CONSULTEE-CENTERED CONSULTATION WITHIN COMMUNITY-BASED RESIDENCES FOR INDIVIDUALS WITH DISABILITIES

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Abstract

Managing the behavioral needs of individuals with developmental disabilities has been a long-standing concern for group home managers and direct care staff. Consultee-centered consultation has a history of documented benefits for children in schools and was theorized to be beneficial to adults with developmental disabilities residing in group homes. Adults with disabilities continue to experience behavioral difficulties while staff lack the training to maintain quality support services. Caplan's consultee-centered consultation (1993) bridges the gap between client centered behavioral consultation and consultee effectiveness in addressing client behavioral concerns. The purpose of this study was to investigate the effects of consultee-centered consultation on client behavior and the group home environment. Three community-based group homes were chosen to participate in this study using matched assignment. Participants included ten clients with challenging behaviors, two consultees (managers of group-homes), three data collectors and direct-care staff working with clients. This study showed encouraging support of a decrease in the frequency of challenging behaviors exhibited by clients residing in two group homes that received consultee-centered consultation for twelve and six weeks. The level of job satisfaction for employees participating in this study did not demonstrate change over the course of the 15-week study. Despite a lack of support for a change in employee satisfaction, both consultees receiving consultee-centered consultation reported that consultation helped them to address staff concerns and improvements in their level of confidence and skills.

Chapter 1: Introduction

Since the deinstitutionalization movement of the 1970's, developmentally and intellectually disabled adults have moved from residing in institutional settings to residing in home- like environments, or group homes (Talbott, 1979). These units are comprised of small groups of individuals with disabilities, who live together and function similarly to family units; the difference being that the residents are not related to one another. Direct-care staff members are responsible for the overall care of residents residing in the group home. This care includes, but is not limited to, providing meals, supervising self-care skills, arranging transportation, and promoting socialization. In addition, staff is also responsible for addressing resident behavior by coaching, teaching, and remedying challenging behavioral patterns. In doing so, direct-care staff become part of the group home system.

Individuals with developmental and intellectual disabilities frequently exhibit challenging behaviors (e.g., Emerson.et al., 2000; Sigafoos, J., Arthur, M., & O'Reilly, M., 2003). Intellectual and developmental disabilities are marked by significant deficits in cognitive and adaptive functioning, such as limited problem solving and communication skills. For example, Chen, Lawlor, Duggan, Hardy, and Eaton's longitudinal study (2006) of individuals, identified with intellectual disabilities age four through adulthood, suggests a link between mild cognitive impairment in childhood and an increased risk for mental health and behavioral problems in adulthood. In addition, the behavioral problems that are manifested may be the result of temporary changes in the environment, conflicts between individual residents or direct-care workers, or moving through experiences in life. Changes in the environment of individuals with intellectual disability or developmental disability may lead to overwhelming emotions, such as confusion and worries, resulting in maladaptive behaviors. These behaviors are a form of

communication, serving a function, which must be understood prior to developing interventions (e.g., Duff et al., 2006; Emerson, 1995).

Individuals with intellectual disabilities and developmental disabilities residing in assisted living facilities require effective and diversified behavioral management approaches. A study by Matson and Boisjoli (2007) that compared single function versus multiple maintaining factors in adults with intellectual disabilities illustrates these challenges. The results of their study depicted a shift in the maintaining characteristics of challenging behavior. Specifically, the data was consistent with previous research that indicated the presence of multiple function behaviors for adults with intellectual disabilities. The implications of this research suggest that over time adults with intellectual disability and developmental disabilities develop challenging behaviors that have more than one function. For example, tantrumming might have originally been viewed as a result of being in pain, but over time has developed into an expression of not receiving enough attention from direct-care staff. Consequently, now the tantrumming behavior has two functions: expressions of pain and lack of attention, making it more difficult for direct-care staff to differentiate between pain tantrumming or attention tantrums. Dyer, Kneringer, and Luce (1996) suggest without proper staff supervision and/or training, regulating such challenging behavior can be difficult (1996).

Direct care of residents tends to be entry-level work requiring minimal education and experience. As a result, this type of work attracts workers with little knowledge or prior experience working with individuals with intellectual and developmental disabilities. As such, when coupled with the stressors of providing services, direct-care workers may experience great difficulty managing the behavioral concerns of clients with developmental disabilities and intellectual disability (Albee & Fryer, 2003).

Traditionally, consultation has served as a supportive technique to facilitate interventions for managing challenging behavior. Consultation is an indirect approach that addresses the needs of the client through the establishment of a collaborative relationship with those working directly with the client; the direct-care workers. There are several types of consultation approaches with empirical support for addressing behavioral concerns (Brown, Pryzwansky, & Schulte, 2006). Although the terms and definitions have changed throughout the years, currently these approaches include: (a) behavioral consultation, which uses a collaborative relationship between the consultant and consultee to address client behavioral concerns; (b) consultee-centered consultation, which uses a collaborative relationship to address third party client concerns by addressing consultee strengths and deficits; and (c) conjoint behavioral consultation, which promotes collaborative and responsive efforts between families and schools (Garbacz et al., 2008).

Behavioral consultation, as utilized in group home environments, adheres more to meeting client behavioral concerns, and less to meeting direct-care worker concerns. Consultee-centered consultation, also called mental health consultation, (Caplan, 1970), currently is the only approach of the three that addresses consultee behavior directly and client behavior indirectly.

In 1993, Hughes and DeForest used nondirective training and case-centered consultation, also known as consultee-centered case consultation, to address behavioral concerns of children in schools. Specifically, the researchers guided consultees, in this case teachers, through the decision making process by supporting the consultee, which then fostered the ability of teachers to make more informed decisions regarding behavioral management strategies. The results of

Hughes and DeForest's study found non-directive, case-centered consultation to be effective in reducing problem behaviors of children in school settings.

This process of guiding the teacher through the decision-making process enables the consultant not only to assist the teacher in trouble-shooting the identified problems or cases, but also to address additional consultee concerns as they arise. Four areas for consultee growth targeted by the consultant and indicated by Caplan (1970), include difficulty with teacher objectivity, confidence, performance, and knowledge. This style of consultee-centered consultation lends a natural flow and flexibility to the consultation process. The collaborative nature of the consultant-consultee relationship fosters skill development for the consultee in a non-directive manner. Increased confidence, critical thinking and self-monitoring skills of the consultee are often a result.

In 1998, Baker took this nondirective consultation approach, originally called mental health consultation by Caplan (1970), and applied it to the group home environment. His study assessed the effectiveness of behavior support training with agency personnel at residential placements as a viable means to decrease problem behavior. Baker's consultation differed from behavioral consultation by addressing the knowledge deficit of agency personnel through introducing behavior support training to indirectly decrease client problem behavior. The results suggested this approach does address behavioral concerns for persons with disabilities residing in group-home environments.

This study utilized consultee-centered consultation, typically used in the school environment, in the group home environment. It was hypothesized that consultee-centered consultation would help direct-care workers to improve the functioning of residents within group home settings. Specifically, the addition of consultee-centered consultation to behavioral

consultation was researched in this study as a means to further decrease challenging resident behavior and promote direct-care worker skill development. This study utilized a case centered approach by closely examining the maladaptive behaviors of each client, similar to Baker's research (1998). Corresponding increases in job satisfaction of the direct-care workers were also predicted. In addition, this study also focused on changes in the consultees, specifically in the four secondary goal areas emphasized in Caplan's consultee- centered consultation model (Caplan & Caplan, 1993).

Chapter 2: Review of Literature

This review will begin with a brief history of the deinstitutionalization movement, followed by an exploration of types of living environments for individuals with developmental and intellectual disabilities. Later, the review will explore challenging behaviors and their prevalence, and conclude with intervention styles typically utilized with individuals with developmental and intellectual disabilities.

Accordino, Porter and Morse (2001) explore the history of the deinstitutionalization movement. The 1950's marked the beginning of the end for institutions servicing the needs of the mentally ill and mentally retarded. Prior to the 50's individuals with mental illness and mental retardation were housed in institutions for the mentally ill. These institutions served as a means for removing individuals displaying an atypical psychological or behavioral pattern of development from mainstream society. Thus, individuals with mental illness, mental retardation and dual diagnosis and marginalized groups such as those with developmental disabilities were grouped together in institutions and removed from the mainstream society.

The Mental Health Study Act of 1955 authorized a study of the mental health treatment system within the United States. The resulting study found inadequate living conditions. Specifically, facilities were housing too many clients leading to overcrowding, with too few staff, in unsanitary conditions, and utilizing inhumane and ineffective intervention techniques. In the 1960's, the civil rights movement further reinforced the need for change in the mental health system with the Community Mental Health Centers Act of 1963 (CMHC) that embraced a "least restrictive environment" approach. CMHC marked the shift from very restrictive institutional settings to smaller community-based treatment centers that proposed to better address the living and care conditions for residents.

An increased public awareness for the well-being of Americans with disabilities was provoked by the airing of a TV documentary by Geraldo Rivera on the living conditions of Willow brook State Hospital for children in the late 70's. Public reaction contributed to the closing of large institutional placements for individuals with disabilities. Even with the dwindling numbers of individuals still residing in institutional settings, the issue of appropriate care was still a concern. The Omnibus Budget Reconciliation Act of 1981 replaced the Mental Health Systems Act, and shifted the financial burden of funding for community-based treatment centers, formerly the responsibility of the federal government, to the states. The 1990's brought the Americans with Disabilities Act, which prohibited the discrimination of all individuals with disabilities and increased the concern for more comprehensive, appropriate care and treatment for individuals with disabilities (Accordino et al., 2001).

Types of Living Environments

The closure of institutions created a number of different living environments. For example, those currently supported by the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) (2008) include four program models: family care, temporary or respite care, Intensive Care Facilities (ICF), and supervised and supported Independent Residential Alternatives (IRA). Family care programs offer a home environment with support, guidance, and companionship within a family unit. Family care providers receive a stipend for taking on the responsibilities of caring for an individual with disabilities in their homes (New York State OMRDD, 2008). Respite care is short-term care within a residential setting, such as a nursing home or an alternate setting, to provide relief for families from the burden of caregiving. ICF's provide health related care and/or services to individuals who do not require the degree of care and treatment that is typically provided by a hospital or nursing home.

Lastly, supervised and supported IRA's consist of 1 to 14 person residences that provide individualized protective oversight supervised by direct-care staff. This type of living environment was the focus of this study.

Challenging Client Behavior

Emerson's research team (2001) studied the prevalence of several challenging behaviors in individuals with mental retardation: aggressive, self-injurious, disruptive, and other challenging behaviors. Although the prevalence rates are variable, challenging behavior was exhibited by 10-15% percent of individuals with mental retardation. This variation in rate of challenging behavior can be attributed to differences in diagnoses such as type of disability, age, sex, living environment, and level of care.

Stancliffe (1995) proposed in an article on prediction of choice and self-determination that challenging behavior is often a result of an individual's inability to communicate choice or exercise control over his/her life. Xeniditis, Russell, & Murphy, (2001) note challenging behavior serves a purpose and can be viewed as biological, social, environmental, psychological, or a communicative in nature. Consequently, understanding the purpose or function of a behavior helps to inform the intervention.

Intervention Strategies

There are a number of intervention strategies typically used by behavioral consultants working with adults with developmental and intellectual disabilities. These are the foundational components of the behavioral consultants' work with clients. Singh, Osborne, and Huguenin (1996), discuss an applied behavioral intervention approach to promote pro-social behavior, thus assisting in the reduction of problematic behavior while promoting positive lifestyle changes. The key steps of this process include: (a) the selection of a measurement technique; (b) a

functional analysis of the target behaviors; (c) the selection of a treatment procedure; and (d) the design of an applied behavioral intervention.

Measurement techniques such as the *Behavioral Observation of Students in School* (BOSS), (Shapiro, 2003) and *Antecedent Behavior Consequence* (ABC) charts (Alberto & Troutman, 1999) are data collection tools utilized across settings and commonly accepted as a viable means for recording behavioral data in the field of psychology. The BOSS is an interval sampling measure while the ABC chart, commonly utilized across school and agency settings, helps to analyze challenging behavior. The BOSS system of data collection allows the observer to calculate the frequency of behavior across categories, but does not indicate specific behaviors. ABC charts, often used in both classrooms and community residences, track a sampling of specific behaviors. An ABC chart is a tool that records the detail of events, while gathering information about what happened before, during and after a behavior. The ABC chart is used to help identify factors maintaining maladaptive behaviors and isolate strategies for shaping new behaviors. Using these measurement techniques, the behavioral analyst evaluates and records behavior to better understand the setting details of an event and to determine baseline levels of behavior.

A *functional analysis* of target behaviors is a process that defines the purpose of a given behavior by determining the relationship between a behavior and its antecedents and consequences. It is based on data from behavioral observations and analysis of how antecedents and consequences are linked to behaviors of concern. The *selection of a treatment procedure* begins with the analysis of an individual's current performance (baseline) in relation to the desired performance (behavioral goals) to reveal the performance discrepancy and utilizes the in-depth evaluation of the function of the behavior (functional analysis). A review of student or

resident history and selection of the least restrictive environment help determine appropriate interventions. Lastly, an evaluation of the risks and benefits of the intervention, completion of a safeguards checklist and obtaining all necessary authorizations help insure that client rights and safety are protected (Singh et al., 1996).

These techniques are commonly utilized in applied behavioral intervention programs to either increase positive behaviors or decrease negative behaviors. Those that promote positive behavior include positive reinforcement, shaping, and stimulus control procedures, while those that involve decreasing negative behaviors include differential reinforcement procedures, extinction, response-contingent aversive stimulation, overcorrection, response cost, and time-out. Singh, et al., (1996) note the aforementioned techniques are well-documented, effective means for promoting behavioral change in individuals with intellectual disability.

Often the presence of a behavior is closely linked to a skill deficit. Gardner, Graeber, and Cole (1996) outline some behavioral problem sources that include coping skill deficits, self-management deficits, and performance deficits. Coping skill deficit training is defined as the teaching of an alternate skill to replace undesired behavior. Self-management skill deficits lead to aggression and conduct issues. An example of this type of intervention might include teaching self-monitoring to children or adults who exhibit impulsive behavior. Lastly, performance deficits refer to the infrequent or inconsistent use of an adaptive behavior present within the individual's skill-set (Gardner et al., 1996).

Erbas, Tekin-Iftar, and Yucesoy (2006) explored the benefits of functional analysis in classrooms for students with developmental disabilities. Specifically they discussed how to train teachers to conduct their own functional analysis within their classroom setting. Functional analysis applies the laws of operant conditioning in order to establish the relationship between

stimulus and response. To determine the function of behavior three things must be analyzed: the antecedent or trigger (A), the behavior (B), and the consequence or what maintains the behavior (C). In this study, five special education teachers and student teachers were taught to identify the four primary functions of maladaptive behavior: gaining *attention*, *escaping* a demand, *sensory* input provided through play, and acquiring something *tangible*. The four maladaptive behaviors addressed by the school staff were throwing objects, being out of a seat, screaming, and not following verbal direction.

Interventions were developed for each of the four functions of the target behaviors. The attention condition allowed students access to toys and educational material; when maladaptive behavior was displayed, teachers would utilize touch control and proximity to discourage the behavior through increased attention. In the escape condition the teachers would present directions for an activity every 30 seconds to students using a three-step prompt (direction; direction and modeling; direction with physical prompting). When the student exhibited target behaviors, activity items were withdrawn and the teacher would sit turned away from the student. In the play condition, students were offered toys or activities and teachers were asked to attend to the students during play every 30 seconds except when students exhibited target behaviors, at which point students were ignored. Lastly, in the tangible condition, students were given specific tangible items such as a preferred toy or piece of an edible item when the target behaviors were exhibited (Erbas, et. al., 2006).

In the first phase of the study, the teachers were given reading material containing practical information about functional analysis, attended a lecture on functional analysis four days later, and viewed a video simulating correct implementation of each of the four test conditions (attention, demand, play, and tangible). At the end of the phase, they were given a

brief 20-question quiz; a score of 90 or above was needed for completion of the phase. The second phase involved two conditions. In the first condition, the teachers received consultation and viewed videotaped feedback sessions of themselves conducting a functional analysis. In the second condition, teachers were asked to develop hypotheses for classroom behaviors after receiving three consultation sessions on how to conduct a functional analysis. The correct identification of the function of behavior between the consultation sessions plus videotaped feedback group and the consultation sessions only group were compared and the results of the study suggested that when feedback was given through review of videotaped sessions, teachers performed better than those that did not receive feedback through review of videotaped sessions. Overall, there were positive changes in teacher opinions concerning the benefits of functional analysis instruction. The authors note professionals may want to consider delivery of behavioral instruction to others in the field utilizing one of a number of consultation models for professional training.

Types of Consultation

Kerwin (1995) explores the evolution of four models of consultation used in schools. These include behavioral consultation, organizational development, instructional consultation and mental health consultation (consultee-centered consultation). Behavioral consultation is a type of consultation that uses a collaborative relationship between the consultant and consultee (teacher) to address student behavioral concerns (e.g., Sheridan, Welch, & Orme, 1996; Gallessich, 1982; Reschly, 1976). This form of consultation has shifted from original research using a within-person focus to an environmental perspective that identifies both the home and school environments as contributing factors to behavior. Organizational development consultation entails improving performance of a group of students, or the student body, while

simultaneously improving the level of interpersonal functioning among school personnel within the school environment on a systemic level. Specifically, smaller support groups such as pre-referral teams or task forces can help schools address issues in a systematic way. Instructional consultation, once limited to task and instructional methods, now includes a collaborative effort whereby the consultant and teacher discuss the curriculum alongside addressing instructional issues. This becomes a cooperative effort to enhance the instructional quality, while ensuring a better match between student and instruction.

Mental health consultation serves to improve skill development for consultees through the generalization of skills, modification of attitudes, and the improvement of teacher understanding of a student's problem or academic performance that could lead to a reduction in the number of special education referrals or other intervention referrals. As the practice of consultation evolves, Kerwin (1995) suggests with the increased opportunity for consultation, (i.e., frequency of consultation sessions), consultees may generalize their consultation experience and be better able to address other areas of concern.

The aforementioned areas loosely couch the dynamic field of consultation. However, because of the depth and breadth of literature and information in the area of behavioral consultation this review will be limited to the following three types of consultation: behavioral consultation (expert model focused on client behavior), conjoint behavioral consultation (parent/school partnership model), and consultee-centered consultation (problem solving model focused on consultee behavior). As consultation practices have evolved, the lines that distinguish one form from another have fused, revealing more refined and effective intervention styles. For instance, mental health consultation, previously utilized in mental health organizations, best remembered for its collaborative aspects and non-directive appeal, has shifted

into consultee-centered consultation, which facilitates collaboration with a non-directive feel, while delivering a problem solving focus. Given the complexity and confusion surrounding the field of consultative practice, it is beneficial to review its foundation in a sequential manner, beginning with the subcategory of behavioral consultation.

Behavioral consultation. The area of behavioral consultation is comprised of an extensive and rich literature foundation. In consideration of the breadth of information within this sub-category, this section will discuss the research articles by Kratochwill et al. (1998), Martens and Witt (1988), and Wilkinson (2003) that provide good examples of the topic.

School-based behavioral consultation is an established method for providing services that benefit the needs of children with challenging behaviors. Wilkinson (2003) suggests that behavioral consultation in the classroom environment provides a viable means for reducing challenging behavior in students. In a case study by Wilkinson, behavioral consultation was implemented with a teacher struggling with a seven-year-old first grade student exhibiting disruptive behavior in the classroom. Disruptive behavior was defined as frequent off-task behavior, arguing, fighting, tantrums, and non-compliance. The stages of consultation that were followed involving the consultant and the teacher (consultee) included: (a) collaborative problem identification phase which identified the tentative goals and procedures for data collection; (b) a problem analysis interview phase that reviewed the baseline data; (c) a review of the functions of behavior; (d) goal identification phase whereby the focus is to set goals for treatment and develop intervention strategies; (e) the treatment plan implementation phase, whereby behavioral change and the intervention plan was monitored; and (f) the treatment evaluation interview phase that served to evaluate the effectiveness of the treatment plan and the established goals as well as address necessary modification and maintenance of the plan. Wilkinson's results indicated a

significant decrease in the student's disruptive behavior. In addition, the author also noted positive treatment effects were maintained after four weeks. These results suggest that school-based behavioral consultation is an effective indirect method that promotes a downward trend in frequency of challenging behavior for students with behavioral concerns. This research highlights the importance of changing a child's behavior on a case-by-case basis, through systematic design, implementation, intervention and evaluation of treatment; two important aspects adopted by consultee centered consultation.

Pertinent to the research proposed here was the work of Harchik, Sherman, Sheldon, and Strouse (1992), that explored the effects of ongoing behavioral consultation in the group home setting by utilizing an ABAB design over an 18-month period. Eight adults with severe or profound intellectual disability and one live-in staff member resided in the home. A total of four staff members, including the live in staff member and two consultants participated in the study. The primary consultant was a professional who implemented ongoing consultation for a period of one year while the secondary consultant was a middle manager, trained by the primary consultant, who implemented ongoing consultation for a period of six months. The consultation process involved a series of mini-workshops to review skill development, observation and data collection procedures, and feedback sessions. Results of this study suggested ongoing implementation of this level of consultation support was necessary to maintain a decrease in target behaviors in the group home.

Martens and Witt (1988) discuss the necessity to expand the role of the behavioral consultant to include a systems perspective. Behavior is maintained within the environment, so a systems perspective applied to behavioral consultation focuses on the child's behavior, as well as the ecology of the environment. Consequently, when applying behavioral interventions, the

intervention should "fit" within this environment. The traditional ABC framework may fail to consider the ecology of the classroom that includes teachers, other students, resources, current levels of support, and reinforcement opportunities.

Martens and Witt also discuss some of the benefits and risks of introducing behavioral interventions. These include regularity, anticipating cumulative side effects, and broadening the scope of behavioral assessment practices. Regularity refers to a system's ability to maintain its balance. Utilizing a behavioral consultative approach, rather than a systems approach, might give way to a more isolated or restricted assessment and evaluation of the relationship between the target behavior and its environment, consequently overlooking important aspects of the system, such as the role and impact a teacher's behavior may have on classroom behavior and system functioning. However, a systems perspective might target system imbalance as a goal, rather than a narrow focus on the maladaptive behavior. In addition, whenever something is introduced into an existing framework, there will be unanticipated side effects. For example, the law of effect suggests when reinforcing a given behavior, the schedule of reinforcement must adjust as the behavior is molded, requiring a higher level of reinforcement as the frequency of the desired behavior is displayed, eventually becoming difficult for the system to maintain. Lastly, these authors noted that it is important to account for secondary or temporal events that are connected to a target behavior when designing an intervention. For instance, if the target behavior to be reinforced is speaking, a secondary result may be volume control. Martens and Witt (1998) emphasize the importance of an environmental perspective when addressing behavioral concerns and anticipating the secondary effects that often result. The failure to consider secondary effects is just one of many assumptions associated with the consultation process.

Kratochwill et al. (1998) addressed five fundamental assumptions underlying behavioral consultation in schools in their review and critique. The five assumptions include: (a) consultation is a superior use of resources when compared to direct intervention; b) consultation is most effective when conducted collaboratively; c) talking to teachers is sufficient to cause them to change their behavior; d) teachers will generalize problem-solving skills developed in consultation to new problem situations with other students; and e) direct contact between the consultant and client is unnecessary. Specifically, the authors note that it is imprudent to assume consultation is superior to direct intervention because the application of intervention should be dictated by a thorough assessment of behavior and its environment, not an intervention's economic cost-effectiveness. Assumption two suggests consultation is the most effective method of intervention when implemented collaboratively, however the authors note that collaboratively must be defined to encompass the wide variety of consultative approaches ranging from case-centered to systems approaches. The third and fourth postulations suggest that talking with teachers is enough to change teacher behavior and assumes change will be generalized to new situations. These assumptions are not supported by a behavioral consultation method because it fails to include the consultee process and difficulties as delineated through consultee-centered consultation. Lastly, Kratochwill et al. (1998) support the value of consultant/client direct contact. Consultation is a process that requires verbal participation between all persons associated with the intervention and its outcome. For the consultant to remain detached from this process would dynamically change the outcome of the intervention.

Conjoint behavioral consultation (CBC). CBC is a collaborative model in which parents, teachers, and service providers come together with the aid of a consultant to work toward addressing the child or client's needs. The focus of this model is to address behavioral concerns

across settings, ensure continuity and consistency of service being delivered, improve communication and skills of individuals working directly with the client, and enhance functionality and integrity of implementation. The CBC model incorporates four stages: needs identification, needs analysis, plan development, and plan evaluation. CBC is an approach typically used to intervene with children who are exhibiting behavioral difficulties in one or more environments. This model specifically promotes congruency between the home and school environments (Sheridan, Eagle, and Doll, 2006; Wilkinson, 2003).

Sheridan and colleagues (2006) utilized CBC to examine its efficacy with diverse students. The premise of this study suggests that diversity is not the direct cause of problems within the child, school, or family, but rather the impasse or discontinuity that exists between child, school, or family system creates behavioral problems. Specifically, the diversity characteristics investigated included ethnicity, socioeconomic status, family composition, maternal education level, and language spoken in the home. Levels of challenging behavior, along with direct observations and permanent products, were used to measure change in the students, while consultee perceptions of goal attainment and subjective ratings of acceptability and satisfaction were examined for the evaluation of each CBC case. The client group was comprised of 125 students exhibiting 92 target behaviors; the consultees included 143 parents and 127 teachers. Increased satisfaction and acceptability of intervention were perceived among the consultees, and positive outcomes in the areas of behavioral change and goal attainment were found for the students. The results of this study suggest consultees benefit from conjoint behavioral consultation, regardless of their background, because the CBC model and consultants integrated multicultural strategies to allow for the presence of individual differences.

Limitations of behavioral consultation. Despite an impressive record of successes, research indicates several limitations of behavioral consultation. Kratochwill and Van Someren (1995) discuss a number of barriers to this process, namely, need for standardization of consultation processes, training of consultants, consultee training, acceptability of behavioral consultation, consultant/consultee relationship, and identifying target behaviors. The practice of consultation is not standardized, making difficult treatment integrity across cases. In terms of consultant training, a lack of practicum or field experience to accompany the consultation course and/or program requirements may result in a graduate consulting student's failure to acquire mastery of consultation skills and implementation (Jason, 1978; Sheridan, Welch & Orme, 1996; Wilczynski, Mandal, & Fusilier, 2000).

The acceptability of behavioral consultation mentioned by Kratochwill and Van Someran (1995) poses an additional concern. Specifically, if an intervention is accepted by the teacher (consultee) and/or the student (client), it is likely to be more successful. However, other factors may impact the behavioral consultation process, such as problems within the consultant/consultee relationship or problems encountered upon entering the classroom. These problems might include imposing observation techniques on the teacher, additional time constraints for development, implementation and evaluation of the plan, deficits in consultee skill development, consultee expectations, structuring of consultation processes, personality characteristics, and styles of interaction. Lastly, identifying a target behavior for change can be difficult in consideration of competing challenging target behaviors.

Harchik et al. (1992) suggested alternative methods of managing behavioral changes in the group home environment that require minimal to no ongoing consultation, which should be explored in future research. Consideration of minimal to no ongoing consultation implies that

the staff skill sets have been developed or remedied by an alternative form of consultation. It also assumes generalization of consultee skills, thus reaching consultee self-sufficiency and independence in addressing future concerns (Tillman, 2000).

Consultee-centered consultation. Consultee-centered consultation (CCC) is a form of consultation that addresses and resolves consultee difficulties as a means for changing client behavior. This form of consultation differs from others because it follows two distinct paths, utilizing both a primary and a secondary set of goals. The former assists in a similar way to behavioral consultation, while the latter works on the deficits that contribute to group functioning, largely with human factors.

The primary goal of Caplan's consultee centered approach (Caplan, 1970; Caplan & Caplan, 1993; Noelle et al., 2005) is for the consultant to work with the consultee, in this case the group home manager, to identify and problem-solve a goal of their choosing. An example of a consultee goal could be a jointly developed behavior support plan or intervention for a client. Once the goal is identified, the consultee and consultant will work toward developing an intervention strategy to address the goal, which will take place during several sessions. For example, if the goal is to develop a behavior support intervention, weekly sessions between the consultant and the consultee might cover some of the following issues: education on the nature of behavior consequences, functional behavior analysis to determine why the problem occurs, data collection, developing an intervention plan that reflects the needed changes to the resident's physical and social environment in consideration of the underlying problem, setting appropriate goals, progress monitoring, and evaluation of the intervention plan.

Caplan's consultee-centered approach incorporates four focus areas for setting secondary goals. These four areas are lack of knowledge, lack of skills, lack of confidence, and lack of

objectivity. The consultant is encouraged to develop goals for the consultee that aligns with one of the four areas of concern targeted by the model. Typically, the CCC model is used in schools when the consultee exhibits deficits that coincide with one of these consultee skill deficits indicated in Caplan's model. Therefore, the consultant works with a teacher or administrator consultee to troubleshoot a student behavior or a staff concern, as well as to develop consultee skills and behaviors. The specific deficit is determined during the problem identification phase of the model. The underlying premise is that behavior can be changed unilaterally and jointly through consultee-centered consultation, with widespread effects in multiple clients as a result of change in the consultee. This model distinguishes itself from behavioral consultation by utilizing a problem-solving approach (addressing the consultee as well as the client needs) rather than simply addressing the identified problem, as is the case of behavioral consultation. See Table 1 for a detailed contrast of behavioral and consultee-centered consultation.

Zins (1993) examined problem-solving skills as a key component of the consultative process. Although consultation always involves solving a problem, it also has the added benefit of consultee growth as a valued outcome. Zins reviewed several methods of improving consultee performance that may facilitate effective problem-solving skills. These include direct training of consultees in problem solving, communication, and intervention techniques, utilizing overt cognitive modeling of the problem identification and solution steps, and pre-service training in consultation-related skills. Zins suggests these methods of improving consultee performance aid in achieving an effective consultation experience. In addition, the problem-solving model of CCC emphasizes the need and importance of consultee skill development and growth; problem solving substitutes long-term growth for on-going consultation.

Meyers, Freidman and Gaughan (1975) investigated the effects of consultee-centered consultation on teacher behavior. Their study supplies a clearer understanding of consultation techniques used to promote teacher growth by providing an avenue whereby teachers can express and clarify their feelings, cognitions, and attitudes regarding teaching. The techniques used by the consultants are: (a) verbal reinforcement (such as "uh huh", "yeah", responses); (b) clarification (for example "you seem to be saying" statements); (c) empathy ("I once had a similar experience when…"); (d) direct confrontation ("I think the real reason you are…is because…"); (e) indirect confrontation (describing a similar situation which might have occurred to someone else); (f) probe for feelings ("how do you feel about?" statements); and (g) providing choice ("What do you think would be the best way to…?"). Teacher behaviors were observed each day for 35 days following a one-week baseline period. This study demonstrated a reduction of negative teacher behavior (e.g. criticism of student work or behavior) as a result of the implementation of consultee-centered consultation.

White and Fine (1976) researched a consultative process similar to Caplan's consultee–centered consultation. The purpose of their study was to examine three modes of client-centered case consultation on teacher and student behaviors. The three modes were labeled as the limited mode, moderate mode, and intensive mode. The difference between the modes was the number of follow-up contacts the school psychologist (consultant) had with each teacher during the consultation process. The limited mode groups received pre/post assessment interviews only, while the moderate and intensive groups received two and four additional contacts respectively, before the post assessment interview. Significant differences in the three modes were reported in the areas of implementation of recommendations for pupil target behaviors, general behavior change ratings of pupils by teachers, and teacher perceptions of the degree to which the

intervention program for the child was perceived as a cooperative effort between the teacher and school psychologist. The results of this study indicated follow-up consultation increased the effectiveness of the school psychological services in comparison to consultation without follow-up.

Baker (1998) introduced the only study found that establishes behavior support strategy training through consultation to residential and vocational direct support staff. The author reported staff difficulty with the implementation of behavioral support plans, which had been designed by outside personnel, and suggested the direct care staff lacked the necessary knowledge and skills while facing barriers to effective behavior support. These barriers included little incentive or reward for staff changes as a result of their behavior, and staff difficulties generalizing acquired skills. For example, a staff member is taught to identify and collect data for target behaviors for Sally, but not John, because John rarely displays challenging behavior. Then the staff witnesses John screaming, swearing and pulling his hair after Carl changes the channel on the TV. The staff member, now armed with a generalized knowledge of behavior management techniques, might choose to list the behavior on an ABC chart and discuss the incident with other members of the team in an effort to manage future challenging behaviors. However, without the knowledge, the employee might turn the channel back to get John to settle down because her shift is over in ten minutes and she has to go to another job. Similarly, if the staff member had generalized the progression of Sally's challenging behavior, she might also have realized that Sally screamed, started swearing, and pulled her hair because someone changed the channel on the TV.

Similar to Erbes et al. (2006), who trained classroom teachers how to conduct a functional behavior analysis using on-going consultation for teacher skill development, Baker

(1998) provides a nondirective, but goal driven, approach of consultation in an effort to address positive behavioral support strategies. Direct-care staff in Baker's study received a series of training sessions on behavioral support strategies, specifically functional analysis approaches and the development of behavior support plans. The results indicated client problem behaviors significantly decreased, suggesting training for direct-care workers is an effective means for addressing problem behavior in group-home environments.

Summary

The review of consultation literature demonstrates that school-based consultation often addresses teacher skills and training. Thus, it can be inferred that inadequate staff training often negatively impacts client behavioral functioning in group homes. Consultation techniques that involve consultee skill development have proven effective in school environments by addressing the teacher deficits that impact classroom functioning. For instance, just as Meyers et al. (1975) investigated negative teacher behavior as a factor that impedes the practice of teaching and a teacher's ability to perform, it is also likely negative behavior dynamics exist among direct-care workers, group home managers, and other personnel within the group-home environment that may obstruct optimal functioning. A sole focus on behavioral consultation can often impede the consultation process by failing to address the needs of the consultee and the direct-care workers, as well as interpersonal dynamics that exist within the group home environment, such as the ability to get along with others, tolerate differences, or maintain equilibrium during crisis.

Within school environments that utilize a team approach framework, behavioral intervention services tend to solicit input from team members collaboratively. For instance, teams within the school context might include teachers, social workers, therapists, parents, and administrators whose equal contributions weave an environmental perspective. The group home

environment also requires a collaboration of services; however, the distribution of power is unequal, thereby contributing to an imbalance of input from team members. More specifically, there tends to be a gap between the level of education and responsibility of direct care workers to management, which establishes a hierarchy, rather than shared power and responsibility. Within this context the direct-care workers and lower level management become responsible for carrying out the services and producing the intended outcome (change in behavior), rather than contributing to the problem-solving team. Within this unilateral model decisions primarily come from the administration or the manager, leaving the direct-care worker with less power, which can lead to less responsibility and motivation to change existing circumstances. A consequence of this imbalance in power between the clinical staff and direct care staff is reduced opportunity for the acquisition, development, and effectiveness of direct-care staff members' skill sets. Therefore, a system is created where responsibility for the care of the clients falls on the manager rather than all parties involved in the welfare of clients. Without a shared responsibility, a rift occurs between the two levels creating negative dynamics, which can impact group home functioning.

Figure 1 simplifies the differences between these approaches visually. More precisely, when differing groups work independently to address a mutual concern a culture of competitiveness is born that consequently creates a power imbalance. However, when differing groups work interdependently to address a mutual concern collaboration is born. Collaboration suggests all parties share equally in the problem and the solution whereby allowing for accountability between groups and a more balanced approach.

The current study provided consultee-centered consultation to group home managers and to examine whether this form of consultation affects employee satisfaction (direct-care staff).

The current study serves to combine the work of Baker (1998), which utilizes a goal driven approach to promote positive change in the group home environment, with Caplan's consultee-centered consultation approach to promoting consultee growth. Since a group home manager's ability to tackle the variety of challenges, both clinical and personal, encountered on the job is similar to a teacher's challenges in school, it is likely consultee-centered consultation may improve a group home manager's ability, just as it has for teachers in schools. Inevitably, this will enable managers to provide more cohesive services while improving the lives of individuals with developmental and intellectual disabilities, specifically demonstrated by the decreasing numbers of challenging behaviors exhibited by clients.

Consultee-centered consultation with its emphasis on consultee performance, objectivity, knowledge, and confidence, is therefore expected to also create a positive change in job satisfaction for direct-care staff. Client change in behavior is expected to be an indirect result of the changes in consultee behavior and corresponding changes in employees. Finally, consultees are expected to demonstrate an increased level of confidence, knowledge, skills and objectivity (Brown, Pryzwansky, & Schulte, 2006).

Chapter 3: Method

Participants

This study was conducted within a nonprofit organization in upstate New York that serves the needs of more than 500 individuals with developmental and intellectual disabilities. Three residential group homes housing clients experiencing high frequency challenging behaviors were matched for client criteria and consented to participate in the study.

Clients. The clients in this study consisted of ten adults with developmental and intellectual disabilities who exhibit high frequency challenging behaviors who were residing in the group homes. All clients had a diagnosis of intellectual and/or developmental disability and exhibited mild to moderate deficits in cognitive and adaptive skills (IQ = or >35<50, moderate; IQ=>50<70, mild).

Group homes. The residential group homes for the purpose of this study were defined as follows: community based residences, housing two or more individuals with developmental disabilities and intellectual disabilities. Group homes met the guidelines set forth by New York State Office of Mental Retardation and Developmental Disabilities (14 NYCRR 633.10). Specifically, part 633 serves as a guideline for all agencies providing residential habilitation services in New York State. This included complying with standards for: care, treatment, living conditions, safety, rights, finances, physical and emotional well-being, conduct and training of employees, abuse, research, medications, confidentiality and protection of individuals with developmental disabilities.

Matched assignment was used to select qualifying group homes, which met criteria for client IQ and level of adaptive functioning. Although sex, age, race, and diagnosis were important variables to consider, they are not evenly represented within this sample. Although

triads of group homes meeting the participation criteria and exhibiting similar client attributes were identified, only one triad met the criteria and thus was assigned to participate in the study. Random assignment, picking numbers from a hat, was used to assign each of the three group homes in the triad to one of the three group home study conditions (12 weeks of consultation, 6 weeks of consultation, control group). There was an uneven number of clients that granted consent to participate in the study within the groups, therefore client participants in group B were randomly selected, while all clients who consented in groups A and C participated.

Consultees. The managers from two of the three participating group homes received consultee-centered consultation intervention. The third manager did not receive the intervention and served as the control group home condition. All managers met the qualifications of a Qualified Mental Retardation Professional (QMRP). These qualifications included a bachelor's degree in a human service related field, a minimum of 1-year experience working directly with individuals with disabilities and at least six months experience managing a group home. Federal guidelines stipulate that a QMRP observes individuals, reviews data and progress, and revises programs based on individual need and performance. In addition, QMRP's provide follow-up to recommendations for services and consistency among external and internal programs and disciplines, coordinate the design and delivery of treatment programs, and ensure environmental supports and assistive devices are present to promote independence (National Association of QMRP's, 2002).

Consultant. The investigator delivered the consultee-centered consultation (CCC) services to the two group home managers. The consultant researcher is a graduate student with course work and field experience delivering consultation services in the group home environment. The consultant researcher has no pre-existing role within these homes.

Direct care staff. Eighteen direct care staff across the three group homes worked directly with the clients and the group home managers. The direct-care staff members were assigned to the group home as their regular assignment and were full or part-time employees. Direct-care staff members who secured the majority of their weekly hours outside of one of the three identified group homes were excluded from the study.

Direct care staff responsibilities included oversight and management of client welfare. Specifically, staff members assisted in activities of daily living for adults with disabilities including cooking, cleaning, recreational activities, driving, administering medications, data recording, attending medical and psychology related appointments, and facilitating communication between client and family. In addition to daily work with the group home manager, direct care staff also were responsible for the implementation of behavioral interventions. Although the direct-care staff had no direct contact with the consultant, their role was just as important.

Data Collectors. Two direct-care workers were recruited from each residence to collect data on resident behaviors for all three group homes (one data collector and a backup data collector per group home). Qualifications for data collectors included a minimum of one-year experience working with individuals with developmental disabilities and intellectual disabilities. Data collectors received an appreciation gift for performing data collection duties for this study that were in addition to their current job responsibilities.

Group Home Demographics.

There were three levels of participants within each Group Home. These consisted of the group home manager, the direct care staff and the clients. The Characteristics of the participants from each of the three group homes are illustrated in Table 2.

Group Home A participants. The group home manager in Group Home A was a 33-year-old female with some college education. She had been working in the field for 12.5 years and had managed the group home for four years. The direct care staff members participating in Group Home A numbered four and were all female, possessed some college experience and had worked in the field ranging from 1-7 years (mean of 5.2 years). There were four client participants in Group Home A. All four clients were female ranging in age from early 20's to late 30's. All clients were diagnosed with mild to moderate intellectual disabilities; specifically three clients were diagnosed with Down syndrome and one with autism. Group Home A client participants lived active lives participating in team sports and holding part-time employment or attending day programs. Group Home A participants exhibited the following behaviors: non-compliance, aggression, self-injurious and tantrumming. The behaviors were defined for Group Home A using ABC data collected daily during the baseline period. Non-compliance was defined as refusing to follow a request or directions, saying no!, refusing to follow directives such as refusing to take medications or get out of the van. Aggression was defined as hitting or attempting to hit others, punching, biting, kicking, spitting, scratching, grabbing, and throwing objects. Self-injurious behavior was defined as causing harm to self or attempting to cause harm to self, such as banging fists against thighs and hitting self in the head. Tantrumming was defined as screaming, yelling, crying, and flopping to the ground. These behaviors defining non-

compliance, aggression, self-injurious and tantrumming were specific to Group Home A participants.

Group Home B participants. The group home manager in Group Home B was a 27-year- old female who had completed college and possessed some graduate school experience. She had been working in the field for approximately 8 years and was the manager of the group home for just under two years. There were seven direct care staff members participating in group two: four female and three male. All possessed some college experience and had worked in the field for 2-10 years; the mean number of years at 4.6 years. There were four client participants in Group B. Three clients were male and one client was female ranging in age from 30's to late 70's. All clients were diagnosed with moderate to severe intellectual disabilities, specifically Down syndrome and autism. Group Home B client participants all attended day program or day treatment centers, however lifestyles varied due to differences in age. Participants in Group Home B exhibited the following behaviors: non-compliance, aggression, self-injurious and tantrumming. The specific behaviors were defined for Group Home B using ABC data collected daily during the baseline period. Non-compliance was defined as refusing to follow requests or directives such as to take meds, shower, and walk or get out of the van. Aggression was defined as hitting or attempting to hit others, biting, head butting, kicking, scratching and throwing objects at others. Self-injurious behavior was defined as causing harm to self or attempting to cause harm to self, such as slapping ears, biting self, scratching self. Tantrumming was defined as screaming, yelling, crying, and flopping to the ground.

Group Home C participants. The group home manager in Group Home C was a 56-year-old male who had completed some college. He had worked in the field for approximately 7 years. There were four direct care staff members participating in Group Home C (control

group): two female and two male. Two possessed some college experience, one participant was a college graduate and one participant did not possess college experience. The direct care workers in Group Home C had worked in the field for 2.7 to 5.5 years (mean of 3.2 years). There were two clients participants in the study from Group Home C. Both clients were male ranging in age from 20's to 30's. Both clients were diagnosed with moderate to severe intellectual disabilities and autism. Group Home C client participants both attended day program or day treatment centers. Participants in Group Home C exhibited the following behaviors: non-compliance, aggression, self-injurious and tantrumming. The behaviors were defined for Group Home C using ABC data collected daily during the baseline period. Non-compliance was defined as refusing to follow requests or directives such as to take meds, shower, and walk or get out of the van. Aggression was defined as hitting or attempting to hit others, biting, grabbing and running at others. Self-injurious was defined as causing harm to self or attempting to cause harm to self, such as banging head against objects, hitting head or other parts of body,. Tantrumming was defined as screaming, yelling, crying, and flopping to the ground.

Measures

Consultees were given two self-report measures to obtain information on the process of consultation and impact on employee self-perceptions. Specifically, each consultee completed a Consultant Effectiveness Scale (Knoff, McKenna, & Riser, 1991) at the end of the consultation process and the Minnesota Satisfaction Questionnaire (Weiss, 1967) before and after implementation of the consultation intervention. Direct-care workers completed the Minnesota Satisfaction Questionnaire (MSQ) prior to and after completion of the study.

The Consultant Effectiveness Scale (CES) is a measure utilized to discriminate between effective and ineffective consultant attributes (see Appendix A). This scale consists of 52 items

from four main categories: interpersonal skills, problem-solving skills, consultation process and application skills, and ethical and professional practice skills. The CES uses a five point Likert scale. The scale's internal consistency reliabilities are as follows: interpersonal skills (.92), problem-solving skills (.86), consultation process and application skills (.87), and ethical and professional skills (.82). Overall, this scale has been proven useful in gauging the perceptions of consultees regarding the consultation process (Knoff, Hines, & Komrey, 1995; Knoff, Sullivan, & Liu, 1995). This scale was used after termination of the study to assess the quality of consultation services provided.

In addition, a follow-up interview, (see Appendix B), helped corroborate qualitative information obtained by the CES, and provide information about the consultee's view of their CCC experience. Consultees participated in a brief follow-up interview intended to elicit information concerning the consultation process. The interviews explored the qualitative information provided from the CES and the consultee's thoughts and feelings. The interviews were conducted by a graduate research assistant in a school psychology training program after completion of the consultation portion of the study. This research assistant was provided with a list of questions to ask each consultee. The research assistant transcribed the consultee responses to each of the questions that comprised the brief follow-up interview and sent the written responses to the consultant for analysis.

The Minnesota Satisfaction Questionnaire (MSQ) (see Appendix C) is a tool designed to measure an employee's job satisfaction, and was used to assess changes in employee job satisfaction following implementation of CCC for the managers. The MSQ was developed in 1967 and has been widely used in the field of industrial psychology (Hirschfeld, 2000; Weiss et al., 1967). Currently, there are two forms commonly used, the long and short forms from the

original 1967 version. The 20 question short form, although convenient to use, provides minimal assessment of each of the 20 scales it is measuring and some researchers have questioned its construct validity see Hirschfeld, 2000. Consequently, for the purpose of this study, the long form was used and is discussed. This form provides valuable information concerning variables employees find and do not find rewarding about their job. The long form consists of 100 items tapping into 20 different scales. It takes approximately 15 minutes to complete. Overall, the MSQ has adequate internal consistency, ranging from .59 to .97 (Hoyt reliability coefficients). Evidence of validity is based largely on the MSQ's strong relation to the Minnesota Importance Questionnaire (MIQ), which is based on the theory of work adjustment, plus numerous empirical articles supporting validity (Hirschfeld, 2000). Consequently, for the purpose of this study, the original (1967), version of the MSQ long form was used prior to and after termination of the study to explore the possibility of change in job satisfaction as a result of the consultation intervention (see Appendix C).

The following high frequency client behaviors were monitored: non-compliance, tantrumming, aggression, and self-injurious, behaviors. High frequency was defined as a behavior occurring a minimum of three or more times per week for the purpose of this study. Non-compliance was defined as failing to follow instructions. Self-injurious behavior (SIB) was defined as all behaviors that may potentially cause harm to self, to include but not limited to skin picking, biting, hitting parts of one's body. Tantrumming was defined as yelling, screaming, and rolling around on the floor. Aggression was defined as verbally or physically exhibiting hostile or violent behavior toward another individual, which includes throwing objects. Aggression differs from tantrumming because it exhibits a clear intent to cause harm toward another person or thing.

Antecedent, Behavior, Consequence (ABC) charting and an adapted version of Shapiro's Behavioral Observation of Students in Schools (BOSS, 1996), were used to obtain frequency and time sampling data on the challenging behaviors exhibited by the clients (see Appendix D).

Design

A multiple baseline technique was used to evaluate the general effectiveness of the independent variable (CCC intervention) across time. This type of design was selected over others because the multiple baseline design did not require the removal of a potentially effective intervention and allowed behavior to be directly monitored to indicate change. The baseline condition was on-going behavioral consultation, which each group home was already receiving, with data collected for three weeks during this condition. Consultee-centered consultation provided by the consultant was the intervention added for varying amounts of time. The three group homes followed the schedule for consultation interventions as indicated in Table 3. Group Home A received Baseline for three weeks, data collection training plus CCC for a period of 12 weeks, Group Home B received Baseline for 9 weeks, data collection training and CCC for only 6 weeks, and Group Home C received data collection training, remained in Baseline for all 15 weeks ices and did not receive the CCC intervention.

Procedure

Baseline behavioral consultation. A behavioral specialist addressing behavioral supports and applying behavioral consultation was already assigned to each group home. A behavior specialist is an individual holding a master's or doctorate degree in psychology or a related field and is responsible for assessing, developing, implementing, and evaluating behavior support interventions for residents residing in group home environments. They develop behavior plans and typically review data monthly on client behavior and attend bi-weekly team meetings.

According to state regulations, changes to intervention plans must occur yearly, but can occur on a six-month basis. The behavior specialists ensured the plans were being implemented, but made no other changes during the course of the study. Therefore, for the purpose of this study, the behavior specialist services and/or behavior support plans in place for baseline, designed by behavioral specialists, remained for all three groups. No new intervention was implemented in addition to those currently being provided during the course of this study. Therefore, any changes in the frequency of resident behaviors during the course of the 12-week CCC intervention could be attributed to the CCC intervention.

*Consultation intervention procedures***.** The three group homes followed the schedule for consultation interventions indicated in Table 3. The consultation sessions for group homes A and B took place weekly over the course of the treatment (6 and 12 weeks respectively) after completing the baseline phase. In order to ensure consistent implementation and continuity of consultant services, process notes were written for each consultation session to verify what occurred during the sessions and consistent delivery of consultation (Appendix E). The phases of consultation followed the seven-step consultation process outlined Table 4. Each phase of the seven-step consultation process was recorded on the process notes. A detailed outline of the sessions served as guidelines for content, pacing and progress of activities during the study found in Table 5. Due to agency confidentiality protocols, consultation sessions were restricted to staff interactions only, absence the presence of clients.

Data collection. The designated direct-care staff members collected data on challenging behavior exhibited by clients. The volunteer data collectors were individually trained on data collection for clients in each of the three group homes.

Accuracy of data collection was essential to enable the client results to be accurately monitored. Data collectors were required to reach inter-rater agreement with the consultant researcher before baseline data collection began. Inter-rater agreement was met when each data collector had successfully reached 80% agreement with the consultant on three independent observations of challenging behaviors utilizing video clips of challenging behavioral episodes. This took 3-5 observations to achieve agreement using the adapted version of the BOSS. Baseline data was established for all group homes before the introduction of consultee-centered consultation intervention. Accuracy was assessed six weeks after commencing the intervention phase.

Observation procedures. The collection of observational data was scheduled to take place for 30 minutes twice weekly for interval data collection using the modified BOSS for each client participant in the study. These samplings of challenging behavior recorded utilizing the Behavior Observation of Students in Schools (BOSS) occurred between the hours of 3-10 pm (or during the evening shift) during the weekdays and occasionally on weekends during the baseline period and periodically throughout the study. However, inconsistent data collection resulted from changes in staffing. Specifically, two of the data collectors left the study. Group Home C data collector left to return to school and Group Home B data collector to pursue work in another organization. Additionally, other direct care staff working in the group homes left the organization. As a result, two new data collectors were trained in groups B and C during the study while all three groups suffered decreases in the number of staff members available to work. Therefore, the actual data collection for adapted BOSS interval data occurred on average 1 or 2 times a week for each client participant during the first 8 weeks of the study leaving gaps where

no data was available for analysis beyond that point. This gap in data is most evident during the last four weeks of the study. BOSS observations consisted of 20-30 minute time samples.

ABC's were completed daily as part of established routine for direct care workers. ABC observations occurred throughout the duration of the baseline data collection and the intervention phases.

The consultation sessions for group homes A and B took place weekly over the course of the treatment (12 or 6 times) after completion of the baseline phase. Weekly CCC meetings occurred face to face for 30 minutes. In addition to weekly face-to-face meetings, weekly emails and phone contact were also used throughout the seven-step process as needed. Specifically, regular email and phone contact served as a means to enhance the establishment of rapport in the beginning phases of consultation and assisted when fading the consultation intervention.

The consultee and the consultant utilized data from ABC charts to support the effectiveness of intervention strategies. The adapted BOSS sheets were meant to gain a time sampling of how the clients periodically spent their time. Specifically, the adapted BOSS determined the percentage of time during sample periods that each client engaged in challenging behavior as compared to attending to some other activity. Observations periods were scheduled twice weekly during the baseline period throughout the study, though not all sessions occurred as scheduled.

The consultee-centered consultation involved two groups of goals. As stated in the review of literature, the primary goal of Caplan's consultee-centered approach is for the consultant and the consultee to identify and problem-solve a collaboratively chosen problem, and then work toward the development of intervention strategies to address the goal. Once the primary goal for the group home manager has been identified, the consultant then works towards

identifying the secondary goal, the consultee goal that aligns with one or more of the four target areas of the model – objectivity, knowledge, skills, and confidence. Thus, the goals of the consultant were to support and address consultee concerns encountered within the group home environment with an emphasis on professional growth, while the primary goal of the consultees (group home managers) were based on current problems or client concerns.

There are a number of obstacles encountered by managers when working with individuals with developmental and intellectual disabilities. These might include managing the stress of working with clients, understanding client behaviors, intervening in client crises appropriately and when necessary, establishing and maintaining a sense of efficacy when responding to client concerns, and developing an ability to maintain professional boundaries. An example of a primary goal might be decrease the frequency of non-complaint behavior in a client or increasing the frequency of helping behaviors in a client. The consultant supported the consultee skill development in problem-solving client behavior related to direct-care worker issues and stressors, other clients not in the study who resided in the group home, and in managing environmental stressors within the home. Secondary goals might include: maintaining professional boundaries (targeting objectivity), acquiring a sense of efficacy (targeting confidence) when responding to client concerns, learning to work better with certain clients or better ways to deal with negative staff interaction (targeting skills), learning to lead with confidence (targeting confidence), or gaining additional training or knowledge to better understand behavior (targeting knowledge).

After the consultation intervention phase of the study, the remaining dependent measures were given to elicit additional information regarding the process, the consultant's behavior and

feelings concerning job satisfaction. These measures included the Consultant Effectiveness Scale (CES), the Minnesota Satisfaction Questionnaire (MSQ) and a follow-up interview.

Chapter 4: Results

Data was collected on three levels (see Table 6). The first level was client behavioral frequency data, which consisted of graphed illustration of data points, derived from the on-going results obtained from the BOSS and ABC frequency measures on challenging client behavior. These data points were used to indicate change in client challenging behaviors over time and throughout the study.

The second level of data was gathered from direct care staff. This included data collected from the Minnesota Satisfaction Scale, which was administered to all participating consultees and direct-care staff before beginning and after completing the study. MSQ means, standard deviations and ranges were calculated to explore change in employee satisfaction.

The third level included consultee perceptions. Specifically, this level consisted of qualitative data regarding consultee growth, and perceptions of consultant attributes from Group Home A and B consultees. Both consultees completed the phone and the Consultant Effectiveness Scale (CES) interview after completion of consultation. This data was analyzed primarily for common themes and convergence of data.

Consultation Intervention Procedures

The consultant met with each of the three groups separately to complete the pretest Minnesota Satisfaction Questionnaire (MSQ). Client baseline data collection began two weeks following the completion of the MSQ and lasted for a period of three weeks.

Group Home A: 12-Week Intervention. The two Group Home A data collectors participated in a data collection training to learn to collect interval data after completion of the MSQ measure. Both met 80% agreement with the consultant for interval data collection. After the three-week baseline period, the consultant began consultee-centered consultation with Group

Home A's manager. The sessions ranged from a half hour to 45 minutes totaling 14 face-to-face sessions over 12 weeks. In addition to the face-to-face meetings, email contact also occurred 1 to 2 times weekly from weeks 1-8. These emails served to supplement the face-to-face consultation sessions and to plan logistics. The consultant and the consultee met at an agreed upon neutral location throughout the course of the study, with the exception of one session that took place in the manager's office at the group home.

Consultation sessions followed the seven-step consultation process outlined in this document (see Table 5). The Entry phase went smoothly. The consultee and consultant easily established rapport during the first two weeks. This phase allowed the consultant to begin to collect necessary background information on the client, staff, and environmental concerns. The assessment phase lasted three weeks, during which the consultant and the consultee began to assess relevant variables serving to maintain the client problem behaviors. Specifically, client #1's mental health history, past and present behaviors, interventions previously attempted with the group home team, and level of parent involvement were discussed. Five weeks were spent in the implementation phase when the consultee and the consultant worked on the agreed upon goal. The final three consultation sessions took place during the last two weeks of the study and were spent evaluating the effectiveness of the plan and terminating the consultation process. Process notes were recorded for each face-to-face meeting along with all email, text and phone messages.

The goal for the consultant and the Group Home A consultee was to learn more about how autism and mental illness manifested in client # 1 and to decrease the following maladaptive behaviors in order to improve her quality of life: self-talk, aggression, crying, agitation and

threats. The secondary goal set by the consultant was to increase the group home manager's level of confidence.

Evidence of the secondary goal of improving Group Home A's manager confidence was demonstrated during the consultation session by an increase in assertiveness and initiative when reporting on her problem-solving abilities. Specifically, the consultee reported the staff now actively sought ways to improve the quality of life for the clients, seemed motivated to work as a team, and appeared to demonstrate an increased level of enthusiasm. The consultee also reported that the regular feedback from the consultant helped confirm she was on the right path for addressing client and staff concerns.

Upon completion of the consultation sessions, the consultant met one last time with Group Home A's manager to complete the Consultant Effectiveness Scale (CES) and prepare the manager for the follow-up phone interview. All staff participants in Group Home A completed the MSQ post-measure and the group home manager then participated in the follow-up interview with a research assistant.

Group Home B: 6 Week Intervention. Two data collectors were trained to collect interval data for Group Home B after completion of the MSQ pre measure. 80% Agreement was met between the data collectors and the consultant and data collection began the following week. Baseline data collection continued for six weeks, prior to beginning the consultee centered consultation intervention with group home B's manager.

The consultation sessions ranged from a half hour to 45 minutes totaling 7 face to face sessions and 1-2 weekly phone and email contacts throughout the six week period. The consultant and the consultee met weekly in the manager's office at Group Home B. Consultation sessions again followed the seven-step consultation process outlined in this document (see Table

5). Two weeks were spent establishing rapport with Group Home B manager. The entry phase was more difficult as the consultee seemed more guarded. During this phase, the consultant collected background information on the client participants and began to learn about the overall functioning of the group home staff, clients and environmental concerns. The assessment phase lasted one week and the problem identification/goal setting phases were combined, also lasting one week. During the fourth week, approximately halfway through the implementation phase of the seven-step process, the consultee changed her goal, thus making implementation, evaluation and accomplishing outcomes difficult. The final (6^{th}) session was spent evaluating the plan and terminating the consultation process. Process notes were recorded for each face-to-face meeting along with email, text and phone messages.

The schedule of treatment proposed was adhered to in an effort to maintain pacing, however some obstacles arose. Specifically, the consultee expressed the need for change, but did not provide evidence of areas in need of change. The consultee's concerns would fluctuate from week to week, forcing the consultation style to be more probing in order to move through the phases.

The Group Home B manager's initial goal for consultation was to develop training for her staff on how to work with client # 6 and individuals with autism; however, there was some degree of hesitancy working toward this goal. During the fourth week of consultation, the consultee changed her goal to working more effectively with staff to improve job performance (e.g. arriving on time, completing job duties, and prioritizing responsibilities so that client needs were addressed). The group home manager appeared to possess the skills necessary to perform in the work place, but seemed to struggle with following through (e.g. holding staff accountable on tasks) revealing a consultee performance deficit. Therefore, the secondary goal for the group

home manager of Group Home B was to improve her performance, specifically in the area of follow through.

Upon completion of the consultation sessions, the consultant met one last time with the group home manager to complete the Consultant Effectiveness Scale (CES) and prepare the manager for the follow-up phone interview, and one time with staff participants in Group Home B to complete the MSQ post-measure. Unfortunately, two staff members had changed jobs, one of whom was responsible for the data collection. Neither of these staff members completed the post-test measure. Therefore, a total of eight staff including the manager completed the MSQ pre and post test measures. The group home manager then participated in a follow-up interview with research assistant.

Group Home C: Control group. Only two clients from Group Home C returned the necessary consent forms to participate in this study. All staff including the group home manager completed the MSQ pre measure. Three weeks into the baseline period, one of the data collectors moved, leaving only one data collector to collect the necessary data for the client participants. Due to this staffing crisis, a replacement data collector could not be trained for two weeks. Data collection continued throughout the course of the study, however the amount of data collected decreased, specifically interval data was collected only once weekly and not at all the last four weeks of the study. No consultee-centered consultation was received by Group Home C and additional contact with direct care staff participants revolved only around the pick-up of data records.

Upon completion of the 15 weeks of data collection for the control group, the consultant met with Group Home C staff participants to complete the MSQ post-test measure. Given that the first data collector left the position and the alternate data collector changed positions during

the study for the control group, only five staff participants were able to complete the MSQ pre and posttest measures. No follow-up interview or CES was completed by group home C's manager given that consultation was not provided to this control group.

Behavioral Frequency Data

ABC data records serve as a record of the occurrence of a behavioral episode, whereas the adapted BOSS observation periods would reflect the percentage of time intervals the client engaged in the target behaviors. Therefore, an adapted BOSS observation reflected the intensity and duration of what might have been a single episode. Group Home A daily frequency data averages from all four clients indicate 1-2 maladaptive behaviors were exhibited on approximately half of the days during each prior to the intervention, (see Figure 2). After the implementation of the intervention, the behaviors appear to occur less often with episodes of 1-2 times occurring during 8 of 12 observation periods. Group Home B daily frequency averages indicate 3-6 maladaptive behaviors are exhibited during each observation prior to the intervention and this appears to decrease slightly to 2-5 maladaptive behaviors daily. Group Home C daily averages indicate 1-4 maladaptive behaviors with monthly spike increases up to 10 in the early stages of the study. Given Group Home C data collection was erratic and stopped during the last four weeks of this study due to staffing changes and fatigue, Group Home C data is too unreliable to use as a means of indicating change for the control group.

Due to data collection consistency and integrity concerns, the bi-weekly behavior interval data point averages were not used to illustrate change over time. Rather interval data points are used to illustrate and expand on the results of the ABC especially for clients identified for behavioral change in consultee goals.

Group Home A client results. Client data from Group Home A tracked the change in the following maladaptive behaviors: non-compliance, aggression, self-injurious and tantrumming (See Figure 2). Client 1A displayed non-compliance, aggression, tantrumming and self-injurious behaviors. Client 2A exhibited non-compliance, tantrumming and aggression. Client 3A demonstrated non-compliance, tantrumming, self-injurious and aggression. Client 4A did not demonstrate any of the target behaviors e.g.-non-compliance, aggression or self-injurious behaviors, but did exhibit verbalizations defined as noises or utterances that are not considered words or verbal language.

Client 1A was identified for the consultee's primary consultation goal and exhibited fewer challenging behaviors with less frequency during the intervention period. Specifically, client 1A displayed non-compliance on four instances during the baseline period, while exhibiting self-injurious behavior once, totaling five target behaviors. Aggression was not demonstrated during the baseline period. When comparing baseline data to intervention data, the occurrence of non-compliance behavior exhibited by client 1A decreased to 1x/month in the last four weeks of the study. Interval data indicated client 1A engaged in tantrumming behavior for 77% of the time during the two observation periods during week 4 of the consultation intervention. However, in the last four weeks of the consultation intervention client 1A engaged in tantrumming behavior 25-31% of the observation period. Non-compliance behavior increased from 11 percent during the baseline period observation intervals, weeks 1-3, to 14 percent in the last four weeks of the intervention period. However, non-compliance was only observed four times during the intervention period. Aggression was observed on one occasion during the intervention period. Self-injurious behavior was not observed during any of the interval data

collection observation periods. Change was calculated utilizing the percent change formula (Rathvon, N. et.al., 2003).

Similarly, client 2A also exhibited fewer challenging behaviors with less frequency during the intervention period. Client 2A displayed non-compliance on one occasion and aggression on ten instances during the baseline period. There were five interval data collection sessions during the baseline period when client 2A engaged in aggression, however only one observation period when client two engaged in aggression during the consultation intervention period. The percentage of time client 2A engaged in aggression decreased from 24% to 6.7% of the intervals. When comparing baseline data to post intervention data, the occurrence of non-compliance behavior exhibited by client 2A decreased from engaging in non-compliance for 56% of the interval observation periods during baseline to 28% of the interval data collection period in the final four weeks of the study. In contrast, frequency data reported one occurrence of non-compliance behavior for client two. Interval data indicated client two engaged in tantrumming behavior for 20% of the intervals during the baseline period, while engaging in this behavior 9% of the observed intervals in the final four weeks of the consultation intervention. Self-injurious behavior was not observed in the frequency data or during the interval data collection periods in this study.

Overall, client 3A exhibited challenging behaviors less often during the 12-week intervention period than prior to the intervention, during baseline. Specifically, 3A displayed non-compliance on eight separate occasions during the baseline period, engaging in non-compliance ranging from 20% to 48% of the time intervals during the baseline data collection period. Although the percentage of time client three engaged in non-compliance during the interval data observations did not decrease, the frequency of non-compliance decreased from

2x/weekly to 1x/monthly. Aggression occurred during baseline with Client 3A on three occasions, engaging in this behavior approximately 11% of the baseline intervals. However, during the last month of the study, no occurrence of aggression was reported. There were four occurrences of tantrumming behavior reported during the baseline data collection period with adapted BOSS data indicating client 3A engaged in this behavior on average 12% of the time. In the final four weeks of the consultation study, there were no reported incidences of tantrumming behavior for client three. There were no occurrences of self-injurious behavior reported during the study for client three.

Client 4A did not display, aggression, tantrumming, or self-injurious behaviors on frequency data or engage in any of the aforementioned maladaptive behaviors before or during the implementation of this intervention. Therefore, no data is reflected for client 4A.

The results illustrate a decrease in maladaptive client behavior in all three of the four clients who displayed target behaviors from Group Home A. The client-level data provided support for the hypothesis that the addition consultee centered consultation implemented in the group home environment would show a decrease in the frequency of client maladaptive behavior. Importantly, the client identified by the consultee for behavioral improvement demonstrated the desired changes.

Group Home B results. Overall, client behavioral frequency data shows a slight decline in maladaptive behavior during the intervention period. Specifically, Client 5 B displayed all four target behaviors. Non-compliance occurred at a high rate specifically 1-4x/daily during the baseline period, with non-compliance observed between 25% and 50% of the time during the interval data. After implementation of the consultee centered consultation intervention, client 5 B displayed non-compliance 1-2x/daily and he engaged in the behavior on average during 12%

of the interval observations that occurred during the intervention period. Aggression occurred 1-3x/daily during the baseline period, with interval data indicating client 5B engaged in this behavior during approximately 10% of the intervals. In contrast, the occurrences of aggression decreased to four incidences in the course of a week, with client 5B engaging in this behavior 2%-4% of the observed intervals in the last four weeks of the intervention. There were no reported occurrences of tantrumming behavior in the ABC data, however, interval data indicated client 5B engaged in tantrumming behavior on average during 14% of the interval observations that took place during the baseline period, and 12% of the time after consultation. This inconsistency highlights concerns regarding data collection procedures, which will be discussed in the limitations section. Self-injurious behavior occurred one to three times daily during the baseline period and client 5 B engaged in this behavior during approximately 6% of the BOSS intervals. After consultation, data reflects self-injurious frequencies decreased to 1x/3 days for an average 4% of the intervals.

Client 6 B was the initial focus of consultee B's primary goal, but change was not reflected through consistent client behavioral data. Although behavioral frequency data indicates behaviors occurred with less frequency during the intervention period than prior, data collection inconsistencies were noted for Client 6 B for non-compliance, aggression, tantrumming and self-injurious behaviors. ABC data was not reported for non-compliance, but was indicated on interval data record occurring approximately 10% of the time during observations from the baseline period. Interval data also indicated this decreased to 5% of the time after the intervention. Aggression occurred on one occasion during the baseline period, but did not occur a second time. Tantrumming behavior also was not reported in ABC data collection, however was indicated on interval data. Results indicate client 6B engaged in tantrumming behavior 2-

10% of the time during observations that occurred during weeks 1-3, the baseline period, and after the implementation of consultation indicating no change in behavior, as Client 6 B engaged in this behavior 2-10% of the after consultation. Similarly, self-injurious behavior was not reported on ABC data, but was also indicated on interval data. Client 6 B engaged in self-injurious behavior on two instances during interval data collection during the baseline period, but did not exhibit this behavior afterwards. It appears low frequency client behaviors were under reported regarding this client.

Overall, there appears to be a decrease in the amount of data available for client 7B. Client 7 B displayed non-compliance, tantrumming, aggression and self-injurious behaviors. Baseline frequency data indicates client 7 B engaged in non-compliance 2-12% of the time during the baseline period. Baseline interval data indicates client 7B increased the amount of time engaged in non-compliance behavior to 9-31% of the intervals. ABC reflected 1-3 instances of aggression during the baseline period. Client 7 B engaged in aggression 5-7% of the observation intervals. After consultation aggression was reported on a less frequent basis, specifically every other week 1-3 times while interval data indicated client 7 B engaged in aggression 1-4% of the intervals. Tantrumming was not recorded on ABC data, but was indicated on interval data. Specifically, client 7 B was observed engaging in tantrumming 7-12% of the observation intervals during the baseline period. Interval data collected after consultation indicates the percentage of time client 7 B engaged in tantrumming behavior ranged from 1-7% of the time. Self-injurious behavior occurred on eight instances during of baseline period. After consultation was initiated, this behavior occurred five times. Interval data indicates client 7 B engaged in self-injurious behaviors 3-4 percent of the time during weeks 1-3 and showed a decrease to 1-2% in weeks 14-16.

Data suggests overall that client 8 B's challenging behaviors occurred with less frequency after implementation of the intervention than prior. Specifically, client 8B displayed non-compliance, tantrumming and self-injurious behaviors. While Client 8 B engaged in non-compliance 1%-13% of the intervals during the baseline period, he showed an increase to 1-26% after implementation of the consultation intervention, Client 8 B engaged in tantrumming behavior 4-15% of the time during the baseline intervals and showed decreased in the percentage of time engaged in this behavior after consultation. In fact, client 8 B did not engage in tantrumming behavior after consultation. Self-injury occurred on two occasions both during the baseline period, with interval data reflecting self-injury from 2%-3% of the time. There was a decrease in the percentage of time client 8 B spent engaging in self-injury after consultation, specifically, data indicated client 8 B did not engage in self-injury during the last four weeks of the study.

The results illustrate a decrease in maladaptive client behavior in some of the clients from Group Home B, supporting the hypothesis that the additional consultee centered consultation implemented in the group home environment was linked with a decrease in the frequency of client maladaptive behavior and a decrease in the amount of time clients spend engaged in maladaptive behavior.

Employee Satisfaction. The second level of data was gathered from direct care staff. This consisted of scores on the Minnesota Satisfaction Questionnaire, which was administered to all participating consultees and direct care staff, at the beginning and after completion of the study. Limited data was available, as approximately 50% of the original staff participants left their positions and were therefore unable to complete the post employee satisfaction questionnaire (MSQ). The post-test staff representation totaled 18 sets of scores.

Table 7 illustrates the results of the MSQ pre/post measures. Five staff members, including the group home manager, completed the MSQ pre and post measure from Group Home A, as three direct care staff of the original group of eight were lost to attrition from Group Home A. Changes in the overall levels of job satisfaction as indicated by the results of the MSQ for Group Home A show 3 of 5 direct care staff participants reported an increase in their overall level of job satisfaction.

Group Home B had eight staff members complete both the pre and post measures of the MSQ; two original staff members did not complete the post MSQ and were lost to attrition. Six out of the eight respondents (# 1, 3, 4, 5, 7 and 8) from Group Home B showed an increase in their perceived level of job satisfaction. One respondent from group home B reported minimal to no change (<5% increase) and one respondent reported a decrease in the perceived level of job satisfaction.

In group home C, five staff members (four direct care staff and one manager) completed the MSQ pre and post measures, while one staff member was lost to attrition. Three out of the five participants that completed both the pre and post MSQ measures showed a decrease in the overall general satisfaction scale.

Overall, it appears staff members in Group Homes A and B that received either twelve or six weeks of consultee-centered consultation, showed modest, but positive increases in their levels of job satisfaction. Of the 13 direct care participants from Group Home A and B, 69% of the participants showed an increase in the level of job satisfaction, 23% showed a decrease in overall job satisfaction and 7 % showed no change. In comparison to Group Home C there were no similarities between respondent reporting for increase or decrease in job satisfaction.

Specifically, 40% of Group Home C respondents reported an increase in overall levels of employee satisfaction was, whereas 60% indicated a decrease in job satisfactions.

Consultee Experiences

The third level of data assessed the perceptions of Group Home A and B consultees regarding the consultant and the consultation process. The two consultees completed the Consultant Effectiveness Scale (CES) after receiving 6 and 12 weeks, respectively, of consultee-centered consultation. The information from the CES and the follow-up interview was analyzed primarily for common themes. The purpose of this data was to qualitatively link comments and ratings on the CES to goals identified by the consultees (See Table 8 for response comparisons). The consultees rated the consultant's attributes as highly effective to a large degree across content areas. The Group Home A manager rated the consultant with full point values for all items on the measure while Group Home B manager rated the consultant similarly, but with fewer points within the two highest ranges. Thus, the overall responses reported on the CES were positive and did not indicate consultant characteristics were of concern to the consultees.

Qualitative data on consultee perceptions regarding skill development and growth was derived from the consultees' responses on the follow-up interview conducted after completion of the consultation sessions. The four question brief follow-up interview asked the consultees about the following items: (a) What were the goals set for consultation, (b) to what degree were they accomplished, (c) what impact did their work with the consultant had on the direct-care staff and the clients, and (d) did the consultant influence their perceived level of confidence, knowledge, skills, and/or objectivity.

In terms of accomplishing goals, the consultee from Group Home A reported accomplishing goals as "expected", and consultee from Group Home B reported "somewhat".

Consultee A's goal was to improve staff understanding of client 1A in order to decrease her challenging behaviors, and client level data suggested this change occurred. Consultee B's goal was to learn more information about autism and how that relates to client 6 B's behavior to decrease his challenging behaviors. The consultee mid-way through the consultation process wanted to change this goal to learn how to assist staff to comply with their job responsibilities.

In terms of the impact of consultation on staff, both consultees reported that consultation helped them to address staff concerns. Consultee A reported consultation improved her confidence, knowledge and objectivity, but did not influence her skills. Upon termination consultee A reported an improvement in her ability to problem solve regarding client challenges. Session notes reported an increase in consultee independence and confidence. In contrast, Consultee B indicated consultation influenced both her knowledge and skills, but did not indicate to what capacity. She did not report that consultation influenced her confidence or objectivity. Upon termination, consultee B reported the length of the consultation intervention made it difficult to gauge whether the goal was met. Specifically, the shorter period (6-week consultation) did not provide the amount of time needed to meet the consultee's goals. No data from the CES or the follow-up interview was obtained from the manager of the control Group Home C.

Chapter 5: Discussion

The purpose of this study was to better understand how consultee-centered consultation influences maladaptive client behavior in the group home environment. There were three research hypotheses for the effects of consultee-centered consultation on the group-home environment: Consultee-centered consultation was expected to a) decrease client challenging behavior b) create a positive change in job satisfaction for direct-care staff and c) demonstrate an increased level of confidence, knowledge, skills and objectivity in consultees. Although the addition of the consultee centered consultation overall did not appear to have a significant impact on client behavioral frequencies as proposed, it did present some positive changes to Group Home A client behavioral frequency data, direct care staff levels of job satisfaction, and consultee's level of confidence, knowledge, skills and/or objectivity. Specifically, Group Home A received 12 weeks of consultation, which presented the opportunity for necessary time at each stage of the consultation process to establish the rapport necessary to collaboratively assess, problem solve concerns, create goals and a plan, and implement and evaluate the plan. Group Home A's manager, through participation in 12 weeks of consultation, was able to use the data collected to inform the consultation process. This appears to have influenced client behavioral data by enabling the group home manager and the consultant to view client behavioral changes and make adjustments as needed in order to meet the needs of the client. Group Homes B, with 6 weeks of consultation exhibited a lesser decrease in client behavioral data frequencies, but also experienced more gaps in data collection. Comparisons between Group Home A and B client behavioral frequency data do not clearly identify whether Group Home A, receiving 12 weeks of consultation showed a greater decrease than Group Home B, with 6 weeks of consultation due to the intervention dosage.

Although the study's aim focused on decreasing challenging behaviors, the level of client engagement in activities increased across groups. For example, during the baseline period of data collection Group Home B client participant interval data indicated clients were actively engaged during the sample periods at 53.8 % while after implementation of the consultation intervention clients were actively engaged during interval samples at or above 72.7 %. These percentages were calculated using a behavioral change equation (Rathvon, 1999). This effect was unintentional was foreseeable. One reason for this occurrence might be that the process of collecting interval data influenced the quality of services provided by direct care staff. Specifically, the process of observing client behavior in ten second intervals that requires attending for long periods may have adjusted the observer's behavior helping the observer to attend more regularly to subtle changes in client behavior, which consequently enabled the observer to see the antecedents that preceded maladaptive behaviors and adjust their own consequences surrounding each behavior. This appeared to increase the level of client engagement.

Another point of discussion is the issue of employee job satisfaction. This study proposed an increase in the level of employ job satisfaction, and the data indicated suggestive, rather than definitive, change in the level of employee job satisfaction. The respondent reports were scattered in terms of where each rated their level of job satisfaction on the pretest. Group Home A respondents rated their overall level of job satisfaction higher on the pretest than the other two groups and Group Home C respondent reports were much lower on the pre measure than Group Home A and B, whose respondents reported their levels of job satisfaction as ranging from low to high. The uneven distribution of the levels of job satisfaction between the groups creates the question: does consultee-centered consultation have a greater impact for groups

whose respondents report initially higher levels of job satisfaction than groups whose respondents report lower levels of job satisfaction? This finding suggests it might be beneficial to further explore how the composition of the direct care staff 's level of job satisfaction influences a group home environments' response to consultation and to changes in client maladaptive behavior.

The consultee level of analysis included qualitative data on consultee perceptions regarding skill development and growth derived from the phone interview after consultation had terminated. The information gathered from the four question follow-up interview on consultee perceptions appeared to acknowledge the usefulness of consultation for the consultee. In terms of accomplishing goals, both consultees reported goals were accomplished to some degree. The consultee from Group Home A reported accomplishing goals as expected and the consultee from Group Home B reported goal accomplishment only somewhat as expected. Group Home A consultee's goal was to improve staff understanding of client 1A in order to decrease her challenging behaviors. Group Home B's consultee goal was to learn more information about autism and how that relates to client 6 B's behavior in order to decrease his challenging behaviors. Group Home B's consultee interview responses could be linked to the difficulty in setting and accomplishing goals for consultation. For example, mid-way through the consultation process Group Home B's consultee chose to shift the focus of the goal from learning about autism as it relates to client 6B's behavior to learning how to assist staff in complying with their job responsibilities. The realization of consultee B's difficulty managing her staff might have exposed the secondary goal of consultation for Group Home B (consultant's goal), which was to improve consultee B's performance issue, with the effect of harming the consultee/consultant relationship in the process. Specifically, consultee B reported difficulty

enforcing direct care job responsibilities. She had the skills and the confidence, but seemed to lack the follow-through to make it happen. The consultant researcher chose to spend time getting to understand what obstructed the consultee' ability to hold the employees to their responsibilities. This appeared uncomfortable for the consultee and the conversation often shifted to another concern or ended before resolution. These difficult discussions regarding the consultee's difficulty managing the staff may have temporarily had the consultee to pull back, rather than to engage in the consultation process.

Both consultees reported that consultation helped them to address staff concerns. Specifically, both consultees discussed direct care job responsibilities as well as direct care work behaviors such as arriving on time, completing assignments and attending to client concerns. Consultee A reported consultation improved her confidence, knowledge and objectivity, but did not influence her skills, whereas, Consultee B reported consultation influenced both her knowledge and skills. Information to clarify what specific aspect of the consultation influenced her skills was not reported. Consultee B also did not report consultation influenced her confidence or her objectivity.

The information from the CES was not as useful for assessing the consultant's ability to resolve consultation issues, as the consultant's ability to build a consultative relationship. Both consultees agreed the consultant exhibited all 52 characteristics to a large and very large degree. Although the consultees were not asked to report areas the consultant could improve upon on formal measures, termination session notes indicate the consultant solicited feedback from the consultees in order to improve the consultation process. Neither consultee reported areas of concern or areas the consultant should develop to improve consultant effectiveness. The follow-up interview conducted by the research assistant also did not give substantial information

regarding aspects of the consultation process that might have influenced the results. Therefore, these measures appeared to gauge the quality of the relationship or the rapport established between the consultant and the consultee's rather than isolating specific components of the process that may have affected the study. Group Home A consultation was given substantially more time, which may have been sufficient to develop a relationship and support some level of change. In contrast, Group Home B's consultee was allotted enough time to establish some degree of rapport, with insufficient time to support significant change. Further research should focus on what length of time is necessary to establish the rapport necessary to support change and/or what variables of the consultation process alongside consultant attributes are most effective.

The convergence of data suggests that consultee-centered consultation conducted over the course of 12 weeks seems to have produced the best results. Given the nature of consultation and the need to establish rapport and address relational impasses that naturally occur in the development of human relationships, the 6 week consultation period for Group Home B forced consultation to occur in a compressed goal oriented fashion, leaving less time for the establishment of a stronger consultative relationship as a foundation to support consultee changes. Given the condensed number of sessions, there was insufficient time to accomplish the goals.

Limitations and complications

Several limitations were identified that impacted the validity of this study. These include staff attrition, the quality and integrity of data collection processes, consultant characteristics, site restrictions, confidentiality, and the length and size of the intervention study.

Attrition. High rates of staff attrition were experienced during the course of this study. Approximately 50% of staff members transferred to another residence for work or left their position. The subsequent need for identifying and training additional data collectors in order to complete the study resulted in gaps in the data collected. The high rates of attrition led to subsequent gaps in the weekly data collection. In addition, quantitative analysis of the MSQ could not be conducted due to low numbers of staff members constant from pre to post-testing. This pattern of attrition can serve as an indicator of larger systems' concerns. For instance, inadequate staffing creates a power imbalance that not only threatens the integrity of the data collection process, but the integrity of the delivery of the services and interventions provided, subsequently enabling procedures to veer away from evidenced based practices and quality care.

Integrity of data collection. Regular data collection was needed to demonstrate changes in the frequency and duration of maladaptive behaviors exhibited. In order to evidence this change effectively, continuity of the data collection process was required. The high rate of attrition weakened the integrity of the data collected in all three groups, leading to contradictory data patterns. For example, the behavioral frequency (ABC) data indicated days when no behaviors had occurred, while interval data indicated behaviors had occurred. These data patterns led to the decision to eliminate portions of the data, including the entire Group Home C dataset. Future studies using client behavioral data should focus efforts to a) improve daily data collection for targeted behaviors and b) achieve congruency between data collection.

Accurate event recording data across the entire day might have more accurately linked to change in the duration of maladaptive behaviors. In the future, alternative focus for data collection may help to improve the quality of information collected beyond client maladaptive behaviors. Specifically, the quality of a client's life cannot be measured solely on the number of

activities in which one engages. Activities that hold meaning for the individual contribute to one's quality of life. Likewise, the length of time one engages in behaviors that influence their life is just as important to consider as the number of and/or kinds of behaviors. How a client spends their time provides useful information on individual motivations and reasons for doing what they do. Increasing the amount of time clients engage in activities that are meaningful while reducing challenging behaviors may help them better connect with others who hold similar interests whereby presenting the opportunity for clients to form meaningful relationships, both of which helping to improve their quality of life more so than the actual number of activities. What could be done differently, should this type of study be repeated in the future, would be to look more closely at the amount of time clients are engaged in both positive and negative activities in combination with the number of activities in which clients participate. This pattern could be an important indicator of quality of life.

Consultant Characteristics. Consultant effectiveness was a variable that may have both promoted and hindered the outcome of this intervention. The age of the consultant closely resembled the age of the consultees enabling rapport to be established quickly, however the limited years of experience of the consultant may have affected the outcome, especially for Group Home B's results. Specifically, the consultant's experience utilizing this form of consultation was minimal, numbering four years, within the majority of the consultant experience stemmed from the school environment, rather than community agencies. However, the consultant did possess 10 years of experience working as a direct care worker in community agencies (group home environments), which may have provided sufficient referent power to offset the consultant's lack of experience with consultees. Specifically, the direct care experience the consultant possessed may have helped to facilitate the relationships, which were

measured positively on the CES, but the lack of consultation experience may have effected CCC problem-solving impacts. .

Site Restrictions. Due to the confidential nature of this study and the need to safeguard sensitive information, on-going direct contact (check-ins) between the consultant and the consultees and data collectors within the group home environment was not permitted. As a result, live observations to support the consultation sessions and preserve the integrity of data collection could not occur. Live observations help the consultant to understand the consultee's experience: how they perceive what is happening. This could help to highlight areas the consultant should address when working with consultees rather than relying on consultee reports to identify discrepancies during consultation sessions. Additionally, having direct observation of the data collectors within the group home environment provides the opportunity to utilize teachable moments and troubleshoot potential difficulties that may have threatened the integrity of the data collection. For example, this appeared to have been more of a concern for Group Home C, which did not receive weekly consultation. Group homes A and B received weekly consultation, and benefitted from the regular discussion between the consultant and the consultee on participant behaviors and progress regarding data collection. This helped to promote accurate and consistent data collection. Therefore, on-going contact with team members such as data collectors in the study would have been useful to establish procedures that help to maintain accurate measures of evaluating outcomes. In addition to influencing data collection practices, on-going access to team members enables the consultant to influence insider verses outsider perceptions. Access to team members helps the consultant to be perceived as an insider.

Size and length of the intervention study. The sample size of the study was also an important variable. The number of clients participating in the study totaled only 10. In the

future, an increased sample size would lead to a better understanding of the effects of consultee-centered consultation process on group home environments.

Additionally, the length of the study posed a competing concern. Specifically, data burnout may have been an influential variable. Collecting interval data on a weekly basis may have been difficult for staff to maintain, given the amount of time consumed in the process. Samplings of data on a monthly or periodic basis might demonstrate change more clearly than on a weekly basis and prevent data burnout.

Implications

The results appear to provide limited support for the hypothesis that the application of consultee-centered consultation to group home managers influences client challenging behavior and employee satisfaction. The level of education reported indicated the majority of staff participating in this study possessed some college experience. The mean age of the direct care staff participants was 37.8 years of age, ranging from 22-71 years of age, with 38% of staff between ages 22 and 33. The average numbers of years staff had worked in their current position ranged from 4.6 to 6.4 years. This important information on the composition of the direct care workforce suggests that attrition may be partially a response to staff pursuing higher education. Providing more incentives for job mobility to staff pursuing a college degree may reduce staff attrition rates, thus influencing the stability and consistency of the direct-care workforce and subsequent quality of services delivered to clients.

CCC was designed to help address consultee concerns with students or clients, as well as consultee objectivity, performance, knowledge and confidence. During the termination phase of the intervention, the consultant asked probing questions in an effort to understand the implications of CCC for the consultees. It appears the length of CCC may be related to the level

of consultee growth and change. In part, enabling sufficient time to establish rapport was necessary in developing a connection strong enough to support change. However, to reasonably establish the rapport necessary to promote systems level change, it would be beneficial to understand the consultee struggles through direct observation. This would allow the consultant to gather confirmatory data to support consultation goals, to utilize teachable moments for discussing and addressing obstacles and to possess a clearer understanding of the consultee's response/perspective during the process.

This researcher would be remiss not to mention some lessons learned. The author has continued to utilize CCC intervention in schools as a means for decreasing challenging behaviors in children and young adults. There tend to be two common perceptions that come to mind when one hears the word consultant: those who operate from within an organization, sometimes seen as a team member or colleague and those thought of as "outside" consultants. There appears to be some degree of controversy over which is more effective. In continuing to utilize the CCC intervention in schools, this researcher has come to understand that regardless of whether the consultant was hired from within or outside the organization, it is imperative the consultant operate as if from within. Operating from within the organization allows the consultant to quickly establish the relationships, while maintaining a stance of perceived "knowing." Specifically, the consultant must appear to have merit in understanding the consultee's context and consequently the consultee's challenges. This influences the pace of consultation. For example, if the consultant is viewed as being an "outsider," the consultees or team members may be less likely to view the consultant as someone that can help, requiring the consultant to spend additional time establishing rapport. When the consultant is viewed as an "insider", they become part of the team and part of the solution. Behavioral consultation differs from consultee-centered

consultation in this way. BC addresses the client behaviors as an extension of the client, rather than a reflection of their environment. CCC understands client behaviors are maintained by the interaction between their environment and the people within it.

"Live" observations are observations conducted by the consultant and are important for a several reasons. First, these observations assist the consultant in gaining and confirming valuable information about the consultee's challenges, contributing to the consultee's perception the consultant sees and understands. This elevates the consultant as a peer or teammate, rather than an outsider, whereby the consultee and other team members perceive the consultant's opinion as more valid. Secondly, observations also allow the consultant to confirm or disconfirm the consultee's concerns. For instance, if the consultee reports client behavioral concerns and the consultant's data confirms this, the focus of consultation might focus on the contextual factors influencing those behaviors, whereas if the consultant's data does not confirm the presence of client behaviors, the focus of the consultation intervention would focus on the contextual factors influencing the consultee's perception of those behaviors such as staff interactions or personal problems of the consultee.

Finally, the intensity and duration of the consultation relationship needs to adapt to changes in the consultee, the consultant/consultee relationship, and outside influences. Human relationships ebb and flow in tandem with an individual's thoughts and feelings throughout the course of a day, a week, a month, or a year. This researcher has found that the rhythm of the consultation intervention must mimic and account for this human rhythm in order to maximize the influence of the intervention. For example, although the consultation process allows for time to establish rapport, work together to problem-solve, space to transfer and practice skills and terminate the relationship, this is only a loose outline. Within the consultation relationship,

inside or outside factors may influence the consultee's new and growing ability to transfer and maintain new skillsets at any given time. The presence of these factors suggests that consultation must adapt by taking the time to address these competing factors by shifting the intensity of the intervention in order preserve and maintain the mobility of the overarching consultation process and improve targeted outcomes.

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Table 1

Comparison of Behavioral Consultation and Consultee-Centered Consultation

Consultation Aspect	Behavioral Consultation	Consultee-Centered Consultation
Goals	▪ Develop a plan to help specific clients; ▪ Assess problem and prescribe the treatment	▪ Improvement of consultee functioning in relation to specific cases ▪ Consultee improvement goal categories: objectivity, knowledge, skills, and/or confidence ▪ Educate consultee using his or her problems with the client as a lever
Roles of the consultant	▪ Expert role ▪ Advise the consultee on client treatment ▪ Meets with team to help diagnose the problem; ▪ Minimal to no client involvement	▪ Collaborative role ▪ Consultant develops goals for the consultee; Consultee develops goals for the client ▪ Regularly meets with consultee ▪ Rarely meets with client ▪ Must recognize source of consultee's difficulties and deal with them indirectly
Participants	Team Facilitator (manager, nurse, staff, social workers, service coordinators)	Consultant and the consultee
Activities	▪ Implementation of behavior support plan (training-consultant only) ▪ Ongoing collection and review ▪ Regularly scheduled team meetings ▪ Direct care staff, teachers, or parents collect data; ▪ Behavioral consultant reviews data collected, writes and reviews plan; ▪ Team meets to evaluate progress	▪ Frequent meeting sessions (one to one) between consultee and consultant ▪ Data collection and interpretation (consultant and consultee) ▪ Trainings ▪ Joint problem-solving concerning client behavior and other environmental concerns ▪ Evaluation and discussion of the process and the data to determine success or failure of project

Table 2

Participant Information

Participant Information	**Group A**	**Group B**	**Group C**
Manager (Consultee)	12-week intervention	6-week intervention	control
Gender	Female	Female	Male
Age	33	27	57
Education Level	Some college	College graduate	High school graduate
Years of Experience (in the field)	12.4	7.9	7
Direct Care Staff			
Male	0	3	2
Female	4	4	2
Age range	22-27	29-71	26-47
Educational Level	Some college-4	High school graduate-1 Some college-4 College graduate-2	High school graduate-1 Some college-2 College graduate-1
Years of experience range	0-7years (mean=5.2 years)	1-12.5 years (mean=6.6 years)	2.5-14 years (mean=6.8 years)
Clients			
Male	0	3	2
Female	4	1	0
Average age	28	62	25.5
Mild impairment	3	0	0
Moderate impairment	1	0	1
Severe impairment	0	3	1
Profound impairment	0	1	
Autism	1	1	1
Down syndrome	3		
Pervasive Developmental disorder			1
Intellectual Disability		3	
Target Behaviors			
Non-compliance	3	4	2
Aggression	3	3	2
Self-Injury	2	4	1
Tantrumming	2	4	2

Table 3

Schedule of Treatment

Group Home	Baseline (3 weeks)	Phase I (6 weeks)	Phase II (6 weeks)	Total Weeks
1	D;BC	D;BC;CC	D;BC;CC	D=15 ; BC=15; CC=12
2	D;BC	D;BC	D;BC;CC	D=15 ; BC=15; CC=6
3	D;BC	D;BC	D;BC	D=15 ; BC=15; CC=0

D=Data collection; BC =Behavioral consultation; CC =Consultee-centered consultation

Table 4

Seven-Step Process for Consultation

1. Entry: establishing a relationship with consultee
2. Assessment: examine variables relevant to the problem
3. Problem definition and goal setting: define the actual problem and set goals for consultation
4. Strategy selection: plan development
5. Implementation: plan implementation
6. Evaluation: look at desired and actual outcomes
7. Termination: the process of ending consultation

Table 5

Schedule of Intervention Activities

Week	Description of Activities		
	Group A	**Group B**	**Group C**
1	Baseline frequencies data collection	Baseline frequencies data collection	Baseline frequencies data collection
2	Baseline frequencies data collection	Baseline frequencies data collection	Baseline frequencies data collection
3	Baseline frequencies data collection	Baseline frequencies data collection	Baseline frequencies data collection
4	Group 1 begins consultee-centered consultation; 2 30 minute sessions: Step 1-Entry: Establish Rapport,	Data collection	Data collection
5	1-Entry; 2-Assessment: continues with consultee-centered consultation; 2 30 minute sessions: Establish rapport problem identification	Data collection	Data collection
6	3-Problem definition and goal setting: continues with consultee-centered consultation; 2 30 minute sessions: client problem identification; determine consultee difficulty from 4 categories (lack of knowledge, lack of skill, lack of confidence, lack of objectivity	Data collection	Data collection
7	3-Problem definition and goal setting: continues with consultee-centered consultation; 2 30 minute sessions: help consultee gain understanding of the issues involved in the case, determine need for (additional training, support from senior co-workers, or insight of own behavior)	Data collection	Data collection
8	4-Strategy selection: continues with consultee-centered consultation; 2/ 30 minute sessions: development of	Data collection	Data collection

	intervention (unique to each consultee)		
9	5-Implementation: continues with consultee-centered consultation; 2/ 30 minute sessions: intervention; problem-solving	1-Entry: Establish Rapport, Group 2 begins consultee-centered consultation; 2 30 minute sessions: client problem identification	Data collection
10	5-Implementation: consultee-centered consultation; 2/ 30 minute sessions: intervention/problem-solving	1-Entry; 2-Assessment; 3-Problem definition and goal setting: continues with consultee-centered consultation; 2/ 30 minute sessions: client problem identification; determine consultee difficulty from 4 categories (lack of knowledge, lack of skill, lack of confidence, lack of objectivity rapport, client problem identification; help consultee gain understanding of the issues involved in the case, determine need for (additional training, support from senior co-workers, or insight of own behavior)	Data collection
11	5-Implementation: consultee-centered consultation; 2 /30 minute sessions: intervention/problem-solving	3-Problem definition and goal setting; 4-Strategy selection; 5-Implementation; : continues with consultee-centered consultation; 2 30 minute sessions: development of intervention (unique to each consultee); intervention; problem-solving	
12	5-Implementation: consultee-centered consultation; 2 /30 minute sessions: intervention/problem-solving	5-Implementation: continues with consultee-centered consultation; 2/ 30 minute sessions: consultee intervention; client/consultee problem-solving	Data collection

13	6-Evaluation: consultee-centered consultation; 2/ 30 minute sessions: evaluation of process, identified client problem, and consultee growth	6-Evaluation: continues with consultee-centered consultation; 2/ 30 minute sessions: intervention/problem-solving; evaluation of process, identified client problem, and consultee growth	Data collection
14	6-Evaluation; 7-Termination: consultee-centered consultation; 1/ 30 minute session: continue evaluation of process, client problem, and consultee growth	6: Evaluation; 7-Termination: 1/ 30 minute session: continue evaluation of process, client problem, and consultee growth	Data collection
15	7-Termination: consultee-centered consultation; 1/ 30 minute session: evaluation of consultant; feedback, phase out	7-Termination: 1/ 30 minute session: evaluation of consultant; feedback, phase out	1/30 minute session: evaluation of consultant; feedback, phase out

Table 6

Levels of Data Analysis

Data levels	Measures	Group Home A	Group Home 2	Group Home 3
Client data	• ABC frequencies • BOSS interval data	Graphed representation of frequencies.	Graphed representation of frequencies.	Insufficient reliable data
Direct-care staff	• Minnesota Effectiveness Scale (MSQ)	Pre-post MSQ	Pre-post MSQ	Pre-post MSQ
Consultee	• MSQ • Consultant Effectiveness Scale (CES) • Interview	Pre-post MSQ Item Analysis; Qualitative Interpretation	Pre-post MSQ Item Analysis; Qualitative Interpretation	n/a

Table 7

MSQ results

	Group	Mean	Standard Deviation	Range	Maximum	Minimum
Pre						
	A	83.5	9.2	24	94	70
	B	41.2	29.3	76.5	87.5	11
	C	40.5	29.7	64	75	11
Post						
	A	80.8	17.0	44	98	54
	B	50	32.1	91	96	5
	C	53	29.9	56	75	19
Change in score						
	A	-2.7	20.4	53.5	20	-33.5
	B	4.9	24.7	90	44	-46
	C	-8.7	17.0	42.5	7.5	-35

Table 8

Consultant Effectiveness Scale results

Item #	Characteristic	Consultee One	Consultee Two
1	Warm	E	E
2	Active	E	D
3	Tactful	E	D
4	Skillful	E	D
5	Flexible	E	E
6	Specific	E	D
7	Tolerant	E	E
8	Pleasant	E	E
9	Empathic	E	D
10	Attentive	E	D
11	Encouraging	E	D
12	Trustworthy	E	E
13	Open-minded	E	E
14	Approachable	E	E
15	At team player	E	D
16	Self-disclose	E	D
17	A good facilitator	E	D
18	An active listener	E	E
19	Identify clear goals	E	D
20	Evaluate/focus ideas	E	D
21	Clarify his/her role	E	D
22	Encourage ventilation	E	E
23	Skilled in questioning	E	E
24	Review client records	E	D
25	Interested	E	E
26	Willing to get involved	E	E
27	Have a positive attitude	E	E
28	Maintain confidentiality	E	E
29	Good at problem-solving	E	D
30	An efficient user of time	E	D
31	Give and receive feedback	E	D
32	Able to overcome resistance	E	D
33	Aware of relationship issues	E	D
34	Accepting (non-judgmental)	E	E
35	Skilled in conflict resolution	E	D
36	Practice in an ethical manner	E	E
37	Have a clear sense of identity	E	E
38	Pursue issues/follow through	E	D
39	Show respect for the consultee	E	E
40	An astute observer/perceptive	E	D
41	Anticipate possible consequences	E	D
42	Effective at establishing rapport	E	E

43	Express affection (be supportive)	E	E
44	Emotionally well-adjusted/stable	E	E
45	Document for clear communication	E	D
46	Collaborative (share responsibility)	E	D
47	Take risk/be willing to experiment	E	D
48	Gives clear, understandable directions	E	D
49	Employ appropriate personal distance	E	D
50	Specify the contract (time, effort, cost)	E	D
51	Maintain an "I'm ok-You're ok" position	E	D
52	Have feelings and behaviors that are consistent	E	E

The key below indicates the degree to which the consultant exhibited characteristics.

Response Choice	Description	Point value	Total points possible	#1	#2
A	Not at all	1 point	52		
B	To a slight degree	2 points	104		
C	To a considerable degree	3 points	156		
D	To a large degree	4 points	208		
E	To a very large degree	5 points	260		
Total Score				260	230

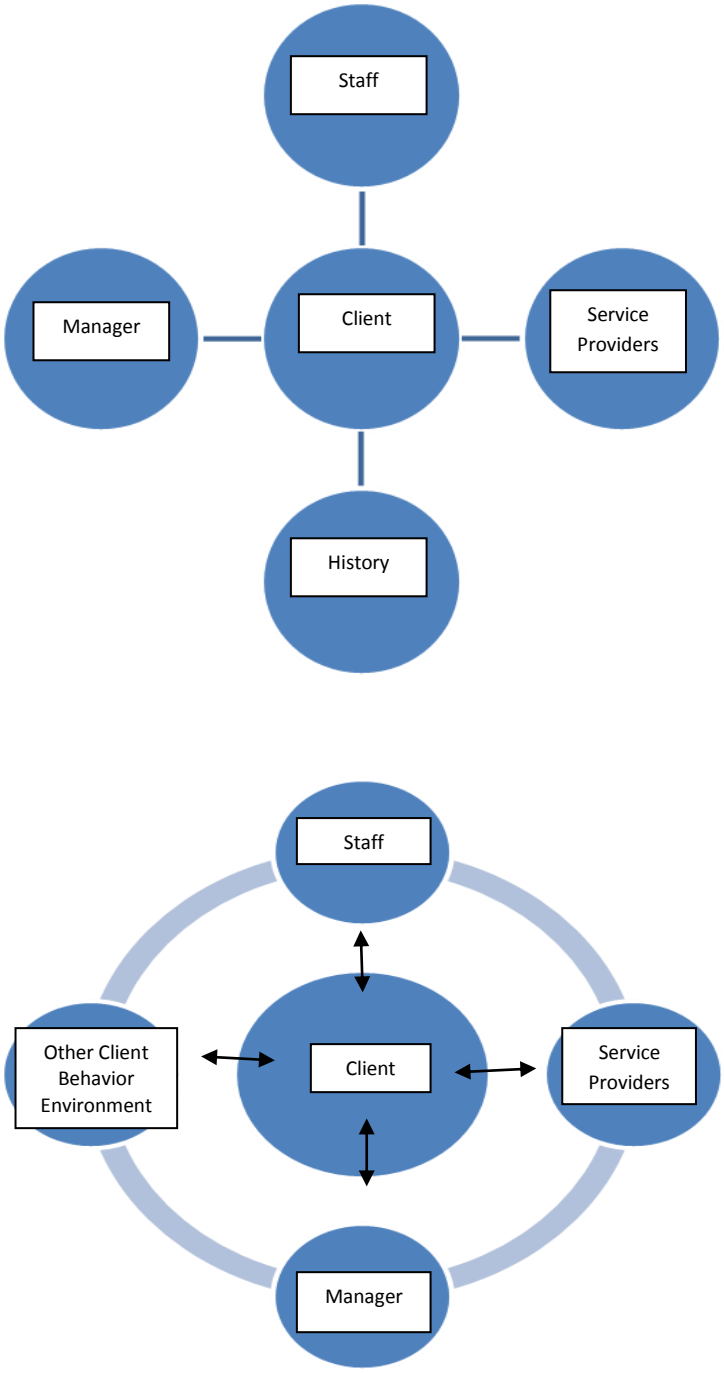


Figure 1. Flowchart: Behavioral Consultation verses Consultee-Centered Consultation.

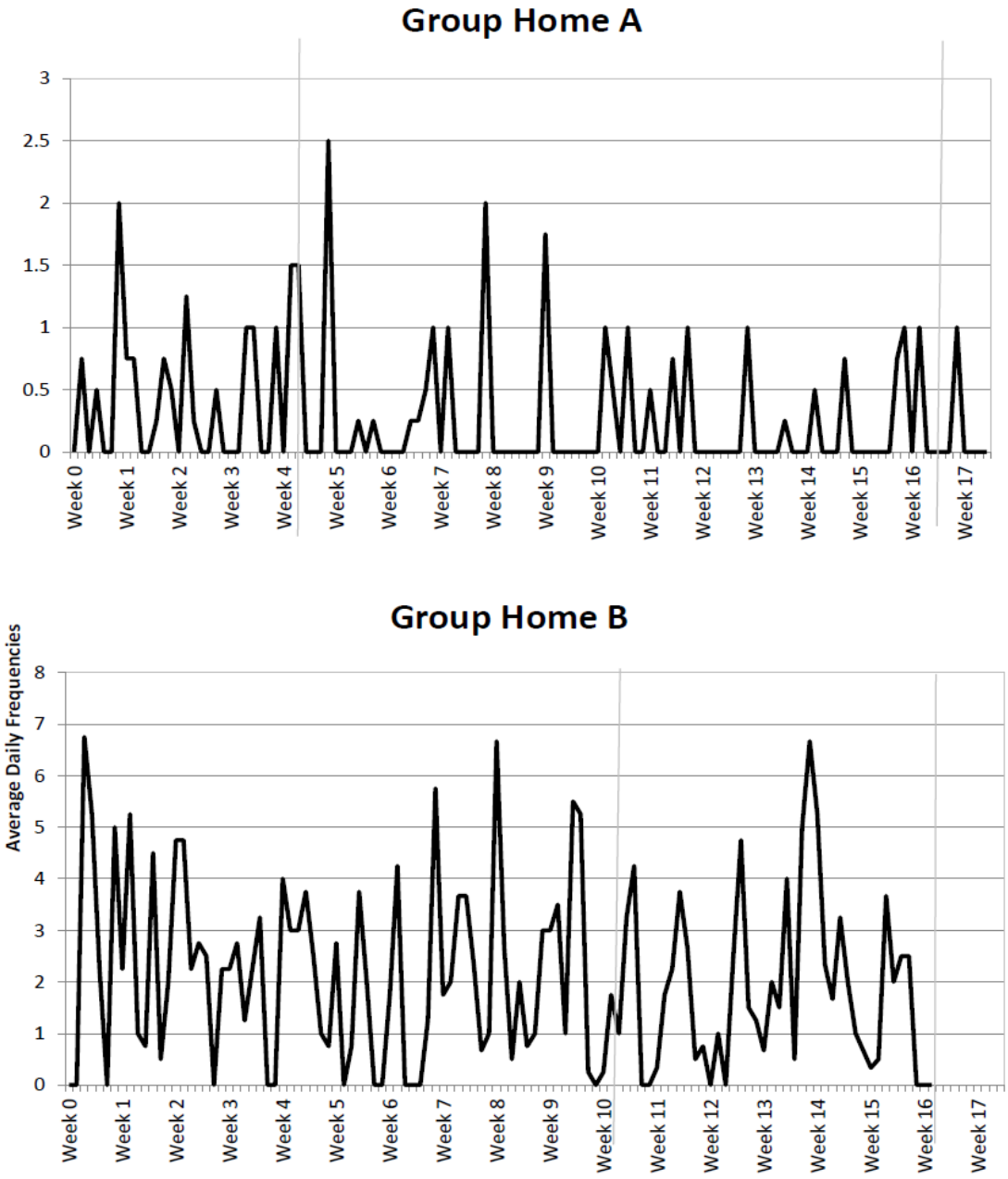


Figure 2. Behavioral Frequency Data (ABC data): All Groups. Average number of all behaviors combined

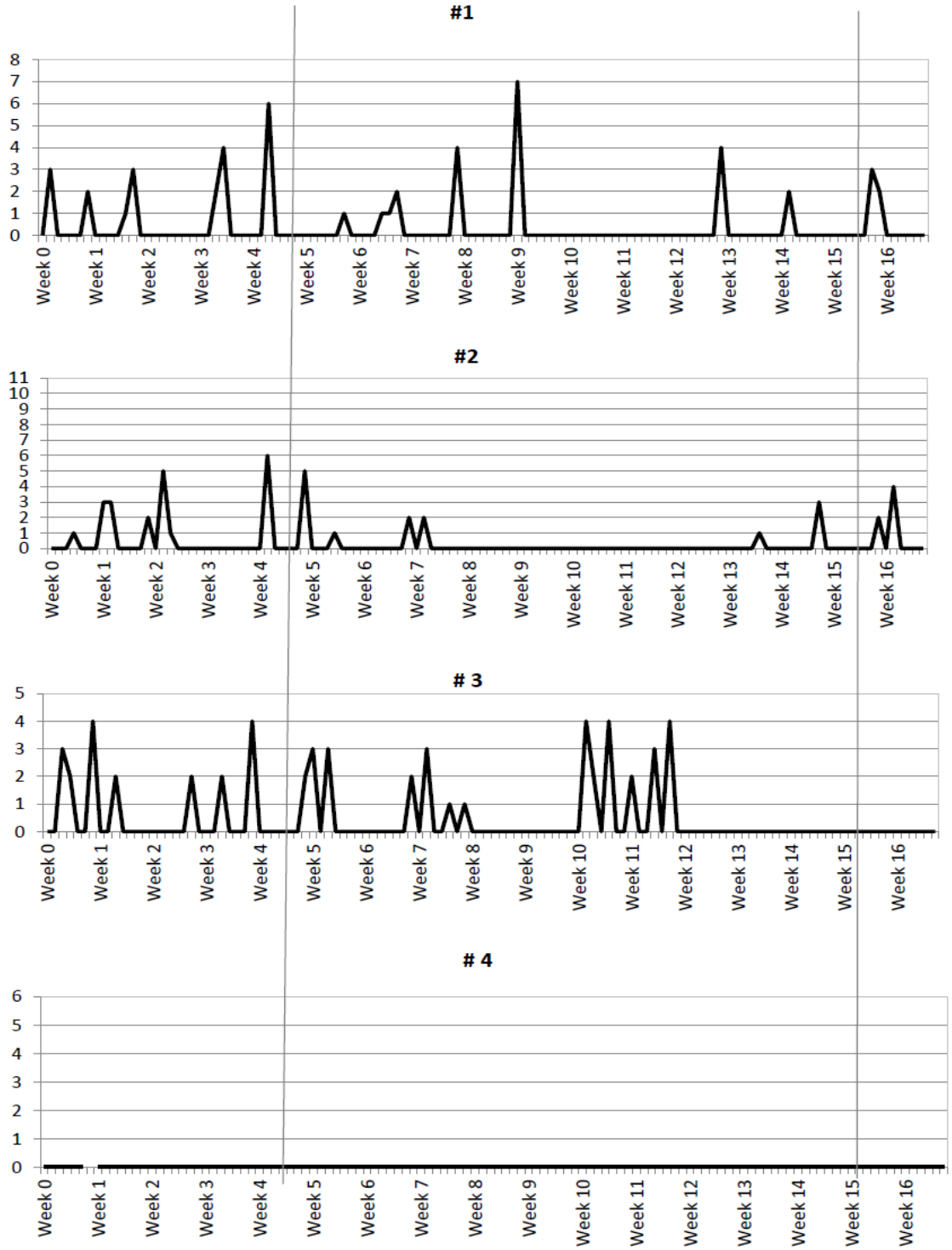


Figure 3. Group A individual client ABC data

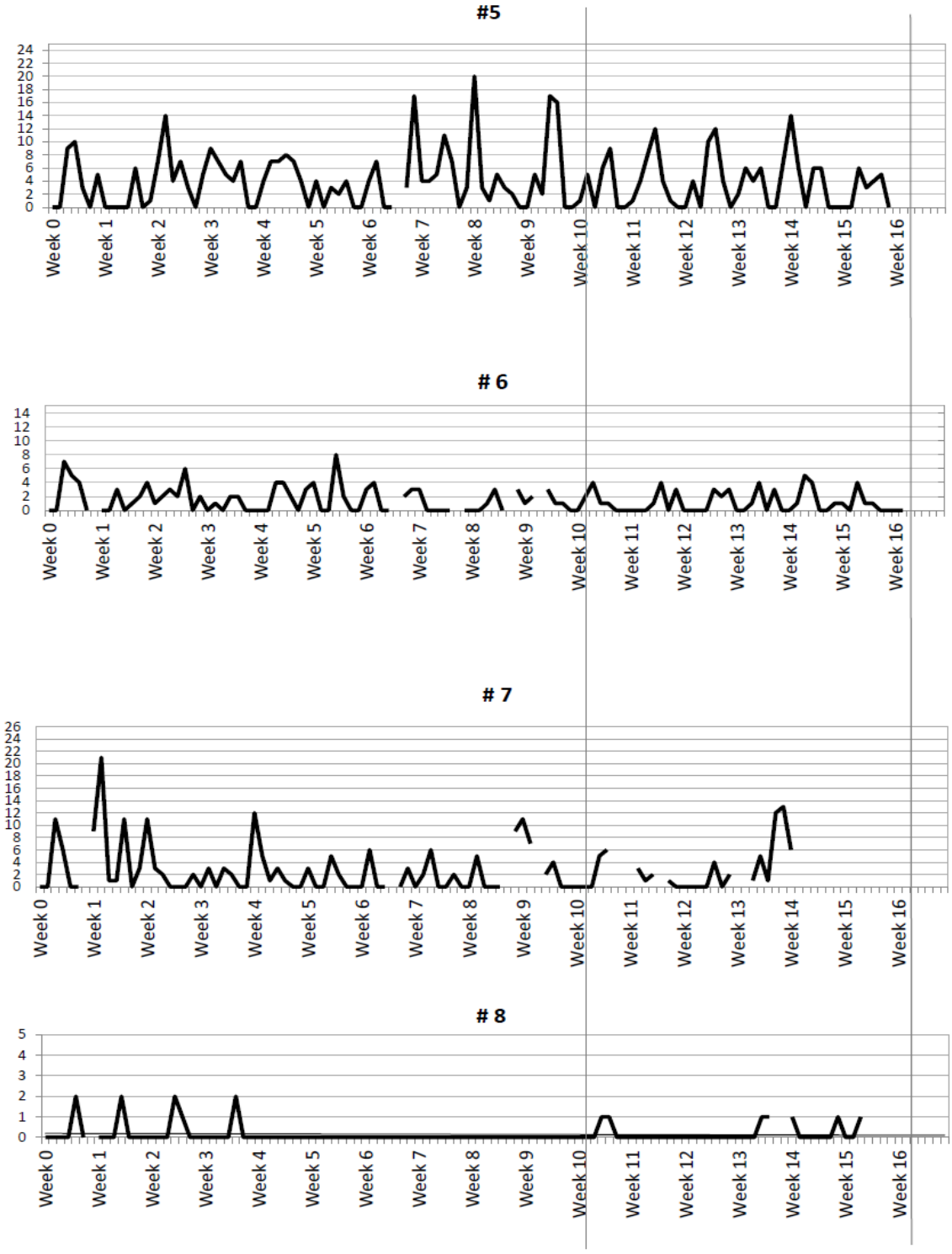


Figure 4. Group B individual client ABC data

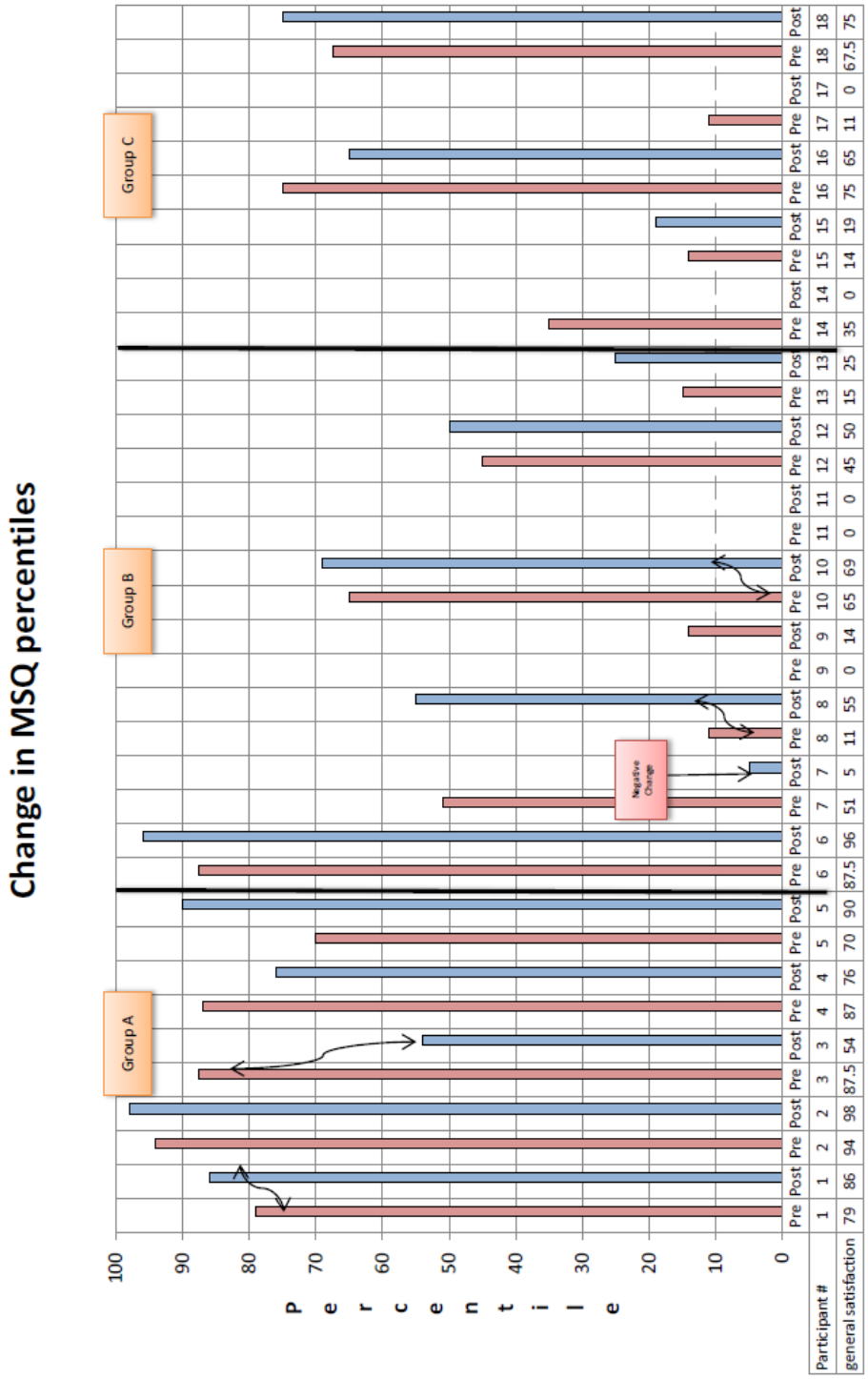


Figure 5. Change in MSQ percentiles

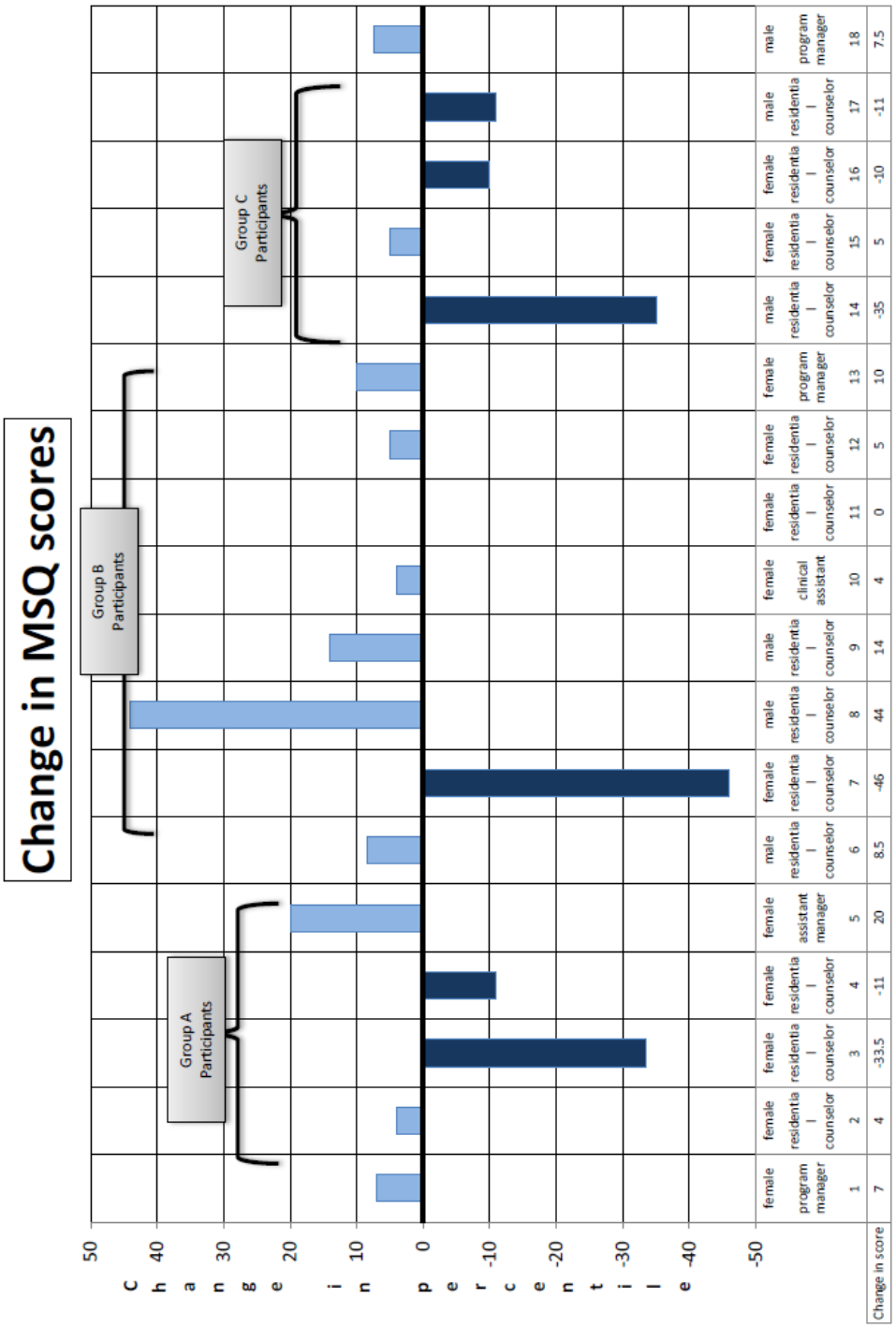


Figure 6. Change in MSQ scores

APPENDIX A

Consultation Effectiveness Scale

Please consider the *consultant* with whom you have just worked. Please rate this *consultant*

on the degree to which she exhibited the characteristics below.

A. Not at all
B. To a Slight Degree
C. To a Considerable Degree
D To a Large Degree
E. To a Very Large Degree

Please circle A,B,C,D, or E to the right

1	Warm	A	B	C	D	E
2	Active	A	B	C	D	E
3	Tactful	A	B	C	D	E
4	Skillful	A	B	C	D	E
5	Flexible	A	B	C	D	E
6	Specific	A	B	C	D	E
7	Tolerant	A	B	C	D	E
8	Pleasant	A	B	C	D	E
9	Empathic	A	B	C	D	E
10	Attentive	A	B	C	D	E
11	Encouraging	A	B	C	D	E
12	Trustworthy	A	B	C	D	E
13	Open-minded	A	B	C	D	E
14	Approachable	A	B	C	D	E
15	A Team player	A	B	C	D	E
16	Self-Disclose	A	B	C	D	E
17	A Good Facilitator	A	B	C	D	E
18	An Active Listener	A	B	C	D	E
19	Identify Clear Goals	A	B	C	D	E
20	Evaluate/Focus Ideas	A	B	C	D	E
21	Clarify His/Her Role	A	B	C	D	E
22	Encourage Ventilation	A	B	C	D	E

23	Skilled in Questioning	A	B	C	D	E
24	Review Client Records	A	B	C	D	E
25	Interested (Concerned)	A	B	C	D	E
26	Willing to Get Involved	A	B	C	D	E
27	Have a Positive Attitude	A	B	C	D	E
28	Maintain Confidentiality	A	B	C	D	E
29	Good at Problem-Solving	A	B	C	D	E
30	An Efficient User of Time	A	B	C	D	E
31	Give and Receive Feedback	A	B	C	D	E
32	Able to Overcome Resistance	A	B	C	D	E
33	Aware of Relationship Issues	A	B	C	D	E
34	Accepting (Non-judgmental)	A	B	C	D	E
35	Skilled in Conflict Resolution	A	B	C	D	E
36	Practice in an Ethical Manner	A	B	C	D	E
37	Have a Clear Sense of Identity	A	B	C	D	E
38	Pursue Issues/Follow Through	A	B	C	D	E
39	Show Respect for the Consultee	A	B	C	D	E
40	An Astute Observer/Perceptive	A	B	C	D	E
41	Anticipate Possible Consequences	A	B	C	D	E
42	Effective at Establishing Rapport	A	B	C	D	E
43	Express Affection (Be Supportive)	A	B	C	D	E
44	Emotionally Well-Adjusted/Stable	A	B	C	D	E
45	Document for Clear Communication	A	B	C	D	E
46	Collaborative (Share Responsibility)	A	B	C	D	E
47	Take Risks/Be Willing to Experiment	A	B	C	D	E
48	Gives Clear, Understandable Directions	A	B	C	D	E
49	Employ Appropriate Personal Distance	A	B	C	D	E
50	Specify the Contract (Time, Effort, Cost)	A	B	C	D	E
51	Maintain an "I'm OK- You're OK" Position	A	B	C	D	E
52	Have Feelings and Behaviors that are Consistent	A	B	C	D	E

APPENDIX B

Follow-up Interview with Consultees:

Date: _____ Group #: _____

1. What were the goals set for consultation?
2. To what degree were they accomplished?
3. What impact did your work with the consultant have on the direct-care staff?

   On the clients?
4. This is a four-part question to better understand the impact your work with the consultant had on your own skills and growth.

Did the consultant impact your perceived level of:

Confidence? If yes, please explain.

Knowledge? In what capacity?

Skills? Please give an example.

Objectivity

APPENDIX C

Minnesota Satisfaction Questionnaire

minnesota satisfaction questionnaire

1967 Revision

Vocational Psychology Research
UNIVERSITY OF MINNESOTA

Confidential

Your answers to the questions and all other information you give us will be held in strictest confidence.

Name_____ Today's Date_____ 19____
Please Print

1. Check one: ☐ Male ☐ Female

2. When were you born?_____ 19____

3. Circle the number of years of schooling you completed:

4 5 6 7 8	9 10 11 12	13 14 15 16	17 18 19 20
Grade School	High School	College	Graduate or Professional School

4. What is your present job called?_____

_____

5. What do you do on your present job?_____

_____

_____

6. How long have you been on your present job?_____ years _____ months

7. What would you call your **occupation,** your usual line of work?_____

_____

8. How long have you been in this line of work?_____ years _____ months

minnesota satisfaction questionnaire

Directions

The purpose of this questionnaire is to give you a chance to tell **how you feel about your present job,** what things you are **satisfied** with and what things you are **not satisfied** with.

On the basis of your answers and those of people like you, we hope to get a better understanding of the things people **like and dislike about their jobs.**

On the following pages you will find statements about certain aspects of your ***present job.***

- Read each statement carefully.
- Decide how you feel about the aspect of your job described by the statement.
  - —Circle 1 if you are ***not satisfied*** (if that aspect is much poorer than you would like it to be).
  - —Circle 2 if you are ***only slightly satisfied*** (if that aspect is not quite what you would like it to be).
  - —Circle 3 if you are ***satisfied*** (if that aspect is what you would like it to be).
  - —Circle 4 if you are ***very satisfied*** (if that aspect is even better than you expected it to be).
  - —Circle 5 if you are ***extremely satisfied*** (if that aspect is much better than you hoped it could be).
- Be sure to keep the statement in mind when deciding ***how you feel about that aspect of your job.***
- Do this for ***all*** statements. Answer ***every*** item.
- ***Do not turn back*** to previous statements.

Be frank. Give a true picture of your feelings about your ***present job.***

*Ask yourself: How **satisfied** am I with this aspect of my job?*

1 means I am ***not satisfied*** (this aspect of my job is much poorer than I would like it to be).

2 means I am ***only slightly satisfied*** (this aspect of my job is not quite what I would like it to be).

3 means I am ***satisfied*** (this aspect of my job is what I would like it to be).

4 means I am ***very satisfied*** (this aspect of my job is even better than I expected it to be).

5 means I am ***extremely satisfied*** (this aspect of my job is much better than I hoped it could be).

On my present job, this is how I feel about . . .	For each statement circle a number.				
1. The chance to be of service to others.	1	2	3	4	5
2. The chance to try out some of my own ideas.	1	2	3	4	5
3. Being able to do the job without feeling it is morally wrong.	1	2	3	4	5
4. The chance to work by myself.	1	2	3	4	5
5. The variety in my work.	1	2	3	4	5
6. The chance to have other workers look to me for direction.	1	2	3	4	5
7. The chance to do the kind of work that I do best.	1	2	3	4	5
8. The social position in the community that goes with the job.	1	2	3	4	5
9. The policies and practices toward employees of this company.	1	2	3	4	5
10. The way my supervisor and I understand each other.	1	2	3	4	5
11. My job security.	1	2	3	4	5
12. The amount of pay for the work I do.	1	2	3	4	5
13. The working conditions (heating, lighting, ventilation, etc.) on this job.	1	2	3	4	5
14. The opportunities for advancement on this job.	1	2	3	4	5
15. The technical "know-how" of my supervisor.	1	2	3	4	5
16. The spirit of cooperation among my co-workers.	1	2	3	4	5
17. The chance to be responsible for planning my work.	1	2	3	4	5
18. The way I am noticed when I do a good job.	1	2	3	4	5
19. Being able to see the results of the work I do.	1	2	3	4	5
20. The chance to be active much of the time.	1	2	3	4	5
21. The chance to be of service to people.	1	2	3	4	5
22. The chance to do new and original things on my own.	1	2	3	4	5
23. Being able to do things that don't go against my religious beliefs.	1	2	3	4	5
24. The chance to work alone on the job.	1	2	3	4	5
25. The chance to do different things from time to time.	1	2	3	4	5

*Ask yourself: How **satisfied** am I with this aspect of my job?*

1 means I am ***not satisfied*** (this aspect of my job is much poorer than I would like it to be).

2 means I am ***only slightly satisfied*** (this aspect of my job is not quite what I would like it to be).

3 means I am ***satisfied*** (this aspect of my job is what I would like it to be).

4 means I am ***very satisfied*** (this aspect of my job is even better than I expected it to be).

5 means I am ***extremely satisfied*** (this aspect of my job is much better than I hoped it could be).

On my present job, this is how I feel about . . .	For each statement circle a number.				
26. The chance to tell other workers how to do things.	1	2	3	4	5
27. The chance to do work that is well suited to my abilities.	1	2	3	4	5
28. The chance to be "somebody" in the community.	1	2	3	4	5
29. Company policies and the way in which they are administered.	1	2	3	4	5
30. The way my boss handles his/her employees.	1	2	3	4	5
31. The way my job provides for a secure future.	1	2	3	4	5
32. The chance to make as much money as my friends.	1	2	3	4	5
33. The physical surroundings where I work.	1	2	3	4	5
34. The chances of getting ahead on this job.	1	2	3	4	5
35. The competence of my supervisor in making decisions.	1	2	3	4	5
36. The chance to develop close friendships with my co-workers.	1	2	3	4	5
37. The chance to make decisions on my own.	1	2	3	4	5
38. The way I get full credit for the work I do.	1	2	3	4	5
39. Being able to take pride in a job well done.	1	2	3	4	5
40. Being able to do something much of the time.	1	2	3	4	5
41. The chance to help people.	1	2	3	4	5
42. The chance to try something different.	1	2	3	4	5
43. Being able to do things that don't go against my conscience.	1	2	3	4	5
44. The chance to be alone on the job.	1	2	3	4	5
45. The routine in my work.	1	2	3	4	5
46. The chance to supervise other people.	1	2	3	4	5
47. The chance to make use of my best abilities.	1	2	3	4	5
48. The chance to "rub elbows" with important people.	1	2	3	4	5
49. The way employees are informed about company policies.	1	2	3	4	5
50. The way my boss backs up his/her employees (with top management).	1	2	3	4	5

*Ask yourself: How **satisfied** am I with this aspect of my job?*

1 means I am ***not satisfied*** (this aspect of my job is much poorer than I would like it to be).

2 means I am ***only slightly satisfied*** (this aspect of my job is not quite what I would like it to be).

3 means I am ***satisfied*** (this aspect of my job is what I would like it to be).

4 means I am ***very satisfied*** (this aspect of my job is even better than I expected it to be).

5 means I am ***extremely satisfied*** (this aspect of my job is much better than I hoped it could be).

On my present job, this is how I feel about . . .	For each statement circle a number.				
51. The way my job provides for steady employment.	1	2	3	4	5
52. How my pay compares with that for similar jobs in other companies.	1	2	3	4	5
53. The pleasantness of the working conditions.	1	2	3	4	5
54. The way promotions are given out on this job.	1	2	3	4	5
55. The way my boss delegates work to others.	1	2	3	4	5
56. The friendliness of my co-workers.	1	2	3	4	5
57. The chance to be responsible for the work of others.	1	2	3	4	5
58. The recognition I get for the work I do.	1	2	3	4	5
59. Being able to do something worthwhile.	1	2	3	4	5
60. Being able to stay busy.	1	2	3	4	5
61. The chance to do things for other people.	1	2	3	4	5
62. The chance to develop new and better ways to do the job.	1	2	3	4	5
63. The chance to do things that don't harm other people.	1	2	3	4	5
64. The chance to work independently of others.	1	2	3	4	5
65. The chance to do something different every day.	1	2	3	4	5
66. The chance to tell people what to do.	1	2	3	4	5
67. The chance to do something that makes use of my abilities.	1	2	3	4	5
68. The chance to be important in the eyes of others.	1	2	3	4	5
69. The way company policies are put into practice.	1	2	3	4	5
70. The way my boss takes care of the complaints of his/her employees.	1	2	3	4	5
71. How steady my job is.	1	2	3	4	5
72. My pay and the amount of work I do.	1	2	3	4	5
73. The physical working conditions of the job.	1	2	3	4	5
74. The chances for advancement on this job.	1	2	3	4	5
75. The way my boss provides help on hard problems.	1	2	3	4	5

*Ask yourself: How **satisfied** am I with this aspect of my job?*

1 means I am ***not satisfied*** (this aspect of my job is much poorer than I would like it to be).

2 means I am ***only slightly satisfied*** (this aspect of my job is not quite what I would like it to be).

3 means I am ***satisfied*** (this aspect of my job is what I would like it to be).

4 means I am ***very satisfied*** (this aspect of my job is even better than I expected it to be).

5 means I am ***extremely satisfied*** (this aspect of my job is much better than I hoped it could be).

On my present job, this is how I feel about . . .	For each statement circle a number.				
76. The way my co-workers are easy to make friends with.	1	2	3	4	5
77. The freedom to use my own judgment.	1	2	3	4	5
78. The way they usually tell me when I do my job well.	1	2	3	4	5
79. The chance to do my best at all times.	1	2	3	4	5
80. The chance to be "on the go" all the time.	1	2	3	4	5
81. The chance to be of some small service to other people.	1	2	3	4	5
82. The chance to try my own methods of doing the job.	1	2	3	4	5
83. The chance to do the job without feeling I am cheating anyone.	1	2	3	4	5
84. The chance to work away from others.	1	2	3	4	5
85. The chance to do many different things on the job.	1	2	3	4	5
86. The chance to tell others what to do.	1	2	3	4	5
87. The chance to make use of my abilities and skills.	1	2	3	4	5
88. The chance to have a definite place in the community.	1	2	3	4	5
89. The way the company treats its employees.	1	2	3	4	5
90. The personal relationship between my boss and his/her employees.	1	2	3	4	5
91. The way layoffs and transfers are avoided in my job.	1	2	3	4	5
92. How my pay compares with that of other workers.	1	2	3	4	5
93. The working conditions.	1	2	3	4	5
94. My chances for advancement.	1	2	3	4	5
95. The way my boss trains his/her employees.	1	2	3	4	5
96. The way my co-workers get along with each other.	1	2	3	4	5
97. The responsibility of my job.	1	2	3	4	5
98. The praise I get for doing a good job.	1	2	3	4	5
99. The feeling of accomplishment I get from the job.	1	2	3	4	5
100. Being able to keep busy all the time.	1	2	3	4	5

APPENDIX D

Data Collection Tools

Narrative ABC Record
Directions: Complete a narrative account of the situation using the boxes below. For each behavior observed, record what happened immediately before (Antecedents) and after (Consequences) each behavior. Note that sometimes a consequence leads directly to another behavior.

Student:
Setting:
Date/Time:

	ANTECEDENTS	BEHAVIORS	CONSEQUENCES
Date/time /location	What happened before?	What was the student doing?	What did you do?

Behavior Observation Form

(adapted BOSS)

10 second interval recording

Target Client:_____ M/F:_____ Age:_____ Date: _____

Group: _____ Observer: _____

Observation #: ____ Activity: _____

Directions: Enter the off-task code that corresponds to the observed behavior. This is a partial interval recording. Put a line through the grid, and make note when environmental conditions change.

Interval	1	2	3	4	5	6	7	8	9	10
client										
peer										

Interval	11	12	13	14	15	16	17	18	19	20
client										
peer										

Interval	21	22	23	24	25	26	27	28	29	30
client										
peer										

Interval	31	32	33	34	35	36	37	38	39	40
client										
peer										

Interval	41	42	43	44	45	46	47	48	49	50
client										
peer										

Interval	51	52	53	54	55	56	57	58	59	60
client										
peer										

Interval	61	62	63	64	65	66	67	68	69	70
client										
peer										

Interval	71	72	73	74	75	76	77	78	79	80
client										
peer										

Interval	81	82	83	84	85	86	87	88	89	90
client										
peer										

Interval	91	92	93	94	95	96	97	98	99	100
client										
peer										

Interval	101	102	103	104	105	106	107	108	109	110
client										
peer										

Interval	111	112	113	114	115	116	117	118	119	120
client										
peer										

Interval	121	122	123	124	125	126	127	128	129	130
client										
peer										

Interval	131	132	133	134	135	136	137	138	139	140
client										
peer										

Interval	141	142	143	144	145	146	147	148	149	150
client										
peer										

Interval	151	152	153	154	155	156	157	158	159	160
client										
peer										

Interval	161	162	163	164	165	166	167	168	169	170
client										
peer										

Interval	171	172	173	174	175	176	177	178	179	180
client										
peer										

Codes:

N=non-compliance: refusing to comply with requests

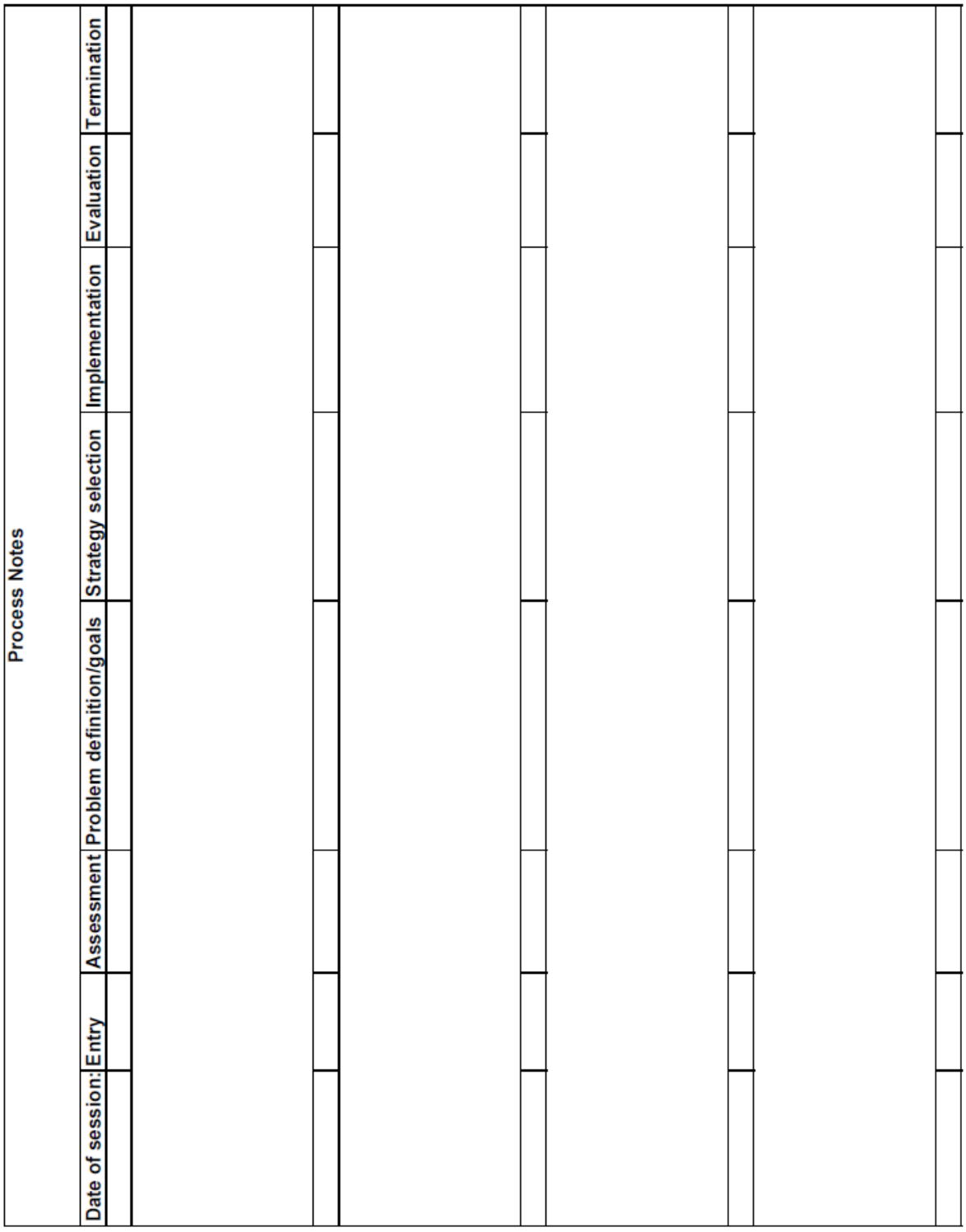
T=tantrumming: yelling, screaming, flopping to the floor, flailing

A=aggression: causing or attempting to harm others

S=self-injurious: causing or attempting to cause harm to self

X=other: please describe briefly

APPENDIX E


Process Notes
Date of session:
Entry
Assessment
Problem definition/goals
Strategy selection
Implementation
Evaluation
Termination

APPENDIX F

Informed Consent Form to be used with Group Home Managers

My name is Jessica K. Williams and I am a doctoral student in the School Psychology Program at Alfred University. I am requesting your participation in a 15-week research project to evaluate the effectiveness of consultee-centered consultation (CCC) on challenging client behaviors in the group home environment. I have worked with adults with developmental and intellectual disabilities for the past ten years in the context of the group home environment. My experience in this environment encompasses work as a direct care staff member and as a behavior specialist. I also have spent the last two years utilizing CCC in the school environment with teachers and other paraprofessionals, to enhance their ability to successfully manage challenging student behaviors.

This research study is designed to explore the impact of consultee-centered consultation on: a) client challenging behaviors such as non-compliance, tantrumming, aggression, and self-injurious behaviors, b) employee job satisfaction, and c) manager efficacy. Client information will be used to determine whether providing consultee-centered consultation to group home managers will decrease client challenging behaviors. Therefore, client challenging behaviors will be observed and recorded in order to determine the possible positive impact of consultations with group home managers. Specifically, two 30-minute adapted versions of the Behavior Observation of Students in Schools (BOSS) interval data form, which is a time sampling data collection form, will be collected each week. Each client will be observed on weekday evenings between the hours of 3pm and 10pm for the duration of this study. This data and the daily Antecedent, Behavior, Consequence (ABC) data collection methods currently in place will be used for one purpose. The results will promote future research in the area of consultee-centered

consultation and its implication for clients in group home environments who demonstrate challenging behavioral needs.

There are a number of potential beneficial outcomes. Initially, CCC may provide immediate support for group-home managers in the areas of objectivity, knowledge, confidence, or skills. These are areas where a manager may encounter challenges when working with staff, clients, and the families of clients in the group home. In addition, the application of CCC may help improve self-awareness by professionals who work with clients who have challenging behaviors and may also improve conditions in the group home. It may improve their understanding of how their own thoughts and behaviors impact successful job performance. Lastly, this study may improve data collection procedures so future data accurately reflects the response to behavioral interventions. This may have an additional benefit of increasing employee job satisfaction.

In addition to the benefits, there are possible risks. Those may include concerns that the level of staff job satisfaction will become public or that time spent on the study will take away from the time spent on daily group home responsibilities. The research design and confidentiality protections should minimize these risks. Moreover, in the event CCC is unsuccessful, it is not likely that it will alter the levels of job satisfaction.

This intervention is not expected to cause or result in any risk or injury. However, in the event that a client or staff member incurs injury during an observation period, staff will immediately follow all procedures for response to injury established by the agency. All staff is trained in crisis intervention and should a crisis arise during data collection, data collection will be suspended. Once the crisis is resolved and the climate is appropriate, the data collection shall resume.

The ethical standards for the conduct of research protect the rights of participants, including confidentiality. The information you provide and any discussion of responses will not use names of specific individuals, agencies or the group home. All hard copy information on individuals participating in this study will be coded by number and stored in a locked box at the researcher's home. Accompanying online data will be stored on a password protected computer also at the researcher's place of residence. Results will be used solely for the purpose of promoting future research in the area of consultee-centered consultation and its implication for clients with challenging behavioral needs. All records and information gathered during this study such as staff information and other confidential material will be kept for a period of one year following the project's completion. It shall be destroyed in accordance with the current guidelines of the American Psychological Association.

If you as a Group Home Manager agree to participate in this research study, you may be asked to do several things.

Complete two questionnaires: the first, the Minnesota Satisfaction Questionnaire, will address your level of satisfaction at your current place of employment. It will take approximately 10-15 minutes to complete and will be administered at the beginning and end of the study. The second, the Consultee Effectiveness Scale, will ask about your level of satisfaction with the consultant and be administered at the end of the study, taking about 30 minutes.

Participate in a series of 30-minute sessions with a consultant over a six or 12 week period of time.

Participate in a 5 to 10 minute phone interview at the end of this project.

I understand the risks and benefits associated with this research projects. I also understand that my participation in this study is free and voluntary and that I may withdraw from participation at any time without penalty or loss of benefits. By signing below, I give my consent to participate in the aforementioned research project.

Name: _____ Date: _____

Signature: _____

The Human Subjects Research committee at Alfred University has approved the research. For additional information concerning the research and the rights of research participants, please contact: Jessica K Williams (student researcher) jkw7@alfred.edu, 518-857-9289, Dr. Nancy Evangelista (Research Advisor) 607-871-2124, fevangel@alfred.edu, or Dr. Danielle Gagne (Chair of the Human Subjects Research Committee) at: gagne@alfred.edu; 607-871-2873.

APPENDIX G

Informed Consent Form to be used with Data Collectors

My name is Jessica K. Williams and I am a doctoral student in the School Psychology Program at Alfred University. I am requesting your participation in a 15-week research project to evaluate the effectiveness of consultee-centered consultation (CCC) on challenging client behaviors in the group home environment. I have worked with adults with developmental and intellectual disabilities for the past ten years in the context of the group home environment. My experience in this environment encompasses work as a direct care staff member and as a behavior specialist. I also have spent the last two years utilizing CCC in the school environment with teachers and other paraprofessionals, to enhance their ability to successfully manage challenging student behaviors.

This research study is designed to explore the impact of consultee-centered consultation on: a) client challenging behaviors such as non-compliance, tantrumming, aggression, and self-injurious behaviors, b) employee job satisfaction, and c) manager efficacy. Client information will be used to determine whether providing consultee-centered consultation to group home managers will decrease client challenging behaviors. Therefore, client challenging behaviors will be observed and recorded in order to determine the possible positive impact of consultations with group home managers. Specifically, two 30-minute adapted versions of the Behavior Observation of Students in Schools (BOSS) interval data form, which is a time sampling data collection form, will be collected each week. Each client will be observed on weekday evenings between the hours of 3pm and 10pm for the duration of this study. This data and the daily Antecedent, Behavior, Consequence (ABC) data collection methods currently in place will be used for one purpose. The results will promote future research in the area of consultee-centered

consultation and its implication for clients in group home environments who demonstrate challenging behavioral needs.

There are a number of potential beneficial outcomes. Initially, CCC may provide immediate support for group-home managers in the areas of objectivity, knowledge, confidence, or skills. These are areas where a manager may encounter challenges when working with staff, clients, and the families of clients in the group home. In addition, the application of CCC may help improve self-awareness by professionals who work with clients who have challenging behaviors and may improve conditions in the group home. It may improve their understanding of how their own thoughts and behaviors impact successful job performance. Lastly, this study may improve data collection procedures so future data accurately reflects the response to behavioral interventions. This may have an additional benefit of increasing employee job satisfaction.

In addition to the benefits, there are possible risks. Those may include concerns that the level of staff job satisfaction will become public or that time spent on the study will take away from the time spent on daily group home responsibilities. The research design and confidentiality protections should minimize these risks. Moreover, in the event CCC is unsuccessful, it is not likely that it will alter the levels of job satisfaction.

This intervention is not expected to cause or result in any risk or injury. However, in the event that a client or staff member incurs injury during an observation period, staff will immediately follow all procedures for response to injury established by the agency. All staff is trained in crisis intervention and should a crisis arise during data collection, data collection will be suspended. Once the crisis is resolved and the climate is appropriate, the data collection shall resume.

The ethical standards for the conduct of research protect the rights of participants, including confidentiality. The information you provide and any discussion of responses will not use names of individuals, agencies or the group home itself. All hard copy information on individuals participating in this study will be coded by number and stored in a locked box with accompanying online data stored on a password-protected computer at the researcher's place of residence. Results will be used solely for the purpose of promoting future research in the area of consultee-centered consultation and its implication for clients with challenging behavioral needs. All records and information gathered during this study such as staff information and other confidential material will be kept for a period of one year following the project's completion and destroyed in accordance with current guidelines of the American Psychological Association.

If you agree to participate in this research study as a data collector, you will be asked to do several things.

Complete a 10 to 15 minute questionnaire concerning your level of satisfaction with your employment in the group home at the beginning and at the end of this study.

Collect weekly interval data (two 30 minute adapted BOSS data during the hours of 3pm-10pm weekdays) in addition to the daily ABC frequency data currently collected on clients.

I understand the risks and benefits associated with this research projects. I also understand that my participation in this study is free and voluntary and that I may withdraw from participation at any time without penalty or loss of benefits. By signing below, I give my consent to participate in the aforementioned research project.

Name: _____ Date: _____

Signature: _____

The Human Subjects Research committee at Alfred University has approved the research. For additional information concerning the research and the rights of research participants, please contact: Jessica K Williams (student researcher) jkw7@alfred.edu, 518-857-9289, Dr. Nancy Evangelista (Research Advisor) 607-871-2124, fevangel@alfred.edu, or Dr. Danielle Gagne (Chair of the Human Subjects Research Committee) at: gagne@alfred.edu; 607-871-2873.

APPENDIX H

Informed Consent Form to be used with Direct Care Staff

My name is Jessica K. Williams and I am a doctoral student in the School Psychology Program at Alfred University. I am requesting your participation in a 15-week research project to evaluate the effectiveness of consultee-centered consultation (CCC) on challenging client behaviors in the group home environment. I have worked with adults with developmental and intellectual disabilities for the past ten years in the context of the group home environment. My experience in this environment encompasses work as a direct care staff member and as a behavior specialist. I also have spent the last two years utilizing CCC in the school environment with teachers and other paraprofessionals, to enhance their ability to successfully manage challenging student behaviors.

This research study is designed to explore the impact of consultee-centered consultation on: a) client challenging behaviors such as non-compliance, tantrumming, aggression, and self-injurious behaviors, b) employee job satisfaction, and c) manager efficacy. Client information will be used to determine whether providing consultee-centered consultation to group home managers will decrease client challenging behaviors. Therefore, client challenging behaviors will be observed and recorded in order to determine the possible positive impact of consultations with group home managers. Specifically, two 30-minute adapted versions of the Behavior Observation of Students in Schools (BOSS) interval data form, which is a time sampling data collection form, will be collected each week. Each client will be observed on weekday evenings between the hours of 3pm and 10pm for the duration of this study. This data and the daily Antecedent, Behavior, Consequence (ABC) data collection methods currently in place will be used for one purpose. The results will promote future research in the area of consultee-centered

consultation and its implication for clients in group home environments who demonstrate challenging behavioral needs.

There are a number of potential beneficial outcomes. Initially, CCC may provide immediate support for group-home managers in the areas of objectivity, knowledge, confidence, or skills. These are areas where a manager may encounter challenges when working with staff, clients, and the families of clients in the group home. In addition, the application of CCC may help improve self-awareness by professionals who work with clients who have challenging behaviors and may improve conditions in the group home. It may improve their understanding of how their own thoughts and behaviors impact successful job performance. Lastly, this study may improve data collection procedures so future data accurately reflects the response to behavioral interventions. This may have an additional benefit of increasing employee job satisfaction.

In addition to the benefits, there are possible risks. Those may include concerns that the level of staff job satisfaction will become public or that time spent on the study will take away from the time spent on daily group home responsibilities. The research design and confidentiality protections should minimize these risks. Moreover, in the event CCC is unsuccessful, it is not likely that it will alter the levels of job satisfaction.

This intervention is not expected to cause or result in any risk or injury. However, in the event that a client or staff member incurs injury during an observation period, staff will immediately follow all procedures for response to injury established by the agency. All staff is trained in crisis intervention and should a crisis arise during data collection, data collection will be suspended. Once the crisis is resolved and the climate is appropriate, the data collection shall resume.

The ethical standards for the conduct of research protect the rights of participants, including confidentiality. The information you provide and any discussion of responses will not use names of individuals, agencies or the group home itself. All hard copy information on individuals participating in this study will be coded by number and stored in a locked box with accompanying online data stored on a password-protected computer at the researcher's place of residence. Results will be used solely for the purpose of promoting future research in the area of consultee-centered consultation and its implication for clients with challenging behavioral needs. All records and information gathered during this study such as staff information and other confidential material will be kept for a period of one year following the project's completion and destroyed in accordance with current guidelines of the American Psychological Association.

If you agree to participate in this research study, you will be asked to complete a 10 to15 minute questionnaire concerning your level of satisfaction with your employment in the group home at the beginning and at the end of this study.

I understand the risks and benefits associated with this research projects. I also understand that my participation in this study is free and voluntary and that I may withdraw from participation at any time without penalty or loss of benefits. By signing below, I give my consent to participate in the aforementioned research project.

Name: _____ Date: _____

Signature: _____

The Human Subjects Research committee at Alfred University has approved the research. For additional information concerning the research and the rights of research participants, please contact: Jessica K Williams (student researcher) jkw7@alfred.edu, 518-857-9289, Dr. Nancy

Evangelista (Research Advisor) 607-871-2124, fevangel@alfred.edu, or Dr. Danielle Gagne (Chair of the Human Subjects Research Committee) at: gagne@alfred.edu; 607-871-2873.

APPENDIX I

Informed Consent Form to be used with Clients' Legal Representative

My name is Jessica K. Williams and I am a doctoral student in the School Psychology Program at Alfred University. I am requesting your participation in a 15-week research project to evaluate the effectiveness of consultee-centered consultation (CCC) on challenging client behaviors in the group home environment. I have worked with adults with developmental and intellectual disabilities for the past ten years in the context of the group home environment. My experience in this environment encompasses work as a direct care staff member and as a behavior specialist. I also have spent the last two years utilizing CCC in the school environment with teachers and other paraprofessionals, to enhance their ability to successfully manage challenging student behaviors.

This research study is designed to explore the impact of consultee-centered consultation on: a) client challenging behaviors such as non-compliance, tantrumming, aggression, and self-injurious behaviors, b) employee job satisfaction, and c) manager efficacy. Client information will be used to determine whether providing consultee-centered consultation to group home managers will decrease client challenging behaviors. Therefore, client challenging behaviors will be observed and recorded in order to determine the possible positive impact of consultations with group home managers. Specifically, two 30-minute adapted versions of the Behavior Observation of Students in Schools (BOSS) interval data form, which is a time sampling data collection form, will be collected each week. Each client will be observed on weekday evenings between the hours of 3pm and 10pm for the duration of this study. This data and the daily Antecedent, Behavior, Consequence (ABC) data collection methods currently in place will be used for one purpose. The results will promote future research in the area of

consultee-centered consultation and its implication for clients in group home environments who demonstrate challenging behavioral needs.

There are a number of potential beneficial outcomes. Initially CCC may provide immediate support for group home managers in the areas objectivity, knowledge, confidence or skills. These are areas where a manager may encounter challenges when working with staff, clients and the families of clients in the group home. In addition, the application of CCC may help improve self-awareness by professionals who work with clients who have challenging behaviors and may improve conditions in the group home. It may improve their understanding of how their own thoughts and behaviors impact successful job performance. Lastly, this study may improve data collection procedures so future data accurately reflects the response to behavioral interventions. This may have an additional benefit of increasing employee job satisfaction.

In addition to the possible benefits, there are some potential risks from this research study. Guardians may have concern about confidential client information being re-disclosed but the procedures described above should minimize any risk of disclosure. An additional concern may include the reactivity of the clients to a new observer or consultant in the environment. However, this is minimized because CCC does not require direct observation of the client by the consultant. Rather, the client will be observed by staff working in the home. The researcher will work directly with the managers.

This intervention is not expected to cause or result in any risk or injury. However, in the event that a client or staff member incurs injury during an observation period, staff will immediately follow all procedures for response to injury established by the agency. All staff is trained in crisis intervention and should a crisis arise during data collection, data collection will

be suspended. Once the crisis is resolved and the climate is appropriate, the data collection shall resume.

The ethical standards for the conduct of research protect the rights of participants, including confidentiality. The information you provide and any discussion of responses will not use names of specific individuals, agencies or the group home. All hard copy information on individuals participating in this study will be coded by number and stored in a locked box at the researcher's home. Accompanying online data will be stored on a password-protected computer also at the researcher's place of residence. Results will be used solely for the purpose of promoting future research in the area of consultee-centered consultation and its implication for clients with challenging behavioral needs. All records and information gathered during this study such as staff information and other confidential material will be kept for a period of one year following the project's completion. It shall be destroyed in accordance with the current guidelines of the American Psychological Association.

If you as the legal representative of the client agree to the client's participation in this research study, you will need to authorize the use and collection of the certain client information, which is listed below.

The sex, age, diagnoses, level of adaptive and intellectual functioning

Review of the records that direct care staff takes on behaviors to see if there is a decrease in the client's challenging behavior.

Collection of additional data on challenging behaviors exhibited by the client through the use of 30 minute adapted BOSS time samples. These will be collected each week throughout the duration of the study from 3pm-10pm.

I understand the risks and benefits associated with this research projects. I also understand that my participation in this study is free and voluntary and that I may withdraw from participation at any time without penalty or loss of benefits. By signing below, I give my consent for the researcher to use the client information listed above.

Name of client: _____

Name of legal representative of client: _____

Signature of legal representative: _____

Date: _____

The Human Subjects Research committee at Alfred University has approved the research. For additional information concerning the research and the rights of research participants, please contact: Jessica K Williams (student researcher) jkw7@alfred.edu, 518-857-9289, Dr. Nancy Evangelista (Research Advisor) 607-871-2124, fevangel@alfred.edu, or Dr. Danielle Gagne (Chair of the Human Subjects Research Committee) at: gagne@alfred.edu; 607-871-2873.

APPENDIX J

Client Assent Form

My name is Jessica Williams. I go to school at Alfred University. I have worked with adults with developmental and intellectual disabilities living in group home homes for the past ten years. I also work in the school environment with teachers and other paraprofessionals, to help teachers work with students that have learning and behavior problems.

I am asking you to take part in my research study because I am trying to learn more about behavior in the group home and to learn whether helping your manager to learn more about you and your staff makes things better for you at the group home. I want to learn how working with your group home manager can improve how you feel and act in your home.

You do not have to be in this study. No one will be mad at you if you decide not to do this study. Even if you start, you can stop later if you want. You may ask questions about the study.

If you decide to be in the study, I will not tell anyone else about what you say or do in the study or about your behavior or personal information.

If you agree, you will be asked to allow me to use information about you such as your sex, age and diagnoses. I will also ask what things you can do independently and what things you are still working on. In addition, I want to know how you think and reason, and what behavioral data was gathered about you in your house.

Signing below means that you have read and understand this form or I have explained it to you and you are willing to be in this study.

Signature of client_____

Client's printed name _____

Signature of investigator_____

Date_____

APPENDIX K

Debriefing statement

This study is concerned with the impact Consultee-Centered Consultation (CCC) will have on the functioning of adults with developmental and intellectual disabilities. Specifically, this study is interested in the effect this form of consultation will have in decreasing challenging behavior in clients residing in group homes, on employee's satisfaction with their positions as group home staff, and on manager perceptions of their effectiveness.

Research supports the use of consultee-centered consultation in schools to assist teachers to modify environmental obstacles that impact the behavioral expression of their students. In particular, consultee-centered consultation enables a consultant to modify challenging behavior in clients as well as identify and modify teacher attributes that may serve as barriers to the process e.g. – teacher : lack of confidence, performance deficits, lack of skills, lack of knowledge, lack of objectivity. These four obstacles severely limit a teacher's ability to do his/her job.

Likewise, group home managers also encounter difficulties within the group home environment e.g. - staffing problems, interpersonal difficulties, and lack of training that may hinder their ability to do their job. These difficulties, similarly to teachers in schools tend to fall into the same four areas: confidence, skills, knowledge, and objectivity.

Addressing these problems through consultation, in the same way it is addressed in schools, will improve a group home manager's ability to tackle the variety of challenges both clinical and inter-personal that they encounter on the job. Inevitably, this will enable managers to provide more cohesive services while improving the lives of individuals with developmental

and intellectual disabilities, specifically by the decreasing the numbers of challenging behaviors exhibited by clients living in group homes.

If you would like to receive a summary of the findings of this research when it is completed, please contact Jessica K. Williams at jkw7@alfred.edu, (518) 857-9289. If you have concerns about your rights as a participant in this experiment, please contact Dr. Nancy Evangelista (Research Advisor) 607-871-2124, fevangel@alfred.edu, or Dr. Danielle Gagne (Chair of the Human Subjects Research Committee) at: gagne@alfred.edu; 607-871-2873.

If you are interested in learning more about group home environments or consultee-centered consultation, you may wish to view the following text:

Caplan, G., & Caplan, R. (1993). *Mental health consultation and collaboration.* San Francisco: Jossey-Bass. Thank you for your participation.