25.2 (2.2)
Teacher Opinion Survey	46	47.8 (4.4)	44	48.00 (4.6)

Table 4 Madison's Scores in the Context of the Group

Child Measure (N = 256)	T1 Madison	T1 CCEP Group Mean (SD)	T2 Madison	T2 CCEP Group Mean (SD)
Risk Factors				
DECA Behavior Concern-Parent	53	65.04 (7.80	51	**61.33 (9.05)
DECA Behavior Concern-Provider	65	65.36 (7.27)	60	**60.90 (8.63)
BASC Hyperactivity-Parent	7	16.68 (5.97)	6	**13.53 (5.68)
BASC Hyperactivity-Provider	22	14.67 (6.12)	4	**12.13 (6.18)

BASC Attention-Parent	5	9.75 (3.36)	0	**8.36 (3.33)
BASC-Attention-Provider	10	11.81 (3.15)	6	**10.19 (3.74)
Protective Factors				
DECA Total Protective Factors-Parent	34	41.04 (9.85)	51	**46.21 (10.66)
DECA Total Protective Factors-Provider	65	39.53 (8.70)	60	**44.54 (10.77)
BASC Functional Communication-Parent	30	16.45 (7.46)	31	**19.23 (7.03)
BASC Functional Communication-Provider	17	10.51 (6.04)	14	**12.99 (5.85)
BASC Social Skills-Parent	24	14.75 (5.19)	26	**16.62 (5.35)
BASC Social Skills-Provider	5	5.47 (3.95)	11	**7.67 (4.35)

4.5 NATHAN

Nathan went to the same child care center in which his mother worked. Nathan spent three hours each weekday in a special education class in the school district in addition to his attendance at the child care center. He had been evaluated by the School District when he turned three years old and was diagnosed with some developmental and speech delays. In the past year, the mother had pursued developmental evaluations for Nathan and other family members, including his older brother, from a reputable behavioral institute for neurological and psychiatric evaluations. The mother was concerned because the children's father had ADHD, and she described the father as very impulsive and quick to react.

Nathan was tall but his behaviors were more characteristic of a 2 ½-year-old. He had difficulty in managing frustration, which would often be expressed through hitting and spitting. Nathan also tended to run out of the room, screaming when he saw his mother and wanting to go to her when her class walked past his room. Nathan's mother was extremely anxious and concerned about Nathan at school. Her concerns were compounded by the fact that she worked at the program and because every disturbance could be heard in the small building housing the program. When Nathan's challenging behaviors occurred, the mother was often asked to help, and sometimes she would intervene or try to leave her classroom to assist Nathan's providers. At home there were other pressures with marital and financial difficulties and problems with Nathan's older brother. The previous year had been difficult too with the involvement of Child Protective Services.

The consultant observed Nathan in his special education class, child care setting and at home. She provided emotional support to the mother and help with her parenting and spent time with the Center director (mother's employer) and Nathan's classroom teacher. She found that his behavior in the special education class was more positive than in other settings and she shared some of their techniques. One particular strategy shared was to identify Nathan's potential triggers for a 'meltdown'. Organizational changes to the classroom environment, such as the inclusion of a 'quiet area', made prevention of challenging behaviors for all children more effective. The consultant talked abut a number of changes that were made to the social-emotional environment and teacher-child interactions, including the point made in the comment below:

> *"..is there a way to spend some one-on-one time during free play*
> *with this child sitting on the floor doing something with him that*
> *he has control of and he wants to do?. And so I usually build this*
> *into a lot of these cases where these kids are really. It's kind of an*
> *automatic for me. And sometimes teachers can't do it because*
> *they're too overwhelmed, but sometimes they do. They move from*
> *group to group as kids are in free play and they can sit in the*
> *group where this child is and maybe do some more relationship-*

> *building, so then they begin to feel a little more positive about the child also, so that's really important."*

Nathan's scores suggest that perceptions of his risk and protective factors improved. His mother's high parenting stress reduced but remained moderately high. Nathan's provider had rated herself as having quite a high existing level of perceived knowledge about social emotional development and did not see CCEP services as having changed this yet her perception of Nathan was now very positive. The case was open for approximately 3 $^{1/2}$ months.

Table 1 Demographic Characteristics for Nathan's Case

Characteristics –(T1)	Nathan	CCEP Group mean (SD) (N=432)
Age (months)	49	42.7 (13.2)
Gender	Male	72.6% male
Race	White	75.3% white
Previous expulsions	0	0.12
Length of consultation (days)	110	142.3 (85.3)
Type of provider	Child Care Center	86.6% child care center
Status of child at conclusion of services (T2)	Same provider	59.8% same provider

Household at T1	Nathan	CCEP Group mean (SD) (N=432)
# Adults in household	2	1.84 (0.7)
# Children in household	2	1.92 (1.0)
Living arrangements	2 biological parents	52.6% 2 biological parents
Primary language spoken in home	English	97.6% English
Household income	Not provided	19.6% less than $15,000
Parent's (respondent) highest level of ed. attainment	Not provided	30.1% Bachelor's Degree

Table 2 Nathan's Parent's Scores in the Context of the Group

Parenting Measure	T1 Nathan	T1 CCEP Group Mean (SD) (N = 333)	T2 Nathan	T2 CCEP Group Mean (SD) (N = 237)
Empowerment	63	66.40 (7.60)	64	69.06 (7.35)
Parenting Stress	75	46.70 (13.42)	63	42.72 (12.97)
Number of Work/ School Absences due to Nathan's Behavior	0	1.32 (3.57)	0	.63 (2.67)

Table 3 Nathan's Provider's Scores in the Context of the Group

Provider Measure (N = 189)	T1 Nathan	T1 CCEP Group Mean (SD)	T2 Nathan	T2 CCEP Group Mean (SD)
Goal Attainment Scale	24	22.5 (2.7)	26	25.5 (2.5)
Teacher Opinion Survey	53	47.8 (4.4)	54	48.00 (4.6)

Table 4 Nathan's Scores in the Context of the Group

Child Measure (N = 256)	T1 Nathan	T1 CCEP Group Mean (SD)	T2 Nathan	T2 CCEP Group Mean (SD)
Risk Factors				
DECA Behavior Concern-Parent	70	65.04 (7.80	72	**61.33 (9.05)
DECA Behavior Concern-Provider	72	65.36 (7.27)	57	**60.90 (8.63)
BASC Hyperactivity-Parent	18	16.68 (5.97)	16	**13.53 (5.68)
BASC Hyperactivity-Provider	21	14.67 (6.12)	7	**12.13 (6.18)
BASC Attention-Parent	11	9.75 (3.36)	9	**8.36 (3.33)
BASC-Attention-Provider	13	11.81 (3.15)	10	**10.19 (3.74)

Protective Factors				
DECA Total Protective Factors-Parent	36	41.04 (9.85)	42	**46.21 (10.66)
DECA Total Protective Factors-Provider	42	39.53 (8.70)	55	**44.54 (10.77)
BASC Functional Communication-Parent	15	16.45 (7.46)	18	**19.23 (7.03)
BASC Functional Communication-Provider	11	10.51 (6.04)	18	**12.99 (5.85)
BASC Social Skills-Parent	17	14.75 (5.19)	20	**16.62 (5.35)
BASC Social Skills-Provider	8	5.47 (3.95)	15	**7.67 (4.35)

4.6 RYAN

Ryan was a 4 year old fraternal twin who lived with both of his biological parents in a middle income household in a busy urban area in Michigan. No extended family lived near by. The parents were both employed in demanding jobs. After going to a child care center recently that closed, Ryan and his brother moved to a program that was housed in a nearby local church. This center had four classrooms attended by 164 preschool children over the summer although enrollment was higher during the academic school year. Ryan's class enrolled approximately 20 children, aged 4 years and up, and was staffed by a lead provider and an assistant. Ryan spent up to 10 hours per day, five days a week at the program.

Ryan had frequent screaming episodes and his behavior was so disruptive at times that his mother was called at work. During these times, the mother attempted to calm Ryan over the telephone. The teacher tried a number of strategies over two months including separating the twins' classrooms. This helped but did not resolve the issues. The teacher was also managing another child in the class who had very challenging behavior at the time and this added to the teacher's stress. The Director discussed referral with Ryan's parents and then invited a consultant from the local CCEP project to help. The mother did not share concerns expressed by the teacher and was not having the same problems at home but acknowledged that he was having trouble fitting into the structured school environment. The mother viewed the issue as arising from the teacher and the teacher viewed the behavior problems as a result of poor parenting.

The classroom teacher was very experienced and caring although she had no formal qualifications. She felt most comfortable with a structured environment with clear limits and expectations. This contrasted with a more relaxed home environment with looser boundaries. The teacher really appreciated the intermediary role that CCEP could bring:

> *"I have never been to Ryan's home, but that's one part that I*
> *really, really appreciate - the relationship of CCEP with me as a*
> *teacher and the parent, …-I thought that was very important and*
> *very awesome because then he could have consistency at school*
> *and home, which was really neat."*

The consultant discussed issues with both parents and teacher separately to begin to develop her role and relationships with both parties and conducted observations in the classroom and at home. She used a positive framework to clarify differences in perceptions of Ryan and his behavior. Observations threw up some sensory issues that had become accepted at home but were causing difficulties at the center. As mother pointed out:

> *"..because anything that's loud, like if you're in a public restroom,*
> *he hates to flush the toilet 'cause he thinks it's so, so loud. It hurts*

his ears. ..And he's had problems like when they do their fire alarms and their tornado drills and things like that because of the loud noise… his teacher would just get mad at him, put him in a time out …but once (the consultant) got involved, then she could see maybe what some of the things, that it really wasn't him just having a fit and him trying to show off. "

The consultant then drew together a Positive Guidance Plan based on her assessment. The plan called for increased focus on joint management of Ryan's behavior, support for Ryan's language and communication skills so that he could better express his feelings at home and school, and an improved understanding of triggers that might provoke an escalation of screaming. Growth in these areas was perceived to contribute to small decreases in Ryan's perceived risk and to an increase in his social–emotional health. While parenting stress actually increased from the beginning to the end of consultation, it was still below average for this group of parents. The provider already had high levels of perceived competence and efficacy and these remained so. Parents and provider had a better understanding of shared concerns and improved communication but while the consultant and the parent felt the time for closure was right, the provider thought that more time was required. The consultant recognized that the teacher, like many others, had wanted a complete resolution and end to the challenging behavior but this idealized solution is rare.

Table 1 Demographic Characteristics for Ryan's Case

Characteristics –(T1)	Ryan	CCEP Group mean (SD) (N=432)
Age (months)	51	42.7 (13.2)
Gender	Male	72.6% male
Race	White	75.3% white
Previous expulsions	0	0.12
Length of consultation (days)	149	142.3 (85.3)
Type of provider	Child Care Center	86.6% child care center
Status of child at conclusion of services (T2)	Same provider	59.8% same provider

Household at T1	Ryan	CCEP Group mean (SD) (N=432)
# Adults in household	2	1.84 (0.7)
# Children in household	2	1.92 (1.0)
Living arrangements	2 biological parents	52.6% 2 biological parents
Primary language spoken in home	English	97.6% English
Household income	Not provided	19.6% less than $15,000

Parent's (respondent) highest level of ed. attainment	Not provided	30.1% Bachelor's Degree

Table 2 Ryan's Parent's Scores in the Context of the Group

Parenting Measure	T1 Ryan	T1 CCEP Group Mean (SD) (N = 333)	T2 Ryan	T2 CCEP Group Mean (SD) (N = 237)
Empowerment	60	66.40 (7.60)	62	69.06 (7.35)
Parenting Stress	36	46.70 (13.42)	46	42.72 (12.97)
Number of Work/ School Absences due to Ryan's Behavior	0	1.32 (3.57)	1	.63 (2.67)

Table 3 Ryan's Provider's Scores in the Context of the Group

Provider Measure (N = 189)	T1 Ryan	T1 CCEP Group Mean (SD)	T2 Ryan	T2 CCEP Group Mean (SD)
Goal Attainment Scale	24	22.5 (2.7)	26	25.2 (2.5)
Teacher Opinion Survey	51	47.8 (4.4)	54	48.00 (4.6)

Table 4 Ryan's Scores in the Context of the Group

Child Measure (N = 256)	T1 Ryan	T1 CCEP Group Mean (SD)	T2 Ryan	T2 CCEP Group Mean (SD)
Risk Factors				
DECA Behavior Concern-Parent	58	65.04 (7.80	58	**61.33 (9.05)
DECA Behavior Concern-Provider	68	65.36 (7.27)	62	**60.90 (8.63)
BASC Hyperactivity-Parent	15	16.68 (5.97)	13	**13.53 (5.68)
BASC Hyperactivity-Provider	15	14.67 (6.12)	10	**12.13 (6.18)

BASC Attention-Parent	14	9.75 (3.36)	10	**8.36 (3.33)
BASC-Attention-Provider	13	11.81 (3.15)	10	**10.19 (3.74)
Protective Factors				
DECA Total Protective Factors-Parent	34	41.04 (9.85)	37	**46.21 (10.66)
DECA Total Protective Factors-Provider	38	39.53 (8.70)	48	**44.54 (10.77)
BASC Functional Communication-Parent	18	16.45 (7.46)	26	**19.23 (7.03)
BASC Functional Communication-Provider	13	10.51 (6.04)	19	**12.99 (5.85)
BASC Social Skills-Parent	12	14.75 (5.19)	17	**16.62 (5.35)
BASC Social Skills-Provider	5	5.47 (3.95)	11	**7.67 (4.35)

4.7 SOPHIA

Sophia was described as a 'sweet but demanding' 3 year old, always distracting her family home provider from giving attention to the other young children in her care by clinging and crying. She fought off the other children by biting and throwing tantrums. Sophia's provider felt that Sophia was insecure and tried to attach to her (the provider). The provider was aware that an older half-sibling had been adopted by a family member and that the mother was pregnant. Sophia's mother lacked confidence in her parenting abilities and was very upset that Sophia was showing some behaviors very similar to those the mother had also shown when growing up. Because of these similarities and the mother's ongoing adult mental health issues, Sophia's mother reported feeling worried that Sophia, too, would suffer from mental health issues as a child and adult. The mother was open to receive all the help available. She invited the CCEP consultant, Julie, to help. Julie set about building the relationship with mother and the provider so that they both felt open and willing to trust her. She talked about some of this work:

> *"Some of the things with the mother maybe got a tad more therapeutic than would be typical for CCEP although along with that, I was able to encourage the mother to follow through on some services of therapy…. There was a lot of work that focused around developing a sense of empathy for the mother in the provider because again, a lot of times once the provider links with the parent and connects with them emotionally, it really extends into their care and their perception of the child."*

This way she could support mother and the provider, offering parenting guidance, connecting them to other services but also suggesting ideas for positive discipline as well as new play and learning activities. Julie also focused on bringing closer together parental and provider perceptions of each other and the reasons behind some of Sophia's behaviors. Their relationship strengthened independently of Julie and the provider began to see some of Sophia's same behaviors in quite a new and positive way. She felt she had learned a lot about providing sensitive, quality care. Mother felt better and more confident about managing her parenting successfully.

> *"I could pick up that phone and call her and say, 'Julie (consultant), you know what, I don't know if this is something that is a concern or shouldn't be a concern or if I'm overanalyzing it' so I could call her and ask her any questions and she was very informative and very helpful and a great support"* Sophia's Family Daycare Home Provider talked about the supportive relationship she developed with her CCEP consultant, Julie, that helped her move towards improved practices and a positive view of the mother and Sophia's challenging behaviors

Consultation services lasted for over 15 months but ended prematurely when the mother had to remove Sophia temporarily from day care to be looked after by her sister. Her $18 pay increase moved her beyond eligibility levels for child care subsidy. However, the consultant viewed this as a case which was successful overall although she did express concerns now that mother could no longer use the provider she had come to know and trust.

> *" I do think that she (Sophia) made ample improvement and I think that in addition to that, I think that the mother got a very solid extension to her immediate support system via this home provider."*

Table 1 Demographic Characteristics for Sophia's Case

Characteristics –(T1)	Sophia	CCEP Group mean (SD) (N=432)
Age (months)	40	42.7 (13.2)
Gender	Female	72.6% male
Race	White	75.3% white
Previous expulsions	0	0.12
Length of consultation (days)	465	142.3 (85.3)
Type of provider	Family Child Care	86.6% child care center
Status of child at conclusion of services (T2)	In care of relative pending funding to maintain enrollment with family child care provider	59.8% same provider

Household at T1	Sophia	CCEP Group mean (SD) (N=432)
# Adults in household	2	1.84 (0.7)
# Children in household	1	1.92 (1.0)
Living arrangements	Full time with mother only	52.6% 2 biological parents
Primary language spoken in home	English	97.6% English
Household income	Less than $15,000	19.6% less than $15,000
Parent's (respondent) highest level of ed. attainment	Less than HS	30.1% Bachelor's Degree

Table   Sophia's Parent's Scores in the Context of the Group

Parenting Measure	T1 Sophia	T1 CCEP Group Mean (SD) (N = 333)	T2 Sophia	T2 CCEP Group Mean (SD) (N = 237)
Empowerment	57	66.40 (7.60)	64	69.06 (7.35)
Parenting Stress	77	46.70 (13.42)	53	42.72 (12.97)
Number of Work/ School Absences due to Sophia's Behavior	0	1.32 (3.57)	0	.63 (2.67)

Table 3 Sophia's Provider's Scores in the Context of the Group

Provider Measure (N = 189)	T1 Sophia	T1 CCEP Group Mean (SD)	T2 Sophia	T2 CCEP Group Mean (SD)
Goal Attainment Scale	22	22.5 (2.7)	25	25.2(2.5)
Teacher Opinion Survey	43	47.8 (4.4)	48	48.00 (4.6)

Table 4 Sophia's Scores in the Context of the Group

Child Measure (N = 256)	T1 Sophia	T1 CCEP Group Mean (SD)	T2 Sophia	T2 CCEP Group Mean (SD)
Risk Factors				
DECA Behavior Concern-Parent	72	65.04 (7.80	56	**61.33 (9.05)
DECA Behavior Concern-Provider	55	65.36 (7.27)	58	**60.90 (8.63)
BASC Hyperactivity-Parent	26	16.68 (5.97)	10	**13.53 (5.68)
BASC Hyperactivity-Provider	10	14.67 (6.12)	9	**12.13 (6.18)
BASC Attention-Parent	15	9.75 (3.36)	12	**8.36 (3.33)

BASC-Attention-Provider	6	11.81 (3.15)	9	**10.19 (3.74)
Protective Factors				
DECA Total Protective Factors-Parent	28	41.04 (9.85)	50	**46.21 (10.66)
DECA Total Protective Factors-Provider	45	39.53 (8.70)	52	**44.54 (10.77)
BASC Functional Communication-Parent	6	16.45 (7.46)	17	**19.23 (7.03)
BASC Functional Communication-Provider	15	10.51 (6.04)	17	**12.99 (5.85)
BASC Social Skills-Parent	6	14.75 (5.19)	17	**16.62 (5.35)
BASC Social Skills-Provider	10	5.47 (3.95)	11	**7.67 (4.35)

4.8 DYLAN

The tables below describe how Dylan's profiles appear relative to other children in the CCEP group.

Table 1 Demographic Characteristics for Dylan's Case

Characteristics –(T1)	Dylan	CCEP Group mean (SD) (N=432)
Age (months)	60	42.7 (13.2)
Gender	Male	72.6% male
Race	White	75.3% white
Previous expulsions	0	0.12
Length of consultation (days)	310	142.3 (85.3)
Type of provider	Child Care Center	86.6% child care center
Status of child at conclusion of services (T2)	Maintained same provider	59.8% same provider

Household at T1	Dylan	CCEP Group mean (SD) (N=432)
# Adults in household	2	1.84 (0.7)
# Children in household	2	1.92 (1.0)
Living arrangements	Biological mother and stepfather	52.6% 2 biological parents
Primary language spoken in home	English	97.6% English
Household income	$75,000-$99,999	19.6% less than $15,000
Parent's (respondent) highest level of ed. attainment	HS Diploma/GED	30.1% Bachelor's Degree

Table 2 Dylan's Parent's Scores in the Context of the Group

Parenting Measure	T1 Dylan	T1 CCEP Group Mean (SD) (N = 333)	T2 Dylan	T2 CCEP Group Mean (SD) (N = 237)
Empowerment	64	66.40 (7.60)	78	69.06 (7.35)
Parenting Stress	70	46.70 (13.42)	44	42.72 (12.97)

Number of Work/ School Absences due to Dylan's Behavior	0	1.32 (3.57)	0	.63 (2.67)

Table 3 Dylan's Provider's Scores in the Context of the Group

Provider Measure (N = 189)	T1 Dylan	T1 CCEP Group Mean (SD)	T2 Dylan	T2 CCEP Group Mean (SD)
Goal Attainment Scale	22	22.5 (2.7)	28	25.2 (2.5)
Teacher Opinion Survey	52	47.8 (4.4)	55	48.00 (4.6)

Table 4 Dylan's Scores in the Context of the Group

Child Measure (N = 256)	T1 Dylan	T1 CCEP Group Mean (SD)	T2 Dylan	T2 CCEP Group Mean (SD)
Risk Factors				
DECA Behavior Concern-Parent	61	65.04 (7.80	45	**61.33 (9.05)
DECA Behavior Concern-Provider	49	65.36 (7.27)	31	**60.90 (8.63)
BASC Hyperactivity-Parent	18	16.68 (5.97)	8	**13.53 (5.68)
BASC Hyperactivity-Provider	6	14.67 (6.12)	1	**12.13 (6.18)
BASC Attention-Parent	7	9.75 (3.36)	2	**8.36 (3.33)
BASC-Attention-Provider	3	11.81 (3.15)	0	**10.19 (3.74)
Protective Factors				
DECA Total Protective Factors-Parent	36	41.04 (9.85)	52	**46.21 (10.66)

DECA Total Protective Factors-Provider	56	39.53 (8.70)	72	**44.54 (10.77)
BASC Functional Communication-Parent	22	16.45 (7.46)	29	**19.23 (7.03)
BASC Functional Communication-Provider	23	10.51 (6.04)	26	**12.99 (5.85)
BASC Social Skills-Parent	13	14.75 (5.19)	25	**16.62 (5.35)
BASC Social Skills-Provider	11	5.47 (3.95)	18	**7.67 (4.35)

4.9 JASON

The tables below describe how Jason's profiles appear relative to other children in the CCEP group.

Table 1 Demographic Characteristics for Jason's Case

Characteristics –(T1)	Jason	CCEP Group mean (SD) (N=432)
Age (months)	71	42.7 (13.2)
Gender	Male	72.6% male
Race	White	75.3% white
Previous expulsions	Not provided	0.12
Length of consultation (days)	411	142.3 (85.3)
Type of provider	Not provided	86.6% child care center
Status of child at conclusion of services (T2)	Maintained same provider	59.8% same provider

Household at T1	Jason	CCEP Group mean (SD) (N=432)
# Adults in household	1	1.84 (0.7)
# Children in household	1	1.92 (1.0)
Living arrangements	Full time with mother only	52.6% 2 biological parents
Primary language spoken in home	English	97.6% English
Household income	Less than $15,000	19.6% less than $15,000
Parent's (respondent) highest level of ed. attainment	HS Diploma/GED	30.1% Bachelor's Degree

Table 2 Jason's Parent's Scores in the Context of the Group

Parenting Measure	T1 Jason	T1 CCEP Group Mean (SD) (N = 333)	T2 Jason	T2 CCEP Group Mean (SD) (N = 237)
Empowerment	70	66.40 (7.60)	69	69.06 (7.35)
Parenting Stress	66	46.70 (13.42)	48	42.72 (12.97)
Number of Work/ School Absences due to Jason's Behavior	Not provided	1.32 (3.57)	0	.63 (2.67)

Table 3 Jason's Provider's Scores in the Context of the Group

Provider Measure (N = 189)	T1 Jason	T1 CCEP Group Mean (SD)	T2 Jason	T2 CCEP Group Mean (SD)
Goal Attainment Scale	22	22.5 (2.7)	26	25.2 (2.5)
Teacher Opinion Survey	52	47.8 (4.4)	55	48.00 (4.6)

Table 4 Jason's Scores in the Context of the Group

Child Measure (N = 256)	T1 Jason	T1 CCEP Group Mean (SD)	T2 Jason	T2 CCEP Group Mean (SD)
Risk Factors				
DECA Behavior Concern-Parent	72	65.04 (7.80	72	**61.33 (9.05)
DECA Behavior Concern-Provider	68	65.36 (7.27)	57	**60.90 (8.63)
BASC Hyperactivity-Parent	30	16.68 (5.97)	26	**13.53 (5.68)
BASC Hyperactivity-Provider	16	14.67 (6.12)	8	**12.13 (6.18)
BASC Attention-Parent	14	9.75 (3.36)	15	**8.36 (3.33)
BASC-Attention-Provider	13	11.81 (3.15)	5	**10.19 (3.74)
Protective Factors				
DECA Total Protective Factors-Parent	54	41.04 (9.85)	49	**46.21 (10.66)
DECA Total Protective Factors-Provider	28	39.53 (8.70)	42	**44.54 (10.77)

BASC Functional Communication-Parent	11	16.45 (7.46)	15	**19.23 (7.03)
BASC Functional Communication-Provider	1	10.51 (6.04)	14	**12.99 (5.85)
BASC Social Skills-Parent	16	14.75 (5.19)	19	**16.62 (5.35)
BASC Social Skills-Provider	0	5.47 (3.95)	6	**7.67 (4.35)

APPENDIX D: RESEARCH BRIEFS:
CCEP PROGRAM IN MICHIGAN

Michigan Child Care Expulsion Prevention Program

Informing Providers About CCEP Services

Survey Summary No. 1 • May 2008

Introduction

In February and March 2008, 29 Michigan Child Care Expulsion Prevention Program (CCEP) consultants from 16 CCEP programs across Michigan, participated in a survey administered by the Michigan State University evaluation team. Consultants reported about the best ways to inform providers about the CCEP program. They were asked about three kinds of providers: center-based providers, family and group home providers, and relative providers. Because the needs of—and access to—each kind of provider can differ, consultants reported about the best ways to reach each group separately.

This fact sheet provides information on:

- The most effective strategies overall for informing providers about CCEP services—that is, the strategies consultants considered at least somewhat effective for each type of provider.
- The strategies that consultants thought most effective for each type of provider.
- Additional strategies that some consultants have used to create awareness among providers as well as barriers that they have encountered.
- Strategies that are not options in some CCEP programs.

Glossary

4C	Michigan Child Care Coordinating Council. A statewide organization that has regional offices.
Core modules	Training modules developed by consultants to CCEP
DHS	Michigan Department of Human Services
Great Start Collaborative	County-based collaborative sponsored by the state- and foundation-funded public corporation known as Early Childhood Investment Corporation
MSUE	Michigan State University Extension. A statewide organization that has county offices.
NAEYC	National Association for the Education of Young Children
Part C	Known as Early On in Michigan. The infant/toddlers component of the federal *Individuals with Disabilities Education Act.*, under the jurisdiction of the Michigan Department of Education and single or multi-county intermediate school districts.
Work First	Michigan's job training and search program for recipients of public assistance

Awareness Strategies

Table 1 provides information about which strategies consultants considered *very* effective for each group of providers as well as strategies that consultants considered at least *somewhat* effective. Notably, word of mouth was the most effective strategy for all groups of providers, which newsletters and brochures were reported to be *somewhat* effective but not *highly* effective in eliciting referrals.

- For **center-based providers**, the most effective strategies were:
    - Word of mouth (83%)
    - Local in-services for advertising the program (45%)
    - Child care provider professional development opportunities from 4C and MSUE (48%)

- For **family and group home providers**, the most effective strategies were:
    - Word of mouth (64%)
    - At child care provider professional development opportunities from 4C and MSUE (36%)

- For **relative providers**, the most effective strategy was word of mouth; however, it was listed as very effective by only 15% of consultants.

Table 1. Percent of Consultants Reporting VERY EFFECTIVE (and SOMEWHAT EFFECTIVE) Ways to Inform Providers About CCEP Services

Strategy	Center-based providers	Family and group home providers	Relative providers
Word of mouth	**83% (17%)**	**64% (29%)**	15% (36%)
Newsletter or other publications from 4C, resource and referral agencies, and DHS child care licensing office	**21% (75%)**	**18% (67%)**	7% (23%)
At child care provider professional development activities from 4C or MSUE	**45% (48%)**	**36% (50%)**	4% (21%)
Through local in-services to advertise program	**48% (40%)**	9% (56%)	0% (25%)
At local or state training or conferences	**33% (52%)**	19% (53%)	4% (10%)
Brochures mailed by local CCEP office	23% (46%)	13% (37%)	9% (13%)
From other service providers, such as Part C Family Service Coordinator	29% (38%)	17% (44%)	4% (17%)

Note. N for each item = 23 to 29 consultants responding; some did not respond because the strategy was not an option for them or they chose not to. Percent reported is of those consultants responding. Bold = at least 80% of consultants indicated that this strategy was very or somewhat effective for these types of providers.

Word of mouth was the only really highly effective strategy, and was considered to be much more effective with center-based providers than other types of providers. Professional development and in-services also worked well with center-based providers. Apart from word of mouth, few strategies were highly effective with family and group home providers, and no strategies were very effective for relative providers.

Other Ways to Inform Providers

Consultants responded to an open-ended question about other ways to inform each type of provider of CCEP services.

Center-Based Providers

Consultants described a number of other ways that they connect with center-based providers to increase their awareness of CCEP services.

- **Email:** Through a director and center support staff listserv as well as email updates and memos.

- **Trainings:** Through advertising and conducting the core module trainings as well as trainings conducted through early childhood workgroups. However, as one consultant reported, "We trained over 60 people last year through (core) modules and they all learned about our services, but we got zero referrals from the trainings."

- **Visiting centers:** Several consultants mentioned, "Stopping at the centers, so they know your face, and become comfortable with you."

- **Community collaborations**: Consultants described working with DHS Protective Service workers, local NAEYC activities, Work First orientations, workforce development centers, and Head Start connections. One consultant reported that "4C has also given us the addresses of all daycares in our service provider group and we have sent brochures and referral forms."

- **Parents**: Through visits at parent groups.

- **Community events**. Attending community events.

- **Repeat business**: "I have found most referrals come from people we have relationships with... that forming a relationship with a provider is the best way to stay connected with them and generate business."

Family and Group Home Providers

Many of the suggestions for family and group home providers were the same as for center-based providers, including email and core module trainings. Consultants also provided strategies specific to this group:

- **Training:** "We held a Dollar Store and Discipline training as a make-it-take-it, specifically for family providers…this yielded success." Another said, "We have a lot of home providers come to our training series, which we advertised through a mass mailing, but most do not refer children to our program."

- **Follow-up Contacts:** Some consultants contact home providers by phone and drop off information at a follow-up visit.

- **Coffee Clubs:** "Child Care Coffee Clubs, where providers come once a month for support resources and small trainings."

- **4C Sponsored Family Day Care Association Meetings. "**We attend the 4C sponsored Family Day Care Association meeting held once a month, where we offer mini-trainings on topics they request."

Relative Providers

Relative providers presented the greatest challenge to consultants, several of whom reported that they had not been able to reach this group. Barriers to informing relative providers included not having their addresses and the lower likelihood of their attending CCEP or other trainings. Word of mouth was deemed most likely of success, with one consultant reporting, "Our relative providers have mainly come from the families we have already served, when the child is no longer in formal care and a relative is now caring for the child." Still, a few suggestions were offered:

- **Coffee Clubs** (described under Family and Group Home Providers)

- **Participation in the local Great Start Collaborative committee** focusing on building play group services for relative providers and the children they care for.

- **Play time meetings**

- **Collaborating with the MSUE Professional Development Coordinator**

Consultants suggested some innovative ways to connect with providers, including hard-to-reach groups of providers. Their comments clearly suggested that personal contacts, word of mouth, and repeat business were critical to building awareness of CCEP.

MICHIGAN STATE UNIVERSITY

Michigan Child Care Expulsion Prevention Program

Child and Family Consultation Processes

Survey Summary No. 2 • June 2008

Introduction

In February and March 2008, 29 Michigan Child Care Expulsion Prevention Program (CCEP) consultants from 16 CCEP programs across Michigan participated in a survey administered by the Michigan State University evaluation team.

Consultants were asked about their practices and procedures during the child and family consultation process. The process begins when a specific child presenting with challenging behavior is referred to the CCEP program. Consultants then conduct intake and assessment, develop and implement a Positive Child Guidance Plan, and ultimately transition families out of the consultation program. Throughout this process, consultants work with providers, parents, and children.

In summer and fall 2007, the state consultants at Michigan Department of Community Health (MDCH) and CCEP staff developed guidelines, recommendations, and tools to facilitate the child and family consultation process. This survey summary presents information on the extent to which CCEP consultants' practices conform to program guidelines and recommendations and the degree to which they use the tools.

This fact sheet provides information on:

- The degree to which consultants use recommended practices and procedures in the areas of intake, observation and assessment, development and implementation of the Positive Child Guidance Plan, conclusion of services, and follow-up.
- The length of time spent visiting child care settings and homes and the purpose of home visits.
- Reasons that children are determined to be inappropriate for CCEP services.
- Reasons that consultants recommend children be moved to a different child care setting.

Visits

Time Spent Per Visit

Consultants were asked to report the typical length of a visit, to identify the amount of time consultants spend on provider and home visits during the consultation process. Table 1 shows the average time per visit reported by consultants.

- On average, consultants reported that visits lasted about 1.5 hours (slightly more at childcare sites, slightly less during home visits).

- Typical visits ranged from 1 hour to 3 hours, suggesting that substantial differences exist among consultants in their approaches to visits.

Table 1. Average Stay Time During Visit (Hours)				
Visit Type	N	Mean	Minimum	Maximum
Childcare site visit	29	1.6	1	3
Home visit	28	1.4	1	2.5

Home Visits

Percent of Families Receiving Home Visits. Consultants were asked about the percent of families with whom they conducted home visits. The 26 consultants who responded reported that on average, they did home visits with 79% of families:

- 27% of consultants did home visits for all families.

- About half of the consultants did home visits with the majority of their families (70% to 95% of cases)

- Less than a quarter of the consultants visited less than half of their families.

Purpose of Home Visits. The consultants also reported the purpose of home visits (i.e., intake/observation or in support of the Positive Child Guidance Plan). In general, more home visits were done for intake and observation; they were less likely to be done once the Positive Child Guidance Plan was in place.

- 11% of consultants did not ever do home visits as part of the intake process.

- 15% of consultants did not ever do home visits in support of the Positive Child Guidance Plan.

Table 2. Purpose of Home Visit (Percent)				
Purpose	N	Mean	Minimum	Maximum
Intake	27	54%	0%	100%
In support of the Positive Child Guidance Plan	27	34%	0%	100%

Overall Fidelity for All Consultants

The child-family consultation process has a number of areas or steps through which consultants progress:: *Initial consultation, observation and assessment, development and implementation of the positive child guidance plan, conclusion of services, and follow-up.* Within each area, a number of activities are outlined in the MDCH guidelines. Consultants were asked "how often" and with "how many families" they conducted each of those activities

An area score was obtained by averaging all the responses within an area. This represents each consultant's overall fidelity for that area. Higher scores indicates that consultants tend to conduct most of the activities in that area in most cases, while lower scores suggest that consultants tend to carry out fewer of those activities with fewer families. Table 3 provides an overall snapshot of the percent of consultants who received the higher or lower scores in an area.

Consultants were most likely to report conducting most of the recommended activities with most families in the areas of:

- Meeting to develop a positive child guidance plan (93% received the higher score)

- Support of parent in positive guidance plan (93% received the higher score)

- Initial consultation with parent (89% received the higher score)

They were most likely to report conducting fewer of the recommended activities with some or few families in the areas of:

- Observation and assessment (93% received the higher score)

- Follow-up (70% received the lower score).

Table 3. Percent of Consultants with Higher Score and with Lower Score			
Service	*N*	*Percent of consultants with higher score*	*Percent of consultants with lower score*
Initial consultation			
With provider	28	68%	32%
With parent	28	89%	11%
Observation and assessment	28	7%	93%
Positive child guidance plan			
Meeting to develop positive guidance plan	27	93%	7%
Support of provider in positive guidance plan	28	79%	21%
Support of parent in positive guidance plan	28	93%	7%
Conclusion	28	79%	21%
Follow-up	27	30%	70%

Higher scores = 2.5 to 3;   lower scores 1 to 2.5.

Not all activities are necessary or appropriate in all cases. In particular, the areas that show the least fidelity are observation and assessment, and follow-up after the conclusion of services.

Initial Consultation

Provider Consultation

Once a family has been referred for CCEP service is initiated, consultants are expected to contact providers before the formal consultation process begins. During the initial consultation, consultants are supposed to provide information about the CCEP program, educate the providers to communicate with parents about CCEP services and have the provider sign formal documents.

Table 4 shows the percent of consultants who indicated that they conducted the activities "in no or few cases," "in some cases," or "in most or all cases" during the initial consultation with the provider. Overall, the results indicated that most consultants conducted the activities in some or all cases.

Actions

- Consultants showed the most fidelity with:
  - Ensuring that the provider understands that the consultation process does not start until the parent has given signed permission (96% reported doing this in most or all cases).
  - Assuring the provider that his/her feelings about the child's challenging behavior are legitimate (82% in most or all cases).
- Some activities, although conducted in most or all cases by the majority of consultants, were also conducted only in some cases by a substantial minority of consultants, including:
  - Educating the provider about how to talk to parents to request CCEP services (36% did in some cases).
  - Ensuring that the provider not mention the child's name until after parental consent is signed (25% did in some cases, 14% in no or few cases)..

Tools

- Consultants were most likely to use the handout "When to Refer a Child to CCEP Due to Social-Emotional Concerns" (54% used gave it to the provider in most or all cases)
- They were less likely to use the handouts "Introducing CCEP Services to All Families with Children in Your Care" and "Encouraging Parents to Accept a CCEP Referral: Tips for Child Care," although most used these handouts with at least some providers.

Table 4. Percent of Consultants by Type of Activity: Initial Consultation with Provider			
Activities	*In no or few cases*	*In some cases*	*In most or all cases*
Actions			
Ensure that the provider understands that the consultation process does not start until the parent has given signed permission.	0%	4%	96%
Assure the provider that her/his feelings about the child's challenging behaviors are legitimate.	4%	14%	82%
Ask the provider's permission to share information she/he gives with the parent before passing that information on.	0%	29%	71%
Educate the provider about how to talk to the parents to request CCEP services.	0%	36%	64%
Ensure that he/he not mention the child's name until after parental consent is signed.	14%	25%	61%
Tools			
Give the provider the handout "When to Refer a Child to CCEP Due to Social-Emotional Concerns."	14%	32%	54%
Give the provider the letter "Introducing CCEP Services to All Families with Children in Your Care."	7%	56%	37%
Give the provider the handout "Encouraging Parents to Accept a CCEP Referral: Tips for Child Care."	15%	48%	37%

Note. N for each item = 27 or 28 consultants responding. Percent reported is of those consultants responding.

Parent Consultation

The initial consultation with the parent is conducted before initiating formal CCEP services to help parents understand the CCEP program, invite them into a partnership, and get their permission to conduct services. Table 5 shows the percent of consultants who indicated that they conducted the activities "in no or few cases," "in some cases," or "in most or all cases" during initial consultation with the parent or parents.

Overall, the results indicated that all types of activities were conducted in some or all cases by the majority of the consultants. Approximately half of the consultants reported that they did the activities in most or all cases.

- While the majority of consultants still conducted the following activities with most or all parents, a few consultants were relatively more likely to do them with no, few, or some families:
  - Get informational packets to the family (not including consent for services forms, release of information forms, etc).
  - Give the parent the handout "How Will CCEP Services Work for My Child and Family."

Table 5. Percent of Consultants by Type of Activity: Initial Consultation with Parent			
Activities	In no or few cases	In some cases	In most or all cases
Actions			
Review and obtain the parent's signature on the "Parental Consent for CCEP Services."	0%	0%	100%
Tell the parent that he/she is the "ultimate expert" on the child.	0%	0%	100%
Get the parent's understanding of why the provider has suggested a CCEP referral.	0%	4%	96%
Review and obtain the parent's signature on the "CCEP Release of Information" form.	4%	0%	96%
Immediately invite the parent into a partnership.	3%	4%	93%
Ask the parent's permission to share information she/he gives with the provider before passing that information on.	0%	18%	82%
Complete the "CCEP Intake Form."	7%	11%	82%
Review and answer questions about the "CCEP Family Rights and Responsibilities" document.	7%	14%	79%
Inform parents of progress on a weekly basis.	7%	36%	57%
Get informational packets to the family (not including consent for services forms, release of information forms, etc).	14%	32%	54%
Tools			
Give the parent the handout "How Will CCEP Services Work for My Child and Family."	26%	26%	48%

Note. N for each item = 27 to 28 consultants responding. Percent reported is of those consultants responding.

Observation and Assessment

Observation and assessment provides critical information to guide the consultation process and develop the positive guidance plan. Certain techniques can assist in obtaining comprehensive observation about the child's behavior and provide an informed assessment of their problems. The tools provided by the

state consultants are generally discretionary and consultants typically have identified the components that they find most helpful or with which they are most comfortable. Unsurprisingly, substantial variation is apparent in the fidelity to the guidelines provided by the state administrators.

Table 6 shows the percent of consultants who indicated that they conducted the activities "in no or few cases," "in some cases," or "in most or all cases" during observation and assessment.

- Most consultants the program guidelines for preparing for and conducting the observation and assessment process with most or all cases.
  - Consultants appeared to find it most difficult to decline if the caregiver asked them to assist with caregiving.
- Consultants varied in the degree to which they used specific assessment tools.
  - The tools most likely to be used were the running record in the child care setting, the "Child's Strengths and Needs" documents for provider and parent interviews, and deliberate interaction with the child. Only the running record in the child care setting was used in most or all cases by a majority (61%) of consultants.
  - Videotaping in the child care setting or the home was used very infrequently, and asking parents or providers to observe the child's behavior was fairly infrequent as well.

Table 6. Percent of Consultants by Type of Activity: Observation and Assessment			
Activities	In no or few cases	In some cases	In most or all cases
Actions			
Ask the caregiver for information about the schedule or child care practices (unless it would disrupt the caregiver's work).	0%	4%	96%
Schedule observations on different weekdays and different times of day.	0%	7%	93%
Respectfully decline if a caregiver requests t you perform a caregiver task.	7%	30%	63%
Tools			
Use running-record in the child care setting.	14%	25%	61%
Use the "Child Strengths and Needs – Provider" document as a guide during the interview with the provider.	18%	50%	32%
Use the "Child Strengths and Needs – Family" document as a guide during the interview with the parent.	12%	58%	31%
Deliberately interact with the child to learn more about him/her.	21%	50%	29%
Use running-record observation in the home.	33%	48%	19%
Use the "Social and Emotional Milestones of Children Birth to Age Five" document during the interview with the *provider* to help identify the child's strengths.	37%	48%	15%
Use the "Social and Emotional Milestones of Children Birth to Age Five" document during the interview with the *parent* to help identify the child's strengths.	39%	50%	12%
Use the "DECCA" during the interview with the parent to help identify the child's strengths.	0%	0%	100%
Give the "CCEP Child Behavior Observation Form" to parents or providers to observe the child's behavior.	52%	41%	7%
Videotape the observation conducted in the child care setting.	82%	11%	7%
Videotape the observation conducted in the home.	89%	11%	0%

Note. N for each item = 26 to 28 consultants responding. Percent reported is of those consultants responding.

When Are CCEP Services Not Appropriate?

One question raised by the state administrators was, How often do consultants meet cases that are not suitable for services or for whom maintaining the existing childcare setting is not appropriate?

Referrals to Other Services

In some cases, consultants immediately refer the children elsewhere and do not open a CCEP case after they receive the referrals.

- Consultants reported that this was an unusual occurrence; across 28 consultants over a year, the average number of children who do not fit CCEP services was reported to be two.

- Roughly 40% of the consultants indicated that they never referred the children elsewhere right away without opening a CCEP case.

- However, two consultants reported the number of direct referrals elsewhere to be as high as 10 and 12.

The consultants also described the circumstances under which the parent, provider and they would decide that CCEP services do not fit a certain child. Their responses fell into the following areas:

- **Child needs intervention, not prevention.** Consultants described cases that had been referred when children had more needs than they felt the CCEP program was set up to support; for example, "major mental health issues" or "The services needed might involve further assessment or a level of intervention as opposed to prevention; however, CCEP is still able to connect with families and providers to help guide the process itself." Consultants particularly referred to the child's needs for programs that would address special education and developmental delay, as well as mental health services.
    - o **Has not happened.** Several consultants reported that they had not yet had a need to refer a child to primary services other than CCEP

- **Not suitable for services**
    - o **"The parent or provider had no interest in working together."**
    - o **Parents or center chose not to participate.** Some consultants mentioned cases where "The center does not want us there or does not want to follow through on suggestions from the consultant, " or "if the parent or provider does not want services (does not think they are necessary, is not willing to partner, etc.), then I close the case as they request."
    - o **Behavior stopped before assessment or does not occur in the classroom.** Consultants mentioned cases where the behaviors improved on their own prior to intake, where "the consultation is brief and parent/provider's concerns are able to be answered in 1-2 meetings," or where "concern is parent driven and mostly related to behavior outside of the care setting."

Referral to Different Child Care Setting

Typically, consultants try to work with the provider to enable the child to remain in the child care setting. However, in some cases, the consultant determines that the existing child care setting is not appropriate for the child. Consultants described when, in collaboration with the parents, they might decide that a child's child care setting should be changed:

- **Provider is unwilling to work with family or consultant.** Several consultants described issues related to "goodness of fit," where the provider was not willing to work with the family and

consultant to learn new skills or was not interested in keeping the child in that setting. In some cases, providers "cannot or will not provide emotional supports to the child despite CCEP consultations." Staff may also want to help the child, but feel that they cannot make the necessary adjustments for the child's level of problems and will not be able to meet the child's needs.

- **Child's needs are not being met.** Consultants reported that needs for additional or different services elicited recommendations for a change in setting. This included not only needs for intensified services, different staff education and training, or extra support services, but also a current environment that was "unsafe" or "the provider believes the child is "bad" despite the child being typically developing, etc.)."

- **Environment is inappropriate for child.** The most common reason cited was overstimulation, particularly in center settings, which tend to be loud, busy, and overwhelming for children with sensory needs, and might suggest benefits to be gained through an in-home provider. However, one consultant also mentioned that some children might benefit from a move to a *more* stimulating environment such as a center. Consultants also mentioned the fit between the child and a more play-based setting vs a more structured setting.

- **The child continues to be a danger to self or others after CCEP services.** Consultants reported determining a need to change settings when "Providers decide their childcare may not be appropriate when other children are at risk of harm due to excessive aggression." "If safety is such an issue that pressure from other parents leaves staff feeling unable to keep children safe or if parents and child care staff conclude so together," and "When child has been through several homes and centers and continues to struggle and harm self and others and behavior continues to increase; Child thrives on 1:1."

- **Parents feel the situation is damaging.** Parents may feel that the setting is harmful to the child and make the decision to remove the child.

- **Poor child-provider relationship.** If the consultant observes that the child-provider relationship is not improving over time, he/she may refer the child to a new childcare setting.

Consultants provided rich examples of how they determine when children are not appropriate for CCEP services and when children should be referred to a different childcare setting rather than working with the existing provider. With respect to not enrolling in CCEP services, while this was a relatively rare event, it did occur, particularly when children presented with special needs that would benefit from more intensive services. CCEP consultants were most likely to refer children to other settings when providers were not invested in the program or in keeping the child, provided an unsafe or negative environment that did not improve, or when children needed a different type of environment—usually less stimulating and more individualized than can sometimes be found in center settings.

Positive Child Guidance Plan

Meeting to Develop Plan

After the observation and assessment process, the consultant meets with the provider and family to formulate a Positive Child Guidance Plan to support the mental health needs of the child both in child care setting and at home. Table 7 shows the percent of consultants who indicated that they did the activities "in no or few cases," "in some cases," or "in most or all cases" in setting up and conducting the meeting for developing the Positive Child Guidance Plan.

Overall, the results indicated very good fidelity to the guidelines. For all activities, the majority of consultants reported conducting the activity in most or all cases. Areas with a lower level of fidelity to guidelines include:

- Framing the process and expectations (i.e., informing the participants that the child's behavior may get worse before it gets better, emphasizing the consultant's role as one of facilitation, emphasizing that the plan belongs to the family

- Communication (i.e., integrating assessment data into an easily digestible form, asking for feedback on the meeting)

- Reflecting about how the family and provider's culture and values may differ from the consultant's own.

Table 7. Percent of Consultants by Type of Activity: Meeting to Develop the Positive Child Guidance Plan			
Activities	*In no or few cases*	*In some cases*	*In most or all cases*
Talk to the parents about the meeting and allow them to ask any questions and invite anyone they want.	0%	0%	100%
Use a framework of "figuring out what the child is trying to tell us."	0%	4%	96%
Help the team (including yourself) brainstorms and prioritize potential action goals and strategies.	0%	4%	96%
State that the plan may need to be revised.	0%	7%	93%
State that it will take time for the plan to work.	0%	7%	93%
Provide all parties with a copy of the Positive Child Guidance Plan after the meeting.	0%	7%	93%
Emphasize that the plan will be most effective if parents and providers use the same strategies and use them continuously.	0%	7%	93%
Refrain from taking sides.	0%	8%	92%
Make sure you get input from any parties who cannot attend the meeting.	0%	11%	89%
Negotiate disagreements among team members when necessary.	4%	15%	81%
State that the challenging behavior may get worse before it gets better.	3%	19%	78%
Emphasize that your role is to facilitate the meeting.	4%	19%	78%
Integrate the assessment data into a form easily digestible by parents and providers.	4%	22%	74%
Ask for feedback on how the meeting went from all parties.	4%	26%	70%
Emphasize that the plan ultimately belongs to the family.	11%	26%	63%
Reflect about how the family and provider's culture and values may differ from your own.	0%	44%	56%

Note. N for each item = 26 to 27 consultants responding. Percent reported is of those consultants responding.

Implementing the Positive Child Guidance Plan

To facilitate the implementation of the Positive Child Guidance Plan, consultants help the families and providers incorporate the plan into their daily life and work, assess the progress of the plan, suggest revisions, and, if necessary, act as a bridge between parents and provider.

Supporting the Provider

Table 8 shows the percent of consultants who indicated that they conducted the activities "in no or few cases", "in some cases" or "in most or all cases" while working with the provider in support of the Positive Child Guidance Plan.

- Fidelity was excellent for monitoring and connecting with the provider, with all consultants doing these activities in at least some cases and nearly all doing them in most or all cases.

- Although most consultants provided resource materials in most or all cases, some consultants provided resource materials less consistently.

- A minority of consultants made it a regular practice to provide training to providers about challenging behavior issues and/or role-play new skills, with the majority of consultants doing this in some cases. Nearly a third of consultants rarely or never conducted role-plays.

Table 8. Percent of Consultants by Type of Activity: Supporting Positive Child Guidance Plan—Provider			
Activities	*In no or few cases*	*In some cases*	*In most or all cases*
Observe the child at the child care setting.	0%	0%	100%
Provide emotional support to the provider.	0%	4%	96%
Engage the provider in reflective discussions.	0%	4%	94%
Provide feedback for the provider as she/he practices new skills.	0%	14%	86%
Provide resource materials or information on how to access resources.	0%	21%	79%
Provide training for the provider on the child's particular challenging behavior or related issues.	4%	64%	32%
Role-play new skills with the provider.	29%	50%	21%

Note. N for each item = 28 consultants responding. Percent reported is of those consultants responding.

Supporting the Parent

Table 9 shows the percent of consultants who indicated that they conducted the activities "in no or few cases," "in some cases," or "in most or all cases" while working with the parent in support of the Positive Child Guidance Plan.

- As with provider support for the Positive Child Guidance Plan, consultants generally showed very high fidelity to the guidelines in providing parent support.

- Similarly, providing resources and training for parents around coping withchallenging behaviors showed less fidelity to the guidelines.

Table 9. Percent of Consultants by Type of Activity: Supporting Positive Child Guidance Plan—Parent

Activities	In no or few cases	In some cases	In most or all cases
Exchange information on how the child is doing at the child care setting and at home.	0%	4%	96%
Provide support to implement new strategies at home, if applicable.	0%	7%	93%
Offer emotional support to the parents.	0%	7%	93%
Discuss how implementation of the Positive Child Guidance Plan is progressing at the child care setting.	0%	11%	89%
Provide resource materials or information on how to access resources.	0%	25%	75%
Provide training for the parents on the child's particular challenging behavior or related issues.	18%	61%	21%

Note. N for each item = 28 consultants responding. Percent reported is of those consultants responding.

Conclusion of Services

After the Positive Child Guidance Plan is implemented and positive change has been observed, services will come to an end. To conclude services on a positive note and promote the sustainability of changes, program guidelines for the transition process include a meeting of the consultant, provider, and family. Table 10 shows the percent of consultants who indicated that they conducted the suggested activities "in no or few cases," "in some cases," or "in most or all cases" when concluding services.

- Consultants varied a fair amount in whether they called a meeting at all, with 53% of consultants doing so only in some cases or not at all.

- They also varied in the degree to which they obtained input from individuals who could not attend the meeting and informed them about the decisions made.

Table 10. Percent of Consultants by Type of Activity: Conclusion of Services

Activities	In no or few cases	In some cases	In most or all cases
Call a meeting of the parents, providers, and any other team members to identify transition activities and dates for completing each activity.	14%	39%	46%
Inform any parties who could not attend the meeting about the decisions made	11%	11%	79%
Get input from any parties who cannot attend the meeting.	14%	18%	68%

Note. N for each item = 28 consultants responding. Percent reported is of those consultants responding.

Transition Period

24 consultants reported on the average length of the transition period to the end of the services:

- The transition period varied from 2 weeks to more than 7 months, with an average length of about 7 weeks.

- Half of the consultants described the transition period as some time between 2 weeks to 4 weeks; only two consultants reported typical transition periods longer than 3 months.

Follow-up Services

Follow-up with families and providers after the conclusion of services are recommended (but consultants are not funded for this activity) in order to monitor progress and, if necessary, suggest re-initiation of services if the problems have emerged again. Table 11 shows the percent of consultants who indicated that they conducted activities "in no or few cases," "in some cases," or "in most or all cases" when following up services.

- Follow-up as an optional activity was relatively rare and occurred more consistently with providers than with parents. About a third of consultants did no follow-up with either parents or providers in any cases.

Table 11. Percent of Consultants by Type of Activity: Follow-Up			
Activities	In no or few cases	In some cases	In most or all cases
Check back in with the family a couple of months after services are concluded.	39%	46%	14%
Check back in with the provider a couple of months after services are concluded.	30%	41%	30%

Note. N for each item = 27 or 28 consultants responding. Percent reported is of those consultants responding.

MICHIGAN STATE UNIVERSITY

Michigan Child Care Expulsion Prevention Program

Programmatic Consultation Processes

Survey Summary No. 3 • August 2008

Introduction

In February and March 2008, 29 Michigan Child Care Expulsion Prevention Program (CCEP) consultants from 16 CCEP programs across Michigan participated in a survey administered by the Michigan State University evaluation team.

CCEP programs offer programmatic consultation for program administrators and staff within child care settings.   Programmatic consultation includes coaching and training designed to improve communication, promote children's social-emotional competence, enhance child care settings, and support partnerships between child care providers and families. Programmatic consultation is generally undertaken in concert with child and family work; in most cases programmatic goals are written into the Positive Child Guidance Plan. In contrast to child and family consultation, programmatic consultation is designed to improve the social emotional quality of the overall childcare setting rather than focus on the needs of a particular child presenting with challenging behavior. The state consultants at Michigan Department of Community Health provide training and technical assistance and recommend strategies to facilitate the programmatic consultation process. In the survey, consultants were asked about their use of those strategies. This survey summary presents information about the degree to which the consultants use those strategies.

This fact sheet provides information on:

- The overall process of the programmatic consultation as currently practiced by consultants.
- The degree to which particular areas of programmatic consultation form standard practice by consultants.
- The degree to which consultants use the recommended strategies targeting supportive adult-child relationships, adult-adult relationships, partnerships with families, activities and experiences, daily routines, environment and program policies, and resources.

Overall Process of Programmatic Consultation

To get a sense of how the programmatic consultation process unfolds, consultants reported who usually made the referral and the first contact with the childcare provider, with whom the consultants usually did the programmatic consultation, and tools used to measure the programmatic quality.

Referrals

The results, shown in Table 1, suggest the majority of referrals for programmatic consultation were from childcare administrators, with about a third of referrals coming from direct caregivers/teachers.

Consultants reported that 7% of referrals were from parents. Given that the focus of programmatic consultation is on the caregiving setting as a whole rather than a specific child, it is surprising that any programmatic referrals come from parents. Child and family consultation that led to more general consultation for the program may account for the parent referrals.

Table 1. Who Makes the Referral	
Type	*Percent of consultants*
Administrator	57%
Caregiver/teacher	36%
Parent	7%

Note. N = 28 consultants responding; Percent reported is out of those consultants responding.

First Contact with the Provider

Usually, the consultants made the first contact with the childcare provider (Table 2). Fifteen percent of consultants reported that the consultant's supervisor contacted the provider either alone or in conjunction with the consultant.

Table 2. Who Makes the First Contact with Childcare Provider	
Type	*Percent of consultants*
Me	86%
My Supervisor	11%
Both	4%

Note. N = 29 consultants responding; Percent reported is out of those consultants responding.

Consultation Participants

As shown in Table 3, consultants conducted programmatic consultation at all levels of childcare staff. Forty-five percent of consultants reported that administrators were usually involved. Consultation was conducted with all staff about a third of the time, while about a quarter of the time, it focused on a specific caregiver/teacher.

Table 3. Target of Programmatic Consultation	
Type	*Percent of consultants*
Administrator	38%
With all staff	31%
A specific caregiver/teacher	24%
Both administrator and staff	7%

Note. N = 29 consultants responding.

Tools for Measuring Programmatic Quality

Consultants have been trained to use a variety of assessment tools to facilitate the programmatic consultation process. Table 4 presents the percent of consultants who reported using each tool. Reflective checklists that ask providers to consider their practices were most commonly used; nearly all consultants reported using the Devereux Early Childhood Assessment (DECA) reflective checklists and the majority of consultants reported using the DECA Infant/Toddler (DECA-I/T) reflective checklists. Observational assessments of childcare settings were used by some consultants, generally in childcare centers rather than family care settings.

Table 4. Tools Used to Assess Programmatic Quality	
Tool	*Percent of consultants*
Devereux Early Childhood Assessment (DECA) reflective checklists	93%
DECA Infant/Toddler (DECA-I/T) reflective checklists	66%
North Carolina Infant/Toddler Environment Rating Scale (ITERS)	21%
Early Childhood Environment Rating Scale (ECERS)	21%
Family Child Care Environment Rating Scale (FCERS)	3%

Note. N = 29 consultants responding.

Currently, programmatic quality consultation tended to be initiated by childcare center administrators and many administrators participated. However, a number of administrators did not. Because administrator support is critical to promote the development of high-quality programs, sustain gains in staff skills made through professional development, and create institutional memory for effective practice, it may be important to increase administrator involvement in the programmatic consultation process..

Use of Programmatic Consultation Strategies

Overall Consultation Focus Areas

During programmatic consultation, consultants work with administrators and staff around (a) supportive interactions, (b) partnerships with families, (c) activities and experiences, (d) daily routines, (e)environment and program polices, and (f) resources. Within each of the above areas, a number of strategies are outlined in the MDCH guidelines. Consultants were asked how often they used each of those strategies, and data are presented for the 28 consultants who responded to at least 75% of the questions within an area.

Consultants who reported often using the strategies within an area can be considered as having a standard practice with which they address that area. To assess the percent of consultants who focused on an area of standard practice, an area response score was obtained by averaging the responses for all the strategies within the area. Higher scores indicate that consultants reported focusing on the area more often (standard practice) while lower scores indicate that the area received less focus. Consultants were

also asked to rank the areas in order of how much time they spent on each during programmatic consultation.

Table 5 provides an overall snapshot of the percent of consultants who reported more or less focus on each area as well as the rankings of the time spent on each.

- Nearly all consultants reported targeting child-focused areas (i.e., activities and experiences in the childcare setting, adult-child supportive relationships, and daily routines) as standard practice in programmatic consultation.

- The majority of consultants also reported targeting areas related to adults and families (i.e., adult-adult supportive relationships and partnerships with families) as standard practice, although some did not.

- The least emphasis was placed on administrative areas such as environment/program policies and resources. However, over a third of consultants did report often using the strategies that focused on these areas as standard practice.

- Consultants reported spending by far the most time on supportive adult-child relationships. They also spent significant time on partnerships with families and daily routines. A moderate amount of time was spent on adult-adult relationships, activities and experiences, and environment and program policies, while the least was spent on resources.

Table 5. Focus of Programmatic Consultation				
Strategies	*N*	*Often use strategies supporting this area*	*Rarely use strategies supporting this area*	*Average ranking of time spent in this area[a]*
Supportive Relationships				
Adult-Child	28	93%	7%	6.7
Adult-Adult	29	72%	28%	3.7
Partnerships with families	29	83%	17%	4.9
Childcare Setting				
Activities and Experiences	29	97%	3%	3.6
Daily Routines	29	90%	10%	4 .3
Environment/Program Policies	29	35%	66%	3.6
Resources	29	41%	59%	1.7

Note: "Often use" represents scores equal to or greater than 2.5 and "rarely use" represents scores below 2.5.
[a]The number of consultants who provided rankings was 24.

Programmatic consultation at this time focuses first on child-centered improvements, then on building relationships with adults and families who are part of the provider's service community, and finally on administrative issues. Consultants' rankings of the amount of time they spent on each area generally followed this pattern. Below, we report on specific strategies emphasized within each area.

Strategies Targeting Supportive Relationships

Adult-Child Relationships

Strategies targeting supportive adult-child relationships address ways that adults can interact with children from birth to 5 years old in support of the development of both trusting relationships and security of surroundings.

Table 6 shows the percent of consultants who indicated that they used the strategies targeting supportive adult-child relationships "rarely," "sometimes," or "often," and the percent of consultants who desired technical assistance around each strategy.

- The majority of the consultants reported often using all the strategies.

- The least used strategy was coaching to implement primary caregiving practices, with just over half of consultants using it often. However, this may be due to a relative lack of need for this type of coaching among providers.

- A few consultants requested TA, all for different strategies.

Table 6. Percent of Consultants by Frequency of Strategy Use for Supportive Adult-Child Relationships				
Strategies	*Rarely Use*	*Sometimes Use*	*Often Use*	*Need TA*
Coaching to understand importance of child-caregiver relationship	0%	0%	100%	0%
Coaching to understand social-emotional development and function of "challenging behavior"	0%	0%	100%	3%
Coaching to support parent-child relationship	0%	3%	97%	3%
Coaching to interact with children consistently in nurturing ways	0%	7%	93%	3%
Coaching to implement primary caregiving practices	10%	35%	55%	0%

Note. N for each item = 28 or 29 consultants responding; Percent reported is out of those consultants responding.

> Most consultants reported often using all the strategies for supporting adult-child relationships; however, coaching to implement primary caregiving practices was used least, potentially because many providers were adequately skilled in this area. Few consultants reported a need for technical assistance.

Adult-Adult Relationships

Strategies targeting supportive adult-adult relationships are designed to help childcare staff and administrators enhance work relationships and address personal factors that influence the quality of caregiving.

Table 7 shows the percent of consultants who indicated that they used the strategies targeting supportive adult-adult relationships "rarely," "sometimes," or "often," and the percent of consultants who needed technical assistance.

- Slightly more than half of consultants reported often using strategies targeting adult-adult relationships, and nearly all consultants used these strategies at least sometimes.
- For each strategy, one coach asked for training and technical assistance.

Table 7. Percent of Consultants by Frequency of Strategy Use for Supportive Adult-Adult Relationships

Strategies	Rarely Use	Sometimes Use	Often Use	Need TA
Helping strengthen work relationships	3%	41%	55%	3%
Helping caregivers with personal concerns that may affect their relationships with children and adults	3%	38%	59%	2%

Note. N for each item = 29 consultants.

Although implemented less frequently than strategies targeting supportive adult-child relationships, most consultants used strategies designed to build the relationships among childcare staff and providers at least some of the time, and many consultants used these strategies often. Little need for technical assistance and training was reported.

Strategies Targeting Partnerships with Families

Strategies targeting partnerships with families address ways to build child care providers' ability to work together with families to build individualized support and continuity of care.

Table 8 shows the percent of consultants who indicated that they used the strategies targeting partnerships with families "rarely," "sometimes," or "often," and the percent of consultants who needed technical assistance.

- Nearly all consultants often used coaching to build and sustain strong partnerships with family members, although a few only used this strategy sometimes. One coach asked for training and technical assistance on this strategy.

- The majority of consultants also often worked on coaching to build an ongoing system for exchanging information with parents about children; 17% did this sometimes, but not often.

- About half of consultants reported often using coaching to facilitate culturally and linguistically competent practices with all children and families, while 10% rarely used this strategy. These consultants may operate in areas with little diversity.

Table 8. Percent of Consultants by Frequency of Strategy Use for Partnerships with Families				
Strategies	*Rarely Use*	*Sometimes Use*	*Often Use*	*Need TA*
Coaching to build and sustain strong partnerships with family members	0%	7%	93%	3%
Coaching to build ongoing system for exchanging information with parents about children	0%	17%	83%	0%
Coaching to use culturally and linguistically competent practices with all children and families	10%	38%	52%	0%

Note. N for each item = 29 consultants responding;. Percent reported is out of those consultants responding.

> Strategies to build partnerships with families were often used by the majority of consultants. A few consultants did not consistently use coaching to ensure that information exchange between providers and parents was effective. However, it is unclear whether this is because they have tended to work with providers who already have excellent communication systems in place or whether these consultants are less likely to place a priority on this area. Finally, coaching for cultural and linguistic competence showed the most variation, but this may be due to a lack of diversity in many of the locations. Consultants did not report a need for training and technical assistance in this area.

Strategies Targeting the Child Care Setting

Activities and Experiences

Strategies targeting activities and experiences are designed to develop child- and adult-initiated opportunities for children to use and explore a variety of skills at their individual developmental level.

Table 9 shows the percent of consultants who indicated that they used the strategies targeting activities and experiences "rarely," "sometimes," or "often," and the percent of consultants who needed technical assistance.

- The majority of consultants reported using all the strategies often, and all used them at least sometimes. Consultants most frequently worked to improve caregivers' ability to promote social-emotional development and prevent or address challenging behaviors.

- Consultants were relatively less likely to coach caregiving staff to use curricula to promote social-emotional development, although nearly three-quarters reported often doing this.

- Consultants were also relatively less likely to coach staff to understand the link between literacy and social-emotional development and coach staff to help children in the language development area, although about two-thirds reported often doing these things.

- One consultant reported a desire for training and technical assistance related to coaching around literacy.

Table 9. Percent of Consultants by Frequency of Strategy Use for Activities and Experiences				
Strategies	*Rarely Use*	*Sometimes Use*	*Often Use*	*Need TA*
Coaching to use strategies that promote social-emotional development and prevent challenging behaviors during activities and experiences	0%	3%	97%	0%
Coaching to use strategies to address challenging behavior during activities and experiences	0%	7%	93%	0%
Coaching to use curricula to promote social-emotional development	0%	28%	72%	0%
Coaching to understand link between literacy and social-emotional development and help children understand language, use language, and use books	0%	32%	68%	3%

Note. N for each item = 28 or 29 consultants responding; Percent reported is out of those consultants responding.

Consultants' responses indicate that coaching to improve children's activities and experiences is a key area of focus, particularly around promoting social-emotional development and addressing challenging behavior. Consultants are somewhat less likely to coach around using curricula to promote social-emotional development and help caregivers understand links between social-emotional development and literacy. Little need was reported for training and technical assistance in this area.

Daily Routines

Strategies targeting daily routine address the ways to plan daily schedule, routines, and transitions.

Table 10 shows the percent of consultants who indicated that they used the strategies targeting daily routines "rarely," "sometimes," or "often," and the percent of consultants who needed technical assistance.

- All consultants used coaching around daily routines at least sometimes, and most used it often.

- Consultants were most likely to often coach to improve transitions throughout the day but were relatively less likely to consistently coach to use visual supports throughout the care setting.

- No consultants reported a need for training and technical assistance in this area.

Table 10. Percent of Consultants by Frequency of Strategy Use for Daily Routines				
Strategies	Rarely Use	Sometimes Use	Often Use	Need TA
Coaching to use best practices re: transitions throughout the day	0%	10%	90%	0%
Coaching to create flexible yet dependable daily schedule that supports the various needs of young children	0%	14%	86%	0%
Coaching to promote social-emotional development by nurturing children during personal care routines	0%	17%	83%	0%
Coaching to use visual supports throughout the care setting	0%	21%	79%	0%

Note. N for each item = 29 consultants responding;. Percent reported is out of those consultants responding.

Coaching related to improving daily routines was reported to be a significant target of the strategies that consultants use in programmatic consultation, with a particular focus on transitions. A few consultants do not implement these coaching strategies in most of their programmatic consultation.

Environment/Program Policies

Strategies targeting environment or program policies address issues of how to set up the physical room and surroundings, use assessment tools, and evaluate global policies and procedures related to personnel and standards of practice.

Table 11 shows the percent of consultants who indicated that they used the strategies targeting environment/program policies "rarely," "sometimes," or "often," and the percent of consultants who needed technical assistance.

- Slightly over half of consultants reported often using coaching to administer child social-emotional screening and assessment tools, helping assess social-emotional environment using assessment scales or checklists, and coaching to make modifications to the physical environment. Seven to 10% of consultants rarely used these strategies.

- Interventions related to the policies of the caregiving setting were implemented less; 38% of consultants made it a practice to coach to strengthen the program's caregiving policies, but only 17% often coached to strengthen personnel policies or helped assess program policies and

practices relative to rules and standards pertaining to social-emotional development. Between 14% and 35% of consultants rarely used these strategies (35% of consultants rarely coached around personnel policies).

- In each area, one consultant requested training and technical assistance.

Table 11. Percent of Consultants by Frequency of Strategy Use for Environment/Program Policies				
Strategies	Rarely Use	Sometimes Use	Often Use	Need TA
Coaching to administer child social-emotional screening and assessment tools	7%	35%	59%	3%
Helping assess social-emotional environment using assessment scales or checklists	10%	35%	55%	3%
Coaching to make modifications to physical environment	7%	38%	55%	3%
Coaching to strengthen program's caregiving policies	14%	48%	38%	3%
Coaching to strengthen program's personnel policies	35%	48%	17%	3%
Helping assess program policies and practices relative to rules and standards pertaining to social-emotional development	14%	69%	17%	3%

Note. N for each item = 29 consultants responding;. Percent reported is out of those consultants responding.

Consultants reported less focus on strategies for improving environment and program policies, especially policies. While the majority of consultants made it a practice to work with providers on assessment of children or environment and physical environment modifications, these areas were clearly targeted less than relationships, activities, or routines. Consultants were much less likely to make it standard practice to coach around program policies, especially personnel policies.

Strategies Targeting Resources

Strategies targeting resources are designed to improve the provider's caregiving quality by linking them with early care and education service agencies and other resources.

Table 12 shows the percent of consultants who indicated that they used the strategies targeting resources "rarely," "sometimes," or "often," and the percent of consultants who needed technical assistance.

- Most consultants reported often helping caregivers access resource materials as part of their programmatic consultation. However, 18% of consultants did this sometimes or rarely.

- Just over half of consultants made it a standard practice to help caregivers access professional development opportunities, while most of the rest did this sometimes, presumably when they perceived a need or opportunities were available in the area.

- Consultants were less likely to help programs access community activities to broaden children's experiences and least likely to help programs access funds. About half of consultants did not appear to see this as part of their services.

- Two consultants requested technical assistance and training around helping access resource materials, while one consultant in each of the other areas requested assistance.

Table 12. Percent of Consultants by Frequency of Strategy Use for Resources				
Strategies	Rarely Use	Sometimes Use	Often Use	Need TA
Helping access resource materials	7%	11%	82%	7%
Helping access professional development opportunities	3%	41%	55%	3%
Helping access community activities to broaden children's experiences	17%	48%	35%	3%
Helping access funds	52%	31%	17%	3%

Note. N for each item = 28 or 29 consultants responding;. Percent reported is out of those consultants responding.

Consultants were less likely to report using strategies that promote access to resources as part of programmatic consultation. While most often helped programs access resource materials, not all did this consistently, and some need for technical assistance was desired. Additionally, while about half of consultants reported consistently addressing professional development, many did this only sometimes. were the least-used strategies and may not be seen as an important part of the consultation process.

While these strategies do not directly deal with children's challenging behavior, they are useful in helping the providers improve child care quality and sustainability. The state administrators should consider whether, despite the relatively lack of reported need for training and technical assistance by consultants, they want to emphasize these areas to a greater extent.

Technical Assistance

In most areas, the desire for training and technical assistance was expressed by one consultant for each. We examined whether these requests were all made by the same consultant or were from a number of different consultants. The results indicated that:

- 79% of consultants did not request any technical assistance.

- Four consultants asked for technical assistance in one area.

- One consultant asked for technical assistance in two areas and one asked for technical assistance in 11 areas.

No specific area or strategy had a significant number of consultants requesting technical assistance; rather, requests ranged across a variety of topics, with one, or at most, two consultants asking for training. Additionally, one consultant requested training in many areas.

Series: Michigan Child Care Expulsion Prevention Survey Summaries

The views expressed are solely those of the authors. For more information about this report, contact Laurie Van Egeren at the above address or phone number, or email: vanegere@msu.edu.

Michigan Child Care Expulsion Prevention Program

Reflective Supervision

Survey Summary No. 4 • August 2008

Introduction

In February and March 2008, 29 Michigan Child Care Expulsion Prevention Program (CCEP) consultants from 16 CCEP programs across Michigan participated in a survey administered by the Michigan State University evaluation team.

Reflective supervision is a critical piece of the CCEP model and is important for improving CCEP service quality. It is also an effective way for CCEP consultants to learn from the issues that they or their fellow consultants encounter. The CCEP program suggests that all consultants participate in reflective supervision at least twice per month. In the survey, consultants were asked to report on their participation in reflective supervision.

Reflective supervision, from a clinically trained supervisor or consultant, supports relationship-based practice by promoting the CCEP consultant's self-awareness of her own emotions and a careful re-evaluation of how her ideas, actions, and interactions contribute to or impede working with providers and families.[1]

This fact sheet provides information on:

- How often consultants participate in one-on-one and group reflective supervision.

- The length of time that consultants spend in one-on-one reflective supervision.

Participation

All consultants reported participating in reflective supervision. However, the form (one-on-one or group), frequency, and consistency varied as described below. In addition, in some cases, there appeared to be problems with the supervision process. One consultant reported that supervision was irregular—not scheduled for several months, then occurring as frequently as every other week for a period, then once per month. This consultant noted, "It gets cancelled or our supervisor 'forgets.'" Another consultant wrote, "It is supposed to be scheduled for bi-weekly, but it rarely happens. If it does get scheduled, my supervisor usually cancels. Currently, we have no supervision scheduled." Both consultants were from the same program.

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[1] Derived from L. Gilkerson, (2004), Reflective Supervision in Infant-Family Programs: Adding Clinical Process to Nonclinical Settings, *Infant Mental Health Journal*, Vol. 25(6), 424-439.

Form

Reflective supervision may be provided in individual or group sessions. One-on-one reflective supervision provides the consultants with the chance to communicate with their supervisor individually and target issues that occurred during their consultation services, ideally giving them the chance for confidential reflection and feedback. During group reflective supervision, several consultants meet their supervisor together and have the opportunity to support each other, increase skills and gain knowledge through interaction. Table 1 shows the percent of consultants receiving each form of reflective supervision or a combination of both.

- The most common form of reflective supervision was a combination of one-on-one and group supervision, with just over half of consultants receiving this form.

- An additional quarter of consultants received one-on-one reflective supervision only, while 14% received only group reflective supervision.

- These results indicate that overall, 74% of consultants received individual reflective supervision and 69% received group reflective supervision.

- Of those who did not regularly participate in one-on-one reflective supervision, a couple of consultants noted that they called their supervisor when they had specially difficult cases or were located far from their supervisor, had difficulty getting to reflective supervision (for example, due to bad weather). One consultant simply wrote, "As needed."

Table 1. Percent of Consultants by Form of Reflective Supervision	
Form	*Percent*
One-on-one only	24%
Group only	14%
Both	55%
Other (scheduled, but does not occur or "on hold")	7%

Note. N = 29 consultants responding.

Frequency

Table 2 presents the frequency of reflective supervision for those consultants who participated in each type of reflective supervision.

- Consultants who received one-on-one reflective supervision were most likely to participate every other week or once per week; only 17% received individual reflective supervision less frequently than every other week.

- Consultants who received group reflective supervision were most likely to participate once per month or every other week. One consultant had group reflective supervision weekly, and 10% had once every two or three months.

- The majority of consultants had the opportunity to meet the CCEP recommended guidelines of some form of reflective supervision at least every other week, and many exceeded this goal. However, about a quarter of consultants were not receiving reflective supervision more frequently than once per month in any form, and some much less. This appeared primarily due to geographic constraints.

Table 2. Frequency of Participation in Reflective Supervision		
Frequency	One-on-one	Group
One time per week	21%	3%
Every other week	41%	24%
One time per month	14%	31%
Every two months	3%	3%
Every three months	0%	7%

Note. N = 29 consultants responding. Percents reported of those participating in each type of reflective supervision.

Time Spent in One-on-One Reflective Supervision

To get a sense of how consultants spend their time on one-on-one reflective supervision, they were asked to report the typical length of sessions.

- On average, consultants who had one-on-one reflective supervision reported that it lasted about 77 minutes.

- Typical one-on-one reflective supervision times ranged from 60 minutes to 120 minutes, suggesting that substantial differences exist among consultants in their individual reflective supervision. Time spent tended to be shorter when reflective supervision occurred more frequently.

Series: Michigan Child Care Expulsion Prevention Program Survey Summaries

The views expressed are solely those of the authors. For more information about this report, contact Laurie Van Egeren at the above address or phone number or email:vanegere@msu.edu

MICHIGAN STATE
U N I V E R S I T Y

Michigan Child Care Expulsion Prevention Program

Group Training and Individual Coaching
of Providers and Parents

Survey Summary No. 5 • August 2008

Introduction

In February and March 2008, 29 Michigan Child Care Expulsion Prevention Program (CCEP) consultants from 16 CCEP programs across Michigan participated in a survey administered by the Michigan State University evaluation team.

CCEP consultants provide group training for providers and parents to support them in successfully nurturing children's social and emotional development. Four core modules are available, and consultants are also asked at times to develop new modules in response to a specific provider's or parent's request.

This fact sheet provides information on:

- Consultants' perspectives on the training services provided.
- Consultants' perceptions of their skill in conducting trainings.
- Areas of need for technical assistance and training around conducting trainings.

Consultant Perspectives on Training Services

Consultants were asked about the importance and degree of emphasis placed on training services, satisfaction with the core training modules, and comfort with developing other training modules requested by providers.

- **Importance:** 86% of consultants felt that the training services were very important; 10% thought they were somewhat important, and only one consultant felt that they were not very important.

- **Emphasis:** With respect to the amount of training services that they provided at the time of the survey, 79% of the consultants felt that the emphasis was fine; 10% felt they should be emphasized more, and 10% felt they should be emphasized less.

- **Satisfaction with core modules:** All consultants were at least somewhat satisfied with the core modules, with 57% of them reporting that they were very satisfied.

- **Comfort with developing other modules:** At times, consultants are asked to design and conduct new training modules to meet the needs of a specific provider. Most (71%) consultants

reported that they were very comfortable designing new modules. However, 25% were only somewhat comfortable and one consultant was not very comfortable with this process.

> Overall, consultants felt that the training modules comprised an important part of their services and were emphasized about the right amount. Although no consultants were dissatisfied with the core modules, many did not express complete satisfaction.

Group Training Skills

Group Training Implementation

A variety of skills are involved in conducting trainings—assessing the types of training needed, planning and conducting the sessions, and evaluating the training outcomes. Consultants were asked to rate their skills levels for the skills required for group training.

Table 1 shows the percent of consultants who rated their group training skills as "good," "adequate," or "less than adequate," and the percent of consultants who thought they needed technical assistance.

- For each area, the majority of consultants rated their skills as good.

- However, two skills were also rated as adequate or less than adequate by a number of consultants: writing learning objectives and creating power point presentations.

- For every skill, only one or two consultants indicated a need for technical assistance.

Table 1. Percent of Consultants by Levels of Skills in Group Training				
Skill	Less than adequate	Adequate	Good	Need TA
Planning the training				
Assessing training needs	0%	26%	74%	7%
Writing learning objectives	0%	46%	54%	7%
Creating PowerPoint presentation	30%	19%	52%	3%
Conducting the training				
Developing training content and materials	0%	25%	75%	7%
Conducting training sessions	0%	22%	78%	7%
Evaluating training satisfaction and outcomes	7%	25%	68%	3%

Note. N for each item = 27 or 28 consultants responding; Percent reported is out of those consultants responding.

Individual Coaching Skills

Initiation

Consultants often coach individual child care providers and parents to develop new skills. Coaching most often occurs in the process of implementing a Positive Child Guidance Plan or a Programmatic Action Plan. Individual coaching steps include: initiation, observation of new skills, action, reflection and evaluation of the coaching process and outcomes.

Consultants often coach providers and individual family members. Initiation takes place at the beginning of the training service. During the initiation process, the consultants interact with providers or parents to build trust, articulate their training needs, and develop the coaching plan.

Table 2 shows the percent of consultants who rated their initiation skills as "good," "adequate," or "less than adequate," and the percent of consultants who thought they needed technical assistance.

- Nearly all coaches felt they were good at building trust, listening, and recognizing and building on provider/parent strengths and individualizing approaches.

- 40% of coaches felt only adequate or less than adequate at developing a coaching plan.

- Little need was expressed for training and technical assistance in this area.

Table 2. Percent of Consultants by Level of Skills in Initiation				
Skills	Less than adequate	Adequate	Good	Need TA
Building trust	0%	7%	93%	0%
Listening	0%	4%	96%	0%
Developing coaching plan (purpose and outcomes)	4%	36%	61%	3%
Recognizing and building on provider/parent strengths; individualizing approaches to the needs of provider/parent	0%	11%	89%	3%

Note. N for each item = 27 to 29 consultants responding; Percent reported is out of those consultants responding.

Observation of New Skills

In their coaching role, consultants introduce new skills to providers or parents. Typically, they discuss the new concepts and skills with providers or parents, model the new skills, and observe their practice.

Table 3 shows the percent of consultants who rated their skills at observation of new skills as "good," "adequate," or "less than adequate," and the percent of consultants who thought they needed technical assistance.

- All consultants rated their coaching skills in observation of new skills as at least adequate, and majority rated their skills good. Modeling new skills had the largest percent of consultants reporting only adequate skills.

- No need for technical assistance was expressed.

Table 3. Percent of Consultants by Level of Skills in Observation of New Skills				
Skills	Less than adequate	Adequate	Good	Need TA
Discussing new concepts and skills	0%	21%	79%	0%
Modeling new skills for parent/provider to observe	0%	27%	73%	0%
Observing provider/parent practice new skill or discuss how they will practice it	0%	14%	86%	0%

Note. N for each item = 26 to 29 consultants responding; Percent reported is out of those consultants responding.

Consultants generally felt skilled at discussing, modeling, and observing providers and parents as they practiced new skills. About a quarter of consultants only felt adequate at modeling new skills, but no consultants reported a need for training and technical assistance.

Action

Providers and parents will be more likely to utilize the new skills in daily interaction with children if they feel confident about their ability to do the new behaviors and use them appropriately. As part of coaching, consultants provide support and feedback to providers and parents on their performance of new skills.

Table 4 shows the percent of consultants who rated their skills at action as "good," "adequate," or "less than adequate," and the percent of consultants who thought they needed technical assistance.

- All consultants rated their skills as at least adequate; the majority reported their coaching skills in action as good.

- No consultants reported a need for technical assistance.

Table 4. Percent of Consultants by Level of Skills in Action				
Skills	Less than adequate	Adequate	Good	Need TA
Supporting provider/parent to practice new skills	0%	21%	79%	0%
Providing feedback on performance of new skills	0%	22%	78%	0%

Note. N for each item = 27 to 29 consultants responding; Percent reported is out of those consultants responding.

All consultants felt they were at least adequate at supporting and providing feedback to providers and parents as they practiced new skills, and most felt that they had good skills.

Coaching Skills in Reflection

Reflection can help providers and parents consider and acquire new skills.. It encourages learning through active thought and action. Reflection is also useful in helping the learner generalize their new skills to other situations.

Table 5 shows the percent of consultants who rated their skills at reflection as "good," "adequate," or "less than adequate," and the percent of consultants who thought they needed technical assistance.

- All consultants rated their skills as at least adequate, and the majority reported their coaching skills in reflection as good.

- Compared to the skill of asking reflective questions/promoting self reflection, fewer consultants reported that they were good at finding opportunities to promote further learning and generalize new skills to other situations. One consultant indicated a desire for training and technical assistance in this area.

Table 5. Percent of Consultants by Level of Skills in Reflection				
Skills	Less than adequate	Adequate	Good	Need TA
Asking reflective questions; promoting self-reflection	0%	22%	78%	0%
Finding opportunities to promote further learning and generalize new skills to other situations	0%	33%	67%	3%

Note. N for each item = 27 to 29 consultants responding;. Percent reported is out of those consultants responding.

> Most consultants felt that they were good at promoting reflection and there was little desire for training and technical assistance in this area.

Evaluation of Coaching Process and Outcomes

Consultants are asked to evaluate the coaching process and determine whether providers and parents have learned new skills.

Table 6 shows the percent of consultants who rated their evaluation skills as "good," "adequate," or "less than adequate," and the percent of consultants who thought they needed technical assistance.

- The majority of consultants rated their coaching evaluation skills as adequate; only about a third of them reported these skills as good.

- One consultant indicated a need for training and technical assistance.

Table 6. Percent of Consultants by Level of Skills in Evaluation				
Skills	Less than adequate	Adequate	Good	Need TA
Evaluating the coaching process	7%	57%	36%	3%
Evaluating coaching outcomes	7%	61%	32%	3%

Note. N for each item = 28 or 29 consultants responding;. Percent reported is out of those consultants responding.

> Of all the coaching skills areas, consultants indicated that evaluation of coaching was the weakest. Only one consultant asked for technical assistance and training on evaluation.

Series: Michigan Child Care Expulsion Prevention Survey Summaries

Michigan Child Care Expulsion Prevention Program

Consultants: Experience, Job Satisfaction, and Organizational Support

Survey Summary No. 6 • August 2008

Introduction

In February and March 2008, 29 Michigan Child Care Expulsion Prevention Program (CCEP) consultants from 16 CCEP programs across Michigan participated in a survey administered by the Michigan State University evaluation team.

The consultants were asked about their demographics and experience, their feelings about their work as a CCEP consultant, their future plans, and what they considered to be the most difficult or satisfying aspects of the job.

This fact sheet provides information on:

- Characteristics of the consultants.

- Perceived support from CMH and home agencies.

- Perceptions of their jobs, including work environment, attitudes about the job, and most difficult and satisfying things about the work.

Consultant Characteristics

- **Gender.** All consultants were female.

- **Age.** The average age was 43, ranging from 27 to 60.

- **Race/ethnicity.** Most (76%) were white, 21% were African American, and one was Asian. None were Hispanic.

- **Education:**

   83% had Master's degrees and 17% had Bachelor's degrees. Slightly more than half (59%) had received their degrees in social work, with 17% majoring in psychology. The remainder had degrees in education, counseling, sociology, child development, and community services. Some had degrees in two areas.

- **Experience:**
    - **In children's mental health field.** On average, consultants had worked directly with young children and families on issues related to children's mental health for about 10 years, ranging from 2 ½ to 30 years. Three quarters had worked in the field for at least 10 years.
    - **In CCEP program.** Consultants had worked in the CCEP program for an average of about 4 years, ranging from 3 months to 9 years. Three quarters had been with the CCEP program for at least 2 years.

- **Licensing and Endorsement:**
  - **Licensing.** Most consultants (83%) were licensed as social workers, psychologists, or professional counselors.
  - **Endorsement from the Michigan Association for Infant Mental Health (MI-AIMH).** The contractual agreement with the Michigan Department of Community Health requires consultants to be endorsed by MI-AIMH.[1] 72% of consultants were at Level 3, 24% at Level 2, and one consultant did not have a MI-AIMH endorsement.
  - **Full or part-time.** 59% of consultants worked full-time for the CCEP program and 41% worked part-time. The part-time consultants reported working an average of 18 hours per week, ranging from 10 to 30 hours per week. Half worked at least 20 hours per week.

> Consultants were female and mostly white, and the majority held Master's degrees. Many were licensed social workers, psychologists, and counselors. Most had many years of experience in the child mental health field and had been in the CCEP program for at least two years. All but one consultant had at least a Level 2 MI-AIMH endorsement, and the majority had a Level 3 endorsement. Slightly more than half were employed full-time in the CCEP program.

Support from Community Mental Health and Other Agencies

Employment Type

Although all contracts were with a county-based Community Mental Health Service Plan (CMH), CCEP consultants were employed in a variety of ways: directly by the CMH, by an agency that subcontracted with the CMH to provide services, or as individual contractors with the CMH or Michigan Child Care Coordinating Council.

- 41% of the consultants were CMH employees.
- About a third (31%) were employed by subcontracting agencies.
- 27% were individual contractors, with 10% subcontracted to the CMH and 17% through 4C.

Support from Employer and CMH

Consultants were asked how supported they felt by the organizations for which they worked. These questions were asked separately for the three types of employees: CMH employees, employees of subcontracting agencies, and individual contractors to CMH and 4C.

Table 1 first indicates the level of support reported by consultants who were employees of CMH or subcontracting agencies. The degree to which consultants who were individual contractors reported support from CMH or 4C is then presented.

- **Employees of CMHs' perceptions of support from CMH.** Few (18%) consultants who were employed directly by CMH felt very supported in their CCEP work. About a quarter explicitly said that they did not feel very supported.
- **Employees from subcontracting agencies' perceptions of support from their home agencies.** Consultants from subcontracting agencies were far more positive, with two-thirds

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[1] For information on endorsement see www.mi-aimh.org

reporting that they felt very supported and the rest reporting that they were somewhat supported by their home agencies.

- **Non-CMH employees' perceptions of support from CMH:**
    - Employees from subcontracting agencies reported relatively low levels of support from CMH. Only one consultant reported feeling very supported, and two-thirds felt only somewhat supported. Twenty-two percent felt not very supported.
    - Two-thirds (6) of individual contractors to CMH also reported only moderate support, with one-third (2) feeling very supported.
    - Individual contractors to 4C felt fairly supported by 4C; 60% (5) felt very supported, with the remainder (3) feeling somewhat supported.

Table 1. Percent of Consultants by Organizational Support					
Who	*N*	*Supported by*	*How supported*		
			Not very	*Somewhat*	*Very*
CMH employees (support by CMH)	11	CMH	27%	55%	18%
Employees of subcontracting agencies (support by home agency)	9	Home agency	0%	33%	67%
Non-CMH employees (from subcontracting organizations or individual contractors)					
Employees of subcontracting agencies (support by CMH)	9	CMH	22%	67%	11%
Individual contractors to CMH (support by CMH)	8	CMH	0%	66%	33%
Individual contractors to 4C (support by 4C)	8	4C	0%	40%	60%

Note. Percent reported is out of those consultants responding.

Slightly more than half of consultants were employed by, or individual contractors with, CMHs. CMH employees reported feeling considerably less supported by CMH than did individual contractors to CMH. Consultants who worked for subcontracting agencies or were individual contractors with 4C reported more support from their home agency.

What Would Make Consultants Feel More Supported

CMH Employees

ISeven consultants made comments as follows:

- **More investment in CCEP from CMH administrators.** Two consultants reported that they had CMH administrators who were not invested in CCEP or lacked time for early childhood programs in general.
- **More clerical support.**
- **Free insurance benefits.**

- **Ability to participate in relevant meetings.** One consultant mentioned wanting to attend meetings where services could be coordinated as well as to learn from and share resources with colleagues doing related work (e.g., home-based group meetings).
- **Continuation of CCEP program through CMH.** One consultant was concerned about the possibility of the program moving to a subcontracting agency that would not provide high-quality services. She felt that by providing services herself through the CMH, she could maintain quality.

Employees of Subcontracting Agencies

By their agencies:

- **Better pay.** Several consultants described the issue of pay, wishing that there was "more funding for the position."
- **Opportunities for advancement.**
- **Equal treatment for teams in the unit.** Because there was no further information, it is unclear what this consultant meant.
- **More collaboration within the agency.** One consultant said:

    "It is difficult to refer clients to other resources at our agency because I have no idea who is good at their job and who isn't… the other programs are mostly a mystery to me."

By CMH:

- **More services for children under the age of 5** (one consultant**).**
- **To participate in CMH activities more.** One suggestion was to be more involved in meetings, trainings and new developments with laws or trends…"However, that requires more time from a single consultant/administrator."
- **Increased budget to hire another consultant.** One consultant felt that this would be helpful because it would give her a regular and lower caseload.
- **Support is fine.** Although the results in Table 1 indicated that few consultants from subcontracting agencies felt very supported by CMH, the open-ended responses from a limited number of consultants suggest that most do not feel a need for high levels of CMH support and may have greater connection with their home agencies. Several consultants reported that they felt "fine with the level of support."

Individual Contractors

Contractors to CMH:

- **Agency support is fine, but need more supervisor support.** Consultants from one program reported that overall, the agency support was fine. However, they commented:

    "Our supervisor does not share the same vision and values about the program as the consultants."

    "If we had a different direct supervisor for the CCEP program, our program would run much more efficiently and the consultants would feel much more supported."

Contractors to 4C:

- **More reflective supervision.** One consultant wrote:

  > *"I would like more one-on-one time with my reflective supervisor and know that my 4C supervisor believes in reflective supervision."*

CMH Employees in the CMH Setting

Part of a supportive, collaborative job environment is having opportunities to connect with other staff and knowing about each others' work. The 12 consultants who were directly employed by CMH were asked about the extent to which they participate in CMH staff meetings and the extent to which their CMH colleagues who work in other children's programs know about CCEP.

- **Participation in meetings.** Three-quarters of consultants directly employed by CMH participated in CMH staff meetings (such as children's mental health staff meetings).

- **CMH staff awareness of CCEP.** 25% of these consultants indicated that other CMH staff were well aware of CCEP, and 58% thought the other CMH staff had some information about CCEP. Only one consultant reported that her CMH colleagues had little or no information about CCEP.

> Consultants reported a variety of areas that would make them feel more supported; no particular issue stood out as reported by a large number of consultants. Some of the common areas, regardless of the consultant's employment situation, were collaboration and inclusion with colleagues, supervisor support, and pay/benefits.

Job Perceptions

Work Environment

Consultants reported perceptions of their jobs—teamwork and collaboration, ethics, resources, pay, and paperwork. Table 2 shows the percent of consultants who agreed or disagreed with whether these conditions were available.

- **Teamwork and collaboration:**
  - Most staff agreed that staff frequently share ideas. Because some programs are staffed by a single consultant, this may account for some of those who did not agree with this statement.
  - On the whole, about 75% of consultants at least mildly agreed that there was an atmosphere of collaboration and teamwork within the CCEP program—openness to change, collaboration between administrators, and staff to improve the program and make decisions. A quarter strongly agreed. However, about 35% were neutral or disagreed that this existed. Again, some of the more negative results may be due to single-consultant programs.

- **Resources, pay, and paperwork:**
  - Most consultants reported that necessary materials were available.
  - Nearly half of consultants were not satisfied with their salaries.
  - A little over half of consultants reported that routine duties and paperwork got in the way of providing services, although only 14% strongly agreed.

Table 2. Work Conditions				
Aspects	*Disagree*	*Neutral*	*Mildly agree*	*Strongly agree*
Teamwork and collaboration				
Staff frequently shares ideas with each other.	7%	10%	21%	62%
Most staff and administrators are open to change and experimentation.	14%	18%	43%	25%
Most staff and administrators work collaboratively to identify needs and improvements for the program.	18%	11%	46%	25%
The program administrators collaborate with staff to make decisions.	14%	25%	36%	25%
Resources, pay, and paperwork				
Necessary materials are available to the staff.	7%	10%	38%	45%
I am satisfied with my salary.	48%	10%	24%	17%
Routine duties and paperwork get in the way of providing services.	17%	28%	41%	14%

Note. N for each item = 28 or 29 consultants responding; Percent reported is out of those consultants responding.

Most consultants felt that work conditions related to collaboration—with other staff and with administrators—were good, although not necessarily as good as they could be. Nonetheless, a number were either neutral or disagreed. Although most wished for greater pay and felt that routines and paperwork tended to get in the way of service provision, necessary materials generally appeared to be available.

Attitudes Toward Work

Consultants described their career plans with regard to their current consultation work (Table 2). More than half would like to make a career in this field, 12% plan to pursue further education and go into administration, and about a third plan to move on eventually.

Table 2. Percent of Consultants by Career Plans	
Plan	*Percent*
I'll move on as soon as something better comes along.	15%
I'll stay for a few more years at most.	19%
I would like to make a career in this field.	54%
I plan to pursue further education in this field and go into program administration.	12%

Note. N for each item = 26 consultants responding; percent reported is out of those consultants responding.

Consultants also reported their attitudes about their consultation work—the extent to which it feels like personal fulfillment or transitional work, their level of commitment and effort, and their non-positive feelings about the work. Table 3 shows the percent of consultants by how much each item reflected their feelings.

- Most consultants reported considerable personal fulfillment in their work and did not see it as transitional work to something better. A third hoped it would be a stepping-stone to a related career or profession.

- Almost all expressed that they put effort into their work and were strongly committed to it.

- Few consultants indicated that they felt like quitting, although more than a quarter were not sure or did feel like quitting.

- Only a third of consultants definitely expressed that the work was not difficult, and half indicated that the work was indeed difficult.

Table 3. Work Perspectives				
Perspectives	*Not the way I feel*	*Not sure*	*Mostly the way I feel*	*Exactly the way I feel*
Personal fulfillment				
Work that I feel I am able to do well.	7%	14%	35%	45%
A job in which I have the opportunities to learn and grow.	7%	14%	41%	45%
My career or profession.	18%	11%	32%	39%
A way of helping someone out.	7%	3%	52%	37%
A personal calling.	23%	19%	27%	31%
Transitional work				
Something I feel stuck in due to few other employment opportunities.	82%	11%	7%	0%
Something to do temporarily until a better job comes along.	82%	14%	0%	4%
A stepping-stone to a related career or profession.	46%	14%	32%	7%
A job with a paycheck.	89%	11%	0%	0%
Commitment				
Work I put a lot of effort into.	4%	0%	21%	75%
Work I feel committed to.	0%	0%	35%	66%
Non-positive feelings				
A job I frequently feel like quitting.	68%	25%	7%	0%
Work that is very difficult.	32%	18%	39%	11%

Note. N for each item = 26 to 28 consultants responding; Percent reported is out of those consultants responding.

The majority of consultants were personally fulfilled by their work in CCEP and did not see it as a transitional job, although more than one third hoped it would lead to career advancement. Almost all expressed substantial effort and commitment to the job. Most did not want to quit; however, a quarter were not sure if they felt like quitting. Many consultants indicated that the work is difficult, suggesting the work in the CCEP program can be fairly stressful.

Most Difficult Aspects of the Job

Consultants reported what they saw as the most difficult aspects of their consultation work:

- **Additional job responsibilities.** Several consultants discussed the difficulties of balancing their CCEP work with other part-time responsibilities, including caseloads from other assignments, covering for colleagues on leave, administrative responsibilities that are not part of direct services, and lack of administrative support resulting in the need to also perform administrative duties.

- **Lack of time.** Consultants expressed that there was "not enough time in the day to get all the aspects of the job done; I often work over 40 hours a week to do my job well."

- **Completing paperwork.** A number of consultants mentioned paperwork, including the evaluation binders.

- **Lack of supervisor support.** Several consultants indicated that they have supervisors who were not committed to CCEP, would not go to meetings (thereby requiring the consultant to do so), or were generally unsupportive.

- **Lack of colleagues. "**Not having other early childhood staff to share ideas and learn from" (one consultant).

- **Lack of buy-in from clients.** Consultants expressed frustration about providers and parents not following through, not admitting there was a problem, or refusing more extensive evaluation of the child if warranted. They were frustrated with providers who blame and label the child rather than making some recommended changes in the center. They also mentioned child care staff who have unrealistic expectations and anticipate "an easy fix."

- **Meeting client needs.** Several consultants described being caught between the needs of the child, director, staff, parents, and the state. One consultant wrote:

  > *"I sometimes feel like the middle man who is referring people on to get them the 'real help' they are looking for. (And then I have to watch them struggle as the people providing the 'real help' handle their cases in insensitive, unsupportive manners, which breaks my heart.)"*

  In addition, one consultant indicated that clients sometimes wanted concrete diagnoses, which consultants were not qualified to provide.

- **Feelings of futility.** Multiple consultants mentioned the drain of working with poor-quality child care centers, where motivation to change can be very low:

  > *"Feeling a pit in my stomach before I go into a center because I know kids are not well taken care of... feeling like our society has settled for less than 'good-enough' child care for our littlest ones."*

  > *"Seeing sorrowful situations can be very difficult but knowing that there are children and families in similar situations that we're not serving—that's the absolute hardest part of this work."*

- **Low salary for intense work (**two consultants).

- **Limited budget and resources** (several consultants**), including lack of funds to attend out-of-town conferences** (one consultant**).**

- **Balancing when to close a case with other needs** (one consultant).

Most Satisfying Aspects of the Job

Consultants reported what they saw as the most satisfying aspects of their consultation work:

- **Making a difference in the lives of children, families, and providers.** Consultants were personally fulfilled by knowing that their work made a difference in the lives of those they served:

  "Serving children and families is my ultimate calling in life—as a CCEP Early Childhood Mental Health Consultant, I am able to reach out to children and families."

  "I am confident that I am able to reach out to hundreds, thousands, of children by offering solid professional training opportunities to Early Childhood Professionals."

- **Making a difference in the community.** Consultants also described the satisfaction in making a difference beyond just the individuals they served:

  "I can hardly think of other work where we could have access to helping so many children. We enter a facility on behalf of one child and that child is actually the ambassador that opens the door to our opportunity to help so many others and to implement meaningful change. How many people get to feel that way about their 'jobs'? It's no job – it's an honor to be a part of this program."

  "Making a difference in a big way among agencies, families, providers, and in the community--having community awareness about CCEP and feeling that the State cares about child care providers."

- **Doing the work.** Consultants particularly noted the satisfaction they gained in working with providers and families, building connections, and developing relationships.

- **Seeing success.** Consultants said a major source of satisfaction was seeing the change in children as a result of changes in their parents and providers; they enjoyed watching children develop socioemotionally and avoid expulsion from the childcare setting. In addition, they observed that they saw greater professionalism in providers that they worked with and that they enjoyed seeing others' attitudes move from " 'the child is the problem' to 'the child has a problem.' "

- **Conducting trainings.**

- **Control.** One consultant mentioned feeling satisfied that she was trusted to handle her job with minimal daily supervision and had flexibility to decide how to do the job.

- **Using the prevention philosophy** (two consultants**).**

- **Have resources to support the work.** Consultants felt that they had other organizations they could get information and support from for their consultation work.

- **Feeling appreciated by the State.** One consultant mentioned working for a state that cares about early childhood in general and the CCEP program in particular.

Series: Michigan Child Care Expulsion Prevention Survey Summaries

Michigan Child Care Expulsion Prevention Program

The Most Important Things Consultants Do

Survey Summary No. 7 • August 2008

Introduction

In February and March 2008, 29 Michigan Child Care Expulsion Prevention Program (CCEP) consultants from 16 CCEP programs across Michigan participated in a survey administered by the Michigan State University evaluation team.

CCEP consultants address the social-emotional needs of children presenting with challenging behavior to prevent their expulsion from child care and promote the social-emotional development of all children in the care setting. . As part of the survey, consultants were asked what the most important things are that they do for children, families, and providers, and the most important ways they do these things. Services that consultants provided were not clearly separated into what they do for children, families, and providers, but were part of a system of partnership among all the participants in the process. For this report, we have separated the answers into areas most relevant to children, families, and providers separately.

This fact sheet provides information on:

- The most important things that consultants say they do for children, families, and providers.

- The most important ways that consultants say they support children, families, and providers.

For Children

Most Important Things Consultants Do…

- **Educate the important adults in children's lives about children's behavior.** Consultants reported that they help parents and providers understand the children's challenging behavior and learn the needs expressed through such behavior. They help adults see each child as a unique individual with strengths and good qualities and build reasonable expectations for that child. Consultants guide the adults to spend time with children to better understand their temperament.

  > *"I think the most important thing I do for children is to help adults understand the 'meaning of their behavior.' I attempt to surround their situation with hopefulness that distressed and exhausted adults sometimes lose sight of."*

  > *"I help adults see children more accurately. I help adults reflect on their own experiences and think about, 'Am I seeing this child as s/he is, or am I seeing something else when I look at this child?' and 'How can I best respond to the child in front of me?' I help adults recognize that children are people who have feelings and experiences (good days and bad days) just like they (the adults) do. I encourage adults to have realistic expectations of children—to keep in mind the children's developmental capabilities, temperament, experiences, etc.--when responding to children throughout the day. In other words, I work to promote more responsive and reflective caregiving practices for children."*

Most Important Ways They Do So…

- **Support the adults.** Consultants work to have parents and providers remain positive and optimistic about their children and offer support in seeking out the most reasonable means to meet the children's needs or to work with children's temperament. They address adults' needs by helping them reflect on their own early experiences and how those affect their caregiving.

  "I first attempt to offer support to the adults around them. As a matter of fact, most of what I do for the children happens through the important adults in their lives."

- **Advocate for children.** Consultants speak on behalf of children about their needs and help adults around to listen to children's voices.

  "Try to give them a voice…speak for them and help the adults to listen to what it is their behaviors are saying. I help the grown-ups to hear together and think as a 'team' about how to best meet the child's needs."

- **Provide encouragement and support to children.** Consultants play and talk with children at their level, look for ways to help them with success, and affirm their ability to solve problems or conflicts. They also model positive ways to deal with everyday conflicts or feelings.

  "Play with them, affirm them, demonstrate genuine concern and caring."

  "Accept, acknowledge who they are, and build on strengths."

- **Conduct assessment and observations.** Consultants observe the children in childcare and home settings, use various tools, such as the Devereaux Early Childhood Assessment Infant/Toddler or Devereaux Early Childhood Assessment behavior instrument, to assess children, and provide valuable information about children's developmental level and social-emotional problems.

For Families

Most Important Things Consultants Do…

- **Provide emotional support.** Consultants listen to families and encourage them to share their experiences with their child. They acknowledge parents' stresses and frustrations and empathize with their struggles. Consultants remind parents of the children's strengths and help them build hope and confidence about parenting. They validate parents' feelings and experiences and help them reframe those feelings in an empowering way.

  "I try to support them by listening to their concerns about their child. I listen for the things they are doing well and try to build on these as a means of encouragement."

  "I think that I offer them a non-judgmental space to give them the emotional safety to explore several facets of their lives that ultimately impact their child(ren)."

  "Listening to them. Providing information specific to their child, honesty that nobody has all the answers. Really just developing a relationship based on mutual respect so there is the opportunity for learning."

- **Help parents understand their children.** Consultants help families gain perspective about their children's behavior and understand the social-emotional development of their children and their individual child's needs.

  "I help support families to better understand their child (temperament, message behind the behaviors) which often leads to families seeing a child through a new 'lens.'"

Most Important Ways They Do So…

- **Train parents to interact with their children.** Consultants talk with families about their parenting practices and validate their experience. They help develop the Positive Guidance Plan to create new strategies to interact with children, highlighting parent-child interaction and positive responses. They use modeling and positive reinforcement. Consultants also give parents handouts relevant to childcare strategies and offer phone support to the families.

  > *"I ask them how they have dealt with their child's concerns or behavior and what has worked and what has not worked. I try to give them some new ideas or tools to help their child."*

  > *"Attend home visits, offer personal in-home training and support."*

- **Provide resources and coordination of services.** Consultants provide opportunities for parents to receive support from other parents via support group or training groups and encourage teamwork between parent and provider. Consultants provide referrals to appropriate resources such as occupational therapy, special education programs, or therapists.

- **Bridge parents with providers.** Consultants work with parents to advocate for their children and build strong communicative relationships with providers. They help build parent-teacher partnerships by facilitating meetings and acting as a go-between to help foster the relationship.

  > *"Provide a safe base on which to build a partnership between the child care center (and parent) – especially under tough circumstances."*

  > *"I am always attempting to bridge families with their providers so that eventually their communication is more direct with each other--and so that the parents can experience themselves as effective advocates for their child."*

- **Be accessible.** Consultants report that it is important to families that they be readily available to them. Consultants emphasize their accessibility through phone contacts, visits at home or the center, group meetings, and being available at times that are feasible for parents.

For Providers

Most Important Things Consultants Do…

- **Provide emotional support.** As with families, consultants provide emotional support to providers by listening and reflecting on providers' work, their contributions, and their feelings about their work with families and children. They validate providers' perspectives about children and help them grow in their relationships with the children.

  > *"I listen to their stories, empathize with their struggle and validate their experience."*

  > *"Listen. Most providers feel like they are not heard and are not supported."*

  > *"Support and recognition of how hard their jobs can be--that they are doing work of incredible value and they want the best for children."*

- **Improve skills.** Consultants help providers recognize better ways to cope with challenging behavior.

  > *"Recognize their strengths and build on these to help in areas where they don't feel as comfortable or struggle with."*

  > *"Support them through their interactions with the child and give them skills to change some of the ways they are interacting with some children and reinforce some of the ways they interact with children, affirm their concern."*

Most Important Ways They Do So…

- **Provide training, reflection and feedback.** Consultants help providers recognize their strengths and weaknesses, identify areas to work on, brainstorm new ideas, and develop a Positive Guidance Plan. They offer professional development and help them adjust their actions, tone of voice, and program to meet the needs of the children in their care. Consultants model the appropriate interaction with children and help providers with the appropriate expectations for children's behavior. They provide feedback after observations and give suggestions about ways to change.

  > *"I often ask questions in a way that helps them realize and verbalize that they have the tools and knowledge to work with a child. Together we come up with some new ideas or resources to try."*

  > *"I use 'teachable' moments--so that providers can see the relevance of child development information."*

- **Reframe.** Consultants suggest new ways for providers to view situations and help them reflect on their existing perspective.

  > *"I challenge their views while respecting them and where they are coming from. I give them an opportunity to think about things differently.... to 'wonder' about possibilities they might not consider on their own."*

  > *"Re-framing and perhaps renaming: for example, 'time out' to become 'time in' and the related changes and slightly different purposes."*

- **Seek resources for teachers.** Consultants talk to the directors to help teachers get resources. They also lend resources and support materials related to social-emotional health (e.g., handouts and tapes).

- **Help develop relationships.** Consultants work on the relationships among staff or between teachers and parents that can affect childcare quality.

  > *"I focus much of the work on 'bridge-building' between staff-to-staff and parent-to-staff hoping that the centers will become a more solid and supportive environment."*

- **Connect with the director.** Center director buy-in is critical for provider improvements to be successful and sustainable. As one consultant described:

  > *"I always begin my work with the director and I consult with her/him during every visit. The building and sustaining of that professional relationship is the primary 'tool' I use to facilitate the work."*

- **Be available and attentive.** Just as consultants are available to parents, they are also available to providers. Consultants check in regularly and are accessible when questions need to be answered. Additionally, consultants provide special attention and recognition that many providers may not often get:

  > *"Showing up to spend time with them, noticing them, and the conversations I have with them. I see providers in a way they are not used to being seen...as capable individuals who have chosen to work in a difficult field."*

Series: Michigan Child Care Expulsion Prevention Survey Summaries

The views expressed are solely those of the authors. For more information about this report, contact Laurie Van Egeren at the above address or phone number, or email: vanegere@msu.edu

Michigan Child Care Expulsion Prevention Program

Collaboration with Michigan Child Care Coordinating Council, MSU Extension, and the Great Start Collaborative

Survey Summary No. 8 • August 2008

Introduction

In February and March 2008, 29 Michigan Child Care Expulsion Prevention Program (CCEP) consultants from 16 CCEP programs across Michigan participated in a survey administered by the Michigan State University evaluation team.

Consultants were asked about their collaboration with three of the primary local organizations with whom they might work for the benefit of children, families, and providers: Michigan State University Extension (MSU-E), Michigan Child Care Coordinating Council (4C), and the Great Start Collaborative. They described the extent of collaboration, how helpful they found collaboration, and the benefits and challenges of collaboration with these organizations.

This summary provides information on:

- Level of collaboration with MSU-E, 4C, and the Great Start Collaborative
- Benefits and challenges of collaboration
- Hardest part of collaboration

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Glossary

4C	Michigan Child Care Coordinating Council. A statewide organization that has regional offices.
Great Start Collaborative	County-based collaborative sponsored by the state- and foundation-funded public corporation known as Early Childhood Investment Corporation (ECIC)
MSU-E	Michigan State University Extension. U.S. Department of Agriculture and state funded organization that has county offices.

Level of Collaboration

MSU Extension and the Michigan Child Care Coordinating Council and CCEP/MDCH are state partners. These three entities have a written agreement to collaborate on training for parents and service providers. CCEP consultants must collaborate with MSU-E and 4C at the local level and are strongly encouraged to

collaborate with the local Great Start Collaborative as well. Involvement can be considered as a four-level continuum, including:

- **Networking:** We know about each other. We don't share information, resources, or decision-making.

- **Cooperation:** We share information with each other. We made decisions independently about how to reach our goals.

- **Coordination:** We share information and resources. We make some decisions together about how to meet our goals.

- **Collaboration:** We are really one system. We share information, resources, and ideas. We make most decisions together and reach consensus about how to reach our goals.

Consultants were asked to report on the degree to which they collaborated with MSU-E, 4C, and the Great Start Collaborative on the scale described above. As shown in Table 1:

- **Michigan Child Care Coordinating Council.** Involvement with 4C was strongest, with 36% of consultants reporting Collaboration (the highest level possible) and an additional 36% reporting Coordination, the next highest level. This means that most consultants worked with 4C to share information, resources, and make at least some decisions together. Many consultants considered their CCEP work and 4C to really be one system.

- **MSU Extension.** Collaboration with MSU-E tended to fall in the middle levels: Cooperation and Coordination. This means that most consultants had a relationship with MSU-E that included information sharing, but that they may or may not have worked together to make decisions about how to reach goals. A quarter of consultants reported the lowest level of collaboration with MSU-E (Networking)—they know of each other but don't share information, resources, or decision-making.

- **Great Start Collaborative.** Collaboration with the Great Start Collaboration was on the lower end of the continuum, but ranged from Networking to Coordination. Few consultants reported a strong Collaboration relationship with Great Start, and some communities did not have a Great Start Collaborative at the time of the survey.

Table 1. Level of Involvement with MSU-E, 4C, and the Great Start Collaborative					
Organization	Networking	Cooperation	Coordination	Collaboration	Organization not available
MSU- E	25%	36%	36%	4%	0%
4C	4%	25%	36%	36%	0%
Great Start Collaborative	32%	36%	23%	9%	21%

Note. N for each item = 28 consultants responding; Percent reported is out of those consultants responding. Involvement levels for the Great Start Collaborative are reported only for consultants who reported it was available.

Involvement is strongest with 4Cs, with about a third of consultants reporting true collaboration with shared decision-making and efforts to meet goals. Involvement with MSU Extension is moderate in most cases, but minimal in about a quarter of cases. Involvement with the Great Start Collaborative is lowest, and at the time of the survey, not all consultants were in counties with a Great Start Collaborative.

Benefits of Collaboration

Was Collaboration Helpful?

Consultants reported on whether collaborating with MSU-E, 4C, and the Great Start Collaborative had been helpful. Out of the consultants who responded (N = 23 to 27):

- 96% reported that collaborating with 4C had been helpful.

- 63% reported that collaborating with MSU-E had been helpful.

- 57% reported that collaboration with the Great Start Collaborative had been helpful.

How was Collaboration Helpful?

4C

- **Promote each other's organization.** Several consultants mentioned that the local 4C helped publicize the CCEP service through their trainings and "have helped inform providers of services and trainings." The local 4C referred parents and providers to CCEP. Consultants wrote, "It has been a good source of referrals" and that "this is so beneficial" to their program's success. Consultants also helped promote local 4C resources and refer children to them as needed.

- **Conduct and coordinate trainings.** Consultants described that they shared training information with 4C, coordinated training schedules to avoid conflicts, and worked together to conduct the trainings for providers. Generally, consultants had "wonderful working relationships with 4C"

- **Participate in advisory meetings.** Several consultants reported that the local 4C had played an active role on their advisory boards and at director meetings.

- **Share resources and support each other.** Consultants had a wealth of resources, mailing, and ideas to share with 4C, which "has allowed a creation of an excellent team that's advocating for children." They assisted each other's cases to meet the needs of the childcare providers. One consultant also mentioned that they participated on Great Start Collaborative together with 4C.

- **Provide support to childcare providers.** Consultants indicated that in some cases, 4C consultants and CCEP consultants worked together to meet providers' needs in their counties.

MSU-E

Although some consultants reported that they haven't begun the collaboration or that it was still in the beginning stages and not productive, several consultants described successful experiences in collaborating with MSU-E::

- **Providing training information and opportunities.** Consultants mentioned that MSU-E had the ability to train more providers than CCEP alone. They shared training information and coordinate training schedules.

- **Sharing resources and referrals.** Consultants said they had "a solid relationship …in sharing resources, trainings, scheduling and outreach" and worked together to avoid duplicating services. In addition, because together they have multiple perspective about service provision, "expertise in multi(ple) areas increases the likelihood of well-rounded services for families/children."

- **Participation in advisory council by MSU-E staff.** One consultant mentioned that MSU-E staff sat on the CCEP advisory council.

Great Start Collaborative

Several consultants said that their county did not have a Great Start Collaborative, they were not involved, or collaboration was just beginning. Others mentioned some benefits:

- **Participate in each other's meetings.** Consultants reported attending every Great Start Collaborative meeting and felt that the CCEP Advisory Committee was welcomed to be integrated within the Great Start meetings. In another case, the Great Start Collaborative coordinator was on the CCEP advisory group, which "has proven to be very helpful in identifying community resources, opportunities for collaboration and networking." Some consultants also participated in workgroups and community events organized by the state-level parent body of the Great Start Collaborative.

- **Share information and support each other.** Collaboration with the Great Start Collaborative increased the access to resources and information. Consultants were "kept informed about early childhood issues" and community needs. They thought together "about ways to reach and support informal providers."

- **Disseminate information about CCEP services and provide referrals.** In some cases, consultants were able to spread information about CCEP services through the Great Start Collaborative and obtain referrals.

Nearly all consultants found collaboration with 4C to be helpful and in a variety of ways: promoting and referring to each other's organizations, coordinating trainings, sharing resources, and providing services to providers. Over half reported that collaboration with MS-E was helpful, particularly by sharing training information as well as resources and referrals. Over half also reported collaboration with the Great Start Collaborative was helpful, taking the form of information-sharing, networking, and referrals.

Hardest Part of Collaboration

- **Time constraints.** Consultants felt that it was hard for them to devote the amount of time needed to collaborate and meet with other organizations on a regular basis.

- **Finding the right person for collaboration.** Some consultant reported that it was hard to know "the correct person and location" to get the right information. They would have liked to collaborate with people who could really understand their services, "not only hear…but see how it could benefit…families." In some cases, the turnover of staff in the organizations also made collaboration difficult.

- **Rivalry between groups.** Some consultants pointed out that rivalry between organizations could present a barrier to collaboration. "There is some history between the programs and a sense of competition which is hard to overcome even when the supervisor is present and able to schedule meetings with the different groups".

- **Lack of knowledge about other organizations.** Consultants wanted to know more about the collaborative organizations so that they could consider how to assist each other in most beneficial ways. However, consultants felt that the organizations were sometimes protective of their information.

- **Organizations not wanting to do the actual work.** One consultant mentioned that "most organizations enjoy meetings, but not getting out there and doing the work. Another consultant: "it seems we have wonderful brochures with little to back up the services offered."

- **Organizations working within their own "silo."** One consultant referred to the "silo effect," with "everyone doing their own thing in the same area and not paying any attention to each other." Sometimes the philosophical differences between organizations made the collaboration hard; for example, one consultant mentioned that they had different philosophy from Great Start Collaborative.

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> Barriers to collaboration included both personal and organizational barriers. Lack of time and knowledge of whom to connect to were cited as important challenges.

Series: Michigan Child Care Expulsion Prevention Program Survey Summaries

The views expressed are solely those of the authors. For more information about this report, contact Laurie Van Egeren at the above address or phone number, or email: vanegere@msu.edu

MICHIGAN STATE
U N I V E R S I T Y

Michigan Child Care Expulsion Prevention Program

State-Level Training and Technical Assistance

Survey Summary No. 9 • August 2008

Introduction

In February and March 2008, 29 Michigan Child Care Expulsion Prevention Program (CCEP) consultants from 16 CCEP programs across Michigan participated in a survey administered by the Michigan State University evaluation team.

At the state level, administrators direct the CCEP program and provide ongoing training and technical l assistance to the consultants through both face-to-face meetings and conference calls. Consultants were asked about how effective they felt various forms of technical assistance were and suggestions for improvement.

This fact sheet provides information on:

- Consultants' perceptions of state administrators' willingness to collaborate.

- The helpfulness of different forms of technical assistance.

- What is most helpful about the state technical assistance and suggestions for improvement.

State-level Collaboration

The state-level administrators and staff initiated and designed the CCEP program in collaboration with local CCEP consultants and administrators. In the survey, consultants were asked about their perceptions of the degree to which the state-level administrators collaborated with program-level staff.

Table 2 shows the percent of consultants who indicated that they agreed or disagreed with the statements about state-level administrators and staff.

- The majority of consultants reported that state-level administrators and staff worked collaboratively to identify needs and improvements for the program and make decisions. About half strongly agreed.

- 62% agreed that state-level administrators were open to change and experimentation. About a quarter strongly agreed.

Table 1. Consultants' Perceptions of State-level Administrators and Staff Collaboration				
Item	*Disagree*	*Neutral*	*Mildly agree*	*Strongly agree*
At the state level, most staff and administrators are open to change and experimentation.	7%	31%	35%	28%
At the state level, staff and administrators of the CCEP program work collaboratively to identify needs and improvements for the program.	7%	14%	28%	52%
At the state level, program administrators collaborate with staff to make decisions.	7%	17%	24%	52%

Note. N for each item = 29 consultechnical assistancents.

In the experience of the evaluators, perceptions of the willingness of state-level administrators and staff to collaborate with program staff were quite high for a state program.

Training and Technical Assistance

Helpfulness

The CCEP program offers state-level technical assistance to support the consultants' service through telephone or email consultation, meetings and training, an email group, and on-site visits from the state technical assistance activities were "not very helpful," "somewhat helpful," or "very helpful".

- Nearly all consultants felt the activities were at least somewhat helpful.

- Consultants were most likely to report that the quarterly technical assistance meetings were very helpful, followed by on-site visits and phone consultations.

- The majority of consultants felt that email consultations were very helpful, and about half thought the email group was very helpful.

- Consultants were least likely to think that the monthly training and evaluation meetings were very helpful (38%), but again, most reported that they were at least somewhat helpful.

Table1. Helpfulness of Technical Assistance Activities			
Technical Assistance Activities	*Not very helpful*	*Somewhat helpful*	*Very helpful*
Quarterly technical assistance meetings	0%	17%	83%
On-site visits	9%	26%	65%
Phone consultations	8%	28%	64%
Email consultations	8%	32%	60%
Email group	3%	45%	52%
Monthly training and evaluation meetings	8%	54%	38%

Note. N for each item = 23 or 29 consultants responding; percent reported is out of those consultants responding.

All forms of technical assistance were considered least somewhat helpful. Consultants viewed quarterly technical assistance meetings as the most helpful form of technical assistance, followed by on-site visits and phone consultations. These results suggest that consultants found individualized human contact to be the most helpful form of technical assistance. While consultants found monthly training and evaluation meetings helpful, they may have also felt pressures to balance attending technical assistance meetings with provision of services.

Most Helpful Things about State-Level Technical Assistance

The consultants felt that the state-level technical assistance was a good resource, especially when they needed assistance in providing consultation services. They described technical assistance as helpful because:

- **The technical assistance is always available and supportive.** Consultants reported that they felt supported all the time as the technical assistance was always available. They described the technical assistance staff as very supportive and responsible in helping them solve problems, advocating changes in the CCEP program, and sharing the best practices.

    "They are always available to answer questions. They are very patient and understanding."

- **The technical assistance is informative.** Consultants reported that they learned how to enhance the consultation process and received information on the program goals and expectations through technical assistance. They felt that the periodic meetings with technical assistance staff for training on related topics were informative and relevant.

- **The state-level administrators are open to suggestions.** Consultants appreciated the openness of sate-level administrators to listen to and act upon suggestions.

    "I have noted that so many of the things that consultants value and bring to the centers and families--respectful listening and responding, relationship building--are all evident at the state level and extend outward to the programs. There is a genuine receptivity to our perspectives and a true exchange of ideas."

- **The state-level technical assistance links the consultants to other resources.** Consultants stated that they were connected to a wide variety of outside consultants and had the chance to share experiences and ideas via technical assistance. They obtained valuable training provided by knowledgeable and experienced speakers through technical assistance. They also reported that they had been connected to other programs and resources by the state-level technical assistance.

- **The technical assistance offers social work credits for training not otherwise available in the area** (one consultant).

Suggestions for State-Level Technical Assistance

Though the state-level technical assistance was clearly helpful to consultants, a few consultants also had suggestions for improvements.

- **More technical assistance, individualized technical assistance, regional technical assistance.** Several consultants reported the need for more technical assistance "maybe divided by region," so that consultants would be able to "meet frequently to discuss concerns, ask questions and get more individual input."

- **Continued and improved support to consultants.** A few consultants suggested various forms of potential support for technical assistance such as free reflective supervision, better follow-through, better definition for quarterly reports, and "developing a more efficient system for consultants to share resources."

- **Decision making.** Two consultants described the issue of realistic demands on consultants. One asked to be engaged in " how to navigate forward with mandated changes" rather than "discussion when the decision has been made;" the other asked for firm decisions across sites.

Overall, consultants were very pleased with the technical assistance provided by the state. They had specific suggestions, with the most common being a desire for more technical assistance and more individualized technical assistance.

Overall Comments for the CCEP Program

The CCEP program was highly valued by the consultants. They realized that their services make a difference in the lives of children and families and they appreciated the opportunity to work for the community through the CCEP program. Additional comments that single consultants made included:

- **Concern about the requirement for a master's degree.** The requirement to have a master's degree for consultants was perceived as devaluing the experience and knowledge base that consultants without such a degree may have.

- **Understand the differences in individual communities.** One consultant wrote:

    "I would like for state staff to have a better understanding of individual differences among communities. There are so many assumptions that are made, but at the local level, things are different than those initial assumptions."

- **More funding.** Individual consultants wanted more state funding to hire more staff, for free reflective supervision, and to be able to make reflective supervision available to child care directors and providers.

Series: Michigan Child Care Expulsion Prevention Survey Summaries

The views expressed are solely those of the authors. For more information about this report, contact Laurie Van Egeren at the above address or phone number, or email: vanegere@msu.edu

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