



Washington State Department of
Early Learning

Child Care Consultation Pilot Project

Evaluation Report June 2010

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Kids' Potential, Our Purpose



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EXECUTIVE SUMMARY

Background and Overview

Studies of preschool classrooms show that young children are expelled from pre-kindergarten programs at a rate three times higher than expulsion in the K-12 system. Research has also shown that expulsion rates decrease when classrooms have access to consultation from mental health professionals. In 2007, the Washington State Legislature provided \$500,000 for the Department of Early Learning (DEL) to pilot a “child care consultation program” that links child care providers with research-based resources to help them care for infants and young children with challenging behaviors. The pilot program was implemented in three counties – King, Thurston, and Yakima – each of which received support from a different consultant group.

In 2008, DEL partnered with the Children’s Mental Health Evidence Based Practices Institute at the University of Washington School of Medicine to conduct an evaluation of the Child Care Consultation (CCC) pilot program. The evaluation was designed to answer three primary questions: (1) What consultation activities are provided by each pilot site? (2) Is child care consultation associated with improved outcomes such as providers’ self-efficacy, skills, and knowledge, and child behavior? (3) Is there evidence that the child care consultation is associated with decreased rate of expulsion from child care?

Evaluation methods relied on three instruments: A consultant survey, a child care center director survey, and a child care provider survey. These instruments were based on several nationally validated, standardized measures. Response rates were generally good, ranging from 58% (N=61) for the provider survey to 86% (N=6) for the consultant survey.

Results

Consultation received. Results revealed that the nature of consultation varied greatly across the three pilot sites. The Child Care Consultation Health Program in King County relied on a mix of child-focused, program-focused, and family-focused consultation, as well as on provider education and empowerment. Catholic Child and Family Services implemented a model in Yakima County that was more behaviorally-focused, and emphasized a balance between child- and program-centered consultation, with no emphasis on family-centered consultation. In Thurston County, the Child Care Action Council implemented a program adapted from the Promoting First Relationships (PFR) program developed at the University of Washington School of Nursing.

Impact on staff self-efficacy, knowledge and skills, and child behavior. Results from provider surveys indicated significant improvements from pre- to post-receipt of consultation on providers' self-efficacy in working with children with behavioral problems, in providers' self-assessment of their skills and knowledge, and in providers' assessments of child behavior in their classrooms and facilities. Among these areas, the largest improvement was found in the area of provider skills and knowledge. Differences were found by pilot site. Implementation in the King County site was associated with larger improvements in provider skills/knowledge and child behavior. Implementation in the Yakima site was associated with less improvement in skills/knowledge. Younger provider staff reported greater improvement in self-efficacy from pre- to post-participation in the consultation project, as did staff who reported receiving relatively more hands-on consultation on behavior planning for specific children.

Provider ratings of impact of consultation. Providers were also asked to provide ratings of the overall usefulness of consultation services. Staff ratings were extremely high, averaging 4.6 out of a scale of 5.0. The vast majority of provider staff from King (average score = 4.88) and Thurston Counties (average score = 4.82) "strongly agreed" that they had used something they learned during the consultation. Though most providers in the Yakima site agreed that they learned something from the consultation, ratings were significantly lower for providers in the Yakima site (average score = 4.09).

Examination of providers' responses to open-ended questions also indicated significant support for the consultation service, with provider staff stating that, for example, "we have really seen a reduction in the frequency and severity of behavioral issues," "we will be able to keep even the most challenging children in the future," and "everyone in child care should know about and take part in this program." Responses to open-ended questions also pointed to needs for improvement, including greater flexibility in scheduling and more flexibility in consultation strategies used.

Impact on expulsion. Assessment of the CCC project's impact on expulsion was measured indirectly through a single administration of a survey of child care facility directors, which presents a major limitation in the evaluation methods. Nonetheless, results indicate that the CCC project was viewed as being a significant success by these directors. While 40% of directors reported that they had expelled a child in the year prior to the receipt of consultation services, only 20% of directors answered that they had expelled a child since receiving the consultation services (a period that ranged from approximately 8-18 months). In addition, 84.2% of directors surveyed believed that the consultation services had helped to reduce problem behaviors in their facility and 73.7% believed that the services had helped to increase the social-emotional development of children in the child care facility. 81% of directors reported that they had retained a child with behavioral problems as a result of receiving the consultation services.

Conclusions and Recommendations

Overall, results of the DEL Child Care Mental Health Consultation pilot were extremely positive. However, it should be noted that interpretation is compromised by significant limitations in study design, particularly reliance on self-report by providers and directors, and time constraints that required collection of both pre- and post-intervention ratings from staff and directors from the same survey administration. The evaluation also did not incorporate a control group to help facilitate interpretation of outcomes for the programs that received the intervention.

Despite these limitations, evaluation results indicate that the Child Care Consultation pilot project was enthusiastically received by providers and directors. Results also suggest that the program was successful in improving the quality of care provided to children across the pilot areas, which likely resulted in positive outcomes for children. Though not assessed directly, facility directors reported that the consultation led to meaningful reductions in expulsions due to child behavioral problems.

The evaluation also points to differences in outcomes across the three pilot sites that may be related to the types of consultation provided across the different counties. Specifically, consultation provided in King County featured the most balanced ratio of child-focused, program-focused, and family-focused consultation. This site also focused on building strong relationships between consultants and child care staff, as well as consultants and caregivers. All these features have been found by research to be associated with more positive impact of early childhood behavioral consultation. It may be that incorporation of these program elements led to this project's increased effectiveness.

In sum, though conclusions are tentative due to the methodological limitations, the results of the current evaluation point to the overall success of the CCC pilot program. Efforts to further expand early childhood mental health consultation in Washington should consider the factors (cited above) that seem to be associated with the greatest positive impact, and adhere to elements of training and consultation found in research to be associated with positive outcomes. Future implementation efforts should also build in opportunities for more rigorous evaluation that can produce more definitive conclusions about the effectiveness and cost-effectiveness of the consultation that is provided.

BACKGROUND AND OVERVIEW

A 2005 nationwide survey of 4,000 preschool classrooms revealed that young children were being expelled from pre-kindergarten programs at a rate that was three times higher than that of expulsion in the K-12 system. The pre-kindergarten expulsion rate was 6.7 per 1,000 pre-kindergarteners enrolled, versus the national expulsion rate for K-12 students which was 2.1 per 1,000 enrolled. Research from Washington State indicates that the pre-kindergarten expulsion rate for Washington students was even higher than the national rate, at 7-10 per 1,000 enrolled.¹

An important finding from this study was that the likelihood of expulsion decreased significantly when classrooms had access to consultation from mental health professionals. The study recommended that states offer ongoing training to early childhood staff in order to support appropriate, positive approaches to children's behavioral problems. Other studies have shown that mental health consultation is also effective in decreasing child problem behaviors (aggression, severe temper tantrums, extreme withdrawal)², increasing pro-social behaviors (positive social interaction, emotional regulation)^{2,3}, and increasing teacher competencies (feelings of self-efficacy, positive interactions with children, feelings of responsibility and control of their work, better skills in observation, reflection, and planning)⁴. A wide range of consultation activities implemented by consultants is associated with more positive results for providers and children³.

In 2007, the Washington State Legislature provided \$500,000 for the Department of Early Learning (DEL) to pilot a "child care consultation program" that linked child care providers with research-based resources to help them care for infants and young children with challenging behaviors. The goal of the DEL Child Care Consultation (CCC) pilot project was to design, implement, and evaluate mental health consultation models that would support parents and paid caregivers to work as a team to support healthy social and emotional development of children in child care. In 2008, DEL partnered with the Children's Mental Health Evidence Based Practices Institute at the University of Washington School of Medicine to conduct an evaluation of the CCC pilot.

The evaluation was designed to answer the following questions:

1. What **consultation activities** are provided by each pilot site?
2. Is access to child care consultation associated with:
 - a. Increases in provider feelings of **self-efficacy**?
 - b. Increases in provider **skills and knowledge**?

- c. Improved **child behavior**, including increased social-emotional development and prevention of problem behaviors?
3. Is there evidence that the child care consultation pilots decrease the rate of **expulsion** from child care?

The Current Report

In the remainder of this report, we present the results and potential implications of this evaluation. Before presenting specific methods, results, and findings, it is worth noting the strengths and limitations of the study. One strength of the evaluation was its use of validated, nationally known measures of CCC implementation and impact. Measures used by the research team were developed by national experts who have used them extensively in previous evaluations of child care consultation projects. Strengths also included successful engagement with and high response rates from key stakeholders on whom we relied for data and information for the evaluation, including the consultants who provided the CCC services in the three pilot counties, the directors of child care centers that received consultation, and the staff at these centers. A third strength was the DEL project's use of three types of consultation by three different CCC teams in three counties. This situation allowed us to compare evaluation results across sites and to examine possible factors (e.g., the types or amounts of consultation provided) associated with outcomes.

At the same time, the evaluation was constrained by several factors that influenced the rigor of the research design, and thus the conclusiveness of evaluation findings. First, the timing of the evaluation placed constraints on potential research methods. Specifically, evaluators were engaged in the project *after* the initiation of the child care consultation services in each pilot site. This meant that no baseline (i.e., pre-CCC implementation) data were collected on any of the target variables. This forced the evaluation team to rely heavily on child care staff and directors' self-report of the impact of the project from pre- to post-CCC implementation.

This constraint, plus the relatively small amount of resource provided to the evaluation, also meant that the evaluation relied on providers' and consultants' responses to written surveys, rather than on direct assessment of children, providers, or consultants. Child behavior, provider behavior, and type and frequency of consultant activities were not directly measured. Moreover, child care providers did not report keeping records of expulsions over time using methods that would have allowed consistent measurement from pre- to post-CCC implementation. Thus, the project's effect on expulsion rates was also assessed via self-report by facility directors.

Last, though we were able to compare outcomes across the three CCC sites, there was no random assignment to different types of consultation, or use of a comparison group as a part of this evaluation. Without a comparison group, there is no way to know whether any gains found in care giving skills and knowledge can be attributed to the consultation program.

METHODS

In order to collect a core set of data to measure the effectiveness of the consultation services, the Evidence Based Practices Institute (EBPI), working with DEL, prepared a set of tools that combined and adapted several nationally validated, standardized measures and administered them to consultants, child care providers, and child care facility directors.

A *Provider Survey (Appendix A)* was developed to collect the following information:

- Provider demographic information (Section 1),
- Provider opinions about their work and self-efficacy (Section 2),
- Provider beliefs about their own skills and knowledge in the area of challenging behaviors and social-emotional skill development prior to and after receipt of the consultation services (Section 3), and
- Provider opinions about the problem behavior and social-emotional development of children prior to and after receipt of the services (Section 4).

The provider survey incorporated items from an instrument called the **Teacher Opinion Survey**, developed by researchers at the Wingspan Works center at Virginia Commonwealth University. The Teacher Opinion Survey was designed to measure teachers' feelings and beliefs about their own self-efficacy and their work with young children. The survey was sent to a random sample (of at least 50% of all providers in each site) who had received the consultation services. Surveys were sent to 106 providers total. Providers were presented with a variety of statements regarding their opinions about providing child care, their beliefs about their skills related to supporting social-emotional growth and managing problem behaviors, and their beliefs about the problem behavior and social-emotional development of the children in their group. They were then asked to rate the degree to which they agreed (on a 5-point scale) with the statements prior to receipt of consultation services and following the receipt of services.

The Director Survey (Appendix B) was created to gather information from child care facility directors regarding their facility's expulsion policies and practices. The electronic survey was sent to the director of each child care facility that had been provided consultation services. Surveys were sent to a

total of 37 facility directors. The directors were asked to answer “yes” or “no” to a short series of questions regarding expulsion policies and practices, as well questions regarding their perception of the effectiveness of the consultation services received with respect to preventing expulsion of enrolled children.

RESULTS

Pilot Site Consultation Models

Three agencies were selected to implement early childhood mental health consultation models, one in each of DEL’s service areas (geographic regions):

- Child Care Health Program—King County (DEL Northwest Service Area)
- Catholic Family & Child Services—Yakima County (DEL Eastern Service Area)
- Child Care Action Council—Thurston County (DEL Southwest Service Area)

King County: The *Child Care Consultation Health Program (CCHP)* was a partnership between Public Health Seattle and King County and Encompass, an early childhood and family support center in the Snoqualmie Valley. The CCHP model placed an emphasis on providing training and support to child care providers that would increase their knowledge and skills in the area of social-emotional development. A major goal of the model was to educate and empower providers to create high-quality environments, form relationships that effectively support social-emotional development, and address problem behaviors rather than relying on the support of an outside expert each time a child presents with a behavioral or emotional concern. Additionally, the model placed an emphasis on assisting providers in strengthening partnerships with families and with other providers in order to create local networks of support for child care providers and families. The key components of this consultation model were:

- Comprehensive training for child care providers
- Consultation to child care providers
- Consultation to families

Yakima County: *Catholic Family & Child Services (CFCS)* implemented a child care consultation model that was focused on providing comprehensive services and support to child care providers and parents to optimize young children’s social-emotional development. Consultation services were provided for children who presented with a range of challenging behaviors or emotional concerns, with an emphasis on providing services that are focused on prevention of or very early intervention for behavioral challenges. The key components of this consultation model were:

- Behavioral training, consultation and support for one pilot site
- Community consultations
- Parent Café
- Parent and provider trainings

Thurston County: Child Care Action Council (CCAC) implemented a mental health consultation model called Supporting Successful Relationships (SSR). This was a training program adapted from the Promoting First Relationships (PFR) program developed at the University of Washington School of Nursing’s Center on Infant Mental Health and Development. SSR was an attachment-based, prevention-focused program dedicated to training child care providers to meet the social-emotional needs of very young children in both center and family home settings. The goals of this consultation program were to promote mutually enjoyable relationships between providers and children, increase providers’ feelings of competence and confidence in their child care roles, and help providers support children’s social-emotional development. The key components of this consultation model were:

- The SSR training & consultation program
- Provider workshops and trainings
- Community Café

Survey Response Rates

The following table summarizes the response rates for the three instruments described above.

Instrument	Number Returned	Percent Returned
Consultant Activity Checklist	6	86%
Director Survey	21	57%
Provider Survey	61	58%

Provider Characteristics

Demographic information was obtained from all respondents through the Provider Survey. Demographic information was collected in the following areas: Provider gender, age, education level, education related to early childhood education, total years worked in child care, years worked at current facility, and age of children cared for in current classroom/program.

Demographics. Results showed that provider staff are overwhelmingly female (98%). Providers vary greatly with respect to age overall, with age well distributed across age categories (under 30 to over 50). Some differences were found by pilot site: providers in Thurston County were found to be somewhat older (64% 40 and over) while providers in Yakima were somewhat younger (65% under 40%).

Provider age was found to be associated with the impact of the CCC intervention. Specifically, younger providers were more likely to report that the consultation services were useful to them. Younger providers also reported greater levels of behavior change from pre- to post-CCC intervention than older providers. No other demographic variables were associated with differential response of providers to the consultation intervention.

Provider Education and Experience. Results of provider staff surveys found that 75% of child care staff have some college experience. However, most providers have not received any specific education in early childhood – only 9%. This percent was highest in King County (12.5%) and lowest in Yakima (4.5%). Providers tend to have many years of experience in the child care field, with half having worked in the field for over 10 years. The mean years of experience was 11.84 years.

Results, part 1: Consultation Activities

What consultation activities are provided by each pilot site?

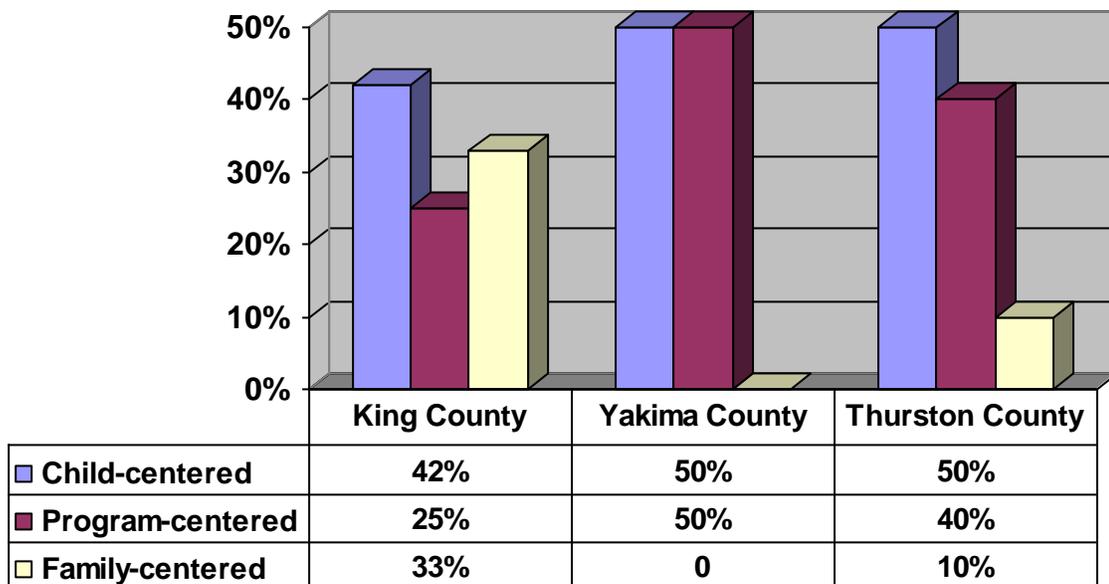
As previously mentioned, each pilot site employed a different approach to promoting social-emotional development and addressing problem behaviors. One way this difference is reflected is in the types of consultation activities employed in each site. The literature on early childhood mental health consultation divides the wide variety of consultation activities into three main categories:

- Child-focused activities (e.g. conducting observations or assessments of an individual child, developing individual behavior plans, etc.)
- Program-focused activities (e.g. assessing overall program quality, attending staff meetings, etc.)
- Family-focused activities (e.g. conducting home visits, leading information sessions for parents, etc.)

Research has shown that consultation models that utilize a well-balanced combination of these approaches are most effective in supporting child care staff. When a consultant provides high levels of all three types of activities, child care staff report increased wellness and staff members are more likely to perceive the consultation services as beneficial to them.³

For this evaluation, frequently-conducted activities were defined as activities that were rated as “few times monthly” or “weekly” by the consultants on the Consultant Activity Checklist. As shown in Table 1, consultation activities differed meaningfully by pilot site, with activities provided in King County showing the greatest balance across the three consultation areas. Activities provided in Thurston County were found to include activities in all three areas, though relatively little (10%) in the area of family-centered consultation. In Yakima County, activities focused solely on child- and program-centered consultation, with no family-centered activity.

Figure 1: Consultation Activities Provided by Pilot Site



Tables 1-3 present the specific types of activities provided by consultants in each consultation area for King County, Yakima County, and Thurston County, respectively.

Table 1: King County - Most Frequent Consultation Activities

	Child-focused	Program-focused	Family Focused
Consultation Activities	-Conduct observations/assessments of an individual child identified because of concerns	-Assess the overall classroom/program environment (i.e., room arrangement, daily schedules)	-Provide informal/one-on-one education to parents/caregivers -Develop home-based strategies to help

	<ul style="list-style-type: none"> -Develop classroom-based strategies to address child’s specific needs -Train providers on strategies to use with a specific child -Provide ongoing support and guidance to providers in implementing strategies -Refer to community resources to meet child’s needs 	<ul style="list-style-type: none"> -Develop strategies to enhance overall classroom/program environment -Provide ongoing support and guidance to providers in implementing strategies 	<ul style="list-style-type: none"> parents/caregivers address child’s challenging behaviors -Provide ongoing support to parents/caregivers in implementing strategies -Help families link to others supports or services in the community
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Table 2: Yakima County - Most Frequent Consultation Activities

	Child-focused	Program-focused	Family Focused
Consultation Activities	<ul style="list-style-type: none"> -Conduct observations/assessments of an individual child identified because of concerns -Develop classroom-based strategies to address child’s specific needs -Train providers on strategies to use with a specific child -Model these strategies in the classroom -Provide ongoing support and guidance to providers in 	<ul style="list-style-type: none"> -Conduct screenings/observations of all children in the classroom program -Assess the overall classroom/program environment (i.e., room arrangement, daily schedules) -Develop strategies to enhance overall classroom/program environment -Model these strategies -Provide ongoing support and guidance to providers in 	

	implementing strategies	implementing strategies	
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Table 3: Thurston County - Most Frequent Consultation Activities

	Child-focused	Program-focused	Family Focused
Consultation Activities	<ul style="list-style-type: none"> -Conduct observations/assessments of an individual child identified because of concerns -Develop classroom-based strategies to address child’s specific needs -Train providers on strategies to use with a specific child -Model these strategies in the classroom -Provide ongoing support and guidance to providers in implementing strategies 	<ul style="list-style-type: none"> -Conduct screenings/observations of all children in the classroom program -Assess the overall classroom/program environment (i.e., room arrangement, daily schedules) -Develop strategies to enhance overall classroom/program environment -Provide ongoing support and guidance to providers in implementing strategies 	<ul style="list-style-type: none"> -Provide informal/one-on-one education to parents/caregivers

Results, Part 2: Impact on Provider Staff and Child Behavior

Does access to child care consultation services lead to positive outcomes for provide staff (staff knowledge, skills, and self-efficacy) and children (behavior)?

The impact of the CCC project on child care providers and the children they serve was assessed primarily through the Provider Survey. As described above, the survey included items that assessed change in three areas:

1. Perceptions of self-efficacy in providing care;

2. Skills and knowledge in managing behavior and promoting social-emotional development of children; and
3. Child behavior.

The Provider Survey also included items that directly asked whether:

- Staff agree that “the number of difficult behaviors in my classroom has decreased since I received the consultation or training services.”
- Staff have “used something I learned from the consultation/training program to help a child or family”

Results in each of these five areas are presented separately below. Results from all items of the Provider Survey are presented in **Appendix C**.

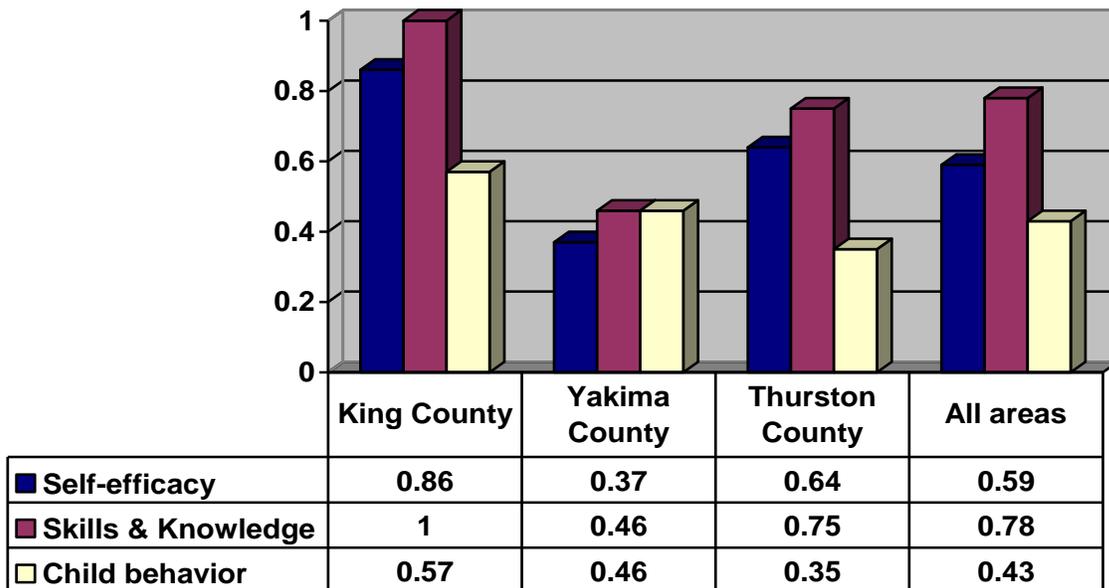
Provider Feelings of Self-Efficacy

To measure change in provider beliefs about their work and self-efficacy, providers were asked to provide ratings of their perceptions of their self-efficacy in providing care to young children. Providers were presented with a statement for each indicator and were asked about their perception from before receiving the consultation services and after the receipt of services using a 5-point scale (1= Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree). Results were analyzed separately for each site and as an average of all three pilot areas combined.

For each “positive” indicator measuring change in provider opinion (i.e. “I can imagine myself caring for infants and young children for several more years”), providers’ scores increased from pre- to post-receipt of consultation, indicating that teachers felt more positively about their work and feelings of self-efficacy after receiving the consultation services. This was true for each pilot area individually, as well as for the entire group. For each “negative” indicator measuring change in provider opinion (i.e., “There are some children in my group I simply can’t have any influence on”), mean scores decreased, also indicating that providers felt more positively about their work and feelings of self-efficacy after receiving the consultation services. This was true for each pilot area individually, as well as for the entire group.

Across all sites, the average change in reported score for items in the Self-Efficacy domain was 0.59. This represents a significant ($p<.01$) change over time in providers’ self-reported self-efficacy. As shown in Figure 2, the average increase in self-efficacy score for King County was 0.86, the average increase in reported score for Thurston County was 0.64, and the average increase in reported score for Yakima County was 0.37. These differences were not found to be statistically significant by site.

Figure 2: Mean Improvement in Self-Efficacy, Skills/Knowledge, and Child Behavior, by Site and Overall



There were four indicators in this section that demonstrated the largest change in score across all three pilot areas. These indicators were:

- *Indicator 1: If I keep trying, I can find some ways to reach even the most challenging child (0.90 overall mean increase)*
- *Indicator 9: I know how to respond effectively when a child becomes disruptive in my group (0.86 overall mean increase)*
- *Indicator 11: I have enough training to deal with almost any group situation (0.74 overall mean increase)*
- *Indicator 4: If some children in my group are not doing as well as others, I believe I should change my way of working with them (0.69 overall mean increase)*

These four indicators, which were all positive statements, related to providers’ opinions about their self-efficacy in addressing problem behaviors. These all showed large increases in reported score with most providers reporting that they strongly agreed with these statements. These results indicate that

providers' self-assessments about their abilities to manage problem behaviors improved after they received the consultation services.

Provider Skills and Knowledge

To measure change in provider feelings about their own skills, providers were asked to rate their perceptions of their skills in managing challenging behaviors and promoting social-emotional development. To measure change in provider beliefs about their skills and knowledge, providers were asked to rate their beliefs about the statement for each indicator, both before receiving the consultation services and after the receipt of services using a 5-point scale (1= Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree). Results were analyzed separately for each site and as an average of all three pilot areas combined.

All indicators focused on positive provider skills, behavior, and knowledge that have been cited in the research literature as being associated with positive child outcomes. For each indicator, providers' self-ratings increased, indicating that providers believed their skills and knowledge related to managing challenging behaviors and promoting social-emotional growth had increased after receiving the consultation services. This was true for each pilot area individually, as well as for the entire group. As shown in Figure 2, across all groups, the mean change in reported score in the Skills and Knowledge area was 0.78. This difference in ratings over time was significant at the $p < .001$ level. Skills and knowledge indicators demonstrated the largest improvement across the three areas assessed in the Provider Survey.

Improvement in providers' self-rated skills and knowledge from pre- to post-CCC intervention varied by county. As shown in Figure 2, the mean change in reported score for King County was 1.0, the mean change for Thurston County was 0.75, and the mean change for Yakima County was 0.46. As assessed via one-way analysis of variance (ANOVA), these differences by county were found to be significant ($p < .01$), with post-hoc tests showing King County providers' ratings increasing significantly more than the other two counties, and Thurston County's provider ratings increasing more than Yakima's.

While the pilot sites showed increases on many of the indicators, there were four indicators in this section that demonstrated the largest change in score across all three pilot areas. These indicators were:

- *Indicator 3: I try to understand the meaning of the children's challenging behavior* (1.11 mean overall increase)
- *Indicator 7: I am aware of supports/services for families and children in the community* (0.86 mean overall increase)

- *Indicator 1: I have an understanding of children's social-emotional development* (0.84 overall mean increase)
- *Indicator 2: I know how to effectively support children's social-emotional development* (0.83 overall mean increase)

These four indicators, which were all statements related to care giving skills and behaviors associated with positive outcomes for children, all showed large increases in reported score with most providers reporting that they agreed or strongly agreed with these statements. These results indicate that providers felt that their skills and knowledge had improved after receiving the consultation services.

The indicator that demonstrated the smallest mean increase in this section was:

- *Indicator 8: I have created a positive and supportive classroom* (0.47 overall mean increase)

Child Behavior

Results of the Provider Survey indicate that the consultation services were effective in decreasing teacher report of child problem behavior and in increasing teacher report of child appropriate social behaviors across all three pilot sites, though the changes in this area were modest.

To measure change in provider feelings of child behavior, providers were asked to rate their beliefs about the statement for each indicator, both before and after the receipt of the consultation services using a 5-point scale (1= Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree). Results were analyzed separately for each site and as an average of all three pilot areas combined. For each indicator measuring change in child challenging behavior (items 1-5), the scores reported decreased, indicating that teachers felt there were fewer challenging behaviors demonstrated by children in their classrooms. This was true for each pilot area individually, as well as for the entire group. For each indicator measuring change in pro-social behaviors (items 6-8), scores increased, indicating that teachers believed that children in their classroom were developing positive social-emotional skills. This was true for each pilot area individually, as well as for the entire group.

Across all sites, improvement in behavioral items from providers' self-assessment from pre- to post-CCC intervention was found to be significant ($p < .01$). However, these items showed the smallest change in mean reported score. As a group, the average change in reported score in this area was 0.43. As shown in Figure 2, the average change in reported score for King County was 0.57, the average increase in reported score for Thurston County was 0.35, and the average increase in reported score for Yakima

County was 0.46. These differences were found to be significant by site ($p < .05$); post-hoc analyses found that ratings by King County providers improved more than for Thurston County.

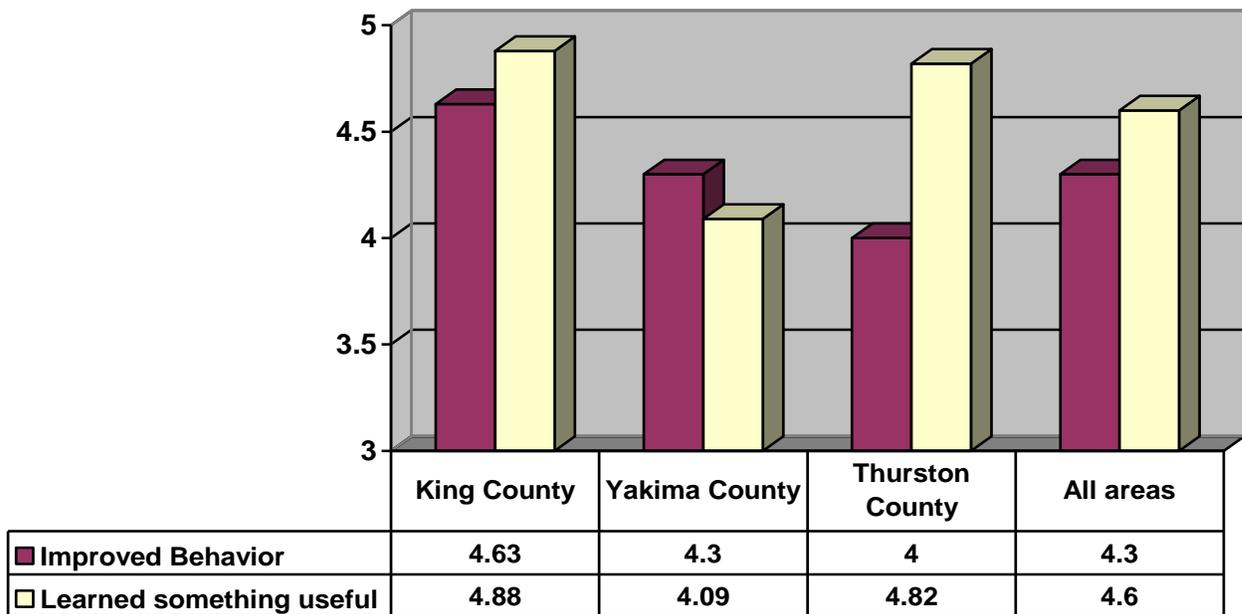
The amount of change for each indicator was fairly consistent and thus differences by item are not presented here.

In addition to being asked about specific child behaviors, participants were asked to rate their beliefs about a question regarding overall reduction in child challenging behavior (Indicator 9). The score for King County was the highest (4.63), Thurston County was slightly lower (4.3), and Yakima County had the lowest score (4). The average score across sites was 4.3. These results indicate that, although the amount of change in reported score for individual behavior indicators was small, respondents across the three areas agreed that the consultation services they received were effective in helping to reduce the overall incidence of problem behaviors in their classrooms.

Provider Rating of Behavior Change

In addition to being asked about specific child behaviors, participants were asked to rate their agreement with the statement, “the number of difficult behaviors in my classroom has decreased since I received the consultation or training services” (Indicator 9), on a scale of 1 to 5. As shown in Figure 3, the average rating across sites was 4.3 and ranged from 4 (Yakima County) to 4.63 (King County). This difference was not significant by site. In general, these results indicate that respondents across the three areas agreed that the consultation services they received were effective in helping to reduce the incidence of problem behaviors in their classrooms.

Figure 3: Mean Provider Ratings of Improvement in Behavior and Perception of Usefulness of Consultation, by Site and Overall



Usefulness of Consultation

In addition to being asked about specific skills and knowledge, participants were asked to rate the overall utility of the consultation services through an item that asked for agreement with the statement, “I have used something I learned from the consultation/training program to help a child or family” (Indicator 9). Ratings were provided on a 5-point scale. The average score across sites was 4.6. The score for King County was the highest (4.88), Thurston County was slightly lower (4.82), and Yakima County had the lowest score (4.09). Differences by county were significant at $p < .01$, with King and Thurston County’s ratings higher than Yakima County’s. These results indicate that respondents across the three areas agreed that since receiving the consultation services, they had used something they had learned through the pilot project to help a child or family in their practice, though Yakima providers’ perceptions of usefulness were lower.

Factors Related to Impact

The research team explored the specific factors that might be related to quantitative ratings provided by provider staff through several exploratory analyses, including Pearson correlations across survey items and linear regression analyses that included variables related to the demographics of providers, site in which they were employed, and amount of consultation received in different areas.

As described above, correlational analyses found that age and experience level of provider was found to be related to reported usefulness of consultation and positive change in child behavior over time, with younger providers and those with fewer years in child care reporting greater usefulness of CCC and impact on behavior. No other demographics were found to be associated with outcomes.

With this finding in mind, we conducted a series of stepwise linear regressions. The five major outcomes (self-efficacy, knowledge and skills, child behavior, ratings of impact on child behavior, and overall impact of consultation) were dependent variables. Predictors of these outcomes were age (entered at step 1), reported types of consultation received (step 2), and site (county; step 3). Results indicated that the reported amount of observation and consultation for individual children was related to positive change in self-efficacy. In addition, after controlling for the above variables, site continued to predict three of the five outcomes (skills and knowledge, change in child behavior, and rating of consultant impact on child behavior). In all three of these areas, participation in the King County CCC effort was found to be associated with more positive outcomes, while for two of the three, participation in the Yakima program was found to be associated with less positive outcomes.

Qualitative Feedback

Areas of Strength

In addition to quantitative results described above, qualitative reports from child care providers and facility directors indicate that access to consultation services was extremely valuable to providers' work with children in many different areas. One common theme was providers' report that they had learned strategies to help reduce challenging behaviors and increase positive social behaviors:

- “We have really seen a reduction in the frequency and severity of behavioral issues in our classroom. The children have responded to the new approach, and we are seeing a steady improvement in their extreme behaviors.”
- “I now have the ability to recognize specific problems with children, based on their behaviors. I can react or intervene properly.”
- “Thanks to the training our staff is receiving we believe we will be able to keep even the most challenging children in the future.”
- “My ‘problem child’ is now just one of the gang.”

Providers also shared that the consultation services had helped them change their practices with all children in their care, even if the consultation had been focused on a specific child, and that these changes in attitude and practice had resulted in positive outcomes for all children in their program.

- “Although I have been in childcare for many years I took away new and valuable behavioral information from these classes. Our consultant was a great speaker. She had a lot of first hand information that could be put directly into the classroom.”
- “Watching the videos really helped me see myself and change the way that I interact with the children. My classroom is calmer now.”
- “My attitude has changed—I need to make changes for the child’s benefit. In the environment, my words, my attitude.”
- “I have found the tips received in the trainings very relevant to my day-to-day work. I have changed my teaching style because of them.”

Feedback from the providers and directors surveyed indicate that the services provided in this pilot project filled an unmet need for child care providers in Washington. Furthermore, they shared feelings that consistent and continued availability of these services would benefit providers across the state and would allow the positive practices and results demonstrated during the pilot project to continue.

- “I believe everyone in child care should know about and take part in this program.”
- “I believe that the consultation was very beneficial to everyone involved and with other children that we have accepted since that time. I would not hesitate to use this program again if a need comes up and it is available.”
- “I would like to see this program extend to more than a once opportunity. Some need ongoing help.”
- “I wish it didn’t have to end. I would love to do this every week or at least once a month.”
- “I believe that the consultation was very beneficial to everyone involved and with other children that we have accepted since that time. I would not hesitate to use this program again if a need comes up and it is available.”

Areas of Needed Improvement.

There was also some feedback from providers and directors that suggest areas of improvement or focus for future implementation of child care consultation models. First, several providers expressed concerns about the timing and availability of consultants.

- “They should be available at more convenient times when the behavior is actually occurring. The times that [I] needed her there [the consultant] was not available.”

Some providers who received feedback or suggestions on behavioral strategies for specific children expressed frustration that the strategies were difficult to implement in a large or busy classroom. These results suggest that flexibility in suggested strategies and attention to both child-focused and program-focused consultation services would be beneficial to providers in the future:

- “[Strategies were] more directed for child care centers as opposed to smaller classrooms. Teachers are responsible for all children, not just the [target] child.”
- “Sometimes information is not specific to the needs [of the classroom]. [I] have a hard time replicating because it doesn’t fit with normal days or behaviors.”
- “Behavioral strategies work for some and not others.”
- “[It is] hard for the teacher to follow through because [there are] too many children. [It is] a bit overwhelming with a larger class.”

Results, part 3: Impact on Expulsion Rates

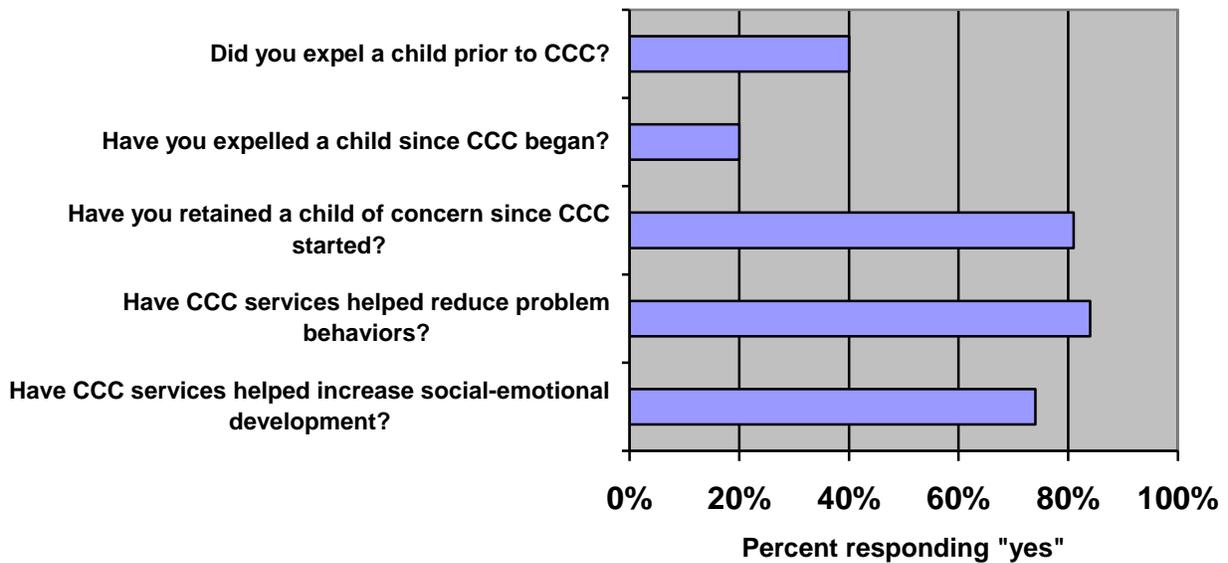
Is there evidence that the child care consultation pilots decrease the rate of expulsion from child care?

Impact of the CCC project on expulsion rates was assessed indirectly via a brief survey of center directors. The survey included items inquiring about expulsion policies, and presented five items about student expulsion and impact of the consultation services on expulsion.

Results of the survey show that expulsion policies were in place in 84.2% of the child care facilities. Expulsion policies described by the facility directors had similar elements. Most policies described behavioral concerns as a primary risk for expulsion; expressed the need to work with families to find a solution to the problem; and finally stated that if a solution could not be reached or child did not “improve” then the child would be removed from care. Despite the majority of child care facilities having written policies that placed a focus on resolution of problem behavior, 60% of directors surveyed stated that their center had expelled a child due to the presence of problem behavior prior to having received the consultation services.

Regarding the project’s impact on expulsion, results of the Director Survey indicate that the child care consultation intervention was perceived to reduce the number of expulsions in the facilities that received the consultation services. In order to evaluate expulsion rates before and after the consultation services, facility directors were asked if they had expelled a child from their facility after the receipt of the consultation services. While 40% of directors reported that they had expelled a child in the year prior to the receipt of services, only 20% of directors answered that they had expelled a child since they had received the consultation services (a period of approximately 8 months). Though far from a rigorous assessment, this reported reduction in expulsion rates suggests that the child care consultation intervention may have contributed to reduced expulsions from child care facilities in the pilot areas (see Figure 4 below).

Figure 4: Directors’ Responses to Expulsion Items (N=19)



In addition to the lower reported expulsion rates after consultation, directors indicated that the consultation services had helped to reduce challenging behaviors and increase the ability of providers to enhance children’s’ social-emotional development (See Figure 4). 84.2% of directors surveyed believed that the consultation services had helped to reduce problem behaviors in their facility and 73.7% believed that the services had helped to increase the social-emotional development of children in the child care facility. 81% of directors reported that they had retained a child with behavioral problems.

DISCUSSION

Despite its substantial limitations, overall, the results of this evaluation indicate that the Child Care Consultation pilot project was enthusiastically received by providers and center directors and was perceived by directors and staff to be associated with improved quality of care provided to children across the pilot areas, as well as positive outcomes for children. At the same time, the evaluation also points to differences in the types of consultation provided across the three pilot sites, as well as outcomes across sites.

Specifically, directors of child care facilities and providers that received the consultation services reported the following:

- Decrease in the rate of expulsion of children who had behavior concerns
- Increase in the retention of children who had been a focus of concern
- Increase in providers' positive opinions regarding their work with children and feelings of self-efficacy
- Increase in providers' beliefs about their own knowledge of social-emotional development and managing problem behaviors
- Increase in providers' beliefs about their ability to use positive care giving behaviors
- Decrease in providers' report of child challenging behavior
- Increase in providers' report of child positive social behavior

The three pilot sites differed from one another in their theoretical approach to promoting social-emotional development, their structures, and their service delivery models, including the frequency and intensity with which consultation services were provided. Despite these differences, the results of the evaluation, including direct feedback from participants, indicate that the services were filling an unmet need in Washington. This is likely due to the fact that all three pilot sites were implementing consultation practices that are considered to be best practice in the mental health literature. These practices include implementing a variety of consultation activities (both program- and child-focused), providing reflective supervision to practitioners, and providing resources related to child development and social-emotional health.

Despite the implementation of recommended practices and the overall positive results demonstrated by the evaluation, significant differences were found between the pilot sites in several areas, with providers in King County reporting significantly greater levels of child and provider behavior change and greater changes in provider knowledge and skills. Providers in King County also rated the overall utility

of the consultation as significantly higher than providers in the other two counties. Ratings from providers in Yakima County trended lower in these areas and were significantly lower on two specific areas. As discussed below, these differences may be accounted for by differences in the nature of consultation provided.

Relative to feedback obtained from providers in the other sites, there were a greater number of negative statements or suggestions for areas of improvement from providers in the Yakima pilot area. Feedback from providers in this area indicate that there were concerns that the strategies suggested by consultants did not match with the philosophy or needs of some child care facilities. Providers who had received services from consultants in Yakima County shared the following comments:

- “Behavioral strategies work for some and not others.”
- “Sometimes information is not specific to the needs [of the classroom]. [I] have a hard time replicating because it doesn’t fit with normal days or behaviors.”

Additionally, some feedback suggests that a potential mismatch between the suggested strategies and the specific needs of individual facilities may have made it difficult for providers to utilize the consultants’ suggestions to make positive changes in their classrooms. Providers stated that:

- “[Strategies were] more directed for child care centers as opposed to smaller classrooms. Teachers are responsible for all children, not just the [target] child.”
- “[It is] hard for the teacher to follow through because [there are] too many children. [It is] a bit overwhelming with a larger class.”).

It is possible that provider perceptions such as these may have attributed lower levels of overall satisfaction with and perceived utility of the consultation services, as indicated by the lower scores and smaller levels of change in provider and child behavior reported by providers in the Yakima pilot area.

With respect to the more positive overall outcomes for the King County pilot site, there are differences in the consultation service delivery model in King County that might account for the more positive response of providers in this area. The main focus of the King County consultation model was on building strong relationships between the consultant and caregivers which has been shown in the research literature to be a key component in the success of mental health consultation models.⁵ The quality of relationships between consultants and child care staff, as well as the ability of the consultant to build coaching and mentoring relationships with staff, has been shown in the research to be associated with

positive outcomes for providers. In a recent study, when providers were asked to name the most effective components of the mental health consultation services they had received, they consistently cited the positive qualifications and personal attributes of the consultant as the most essential characteristic. The more positive the relationships between staff members and consultants, the more likely the staff members were to report that the services were effective and helped them feel supported in their work⁵.

The King County consultation model began with a series of trainings in which the consultant aimed to help caregivers build their knowledge and skills in the area of child development. The training and support activities were structured to encourage the participation and motivation of providers, and to directly target increasing the providers' well-being, skills, and feelings of competence. The initial training provided by the King County model, called "Taking Care of Ourselves," was focused on adult mental health, stress management and relaxation. All trainings provided through this model were held on Saturdays (identified as the most convenient day by providers), had child care available, and had a meal served following the training in order to encourage conversation, participation, and networking among providers in attendance. It is possible that this initial focus on building positive working relationships with the child care providers contributed to the success of this model, at least as assessed via staff and director self-report.

Another possible explanation for the increased change in providers from King County is the ratio of consultation activities (i.e. child-focused, program-focused, family-focused) provided by the mental health consultant in this model. As discussed in the Consultation Activities section, the King County consultation model provided the greatest balance of the three types of consultation activities. Research has shown that consultation models that utilize a combination of these approaches are most effective in supporting child care staff. High levels of all types of activities by a consultant have been associated with increased reports of staff wellness and increased perception of the positive benefits of the consultation services by providers³. A recent study reported that the consultation activities listed most as helpful to support providers in caring for children with challenging behaviors were individual on-site consultation with a mental health expert (also found in our evaluation to be positively related to outcomes), workshops on behavior management strategies, and written materials on behavior management strategies⁶, all of which were provided by the King County consultants. It is possible that this balance of consultation activities provided by the King County pilot site allowed the consultants to individualize the services provided to child care professionals in order to respond flexibly to the individual needs of the facilities, the providers, the children, and the families who utilized their services, and resulted in more positive outcomes in three of the five areas assessed.

It is worth noting, similarly, that the Yakima consultants reported the least diversity across these three areas of consultation, with no reported activities focused on families of children in care. Along with the overall lower perception of quality and flexibility, this lack of diversity of activities may have resulted in trends toward poorer outcomes in the Yakima pilot site.

Limitations

The findings of this evaluation are limited by several research design characteristics. The timing of the evaluation placed constraints on potential research methods. As the evaluation began after the initiation of the child care consultation services in each pilot site, no baseline data were able to be collected on any of the target variables; therefore, no true comparison of outcomes from pre- to post-intervention are available.

The evaluation also relied on providers' and consultants' responses to a written survey; therefore, the outcomes are based on perceptions rather than on direct assessment of children, providers, or consultants. As noted above, the King County project appears to have dedicated more time to relationship building between consultants and providers than in the other two sites, and also found more positive staff-reported outcomes. It may be that relying on staff self-report has led to a "halo effect" whereby ratings provided by providers in King County are also more positive due to the alliance between the consultants and staff, on whose ratings measurement of outcomes primarily relied.

Additionally, the timing of the survey administration is a potential limitation. Participants were surveyed just once, after they had received the consultation services. In order to measure change, participants were asked to rate the target variables (i.e. expulsions, child behavior, provider knowledge) both before they received the intervention and after they received the intervention. Since the survey was administered after the consultation services were complete, participants were required to base their pre-intervention perceptions on their own recall. This makes these results open to bias due to recall or demand characteristics.

Measuring expulsion rate was also limited by the time and available resources. There was found to be no consistent source of administrative data around expulsions across child care facilities. Moreover, time limitations prevented even self-report baseline expulsion data from being collected; therefore, in order to measure change, facility directors were asked to recall whether they had expelled children pre-consultation and also whether this had occurred post-consultation. It is possible that the results of this evaluation are limited by difficulties with memory and reporting by participants. Additionally, pre-kindergarten expulsion rates are driven by a variety of factors that were not measured in this study.

Externalizing behaviors (aggression, property destruction, etc.) by children is a common factor, but facility type also contributes to expulsion rates, with state-funded programs such as Head Start reporting lower rates of expulsion than private or religious programs. Such factors may have varied across the sites served. Due to these complex factors, the results of the evaluation regarding change in expulsion rates are limited.

Last, there was no random assignment to a comparison group as a part of this evaluation. Without a comparison group, there is no way to know whether a similar group of child care providers might have experienced similar outcomes over time.

Conclusions and Recommendations

Despite the methodological limitations, results of the current evaluation certainly point to positive outcomes of the DEL child care consultation pilot. Certainly, feedback from staff and facility directors indicate a high level of perceived helpfulness of the consultation (though ratings and qualitative data collected from the Yakima site were less positive). And, though the methods employed make it impossible to make definitive conclusions about impact, results indicate that child care staff view the consultation as having a positive effect on child outcomes. Based on the positive results, as well as research from other studies nationally, it is recommended that mental health consultation services for pre-kindergarten education and development facilities in Washington continue to be supported. Ongoing access to services and responsive availability by consultants was a need expressed by many service providers.

Services provided by mental health and behavioral consultants should adhere to best practice recommendations from experts in this field. While local agencies will certainly differ from one another in their service delivery models, range of experience and training of consultants, and theoretical approach to promoting social-emotional development, there are specific consultation practices that have consistently been shown to be related to more positive outcomes for children and staff. These consultation practices include provision of a wide range and well-balanced menu of consultation services to children, staff, and families, development of positive working relationships with child care staff and families, and individualization of services and resources provided based on the needs of families and child care facilities.

Such recommendations are supported not only by national research but also by results of the current evaluation that indicate the strongest impact across counties may have been achieved through the consultation provided by the Child Care Consultation Health Program in King County, which

incorporated these components into its programming and included the above-referenced balance between child-, program-, and family-centered activities.

Results of the current evaluation also indicate that consultation that engaged staff in observation and planning for specific children was associated with more positive changes in staff-rated self-efficacy. This aligns with research on adult learning that shows that active, in-vivo coaching is related to deeper learning and skill development. Future efforts to develop early childhood mental health consultation efforts in the state should consider all the above points, and attempt to actively promote programming that adheres to these best practice elements of training and consultation. Given the findings that only 9% of staff had formal training in this field, and that young and less educated staff seemed to benefit the most from the consultation provided, DEL may wish to consider how to target this group more proactively.

Finally, it is recommended that future efforts to implement consultation and/or training programs are supported by a process of participatory evaluation that includes directors, providers, DEL staff, and evaluators well in advance of implementation. This will allow information needs to be identified in advance, and methodology to be developed that features adequate rigor to make more definitive conclusions about both implementation as well as impact on providers and children.

End Notes

¹ Gilliam, W. (2005). *Pre-kindergarteners left behind: Expulsion rates in state pre-kindergarten systems*. New Haven: Yale University Child Study Center.

² Perry, D., Dunne, C., McFadden, L. & Campbell, D. (2008). Reducing the risk for preschool expulsion: Mental health consultation for young children with challenging behaviors. *Journal of Child and Family Studies, 17*, 44-54.

³ Green, B., Everhart, M., Gordon, L. & Gettman, M. (2006). Characteristics of effective mental health consultation in early childhood settings: Multilevel analysis of a national survey. *Topics in Early Childhood Special Education, 26*(3), 142-152.

⁴ Alkon, A., Ramler, M. & MacLennan, K. (2003). Evaluation of mental health consultation in child care centers. *Early Childhood Education Journal, 31*(2), 91-99.

⁵ Green, B., Everhart, M., Gettman, M. & Gordon, L. (2003). *Mental health consultation in Head Start: Selected national findings. (Mental Health Services Survey Report)*. Portland, OR: Portland State University, Research and Training Center on Family Support and Children's Mental Health.

⁶ Cohen, E. & Kaufmann, R. (2005). *Early Childhood Mental Health Consultation*. DHHS Pub. No. CMHS-SVP0151. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

APPENDIX A: PROVIDER SURVEY

Thank you for participating in this survey to help us evaluate the Department of Early Learning's social-emotional consultation & training pilot project.

In order to evaluate the usefulness of the consultation & education services you received, please reflect on your experiences as a teacher both **before** you received the services ("THEN") **AND since** you've received the consultation services ("NOW"). Rate the extent to which you agree or disagree with the statements in Sections 2-4 using the following rating scale:

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

Circle one number in the "THEN" row and one number in the "NOW" row for each item.

Section 1:

1. Gender:

- Male
- Female

2. Age:

- Under 30 years
- 30-39 years
- 40-49 years
- 50+ years

3. Educational level:

- High school diploma/GED
- Some college
- CDA

2-year degree
What is your 2-year degree in? _____

4-year degree
What is your 4-year degree in? _____

4. Have you received any education specifically related to early childhood education?

- No
 Yes

If you answered "Yes", please specify:

5. How many years have you worked in the child care field?

_____ years

6. How many years have you worked at your current child care facility?

_____ years

7. What age of children do you care for in your current child care classroom?

- Infants (1-11 months)
 Toddlers (12-29 months)
 Preschoolers (30 months to kindergarten entry)
 School age (kindergarten to 12 years)

8. What type of services did you (or children/families in your group) receive through the consultant or consultation project? Please check all that apply.

- Observation, consultation, strategies and/or training to meet the needs of a particular child
 Direct intervention or therapy with a particular child
 Observation, consultation, strategies, and/or training to meet the needs of all children in my group
 Assessment, observation, strategies, and/or training to make changes to my classroom environment
 Group training session at my child care center
 Group training in the community

-
- Direct training and/or support to families
 - Referral to community resources for a family or child

Section 2:

Please rate the extent to which you agree with the following statements by **reflecting on your teaching experiences** before you received the services (THEN) and since you've received the services (NOW) using the following rating scale:

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

As a teacher:

1. If I keep trying, I can find some ways to reach even the most challenging child

THEN:

1 2 3 4 5

NOW:

1 2 3 4 5

2. I can help infants and young learn skills that they need to cope with adversity in their lives

THEN:

1 2 3 4 5

NOW:

1 2 3 4 5

3. There are some children in my group that I simply can't have any influence on

THEN:

1 2 3 4 5

NOW:

1 2 3 4 5

4. If some children in my group are not doing as well as others, I believe I should change my way of working with them

THEN:

1 2 3 4 5

NOW:

1 2 3 4 5

5. As a caregiver, I can't really do much, because the way a child develops depends mostly on what goes on at home

THEN:

1 2 3 4 5

NOW:

1 2 3 4 5

6. I know things I can do to help children develop skills to make successful choices later in life

THEN:

1 2 3 4 5

NOW:

1 2 3 4 5

7. I feel a sense of hopelessness about the future of the children I work with

THEN:

1 2 3 4 5

NOW:

1 2 3 4 5

8. I can imagine myself caring for infants and young children for several more years

THEN:

1 2 3 4 5

NOW:

1 2 3 4 5

9. I know how to respond effectively when a child becomes disruptive in my group

THEN:

1 2 3 4 5

NOW:

1 2 3 4 5

10. I frequently feel overwhelmed by my job

THEN:

1 2 3 4 5

NOW:

1 2 3 4 5

11. I have enough training to deal with almost any group situation

THEN:

1 2 3 4 5

NOW:

1 2 3 4 5

12. On a typical day, I feel a sense of accomplishment as a caregiver of infants and young children

THEN:

1 2 3 4 5

NOW:

1 2 3 4 5

Section 3:

Please rate the extent to which you agree with the following statements by ***reflecting on your on your teaching skills and abilities*** before you received the services (THEN) and since you've received the services (NOW) using the following rating scale:

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

1. I have an understanding of children's social and emotional development

THEN:

1	2	3	4	5
---	---	---	---	---

NOW:

1	2	3	4	5
---	---	---	---	---

2. I know how to effectively support children's social and emotional development

THEN:

1	2	3	4	5
---	---	---	---	---

NOW:

1	2	3	4	5
---	---	---	---	---

3. I try to understand the meaning of the children's challenging behavior

THEN:

1	2	3	4	5
---	---	---	---	---

NOW:

1

2

3

4

5

4. I feel confident managing children's challenging behavior

THEN:

1

2

3

4

5

NOW:

1

2

3

4

5

5. I know how to effectively support and respond to a child in distress

THEN:

1

2

3

4

5

NOW:

1

2

3

4

5

6. I have a positive attitude about working together with parents

THEN:

1

2

3

4

5

NOW:

1

2

3

4

5

7. I am aware of supports/services for families and children in the community

THEN:

1 2 3 4 5

NOW:

1 2 3 4 5

8. I have created a positive and supportive classroom climate

THEN:

1 2 3 4 5

NOW:

1 2 3 4 5

9. Overall, I feel that have used something I learned from the consultation/training program to help a child or family

1 2 3 4 5

Section 4:

Please rate the extent to which you agree with the following statements by ***reflecting on the behavior and skills of the children or a particular child in your classroom*** before you received the services (THEN) and since you've received the services (NOW) using the following rating scale:

Strongly Disagree Disagree Neutral Agree Strongly Agree

1 2 3 4 5
NOW:

1 2 3 4 5

5. Kid(s) often act shy or refuse to interact with others

THEN:

1 2 3 4 5

NOW:

1 2 3 4 5

6. Kid(s) often play and get along well with others

THEN:

1 2 3 4 5

NOW:

1 2 3 4 5

7. Kid(s) often allow an adult to comfort or help them when they are sad/upset

THEN:

1 2 3 4 5

NOW:

1 2 3 4 5

8. Kid(s) often seem to be happy and enjoy playing in the classroom

THEN:

1 2 3 4 5

NOW:

1 2 3 4 5

9. Even though kid(s) in my classroom might still have some challenging behavior, *overall* the number of difficult behaviors in my classroom has decreased since I received the consultation or training services

1 2 3 4 5

Appendix B: Director Survey

1. Does your child care center have a policy regarding expulsion?

2. If you answered "yes" to Question 1, please describe your center's expulsion policy.

3. If you answered "yes" to Question 1, was your expulsion policy in place before you received child care consultation services?

4. Prior to receiving the child care consultation services had your center expelled a child from care due to behavior concerns?

5. Since your center/staff received the services, has a child been expelled from your center due to behavior concerns?

6. Since your center/staff received the services, has a child been retained who had been a focus of concern due to behavior?

7. Did the consultation services help reduce problem behaviors in your center?

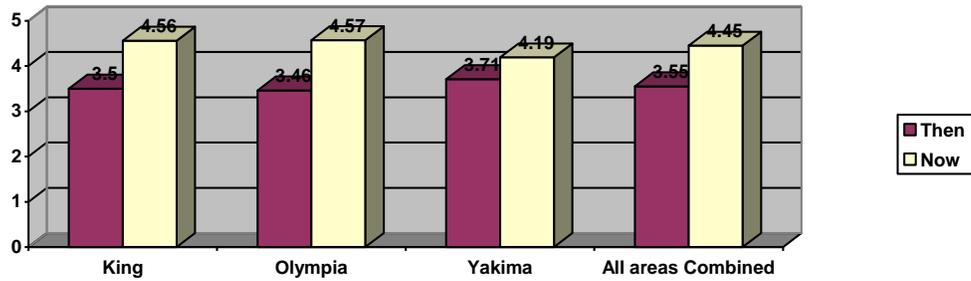
8. Did the consultation services help you and/or your staff meet the social-emotional needs of children in your center?

9. Additional comments or feedback?

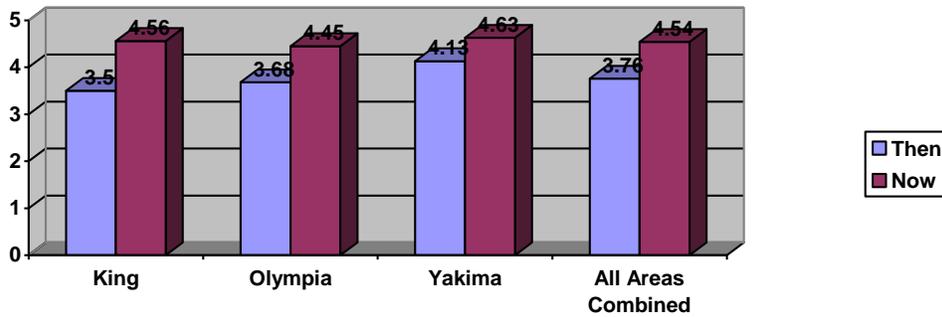
Appendix C: Provider Survey Results

Provider Feelings of Self-Efficacy

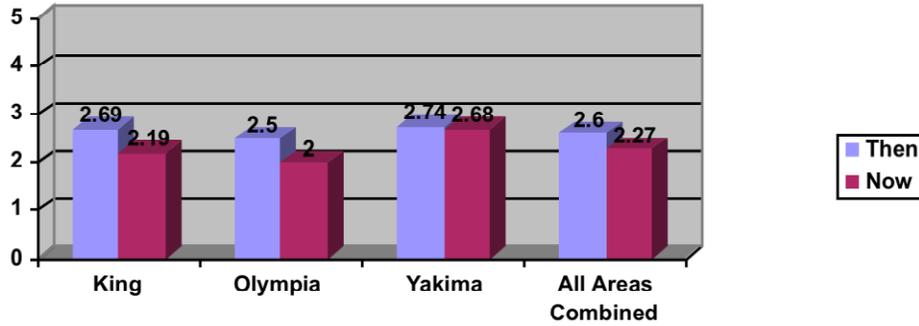
1. If I keep trying, I can find some ways to reach even the most challenging child.



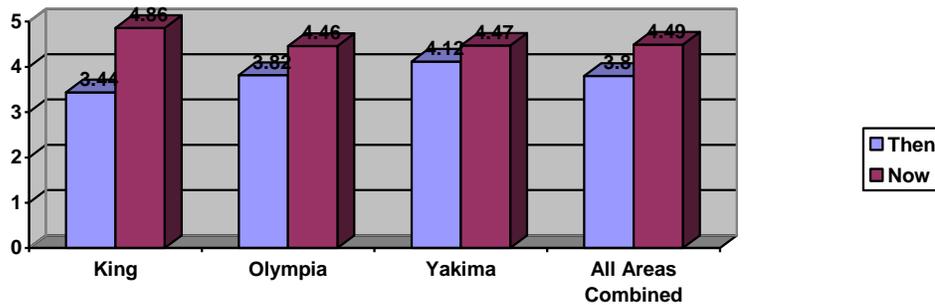
2. I can help infants and young children learn skills that they need to cope with adversity in their lives



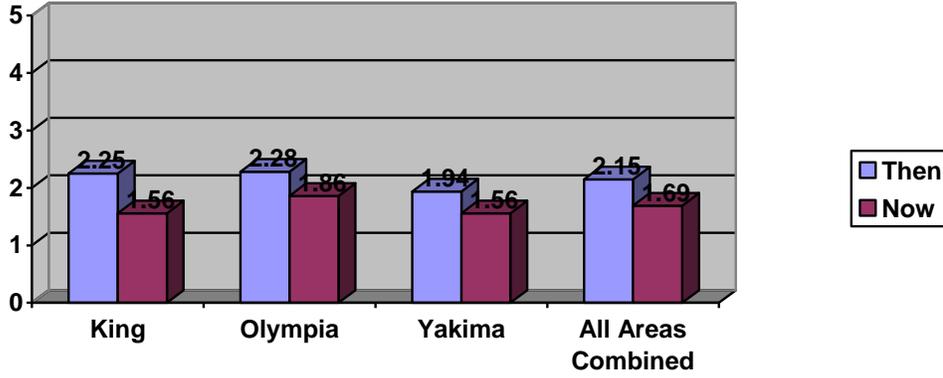
3. There are some children in my group that I simply can't have any influence on



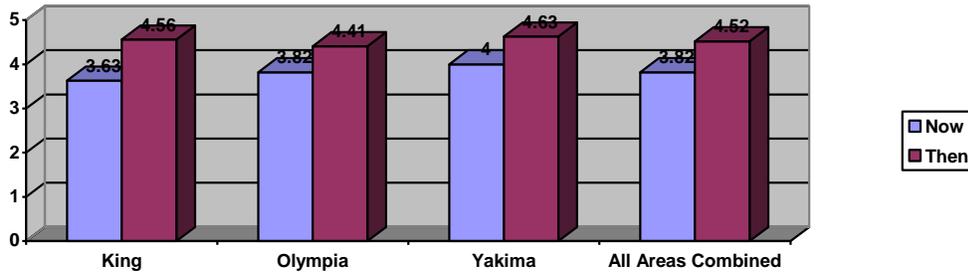
4. If some children in my group are not doing as well as others, I believe I should change my way of working with them



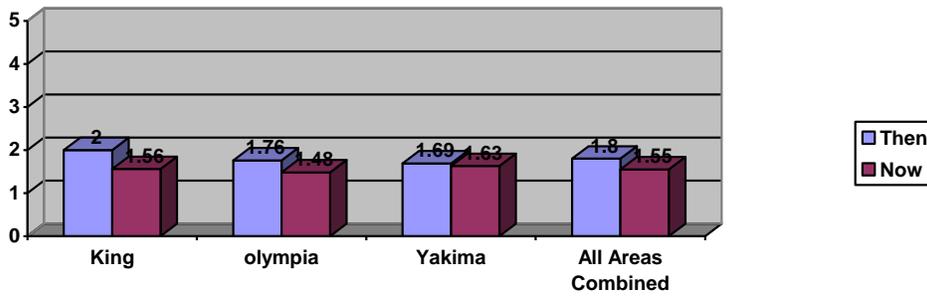
5. As a caregiver, I can't really do much because the way a child develops depends mostly on what goes on at home



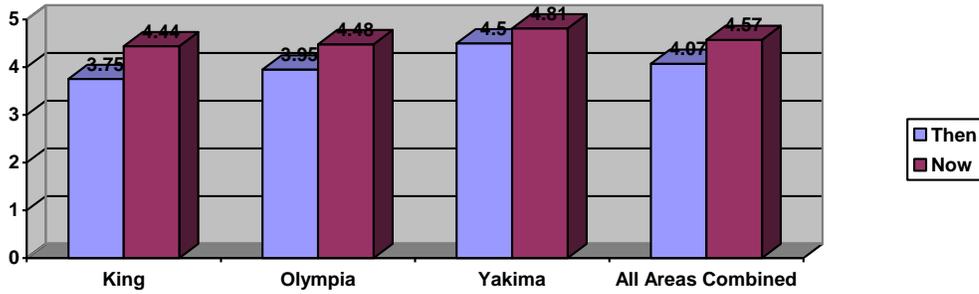
6. I know things I can do to help children develop skills to make successful choices later in life



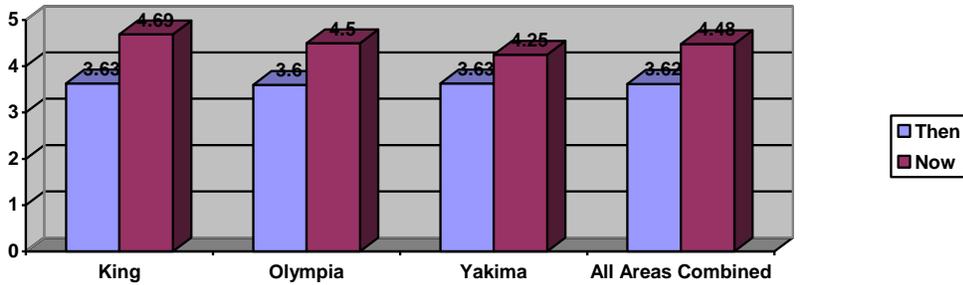
7. I feel a sense of hopelessness about the future of the children I work with



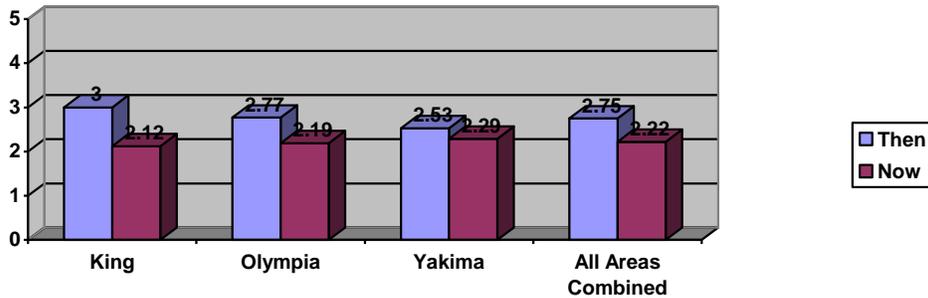
8. I can imagine myself caring for infants and young children for several more years



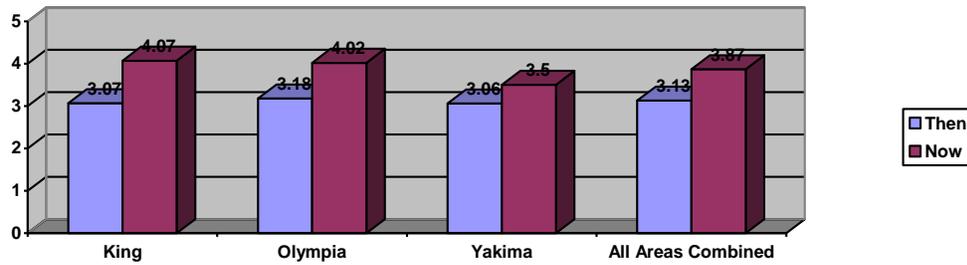
9. I know how to respond effectively when a child becomes disruptive in my group



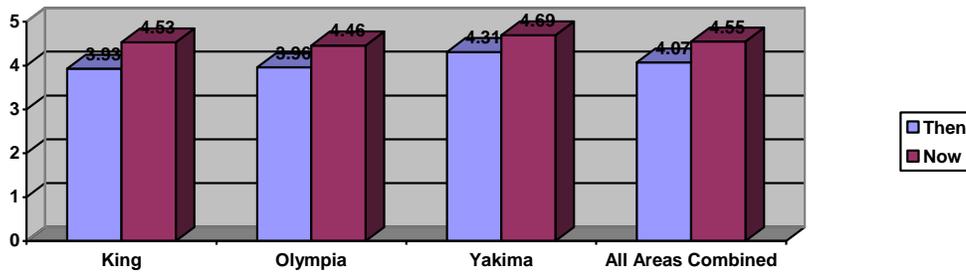
10. I frequently feel overwhelmed at my job



11. I have enough training to deal with almost any group situation

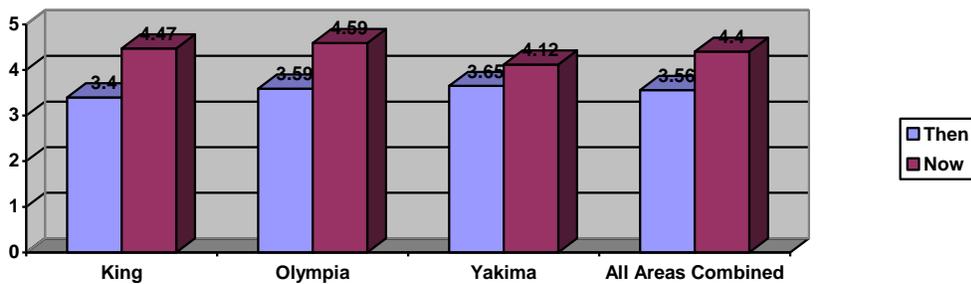


12. On a typical day, I feel a sense of accomplishment as a caregiver of infants and young children

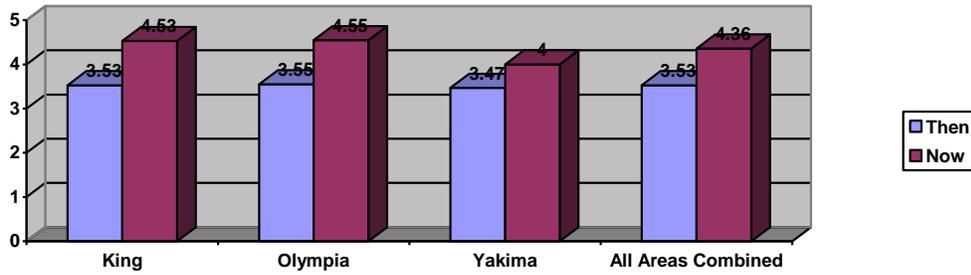


Provider Skills and Knowledge

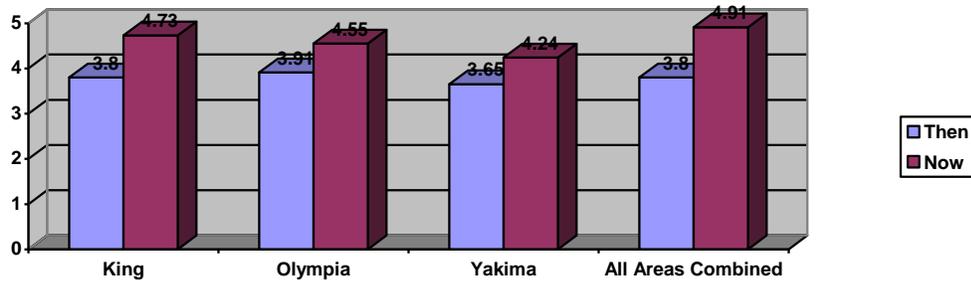
1. I have an understanding of children's social and emotional development



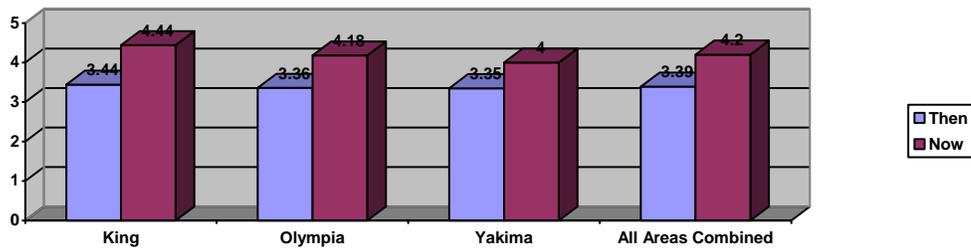
2. I know how to effectively support children's social and emotional development



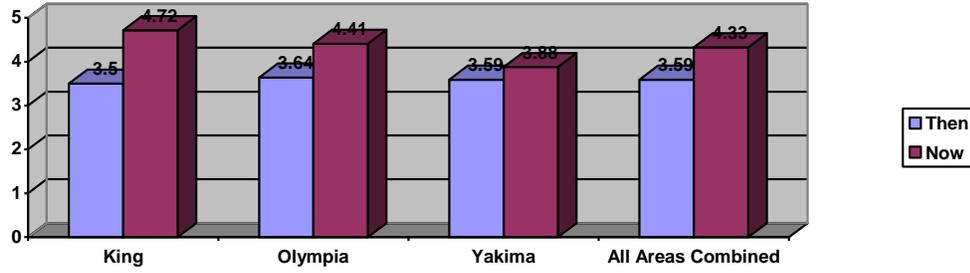
3. I try to understand the meaning of the children's challenging behavior



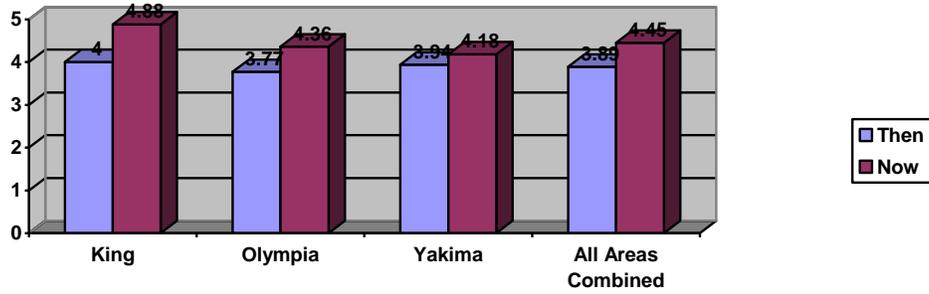
4. I feel confident managing children's challenging behavior



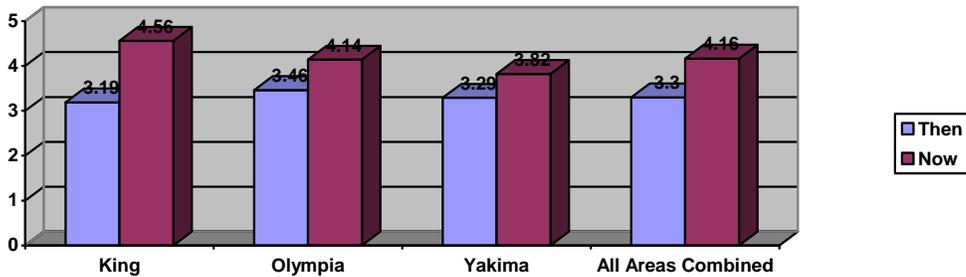
5. I know how to effectively support and respond to a child in distress



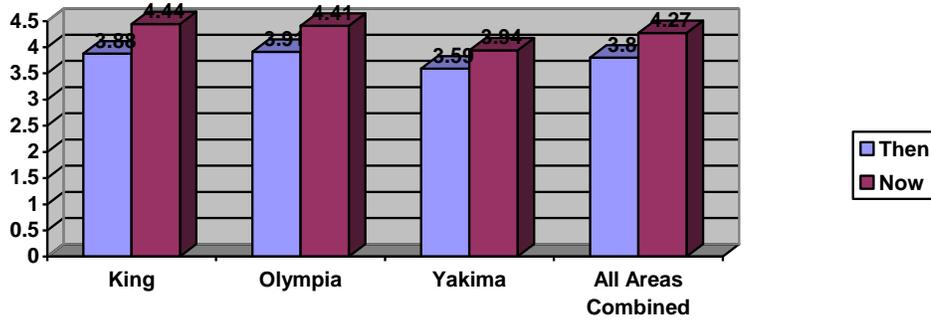
6. I have a positive attitude about working together with parents.



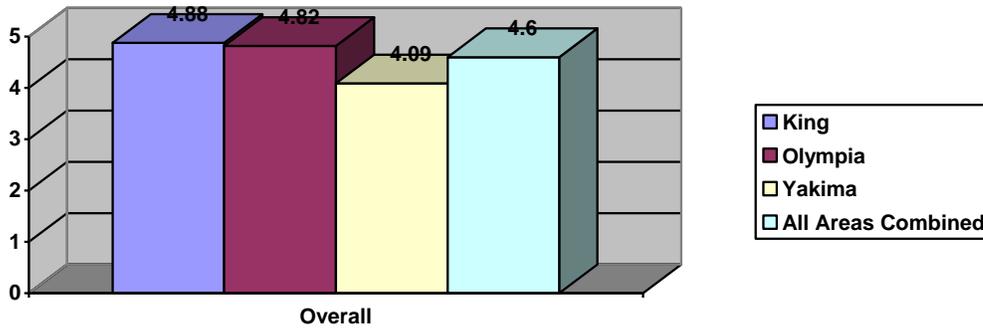
7. I am aware of supports/services for families and children in the community



8. I have created a positive and supportive classroom

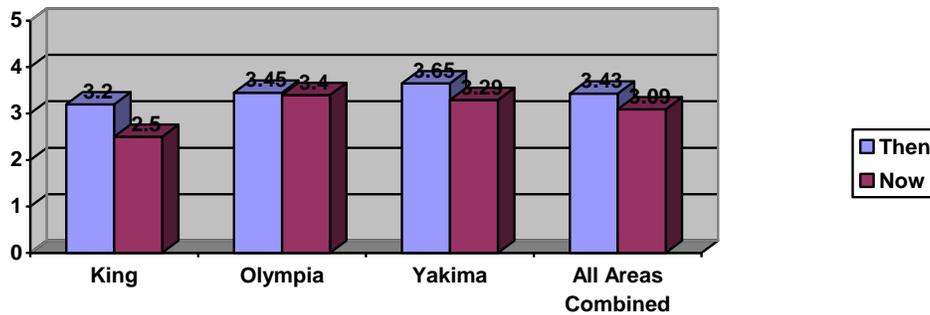


9. Overall, I feel that have used something I learned from the consultation/ training program to help a child or family

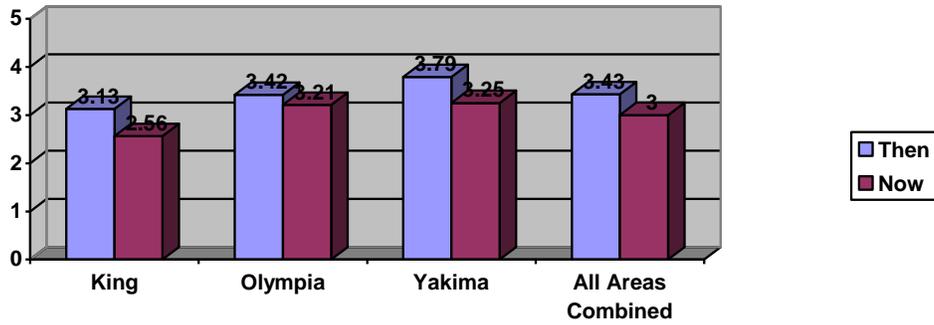


Child Behavior

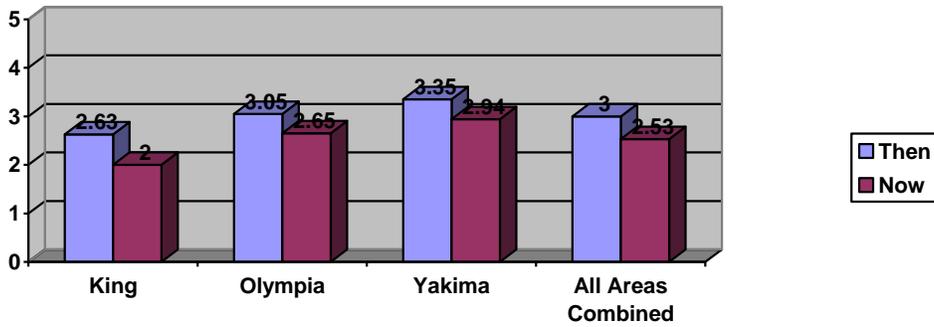
1. Kid(s) often have temper tantrums (crying, screaming, protesting, etc.)



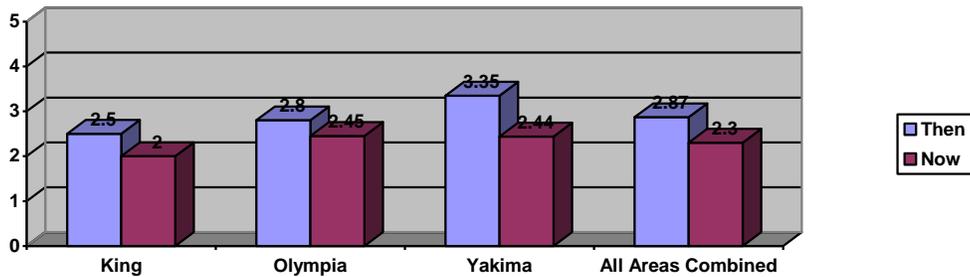
2. Kid(s) often use aggressive behavior (hitting, kicking, biting, etc.)



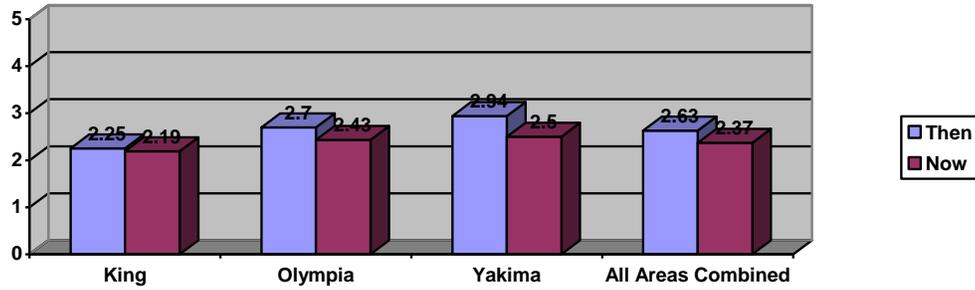
3. Kid(s) often harm or destroy classroom property (throw objects, knock things over, break toys etc.)



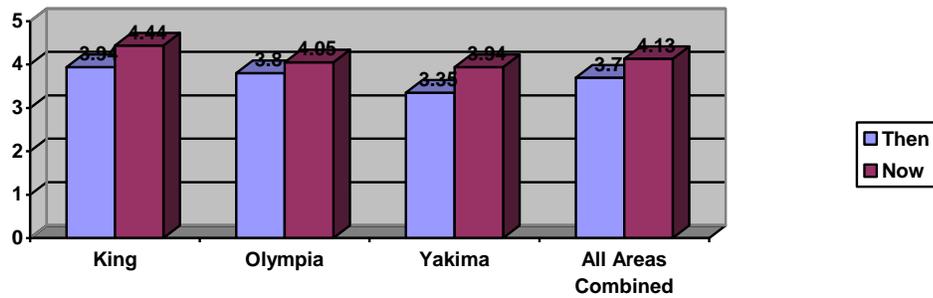
4. Kid(s) often say no or don't follow directions I give



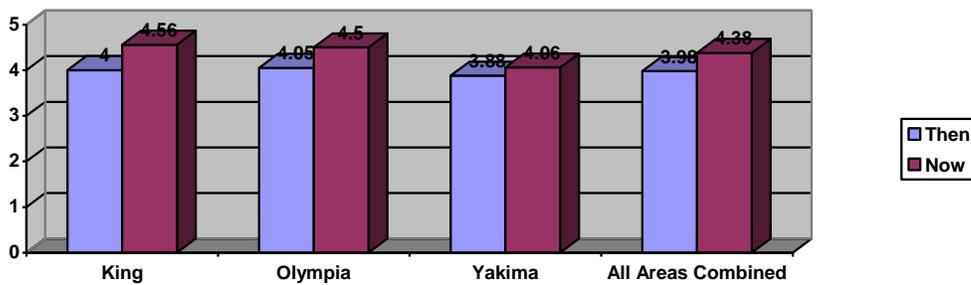
5. Kid(s) often act shy or refuse to interact with others



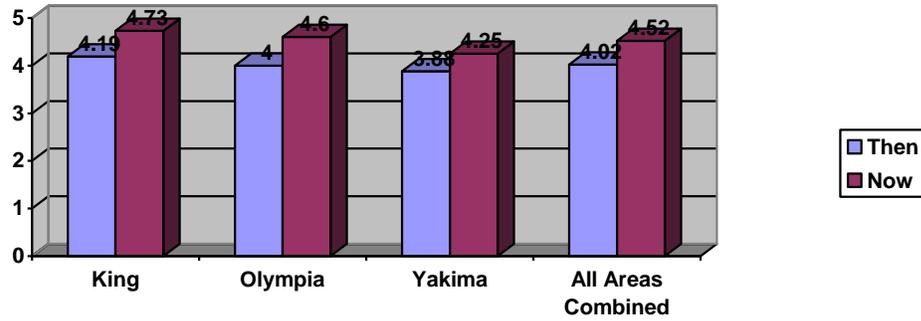
6. Kid(s) often play and get along well with others



7. Kid(s) often allow an adult to comfort or help them when they are sad/upset



8. Kid(s) often seem to be happy and enjoy playing in the classroom



9. Even though kids in my classroom might still have some challenging behavior, overall the number of difficult behaviors in my classroom has decreased since I received the consultation or training services.

