QIC-EC

South Carolina

Implementation Manual

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1. Purpose of QIC-EC

The National Quality Improvement Center on Early Childhood (QIC-EC) was established in 2008 as a five-year cooperative agreement between the Children's Bureau and three partner organizations: Center for the Study of Social Policy (lead agency), National Alliance of Children's Trust and Prevention Funds, and ZERO TO THREE: National Center for infants, Toddlers, and Families.

The QIC-EC was established to test evidence-based and evidence–informed approaches that build protective factors and reduce risk factors in order to promote optimal child development, increase family strengths, and decrease the likelihood of abuse and neglect among infants and young children. To this end, the QIC-EC funded four research and demonstration projects. In addition, funding was provided for five doctoral students whose dissertation research was related to the focus of the QIC-EC. Through its Learning Network, the QIC-EC engaged a multidisciplinary group of professionals in dialogue and information exchange on key policy, research, and practice issues related to the prevention of maltreatment.

The QIC-EC is funded by the United States Department of Health and Human Services, Administration for Children, Youth and Families, Office on Child Abuse and Neglect and is supported by matching funds from the Doris Duke Charitable Foundation.

2. Purpose, Goals, Objectives of the Project

The Family Networks Project had two primary goals: 1) to examine the potential of Stepping Stones Triple P (SSTP; Sanders, Mazzucchelli & Studman, 2003a) as an evidence-based parenting intervention in improving key protective factors for families with a young child with developmental disabilities, and 2) to consider the synergistic impact of SSTP along with the

workforce enhancement curriculum of Preventing Child Abuse and Neglect: Parent-Provider Partnerships (PCAN; Seibel, Britt, Gillespie, & Parlakian, 2006) for early interventionists. Both PCAN and SSTP build on family strengths, have explicit goals to support parent self-determination and self-regulation, and can directly impact risk factors for child maltreatment operating at the individual/family (caregiver-child relations with SSTP) and community level (community connections with families via PCAN). Study One was an efficacy trial of Stepping Stones Triple P (SSTP) for caregivers of young children with disabilities, and was conducted in the midlands region of South Carolina. Study Two also was an efficacy trial of SSTP, but it included a component at the community level of the social ecology--an examination of the potential impact of an additional curriculum (Preventing Child Abuse through Parent-Provider Partnerships or PCAN) designed to increase awareness of child maltreatment for IDEA Part C special instruction providers.

3. Theoretical Base/Guiding Principles of Project

Our theoretical framework was built on the socio-ecological and social learning models (Bronfenbrenner, 1977; Patterson,1982; Sanders, Markie-Dadds & Turner, 2003). The socio-ecological view posits that children's development and behavior is influenced by nested, interacting factors operating at the individual, parent, family, and community level. Risk factors for maladaptive outcomes operate at and between each of the levels and have the ability to impact children's social, emotional, behavioral, and cognitive functioning. Strengthening protective factors that operate at more than one level is thought to further reduce risk for maltreatment. Social learning principles formed the basis for behavioral family interventions, which have the strongest empirical support among interventions designed to prevent and treat behavioral problems in children (Taylor & Biglan, 1998). The collaborative intervention that we

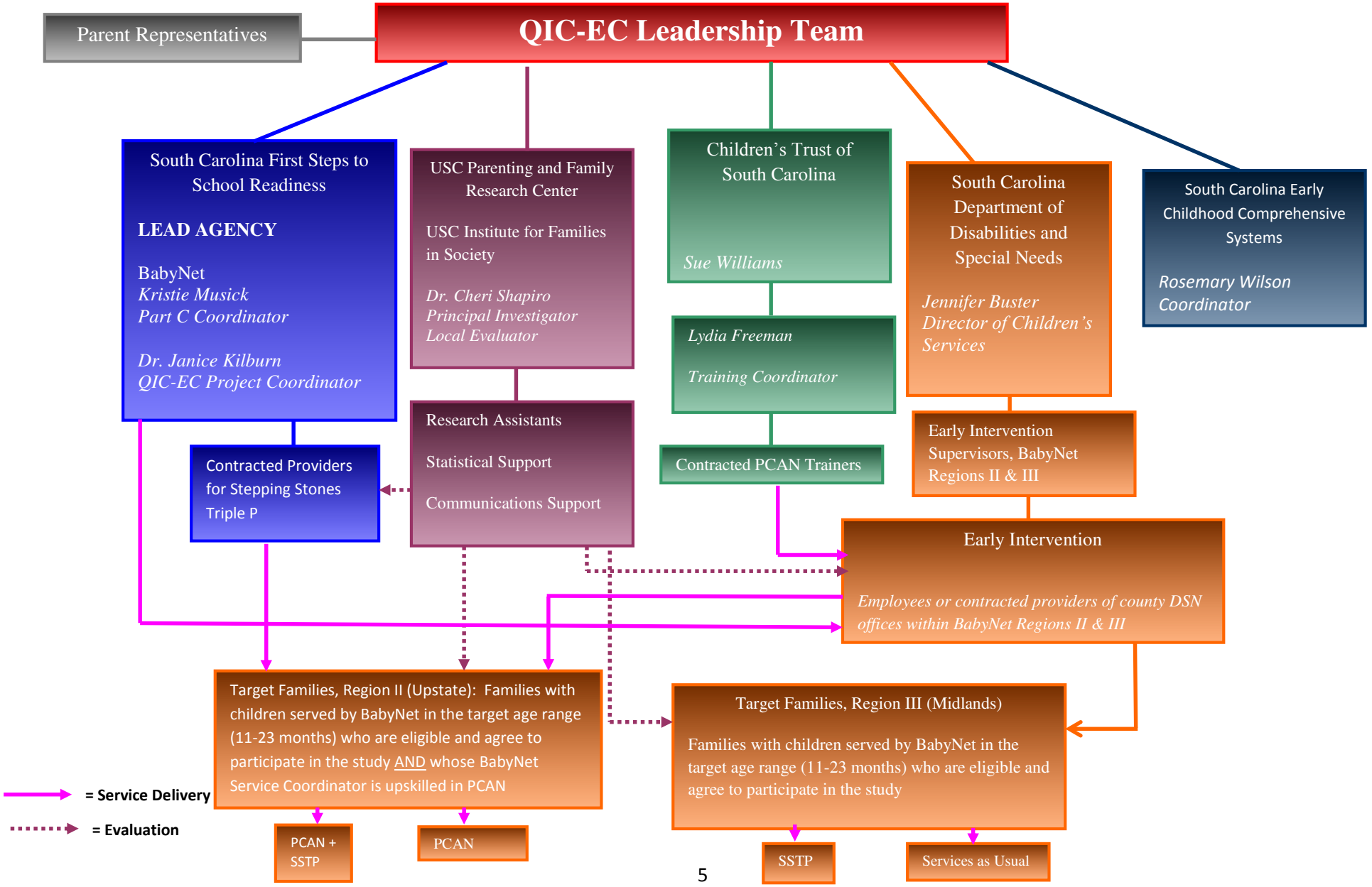
examined combined a socio-ecological approach with a behavioral family intervention based on social learning principles to increase the likelihood of positively impacting both the parent-child relationship and the connections between the family and the community.

4. Logic Model

PROJECT TITLE: **A comparison of collaborative interventions for strengthening families and reducing maltreatment risk in young children with developmental disabilities.**

Need: There is a need to develop knowledge of how to prevent child maltreatment in vulnerable children below age 2.					
PROJECT GOALS & OBJECTIVES	**TARGET POPULATION**	**INPUTS (RESOURCES)**	**ACTIVITIES/ OUTPUTS**	**SHORT TERM OBJECTIVES**	**LONG TERM OBJECTIVES**
Assess impact of an evidence-based parenting intervention developed specifically for parents of young children with developmental disabilities (SSTP) delivered in a context of enhanced service coordination under IDEA Part C	Parents of children ages 11-23 months with developmental disabilities served by BabyNet of SC in two regions of the state	PCAN training for BabyNet Service Coordinators SSTP training for select parent educators Expertise of Project Leadership Team Access to agency and university resources	Provision of BabyNet Service Coordination Home-based delivery of 10-session SSTP	Improve child social-emotional-behavioral functioning Enhance parenting competence (skills) and knowledge Enhance parent confidence and resilience Create strong provider-parent relationships	Improved child well-being Strengthen families Decrease likelihood of child maltreatment

5. Project Administration/Organizational Structure



The lead organization of the Family Networks Project is South Carolina First Steps to School Readiness (SC First Steps), a quasi-governmental state agency whose primary mission involves support for children 0 – 5 and their families. First Steps was signed into law in 1999 to help improve school readiness for the state's youngest learners. It is a comprehensive, results-oriented statewide education initiative to help prepare children to reach first grade healthy and ready to learn. Through its 501(c) 3 status, SC First Steps mobilizes resources beyond state-allocated dollars, leveraging local private and public funds, federal grants, planned gifts, in-kind contributions, and volunteer time. Its five broad strategy areas include family strengthening, healthy start, quality childcare, early education, and school transition (SC First Steps, 2006). Other projects of SC First Steps include coordination of the state's Nurse-Family Partnership, 4K program (Child Development Education Pilot Program for private and non-school district providers), and Countdown to Kindergarten.

Key staff includes Susan DeVenny, Executive Director; Dan Wuori, Chief Program Officer; Debbie Robertson, Director of Quality and Business Engagement; and Kristie Musick, Part C Coordinator for South Carolina.

SC First Steps is the lead agency for BabyNet, which is the South Carolina IDEA Part C early intervention system for infants and toddlers under three years of age with developmental delays, or who have conditions associated with developmental delays. Early intervention consists of the provision of services for children who qualify for BabyNet services and their families for the purpose of lessening the effects of the delay(s). Early intervention services can be remedial or preventive in nature--remediating existing developmental problems or preventing their occurrence. These services are available in South Carolina through County Departments of Special Needs (DSN) Boards and by private providers.

The BabyNet early interventionists who provided special instruction services to eligible families formed the workforce that was upskilled with the PCAN curriculum and then integrated the knowledge and skills obtained from PCAN into the services they provided to families. They also were responsible for recruiting a majority of the families for this project. Special instruction within the BabyNet community includes:

i. "The design of learning environments and activities that promote the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction;
ii. Curriculum planning, including the planned interaction of personnel, materials, and time and space, that leads to achieving the outcomes in the child's individualized family service plan;
iii. Providing families with information, skills, and support related to enhancing the skill development of the child; and
iv. Working with the child to enhance the child's development." (Team for Early Childhood Solutions, 2007).

Key staff for the project is: Dr. Cheri Shapiro, Principal Investigator and Local Evaluator; Dr. Janice Kilburn, Project Coordinator; and Research Assistants Lori Shakespeare and Bonnie Barte.

6. Required Resources

Staff for the Family Networks Project included a principal investigator/local evaluator (.3 FTE), project coordinator (full time), research assistant (.7 FTE), and data manager (.5 FTE).

We contracted with individual vendors to provide SSTP to the families. We trained 22 mental health/education specialists for accreditation in SSTP. When a family was randomized to receive the SSTP services, we matched them with one of the accredited providers, based upon family and provider location and schedules. Of the 22 accredited providers, we contracted with thirteen to provide the SSTP intervention.

In addition to the project staff and contracted providers mentioned above, special instruction providers and their supervisors provided services for the project. They received training in the PCAN curriculum to increase their skills in connecting with and supporting the families on their caseloads. For the purposes of the Family Networks Project, services provided to IDEA Part C eligible families were in-kind contributions.

Administrative support for the project required a grants officer (0.15 FTE), finance manager (0.05 FTE), and office manager (0.05 FTE). In the final year of the project, we also required a BabyNet data coordinator (0.25 FTE) to retrieve data from the BabyNet database for data analysis. An example of needed information from this database is date and reason for exiting the BabyNet system.

Our advisory group for this project was the Family Networks Project Leadership Team. It consisted of representatives from our collaboration team: SC First Steps, Parenting and Family Research Center at the University of South Carolina (PFRC), the Institute for Families in Society at the University of South Carolina (IFS), South Carolina's Early Childhood Comprehensive Systems initiative (ECCS), BabyNet, South Carolina Department of Disabilities and Special Needs (SCDDSN), Children's Trust of South Carolina (Children's Trust). Our advisory group also consisted of a parent representative who had a child who received IDEA Part C services and a special instruction provider representative. We met approximately every six weeks during the course of the project. For more information on agencies on the leadership team and on the leadership team itself, please see Section 7, "Partners/Collaboration."

Space required for this project was minimal. Since all data collection, SSTP intervention, and IDEA Part C service provision activities occurred in the families' homes, the needed office space required the typical office amenities (phone, computer with internet access, etc.).

Materials for the practitioners (SSTP providers and special instruction providers) and families were needed. Special instruction providers received a notebook of handouts and other materials for their training on the PCAN curriculum (Seibel et al., 2006). As a part of the contracted training of SSTP, providers received the Practitioner's Kit for Standard Stepping Stones Triple P, which includes the Practitioner's Manuals for Standard Stepping Stones Triple P (Sanders et al., 2003a), a copy of the Stepping Stones Triple P Family Workbook (Sanders, Mazzucchelli & Studman, 2006), and the DVD entitled, "Stepping Stones Triple P: A Survival Guide for Families with a Child who has a Disability" (Sanders, Mazzucchelli & Studman, 2003b). Families who received the SSTP intervention received a copy of the Stepping Stones Triple P Family Workbook (Sanders et al., 2006).

7. Partners/Collaboration

In order to carry out the interventions of the Family Networks Project, multiple partners were needed. Fortunately, we had the advantage of strong alliances among our collaborating agencies prior to the current project. Our collaboration included SC First Steps; PFRC at the University of South Carolina—which is the university team that conducted the U.S. Triple P Population Trial; IFS at the University of South Carolina; ECCS, which is the collaborative, multi-partner effort to support the health and wellbeing of children 0-5; BabyNet, the state entity charged with service provision via Part C of IDEA to our youngest citizens who are at risk for or are evidencing developmental delays; SCDDSN, the agency that serves approximately 70% of BabyNet-eligible families with early intervention and service coordination; and Children's Trust,

the lead agency for the state charged with prevention of child maltreatment and that serves as the state's lead agency for Community-Based Child Abuse Prevention (CPCAP) funds.

Within this collaboration, we were able to identify young children with developmental delays who were being served by BabyNet, to upskill a work force to implement PCAN to individual families, to evaluate our efforts across a range of critical outcome domains, and to begin to plan for sustaining PCAN and SSTP for the BabyNet workforce.

SC First Steps and PFRC worked together to implement *Triple P* as part of the U.S. Triple P Population Trial since 2003. Both the state First Steps office and First Steps county partnerships became early adopters of *Triple P*, and promoted use of the intervention with the families they serve. Faculty and graduate students associated with the PFRC worked with SC First Steps on program evaluation, program review, and most recently, to support statewide strategic planning efforts for the agency. SC First Steps representatives serve on the Leadership Team for ECCS and collaborated with other leading early childhood agencies and organizations to draft the state's ECCS Plan. ECCS and SC First Steps have worked together extensively to examine the needs of our youngest state residents, especially in identification of factors that impact school readiness. ECCS-supported research linking birth characteristics to school failure by grade 3 for South Carolina Kids Count (The Annie E. Casey Foundation, 2013), subsequently became the basis for prioritizing client services within all SC First Steps-funded programs.

As of January 2010, SC First Steps became the lead agency for BabyNet, the state interagency system for identification and service coordination for infants and children in the 0-3 age range who are eligible for services under Part C of IDEA. SCDDSN has representation on SC First Steps Board of Trustees, per SC First Steps legislation, and is a member of the

Interagency Coordinating Council that oversees BabyNet. The Children's Trust has collaborated with the PFRC to assist in *Triple P* dissemination efforts for the U.S. Triple P Population Trial, is the lead agency promoting the five protective factors articulated in the Strengthening Families through Early Care and Education framework in South Carolina, and implemented a training grant with First Steps to create an initial, 40-member cohort of PCAN trainers for South Carolina, funded by Zero to Three. Furthermore, Children's Trust currently contracts with SC First Steps to expand Nurse-Family Partnership (NFP) in South Carolina, through its ACF grant *Supporting Evidence-Based Home Visitation Programs to Prevent Child Maltreatment,* and uses SC First Steps and private foundation funding for NFP to draw down additional CBCAP dollars for the state.

In sum, our partnership history encompasses the entire coordination-cooperation-collaboration continuum. We refer clients to one another's services, serve on each other's boards, adopt common curricula and training models, and work together on interagency teams and work groups to solve issues that could not be addressed by a single agency or organization. We jointly administer grant projects and share funding. Through our unique collaboration of public and private partners, we were in a strong position to carry out this project. Our team is especially well suited to coordinate services across sectors of health, childcare, and family support.

We maintained these important relationships through regularly held Family Networks Project leadership team meetings for the duration of the project. These were held approximately every six weeks. Initially, agenda items included updates on progress in workforce enhancement efforts (PCAN and SSTP training), family recruitment, and family enrollment. During the final months of the project, the focus of the leadership team shifted to sustainability for PCAN and SSTP within BabyNet in South Carolina.

As the project approached its conclusion, we added additional members of the leadership team to help promote sustainability. These included a licensed independent clinical social worker and Triple P trainer and consultant; a special instruction provider and a special instruction provider supervisor (both of whom received the PCAN training); four individuals trained in SSTP through the Family Networks Project and then contracted to provide SSTP Level 4 services; the training and state directors of a private agency that provides special instruction provider services; and training and technical assistance specialists with the state's IDEA Part C system of personnel development.

We were disappointed that we were not able to recruit a parent representative from the Upstate region. We made several attempts, especially though PRO-Parents, the South Carolina Parent Training and Information Center and Information Center funded under IDEA, as outlined in the proposal. Our selected standard leadership meeting time, Friday afternoons, while convenient for leadership team members with professional positions, undoubtedly was not feasible for potential parent representatives because of family obligations at this time, when older children would be returning home from school.

8. Level of Volunteerism/In-kind Service Needed to Implement Project

We did not use volunteers. Because all records of service provision for children eligible for IDEA Part C services are confidential, use of volunteers was not feasible. In-kind support for program implementation was in the form of services provided by special instruction providers for children/families on their caseload. Other in-kind service was the time and effort leadership team members spent in service of the project. This included attendance at leadership team meetings, preparing for project events (especially PCAN training), and encouraging special instruction providers to recruit eligible families.

9. History/Evolution of the Project

While rates of maltreatment are highest among children below age two, children in this age range with disabilities may be a particularly vulnerable population for risk of child maltreatment because of a confluence of risk factors: increased rates of child behavior problems, increased parental stress, and increased social isolation. The vulnerability of this population is highlighted by research that has strongly linked child maltreatment and disabilities (Sullivan, 2009; Sullivan & Knutson, 2000) as well as the development of evidence-based parenting interventions for this population specifically (Tellegen & Sanders, 2013). Leaders from several key child-serving agencies in South Carolina were drawn to the QIC RFP for several key reasons. First, South Carolina was the site of the U.S. Triple P System Population Trial, funded by the Centers for Disease Control and Prevention, in which geographic units (counties) were randomly assigned to receive the multi-level suite of Triple P interventions in order to examine impact on prevention of child maltreatment at a population level (Prinz, Sanders, Shapiro, Whitaker & Lutzker, 2009).

The Triple P Positive Parenting Program (Sanders, 2008) is an evidence-based system of parenting support and interventions that is based on a public health model. Triple P consists of tiered interventions that incorporate principles of behavioral family interventions and parent management training to prevent social, emotional, and behavioral problems in youth by promoting parent competence and confidence on a population level. Triple P has proven effective in reducing behavior problems and improving parenting in many randomized control trials with a variety of populations (Sanders, Turner & Markie-Dadds, 2002). At the present time, Triple P has a substantial empirical basis and is included in NREPP, SAMHSA's National

Registry of Evidence-based Programs and Practices (www.nrepp.samhsa.gov/viewIntervention.aspx?id=1).

The U.S. Triple P Population Trial lead to the partnering of researchers at the University of South Carolina (i.e. the Project Director for the Population Trial) and SC First Steps. Near the time the QIC RFP emerged, SC First Steps became the home for the IDEA Part C services for children in the state (BabyNet), the federal program responsible for supporting infants and toddlers with disabilities. This convergence of events lead to a desire to form a collaboration to support parents of very young children with disabilities through use of evidence-based parenting interventions.

In addition to the emerging collaboration between the university and state agencies serving young children with disabilities, the Triple P System of Interventions was expanded to include Stepping Stones Triple P (SSTP: Sanders et al., 2003a), a variant of the Triple System designed specifically to support parents of children with disabilities. SSTP had not been available to use during the U.S. Triple P System Population Trial, and there was great interest in examining the potential for this curriculum to strengthen families of very young children with disabilities.

In addition to SSTP as a new resource, a second curriculum relevant for child maltreatment prevention had an extensive history of use in South Carolina and represented a second significant resource. Preventing Child Abuse and Neglect: Parent-Provider Partnerships or PCAN (Seibel et al., 2006) is a published and copyrighted training curriculum developed by Zero to Three, a national nonprofit organization that informs, trains, and supports professionals, policymakers and caregivers in their efforts to improve the lives of infants and toddlers. The

purpose of the PCAN curriculum is to engage the child care community in helping to reduce the risk of child abuse and neglect of infants and toddlers. SC First Steps, along with other child-serving agencies including the Children's Trust, had supported PCAN training for childcare providers and other professionals in the state since 2007. However, early interventionists within the state had not been exposed to this curriculum as it was not developed for this particular workforce.

Significant strengths present at the time for applying for QIC funding included:

- a desire among key child-serving agencies at the state level to partner to improve services for parents of young children with disabilities,
- the desire of these state partners to improve knowledge of what can work to prevent maltreatment in a potentially vulnerable population,
- the extensive history of use of the PCAN curriculum within the state,
- the well-established university-community partnership around the Triple P System of Interventions,
- the availability of the SSTP curriculum
- incorporation of the IDEA Part C service system into SCFS.

The overall project goals at the time of application for funding included extending the evidence base for SSTP as an early intervention and prevention strategy both by child age (downward below age two) and by examining the impact on protective factors that may decrease the likelihood of later maltreatment. In addition, we sought to examine the potential for a unique synergy that could be created by combining SSTP with IDEA Part C delivered by a workforce

upskilled in PCAN. Both PCAN and SSTP build on family strengths, have explicit goals to support caregiver self-determination and self-regulation, and can directly impact risk factors for child maltreatment operating at the individual (caregiver-child) and community level (community connections).

10. Required Staff Training, Coaching, Supervision

In addition to required resources of staff, administration, space, and materials outlined in Section #6 of this document, certain supports must be in place to assure that the project meets its goals and objectives, especially in regards to delivery of the SSTP intervention. These supports include staff training of special instruction providers and SSTP providers, and clinical supervision of the SSTP providers.

Staff Training

PCAN training. The PCAN curriculum (Seibel et al., 2006) is a published and copyrighted training curriculum developed by Zero to Three, a national nonprofit organization that informs, trains, and supports professionals, policymakers and parents in their efforts to improve the lives of infants and toddlers. The purpose of the PCAN curriculum is to engage the child care community in helping to reduce the risk of child abuse and neglect of infants and toddlers.

PCAN curriculum modification for special instruction providers. For the purpose of the Family Networks Project, the curriculum was modified to meet the unique needs of early interventionists who serve the IDEA Part C population. BabyNet system personnel who participated in PCAN training and successfully demonstrated competencies related to the curriculum content were awarded a specialized endorsement as a part of their Part C Credential.

The initial step in adapting the PCAN curriculum to the early intervention system was to introduce it to special instruction provider supervisors. A PCAN supervisor training webinar was conducted on the two PCAN units specifically designed for supervisors: Relationship-based and Reflective Organizations (Unit 9), and Supporting Staff in Their Work with Parents (Unit 10).

Following the training, an online survey was emailed to special instruction providers in the region of the state targeted for the project. Their responses shaped the decisions to include all 48 PCAN content areas in the training.

An initial round of training was conducted with special instruction providers. In addition to the three training days, a one-half day follow-up training was held a few months later. The purpose of this schedule was so that the PCAN training would mirror the same schedule as the SSTP training—3 full days of training with a follow-up day several weeks later. For the sake of the research aspect of this project, special instruction providers who attended at least two of the three training days (not follow-up) qualified to participate in the project—i.e., refer families on their caseloads to the Family Networks Project.

Based upon the pre- and post-assessments of knowledge and course evaluations of the first round of training, modifications were made to the PCAN curriculum. This included the order of presentation of the units and some exercises. The training content still derived from Units 1-8 of the PCAN curriculum, and the delivery schedule (three days with half-day follow-up several weeks later) remained the same. Changes between the first and second rounds of training included order of presentation of units and changes in activities to be more relevant to the profession of early intervention. For this second round of training, fourteen special

instruction providers plus two agency directors attended at least two of the three full days of training.

Please see Appendix 1, "Preventing Child Abuse and Neglect through Parent-Provider Partnerships: Training an Early Interventionist Workforce Final Report", for more detailed information along with results of the pre- and post-assessments of knowledge and the course evaluations.

It is the modified curriculum for this second round of training that we recommend in subsequent training of the PCAN curriculum for early interventionists. One other change (based upon feedback from the training participants) would be condensing the training units for fewer training days.

SSTP training. Triple P Positive Parenting Program (Sanders, 1999) is a published and copyrighted program for parenting and family support. It incorporates the principles of behavioral family interventions and parent management training and has proven effective in reducing behavior problems in many randomized control trials with a variety of populations (e.g., Sanders et al., 2002).

SSTP (Sanders et al., 2003a) is the adaption of Triple P for families of children with developmental disabilities. SSTP was developed to prevent severe behavioral, emotional, and developmental problems in children by enhancing the knowledge, skills, and confidence of parents. It incorporates five levels of intervention on a tiered continuum of increasing strength, depending on the level of intervention required. Level 4 Triple P is an intensive ten session parent training program. It consists of sessions on assessment, positive parenting skills, parent practice, planned activities training, and closure. It includes the DVD, "Stepping Stones Triple

P: A survival guide for families with a child who has a disability" (Sanders et al., 2003b) and a Family Workbook (Sanders et al., 2006). Children's competencies promoted through SSTP are social and language skills, emotional skills, independence skills, and problem solving skills.

Mental health and education specialists who provided the intervention for the Family Networks Project were trained by completing and becoming accredited in SSTP (Sanders et al., 2003a) by Triple P America, the organization that oversees all Triple P training and material in the U.S. SSTP training is manualized and delivered by individuals specifically trained to do so by Triple P America.

SSTP training consists of two parts: The initial three-day training provides an overview of all aspects of the SSTP intervention, from initial intake and assessment processes to delivery of all session content. Providers received the SSTP manual and a copy of both the DVD and the family workbook to be used to support intervention delivery. See Section #6, "Required Resources", for more information.

For the second part of the training, SSTP providers completed a knowledge quiz and role-play to demonstrate key intervention competencies with a trainer. This second part of the training follows the first part of training by approximately eight weeks. Successful completion of both parts of training resulted in those individuals becoming Accredited SSTP Providers. SSTP has built-in pre and post intervention evaluation measures, as well as content fidelity checklists for each session. More information about Triple P, Stepping Stones Triple P, and the training is available at their website: www.triplep.net.

Clinical Supervision

For this project, SSTP providers received clinical supervision after each family visit they made. This came in the form of a telephone call with a licensed clinician with experience in Triple P. Generally the telephone supervision took 15-30 minutes, and the clinician contracted with and billed the project for the work in 15-minute increments. In addition, group supervision in the form of conference calls with the PI/local evaluator and project coordinator was available during the phase of the project with the most SSTP sessions occurring, November 2010 through April 2012. For those not able to join the calls, summaries of topics discussed were distributed via e-mail.

Fidelity checks were instituted as an important part of the research aspect of this project. However, they also can be used as a part of clinical supervision to assure that the intervention is being implemented as it should. A licensed clinician with expertise in Triple P listened to the audiotapes of every session to assess fidelity. Appendix 2 is an example of the scoring worksheet.

All SSTP sessions were audio-taped. The tapes were then downloaded into dropbox (www.dropbox.com), a file hosting service operated by Dropbox, Inc. that offers cloud storage and file synchronization. It allows users to share files (in our case, audiofiles) in a very secure environment.

11. Description of and Rationale for Target Population; Eligibility Requirements

Description

Our study had three target populations: two were at the community level and involved upskilling the existing special instruction providers workforce and training mental

health/education specialists in SSTP. At the individual level, our target population was families that met eligibility criteria for enrollment in the Family Networks Project.

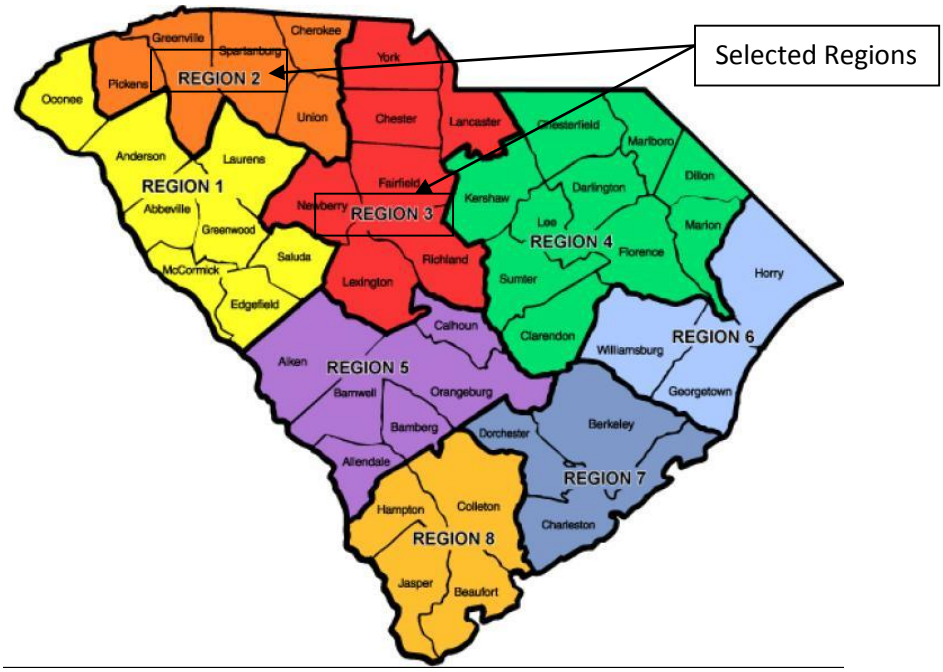
Target population at the community level. All BabyNet System Personnel, including those service providers contracted by BabyNet, must meet the requirements of the Comprehensive System of Personnel Development (CSPD), a credentialing process with the purpose of providing a common knowledge and skill set across interdisciplinary IFSP teams. The South Carolina Part C Credential requires satisfactory completion of an online curriculum (based on competencies from the National Council for Exceptional Children, Division of Early Childhood), and demonstration of knowledge and skills through assessments of learning, self-assessment, and observation. Service coordination and special instruction are considered unlicensed services; i.e., providers may be hired from any discipline relevant to early intervention, and as such come to the position with a high level of variance in educational backgrounds, experience, and professional development needs.

Also at the community level was the group of mental health/education professionals who provided the SSTP intervention to those families randomly assigned to the study condition. All individuals trained in SSTP had experience and expertise in mental health and/or education with a background in working with families.

Target population at the individual level. South Carolina residents under age three are eligible for IDEA Part C services through the BabyNet system when established risk (diagnostic conditions) and/or developmental delay are documented and meet state eligibility criteria. Referrals may come to the BabyNet Part C early intervention system from any source. On average, approximately 30% of all referrals are found to meet BabyNet eligibility criteria *(Source: BabyTrac Data System, 13jan10).*

Families that had a child between the ages of 11 and 23 months[1], that were receiving BabyNet services from a special instruction provider who had agreed to be a part of the study, and who lived in two regions of South Carolina that together encompass 12 counties met the primary eligibility requirements for enrollment in the Family Networks Project. In 2010, these regions served 711 children in this age range who were deemed eligible for BabyNet, and who received service coordination and special instruction along with other services. See map below.

BabyNet Regions



Rationale

Very young children with developmental disabilities may represent an especially vulnerable population for negative developmental outcomes, including the potential to be victims

[1] In the early stages of the project, we received clarification from our funder that we could include children who were past the chronological age of two years if their gestationally corrected age (for preterm infants) was less than two years of age.

of child maltreatment. Youth who are eligible for services in BabyNet either possess a diagnosable condition that is known to be associated with developmental delays, or who evidence developmental delays in one or more areas (communication, motor skills, cognition, social/emotional behavior, adaptive functioning) based on screening and assessment. Conditions that increase the likelihood for later developmental delays, and youth with developmental delays, are likely to exhibit more challenging behaviors and to be at higher risk for maltreatment as compared to peers without such conditions or delays (Sullivan, 2009). Therefore, this group of very young children with developmental delays is at higher risk for maltreatment than the general population, and much more research is needed to understand how risk and protective factors operate in the context of early intervention to impact a range of outcomes.

These two regions of the state were selected for the project because they had the concentration in population that would likely produce the most families who met project eligibility. Region 2 is Upstate South Carolina and includes Greenville and Spartanburg as well as rural and suburban regions. Approximately 79% of the population is White/Caucasian and 19% is Black/African American (US Census Bureau, 2011). Median household income is approximately $42,000 (South Carolina Department of Health and Environmental Control, 2012). Region 3 is considered the Midlands of South Carolina, and it includes Columbia along with rural and suburban regions. Its ethnic distribution is approximately 66% White/Caucasian and 31% Black/African American (US Census Bureau, 2011). Median household income is approximately $43,000 (US Census Bureau, 2011).

It should be noted that the target population shifted to some extent during the course of this project. As subject recruitment was beginning, BabyNet eligibility criteria changed, becoming more stringent. This means that the number of eligible families estimated when the

proposal was developed was greater than the actual number at the onset of subject recruitment.

Eligibility Requirements

Other eligibility criteria for the Family Networks Project were a willingness to participate in the project, including random assignment to a study condition, a willingness to participate in home-based parenting intervention services, no history of a founded case of child abuse or neglect as verified by the SC Department of Social Services (SCDSS)[2], English language proficiency, have a telephone, and severity of the disability NOT to the extent that would suggest a high likelihood of out-of-home placement during the time of the project.

12. Project Implementation

Outreach, Identifying, Recruiting, and Building Relationships with Target Population

For this project, there were three target populations to be recruited: two were workforce recruitment at the community level, and one was at the individual/family level. At the community level, upskilling the existing workforce of special instruction providers meant recruiting them for training in the PCAN curriculum. Also at the community level was recruiting and then training individuals who would provide the SSTP intervention. At the individual/family level, families were recruited for participation in the project.

Workforce recruitment for PCAN training. (Note: Workforce recruitment for PCAN training occurred in Study Two only.) On June 11, 2010, two webinars, for two regions of the state targeted for the Family Networks Project, were conducted to introduce the project to special instruction providers, supervisors, and directors. After arrangements were finalized to conduct the initial round of PCAN training, an invitation was e-mailed by the director of the Office of Children's Services of South Carolina's Department of Disabilities and Special Needs

[2] The only exception was cases of prenatal exposure to psychotropic substances and, since shortly after birth, the child had been in the care of a legal guardian with permanent custody--not the biological parent.

(SCDDSN) to all special instruction providers in the targeted regions of the state, inviting them to participate.

Special instruction providers were recruited for Round Two of the PCAN training in a similar fashion: an e-mail notification was sent to all special instruction providers who had not received the training and their supervisors of the designated region of the state. Again, it was sent by the director of the Office of Children's Services of SCDDSN.

Recruiting SSTP providers. (Note: SSTP provider recruitment occurred for both studies.) Through the work with the U.S. Triple P Population Trial (Prinz et al., 2009), the local evaluator/PI had established partnerships with organizations and agencies with some background in Triple P. Primarily through these contacts, individuals were recruited for the SSTP training. Other candidates were nominated from agency directors or through word of mouth. As a result, ten individuals were trained in the first round of training, eight more in the second round, and four more in the third round of training.

Recruiting families (same for both studies). The majority of families (77%) were recruited from their special instruction providers. Another 18% of families responded to project flyers (see Appendix 3) that were mailed to eligible families (based upon geographic location and child date of birth). For these mailings, the names, addresses, and child's date of birth were obtained from the BabyNet database. The additional 5% of enrolled families responded to information about the project that they saw on a website (e.g., BabyNet or SC First Steps websites), or they learned of the project from other agencies, such as an outpatient pediatric clinic.

Since our prime referral source was special instruction providers, we frequently presented information about the Family Networks Project to key stakeholder agencies, (including

shameless tactics such as sending cookies and setting up a poster of the recruiting flyer with mylar balloons in an agency foyer). We also made presentations at the meetings of SCDDSN counterpart participants who provide IDEA Part C services.

In instances in which the referral was from the family's special instruction provider, the special instruction provider gave the family a study flyer (Appendix 3). If the caregiver (mother/father/legal guardian) was interested, permission was obtained by the special instruction provider for two-way communication release of information between the Family Networks Project and the special instruction provider. See Appendix 4. Written permission also was obtained for the South Carolina Department of Social Services to verify absence of a founded case of child abuse or neglect, a requirement of our funder. See Appendix 5.

In cases in which the caregiver initiated the referral (e.g., by calling the project coordinator after receiving the project flyer in the mail), the necessary permission forms (Appendix 4 and Appendix 5) were mailed, faxed, or scanned and e-mailed to the caregiver. After the forms were completed by the caregiver and returned to the project coordinator, and no substantiated child maltreatment report on the target child was verified, the initial intake was initiated.

Initial Intake and Assessment; Assessment Tools

After absence of a child maltreatment report was verified, the project coordinator contacted the caregiver to complete a phone screening to assure all eligibility criteria were met and to rule out presence of exclusion criteria. She followed the protocol in Appendix 6. At that time, more information about the project was provided to the caregiver, and the caregiver had an opportunity to ask questions. If the caregiver expressed an interest in enrolling, the project coordinator scheduled a home visit.

For this initial visit, the project coordinator met with the caregiver to review the project, discuss and obtain signed consent for participation from the caregiver(s) (Appendix 7), and to complete some of the baseline evaluation measures.

Following this visit, the research assistant contacted the family to schedule the second visit of the pre-treatment assessment. In addition to administering more assessments, random assignment was revealed to the family at that time. That is, the caregiver was informed if he/she/they would be receiving the SSTP intervention or if the family was in the comparison group and would not be receiving the intervention.

The majority of evaluation sessions were conducted in the family's homes. Exceptions were if the caregiver requested a different location, such as the caregiver's workplace, the caregiver's church, or a quiet restaurant. An alternate location was more likely for the first home visit since it was not necessary for the child to be present at that visit.

The table below lists all local measures for both studies as well as the time point at which they were administered; information on the relevant protective factor is also included where appropriate.

Table 1: Local Evaluation Measures

Protective Factor	**Domain**	**Measure**	**Time Point** **B=Baseline, M-Midpoint** **F=Follow-up**
Social and emotional competence of children	Child behavioral & emotional functioning	Child Behavior Checklist 1.5-5 (CBCL)	B, M, F

Knowledge of parenting and child development	Parenting style	Parenting Scale	B, M, F
Knowledge of parenting and child development	Quality of parent-child relationship	Keys to Interactive Parenting (observational measure)	B, M, F
Parental Resilience	Parental Self Efficacy	Toddler Care Questionnaire	B, M, F
Parental Resilience	Parent personal functioning	Depression, Anxiety, Stress Scales-21 (DASS-21)	B, M, F
Social Connections	Parent-Provider Relationships	Working Alliance Inventory	B
NA	SSTP Fidelity	Session checklists and audiotape reviews	During and after intervention
NA	PCAN Training	Measures of knowledge of PCAN content and relevance developed for this project based on existing PCAN Knowledge Assessment Forms included in the curriculum for each PCAN unit. Consumer Satisfaction with training	Before and after PCAN training courses At completion of PCAN training

Participation in the QIC-EC entailed collection of common or cross-site measures. These measures were administered at baseline and a 5-month midpoint assessment (i.e. end of treatment). These included a Background Information Form (demographic), the Caregiver

Assessment of Protective Factors, the Parenting Stress Index, the Adult-Adolescent Parenting Inventory-2, the Self-Report Family Inventory, and a Social Networks measure. How these were incorporated is noted in Table 2, below, which also offers an overview of all data collection activities, both local and cross-site.

Table 2: Data Collection Activities				
Study One				
Sources of Data	**Caregiver**	**Special instruction provider**	**SSTP provider**	**Accredited SSTP trainer**
Pre-intervention data collection				
Both treatment and comparison groups	Local measures, cross-site measures	WAI (local measure)		
Post-intervention data collection				
Treatment group (conducted after SSTP intervention)	Local measures, cross-site measures	WAI (local measure)	WAI (local measure)	Fidelity checklists
Comparison group (conducted 5 months after pre-intervention data collection)	Local measures, cross-site measures	WAI (local measure)		
Follow-up data collection (conducted 12 months after enrollment)				
Treatment group	Local measures; AAPI	WAI (local measure)	WAI (local measure)	Fidelity checklists
Comparison group	Local measures; AAPI	WAI (local measure)		
Study Two				
Sources of Data	**Caregiver**	**Special instruction provider**	**SSTP provider**	**Accredited SSTP trainer**
PCAN Training		PCAN knowledge assessments PCAN course evaluations		
Pre-intervention data collection				
Both treatment and comparison groups	Local measures,	WAI (local measure)		

	cross-site measures			

Post-intervention data collection				
Treatment group (conducted after SSTP intervention)	Local measures, cross-site measures	WAI (local measure)	WAI (local measure)	Fidelity checklists
Comparison group (conducted 5 months after pre-intervention data collection)	Local measures, cross-site measures	WAI (local measure)		
Follow-up data collection (conducted 12 months after enrollment)				
Treatment group	Local measures; AAPI	WAI (local measure)	WAI (local measure)	Fidelity checklists
Comparison group	Local measures; AAPI	WAI (local measure)		

While we administered all assessments listed previously, we do not necessarily recommend that those interested in replicating this project do the same. Therefore, we recommend administration of one measure per key domain of functioning, and that brief or screening measures be used whenever possible. Maintaining parent focus for assessments that are multi-hour and that occur within the family home is challenging; thus, a minimally sufficient approach to assessment is recommended.

Method of Determining Protective Factor(s) of Focus for Individual Participants

Importantly, the interventions chosen for this study were selected because of their ability to support particular protective factors. Thus, individual participants were not evaluated in terms of which protective factor was most relevant for that family at that time.

PCAN was developed specifically to increase awareness of child maltreatment risk factors and is thus expressly aligned with the protective factors identified as part of the Strengthening Families Approach and Protective Factors Framework (Center for the Study of Social Policy, 2012). With the early intervention workforce trained in this approach, special

instruction providers have in their repertoire the skills to identify and then address the specific protective factors whose focus would be of the most benefit for each individual family.

SSTP was designed to focus on some of the protective factors; it was provided to those families randomly assigned to the treatment group. SSTP is especially well suited to increase the protective factors of: 1) knowledge of parenting and child development, 2) nurturance and attachment, 3) social and emotional competence in children, and 4) parental resilience. This content, when combined with the self-regulatory framework of intervention delivery that is unique to Triple P, form the basis of determining protective factors for individual participants. The self-regulatory framework is designed to promote parental self-sufficiency, self-efficacy, self-management, personal agency, and problem solving. That is, SSTP providers work with caregivers through a process of shared understanding, mutual respect, and promotion of parent self-regulation. Together, but primarily through the parents' decisions, they determine the best strategies and protective factors on which to focus for their individual needs. Within the SSTP model, caregivers were able to independently select and implement a range of positive strategies to meet goals that they set for themselves and their children. In addition to setting goals that they select, parents also develop beliefs that they can be effective, have strategies to implement their chosen goals, and assess their own progress toward their goals.

Project Strategies Implemented/Services Provided

One-half of the families were randomly assigned to receive the SSTP intervention. Key principles of SSTP are: 1) ensuring a safe, interesting environment, 2) creating a positive learning environment, 3) using assertive discipline, 4) adapting to having a child with a disability, 5) having realistic expectations, 6) being part of the community, and 7) taking care of yourself as a parent (Sanders et al., 2003a). These services were delivered in the families' homes

by the trained and accredited SSTP providers. SSTP services were designed to be delivered weekly; the SSTP provider adhered to a weekly schedule to the extent that the family's schedule allowed.

In addition, special instruction providers received training in the PCAN curriculum with the intent that they would be empowered to address the protective factors in their work with families on their caseloads. In that way, protective factors were infused into the IDEA Part C services for families in South Carolina.

How Project Strategies/Services Provided Support the Building of Protective Factors

As stated previously, PCAN (Seibel et al., 2006) was developed specifically to increase awareness of child maltreatment risk factors among early care and education providers, and therefore is aligned with the (five plus one) key protective factors. PCAN (Seibel et al., 2006) was developed by Zero to Three to support the child care community in helping reduce the risk of child abuse and neglect of infants and toddlers. The PCAN training was designed to empower child care providers to put the protective factors to work in their programs. The PCAN curriculum was modified for this project for IDEA Part C service coordination, and it is intended to empower special instruction providers to put the protective factors to work in their programs.

As stated previously, SSTP is especially well-suited to increase protective factors of: 1) knowledge of parenting and child development, 2) nurturance and attachment, 3) social and emotional competence in children, and 4) parental resilience. It supports the building of these protective factors by promoting knowledge of parenting and increased understanding of child behavior and development. This is accomplished by discussing causes of child behavior problems and introducing a range of parenting strategies. SSTP interventions are also specifically geared to improve and strengthen the parent-child relationship and nurturance and

attachment. Improvements in parent competence (i.e. parenting skills) can impact the development of social, emotional, and behavioral competence in children.

In terms of parental resilience, knowledge of parenting interventions within SSTP can be thought of as the content of the intervention. We posited that this content, when combined with the self-regulatory framework of intervention delivery that is unique to *Triple P*, would result in improvements in parental resilience. Thus, through the manner in which SSTP is delivered, parents feel empowered to select their own parenting goals, develop beliefs that they can be effective, have strategies to implement their chosen goals, and are able to assess their own progress toward their goals. These skills promote parent resilience in managing their children, which can generalize beyond parenting situations to improve their own personal functioning (decreasing feelings of stress, anxiety, and depression) and their relationships with others in their immediate environment.

The other two factors were also addressed in the SSTP intervention but perhaps more indirectly. For example, when parents feel more competence and confidence in parenting, social connections – or, more specifically, relationships with others in their immediate environment – can improve. Concrete support in times of need was addressed through the presence of an SSTP provider as well as a consistent BabyNet special instruction provider. For the families in Study Two, in which the special instruction provider had been trained in PCAN, we hypothesized that this support is enhanced to an even greater extent.

How Project Strategies/Services Provided Relate to the Various Domains of the Social Ecology

At the community level. For caregivers of young children with developmental disabilities, enhancement of caregiver and child functioning (individual level) may be

insufficient to impact risk and protective factors for child maltreatment. Young children with developmental delays or disabilities often have multiple needs, and require multiple services and supports. Thus, it becomes critical for these caregivers to form and sustain community connections with organizations as well as formal support programs and service providers. Therefore, one of the two core areas of focus was on the community level of the social ecology. Through provision of PCAN training to IDEA Part C early interventionists, we aimed to enhance the ability of this critical workforce to form meaningful relationships with families and to assist families in building strengths and in utilizing recommended services and supports.

At the individual level. SSTP was designed to focus on some of the protective factors; it was provided to those families randomly assigned to the treatment group. SSTP is especially well suited to increase the protective factors of: 1) knowledge of parenting and child development, 2) nurturance and attachment, 3) social and emotional competence in children, and 4) parental resilience. This content, when combined with the self-regulatory framework of intervention delivery that is unique to Triple P, form the basis of determining protective factors for individual participants. The self-regulatory framework is designed to promote parental self-sufficiency, self-efficacy, self-management, personal agency, and problem solving. That is, SSTP providers work with caregivers through a process of shared understanding, mutual respect, and promotion of parent self-regulation. Together, but primarily through the caregivers' decisions, they determine the best strategies and protective factors on which to focus for their individual/family needs. Within the SSTP model, caregivers were able to independently select and implement a range of positive strategies to meet goals that they set for themselves and their children. In addition to setting goals that they select, caregivers also develop beliefs that they

can be effective, have strategies to implement their chosen goals, and assess their own progress toward their goals.

Incentives

At the community level. Special instruction providers received quality, free-of-charge training on the PCAN curriculum for professional development hours. Lunches were also included free of charge. Special instruction providers received educational toys when they provided requested documentation—completed WAIs and children's IFSPs.

At the individual level. Study participants received Wal-Mart gift cards to compensate for their time. For the pre-intervention assessments, participants received a $50 card; at the time of post-intervention, they received a $75 card; and they received a $100 gift card after completing the follow-up assessments. The research assistant and project coordinator also brought gifts of books, puzzles, and other educational toys for the children in the study and siblings when they made the home visits.

Retention Plan

At the community level. Special instruction providers were encouraged to continue to be engaged in the project via frequent contacts from the project coordinator. After a family was enrolled in the project, an e-mail message was sent to the special instruction provider with information about the project and information on which group (treatment or comparison) the family was randomly assigned to, a request for documents and completed questionnaires, and to ask them to select a "thank you" gift—one of several educational toys. See Appendices 8 and 9.

At the individual level. In addition to the incentives and gifts offered at the three assessment points, parents received informational newsletters from the project during their seventh month of enrollment in the project. This newsletter thanked them for their continued

participation and requested that they contact us should their contact information change; see Appendix 10. Birthday cards were mailed to all children in the project. Also, copies of the DVD of the parent-child interaction of the KIPS assessments were mailed to the caregiver(s) following each evaluation session.

Termination Plan

When initial information was provided to eligible families before their enrollment in the project, they were informed that their involvement would be for one year. They also were informed that their participation in SSTP, if they were randomly assigned to that group, would be time-sensitive and ten sessions (usually about ten to fifteen home visits) as specified in the SSTP manual. Initial information provided to all special instruction providers informed them that eligible families would be enrolled in the project for one year; we reminded them of this each time one of the families on their caseload enrolled in the project.

13. Challenges in Implementing Project and How Addressed

Changes in Eligibility

As stated previously, the target population shifted to some extent during the course of this project. As subject recruitment was beginning, BabyNet eligibility criteria changed, becoming more stringent. This means that the number of eligible families estimated when the proposal was developed was greater than the actual number at the onset of subject recruitment.

Family Recruitment

One of our primary challenges was recruiting a sufficient number of eligible families for the project. While we originally planned to enroll one hundred families, in spite of our best efforts, we were only able to enroll ninety. We had an additional challenge in that eligibility requirements for BabyNet services became more rigorous just prior to initiation of our

recruitment efforts. Therefore, our pool of eligible families to be recruited dropped significantly from the number we had projected.

A majority of our referrals came from the families' special instruction providers. We kept in close contact with special instruction providers, their supervisors, directors of special instruction provider agencies, and other key stakeholders, frequently reminding them of the project and troubleshooting possible reasons for not making referrals. It seemed that, if a special instruction provider made one successful referral, she was more likely to make more referrals. The challenge, then, was to encourage the special instruction providers who had made no referrals to approach at least one of her families that might be eligible for the project. As noted previously, we were not above such shameless tactics as sending mylar balloons and cookies to referring agencies or attempting to pit agencies against each other in friendly (or not-so friendly) referring competitions.

Contacting Families and Scheduling Appointments

Another challenge was contacting families to schedule appointments. Sometimes the phone service of our families was discontinued or changed. We also noticed with several of our families that keeping appointments (even in their own homes) was difficult for them—perhaps due to several other demands and pressures or lack of familiarity or practice with keeping schedules. This was problematic for our SSTP providers as well. On occasion an SSTP provider would have a "no-show" at the caregiver's home, even after confirming the appointment in advance.

Most problems here were readily resolved by contacting the special instruction provider. Since they are in touch with the families on a regular basis, and because we had signed consent for release of information, we were able to obtain new contact information from them. If the

family did not have phone service, the special instruction provider would leave messages during their home visits for the caregiver(s) to contact us.

Because most families had busy schedules, it is important that home visitors (SSTP providers and interviewers) have flexible schedules. Several of our visits were made during evening hours and/or during weekends or holidays.

Especially for visits that were several miles from our office, we contacted the caregivers a day before the appointment to remind them of the upcoming visit. We encouraged the same of our SSTP providers. If the caregiver did not answer the phone, we left a message, stating, "I need to hear from you, because it is quite a distance from our office." If the caregiver did not call us before we were to leave our office, we did not make the trip. This rarely happened, as most caregivers contacted us as we requested and were expecting us at our scheduled appointment time.

Regarding SSTP providers who must deal with a "no show" appointment, we recommend that a policy be put in place beforehand that outlines how/if there would be payment for home visits that did not occur, especially when the SSTP provider made the trip to the caregiver's home.

Challenges of Home Visits

In general, we had very few challenges actually conducting the home visits. Undoubtedly this was due, at least in part, to the fact that the families were accustomed to home visits by special instruction providers, therapists, etc. There were some challenges though.

Confidentiality. Imagine our surprise when, conducting an in-home post-intervention assessment with #111, that #222 entered #111's living room! These two mothers were referred to us by different special instruction providers from different agencies. Our challenge, of course,

was to maintain confidentiality; even though these two mothers could disclose information to each other about how they knew us, we were careful to not offer any new information ourselves. We were careful to not acknowledge our acquaintance with #222 until she disclosed our connection. The remainder of the conversation was such that we were careful to only nod and make general statements about the project, providing no information about our relationship with one mother to the other.

Mandated reporter issues. Via the consent form, caregivers were aware that our home visitors were mandated reporters and so were obligated to report suspected child maltreatment. On one occasion, we were obligated to report a family to the State Department of Social Service (DSS) because of suspected abuse of a child. This was for a child not in our project (a relative of our family) by a family member not in our project. We knew, of course, that this report could jeopardize the family's relationship with us and the project. In fact, shortly thereafter, our family did drop out of the study with no explanation. We kept in mind though that a child's safety outweighed our quest for data for this project and so we were reassured that we made the right decision.

There were other instances that caused concern, even though we did not see them as suspected abuse/neglect. On one occasion, we reported concerns to the family's special instruction provider because we observed behaviors that, although not abusive per se, seemed harsh.

Conducting assessments. Our priority was administering the assessments in the most valid manner while still maintaining a relationship with the parent and child so we would be welcomed back for future assessments. Generally this was fairly simple and required a spirit of

friendliness and interest in the child (of course yours is the sweetest baby we have ever encountered!) balanced with professionalism and no-nonsense efficiency.

There were several assessments that spurred parents to talk (perhaps vent?). Here, we tried to be supportive while attempting to re-direct the caregivers back to the task of completing the questionnaires. The questions that prompted the greatest amount of talking by the caregivers were those about the caregiver's relationship with his/her significant other. In addition, many caregivers felt compelled to explain their responses to questions about their highest levels of education, often explaining how and why they had not attained higher levels. Several seemed uncomfortable answering questions about their own abuse as a child (from the AAPI-2).

Some responses by parents about spanking seemingly were scored inaccurately. Parents told us that, although they are answering the question to state that they do not spank their child, they, if fact, do. It is apparent that they were mindful of possible reports to DSS at all times.

We recognized that there would inevitably be distractions, but we tried to stay focused on the assessments and keep the parent and child as focused as possible. By far, the most difficult assessment was the Keys to Interactive Parenting (KIPS, Comfort & Gordon, 2006). This is the assessment in which the caregiver and child are video-recorded while engaging in free play. Here, we found that taking more of a leadership role was most helpful. We asked if drapes could be opened, lights turned on, furniture moved, etc. We made a point, however, to NOT direct the caregiver in his/her interactions with the child, since that is what this measure assessed.

Differences in opinions in parenting styles. We prided ourselves in remaining neutral and unbiased as much as possible during the home visits. However, we cannot deny that at times this proved to be challenging and perhaps even unjustifiable. When a young child swallowed a coin, we chose to dig it out of his mouth immediately rather than direct the mother to do so,

knowing that time, even a few seconds, could have led to a tragic outcome. If a home was not the same as our typical surroundings (e.g., louder, less clean, less organized), we knew we could retreat to our car for a few minutes to retrieve another pen (for example) for a few minutes to regain composure.

General recommendations. We offer broad suggestions, which include: 1) wear professional yet machine washable clothing, 2) keep hand sanitizer in your car and apply immediately after each home visit, 3) whenever possible, make appointments only during daylight hours, 4) ask the special instruction provider in advance if there is reason to take specific precautions about personal safety, 5) notify another staff member of your whereabouts whenever conducting a home visit and contact him/her when the assessment is finished and you are in your car/home, 6) thank the caregiver(s) for agreeing to be a part of the project and for allowing you into their home—this includes the caregiver who is not enrolled in the project (if in a two-parent home). Above all else, we were mindful that we were guests in their home.

It goes without saying that, in most cases, it is helpful to suspend judgment and expect the unexpected. For example, we needed to re-schedule an appointment because, as we approached a home for a scheduled appointment, we learned that the police had already arrived to take the caregiver to jail for nonpayment of child support.

A sense of humor helps also. With the KIPS video-recording, every female caregiver wanted/needed time before the session to freshen her makeup and make certain that she was wearing clothing she considered attractive. More often than not, this meant that her top was at least somewhat revealing. We had only one Janet Jackson-type wardrobe malfunction but several other close calls.

Pets and their tricks also called for patience and a cool head. We were faced with squawking birds, barking dogs, and fur-shedding/crawling all over us cats. Our research assistant, Lori Shakespeare, did a yeoman's job in encountering all of the above while still maintaining rapport, gaining trust, producing valid videotaped play sessions, and keeping parents involved and motivated.

14. Project Products Developed

As stated previously, as a result of the Family Networks Project, the PCAN curriculum (Seibel et al., 2006) was modified to meet the unique needs of early interventionists that serve the IDEA Part C population. Although this project included only one type of BabyNet credentialed professional--special instruction providers, the curriculum is also appropriate for other early interventionists, including speech, occupational, and physical therapists who also provide IDEA Part C services. See section #10, "Required Staff Training, Coaching, and Supervision," for more information. In South Carolina, we currently are meeting with leadership team members to determine how best to integrate this modified curriculum into our state's Comprehensive System of Personnel Development (CSDP) for BabyNet personnel.

A Family Networks Project flyer (Appendix 3) was developed and distributed primarily to potential referral sources. Also, information was posted on relevant websites such as BabyNet and SC First Steps. They were removed after family enrollment ended. Project information also was presented on a poster at the 2011 Children's Trust Prevention Conference on September 19 and 20, 2011, in Columbia, SC. The purpose of these dissemination products was to recruit families for the project. A factsheet for Family Networks Project participating caregivers is being developed.

15. Evaluation of Implementation

In general, the process of implementation progressed smoothly. We were able to adhere to the proposed project very closely. Please see Section # 13, "Challenges in Implementing the Project" and Section #16 "Lessons Learned" for more some information. Also, please see Section #10, "Required Staff Training, Coaching, and Supervision", for a discussion on fidelity of implementation measures.

16. Lessons Learned

Family Recruitment

We did not reach our target goal of 100 families recruited for the project, falling short by 10 families. We relied a great deal on special instruction providers to recruit eligible families for the project, but 23% of our families were not recruited by their special instruction provider. As we reflect back on the sample, we realize that we should have executed additional strategies to recruit families.

Lessons learned. We recommend that a recruitment approach that is even more aggressive and multi-pronged than ours be put into place. Since we know that special instruction providers were not inviting all eligible families to enroll, we wonder if there might be other ways to approach eligible families that do not involve the special instruction providers. With prior IRB approval, perhaps someone working within the provider agencies and with access to the confidential caseload information would be willing to work for the project on a part-time and temporary basis to identify and then contact and invite potentially eligible families.

Attrition from Intervention

The primary reason families gave for dropping out of the project, dropping out of the intervention, and failing to be enrolled after screening was busy schedules. Thirteen of our ninety families dropped out of the intervention but not the project itself (i.e., they did not receive all ten sessions of the intervention but agreed to complete the assessments at the times of post-intervention and follow-up). An additional five families dropped out of the study completely. That is, eighteen (20%) of our families did not complete all of the treatment sessions and/or assessments of the project.

The attrition rate in this project was within expected limits (see e.g., Hudson et al., 2003; Roberts, Mazzucchelli, Studman, & Sanders, 2006). The reality of our target population is that they are busy families. While schedules of all families with young children could be considered demanding with family and work obligations, our families had additional scheduling demands with appointments for their child with therapists and often medical professionals.

Lesson learned. It might be that implementing an intervention that was shorter in duration would have resulted in fewer intervention dropouts. We also recommend hiring very competent, professional, and pleasant individuals to assure that families find the project enjoyable, to keep dropouts to a minimum. It is important to note that the Family Network Project did hire such capable individuals, undoubtedly preventing more dropouts.

Challenges of Home Visits

See Section # 13 for a discussion of challenges our research assistant and project coordinator faced when conducting the assessments as home visits. We see these as within the parameters of "typical" home visits and therefore suggest that others planning to implement a similar project expect to face similar situations.

Lesson learned. We recommend that careful attention be paid to hiring data collectors who will be conducting home visits: A specific skillset is required that is unique to other project responsibilities. It calls for a level of maturity, level-headedness, quick wit, enthusiasm, compassion and empathy.

Hiring Outside Contractors

Projecting for and hiring contractors were difficult because families were assigned to the intervention by random assignment. This meant that we had no control over, and could not project in advance, the geographic location or schedules of our families that would receive the intervention. This was challenging in deciding from which geographical locations to recruit SSTP providers, our contract vendors. Also, since the SSTP providers had their own schedules, it often was difficult to match the schedules of families with the schedules of SSTP providers. In fact, as stated previously, the project paid for training and accreditation of 22 SSTP providers, but only thirteen actually provided the intervention to families. We were not able to retain the services of the other nine providers because they were too far geographically from families, because they moved, or because they (the SSTP providers) were too busy with other obligations. An additional challenge with SSTP providers was with the quality and fidelity with which they provided the intervention: they varied substantially among the SSTP providers.

Lesson learned. We recommend that, rather than hire outside contractors to provide the intervention, a full time SSTP provider be hired. Important requirements would be that this employee would have demonstrated excellent provision of the SSTP intervention, have a schedule flexible enough to manage the schedules of families, and be willing to travel to any location to meet with the families.

Working within the Confines of State Bureaucracy

The Family Networks Project was implemented during the time period in which the lead agency, a quasi-governmental state agency, went through its own transitions, first transitioning away from the state department of education and then back with this department. This meant that tasks such as paying vendors and making reimbursements for travel were difficult and frustrating.

Even without the lead agency's transitions, as a state agency, it lacked flexibility in handling tasks that were outside its typical purview. An example was handling the requirement that we give advance notice of the amount we will pay each vendor (e.g., SSTP provider) for services rendered. Accurately making these projections was not feasible. Different families progressed through the sessions at different rates of time, some requiring more home visits, and some requiring fewer. Also, unfortunately some families dropped out of the intervention, discontinuing the home visits with the SSTP provider. In addition, since we had no control over the random assignment of families, we found ourselves hiring some of the same providers over and over again—so that some were providing the intervention to several families at the same time—if their locations and schedules were the best match for the particular families. We did our best to project the amount of funds needed, but several factors simply were out of our control.

Lesson learned. We strongly recommend that the practices and procedures of the lead agency be scrutinized thoroughly ahead of time to assure that it is able and flexible enough to easily manage the necessary tasks.

Implementing the Intervention within a Four-Month Time Frame

We originally anticipated that the ten-session intervention could be handled within fifteen or fewer home visits and within a time frame of four months. While the intervention rarely included more than fifteen visits, it was not uncommon for it to require five or even more months to complete. This generally was due to the caregivers' schedules and unanticipated occurrences such as illness, so that weekly appointments at the same time and day of the week frequently were not feasible.

Lesson learned. Again, it might be more practical to implement a shorter version of the SSTP intervention or to at least be prepared for the intervention to perhaps take several months to complete.

Obtaining Accurate Data on Participant Maltreatment Data

We had a Memoranda of Agreement for Administrative Data from the South Carolina Department of Social Services in place well before implementation of the Family Networks Project. Data required was twofold: 1) verification that prospective study participants had no substantiated Child Protective Service (CPS) reports, and 2) the date, nature, and disposition of any reports of child abuse and/or neglect during the child's/family's enrollment in the Family Networks Project. We had an excellent relationship with staff that checked the data base for requested information, and requested information was obtained promptly.

Unfortunately, the accuracy of the requested information is questionable. One example is that two initial CPS screens indicated no reports of substantiated maltreatment. However, when the child and family exited the project after one year participation, we were provided with reports of substantiated child abuse/neglect that occurred prior to the child's enrollment in the Family Networks Project. Clearly this would have excluded them from the project if we had that

information at the time of screening. It is clear that CPS reports are not submitted and/or recorded in a timely fashion. We appreciate that, especially in a state with limited resources, priorities must be made and that assistance for families in need takes precedence over accuracy of data. We are left, however, with limited confidence in the accuracy of our data.

Lesson learned. We are aware of other methods to collect information on child abuse/neglect, but all are wrought with potential problems.

17. Dissemination/Communication about the Project with the Broader Community

See Appendix 11 for information on formal and informal presentations made by the evaluator/PI and the project coordinator. In addition, a write-up on the Family Networks Project is now up on the Success Story page on the KIPS (Keys to Interactive Parenting) website - http://comfortconsults.com/assessing-parenting-success-stories/.

Plans for Dissemination

The PI has been asked to be the plenary speaker at a conference sponsored by South Carolina Leadership in Neurodevelopmental Disabilities (SC LEND), a federally-funded training grant to promote leadership in neurodevelopmental disabilities. The focus of this address will be Stepping Stones Triple P (SSTP) and the Family Networks Project, as well as population-level SSTP interventions occurring now in Australia. Discussion is underway regarding research projects for future SC LEND trainees based on SSTP and the state early intervention system. This conference will occur in Greenville, SC on February 28, 2014.

In addition, the PI has submitted proposals for two presentations at the 16th Annual Helping Families Change Conference, which will be held in Sydney, Australia in February 2014. Presentations will be "Integration of evidence-based parenting programs in several delivery

systems" and "Four Stepping Stones Triple P research projects in different populations/contexts."

Documents to be Considered for Publication

One manuscript, "Use of Participatory Action Research in Modifying a Curriculum for Early Interventionists to Prevent Child Abuse and Neglect", was submitted to the journal Topics on Early Childhood Special Education but was not accepted for publication. This manuscript was shortened in length and submitted as a brief report to the journal Child Maltreatment; it was not accepted by the editor as it described a modification of a curriculum used in practice and was not sufficiently research-focused for that particular outlet. The original (longer) manuscript was revised and has been submitted (October 2013) to the journal Child Abuse and Neglect: The International Journal for review.

Four manuscripts are currently under development; two for each of the studies in this project and two utilize data collected to consider theoretical models. Tentative titles are:

1. "Prevention of behavior problems in a selected population: Stepping Stones Triple P for parents of young children with disabilities" (primary outcome manuscript for Study One).

2. "A comparison of collaborative interventions for strengthening families and reducing maltreatment risk in young children with disabilities" (primary outcome manuscript for Study Two).

3. "Examination of a theoretical model of implementation dimensions and their effects on outcomes in a manualized prevention program for parents of young children with disabilities"

4. "Examination of a theoretical model on the role of social support in parenting a young child with disabilities"

18. Sustaining the Project

The final several months of the Family Networks Leadership Team meetings focused on sustainability of the interventions in the IDEA Part C community in South Carolina. For SSTP, a work group will address this at the project's completion.

For PCAN, a working group was formed on May 28, 2013. The purpose of this group was to consider sustainability of the PCAN efforts in South Carolina for IDEA Part C. Because PCAN training is consistent with the early intervention philosophy and modified training was favorably received, we are finalizing plans for a pilot project in a two-county region of the Midlands (where PCAN training did not occur) to target a workforce of 55 early intervention providers. Format of training (online/face to face or combination) as well as outcome measures are being discussed. In addition, and at a policy level, IDEA Part C policy and procedures now has a protective factors framework so PCAN as a set of strategies can be incorporated.

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