Training foster carers in a preventive approach to children who challenge
Mixed messages from research

Jan Hill-Tout, Andrew Pithouse and Kathy Lowe set out key features of a two-year semi-experimental investigation, completed in April 2001, into the impact of training foster carers in techniques to manage challenging behaviour. The results suggested that training, as designed and delivered in this study, had limited impact on child conduct and carer capacity. However, the training was perceived very positively by foster carers who claimed they put into practice what they had learned and that the training had been useful.

Introduction
The behavioural profile of children receiving foster care today increasingly requires carers with skills to look after children who present a range of challenging behaviours. The importance of stability and good parenting capacities is fundamental to the durability of placements for such children, but in some circumstances additional specialised support is needed. The chronic nature of some children’s difficulties means that the children need a ‘whole system’ approach that will provide consistent management approaches at home and elsewhere. They will need appropriate and targeted health inputs and social services support systems that are well informed about best practice in the management of challenging behaviour. A well-established literature continues to reveal that specifically targeted training is relatively undeveloped, that the diagnosis of health problems is often reported to be inadequate and mental health systems in particular (when available) tend to use clinic-based models that do not necessarily engage with the wider service system. In an attempt to address some of these issues, an inter-disciplinary research team with expertise in clinical psychology and social work developed a training scheme to help foster carers manage children who challenge. In describing the scheme we commence by acknowledging the important study by Minnis and Devine (2001) which was published as we completed our own. Minnis and Devine found no clear evidence of the impact of a carer training programme on foster children’s emotional and behavioural functioning. Our enquiry lends support to their important findings, but our research design differed in several respects and revealed different insights into this complex field.

First we set out the parameters of our own investigation, which recognised that challenging behaviour is not a single entity and that training in this field cannot be made to fit all needs. Thus, some profiling of current problems was required early on in our study and it soon became clear that most children so defined were not the subject of clinical definition. Therefore, it became important to apply a checklist in order to identify our study population. A definition of challenging behaviour, based on that developed by Qureshi and Alborz (1992), was given to local authority social work staff as a...
guide for identifying relevant children on their caseloads. Our checklist assumed a wide and multiple range of challenging behaviours such as absconding, theft, self-harm, violence, attention deficit and hyperactivity disorders deriving from disadvantaged backgrounds, emotional damage and perhaps borderline disabilities. The checklist also sought to grasp the topography of the behaviours experienced in relation to frequency and intensity. It was also important to establish some profile of the carers as this variable would need to be considered in relation to outcomes, not least because training was intended to alter the behaviour of carers as well as of those fostered. In order to identify a sample that would allow reasonable statistical manipulation it became necessary to involve four local authorities with social services responsibilities. This allowed us to include in the programme 106 carers looking after some 103 children and young people perceived as presenting challenging behaviour. We were unable to identify the prevalence of such behaviours in the wider population.

**Training course content**

The training we delivered was designed towards understanding and managing behaviour through skills that have a clear preventive dimension around problematic conduct. In this respect, skill development would centre on behaviour assessment and analysis in order to provide carers with a systematic approach to intervention. That is, training would give them three core capacities: the ability to develop positive alternatives to inappropriate conduct; a capacity to develop a preventive approach to managing behaviour; and reactive strategies to deal with emergencies. While we recognised that there is no single medium for training, it was essential to ensure that treatment integrity was maintained during the study period so that we could identify clearly the connections between treatment mode, provider and recipient. Assuming that training would be targeted towards broad categories of problematic behaviour it was essential to design a training pack that could respond with some limited flexibility towards a range of carer and child needs. At the same time it was imperative to achieve uniformity of training intervention. The careful delivery of the materials by one member of the study team (a clinical psychologist aware of the importance of support, warmth, empathy and humour as essential requisites for trainers in this field – see Sanders and Dadds, 1993) was, we believed, a means of ensuring some consistent impact. We could not find ways to reduce ‘contamination’ by researchers (ie research team measuring the outcomes of training it provided to carers).

Our conceptual approach to identifying the training strategy best suited to responding to challenging behaviour drew on the following sources and assumptions. Kazdin (1997) identifies four types of treatment for conduct disorder in children and adolescents that we considered promising for our study and which informed the conceptual framework for our training regimen. These were: cognitive problem-solving techniques, parent management training, family therapy and multi-systemic therapy. We drew upon proven techniques and training manuals in parent training (see Patterson and Gullion, 1968; Webster–Stratton, 1984; Brestan and Eyberg, 1998) based on principles of parent training originally described by Hanf (1969). While there are many other approaches to behavioural problems, for example group therapy, general relationship counselling and psycho-dynamically oriented treatments, these treatments have the best supporting evidence of efficacy, each has multiple controlled studies and parent management training has been extensively evaluated (Barlow, 1997; Kazdin, 1997).

The training could be delivered to the person’s own environment rather than from a clinic, which we considered important given the view that maladaptive behaviour can be changed more effectively in ‘natural’ settings (Tharp and Wetzel, 1969). Like Goldiamond (1974), we were keen to endorse a constructional rather than a pathological approach and to focus on how a person might behave more appropriately in the future rather than simply seeking to extinguish inappro-
appropriate conduct. The encouraging evidence in the sources above indicates that parents can be enlisted successfully as agents of change. However, it has long been recognised that foster carers face the extra dimension of looking after children whose emotional needs and learned behaviours may well test their skills to the limit (Triseliotis et al., 1995; Landy and Munro, 1998). In such circumstances, we believed that foster carers might benefit from interventions that enhance their behavioural management skills. We point out, however, that we did not simply assume that what might ‘work’ with parents would automatically do so with carers. Indeed, we recognised that carers, just like parents, might have personal and environmental concerns (marital problems, lack of social or material support) that could impede their participation in training (Rhodes, 1967; La Vigna and Willis, 1995). Thus, in drawing on these sources and ideas we also drew upon research on care staff training in challenging behaviour (Lowe et al., 1996) and this, too, informed our design and delivery of training.

In identifying our training intervention model we were also aware of issues that were likely to influence most efforts to engage with service users, such as treatment drop-out (Prinz and Miller, 1994; Eyberg, 1996) and use of incentives to retain people’s involvement (Black and Holden, 1995). Also, realistic focusing upon ‘coping’ rather than ‘curing’ the chronic nature of much disruptive behaviour was considered an essential message to foster carers (Cunningham et al., 1993; Johnston, 1996; Kazdin, 1997; McDonnell, 1997). Likewise, the meaning attached by carers to children’s behaviours was a topic of scrutiny and grasped from a behaviourist dimension that described the likely impact of such meanings (attributions) on child behaviour (Carr et al., 1994; Hastings, 1997). Similarly, problem-solving techniques and a focus upon ‘positive’ rather than ‘punishment’-oriented techniques featured prominently in the training we offered to carers (Emerson, 1995; Ball and Walsh, 1998; Iwata, 1998).

Overall, we were inclined towards behavioural management which focused on the construction of functional behavioural repertoires in real environments. The use of a model whereby the specialist adviser works with and through the support systems, using approaches underpinned by learning theory, was another persuasive theme in the literature (Carr et al., 1994; Kazdin, 1997). In light of this, the training course was designed to incorporate methods and approaches that would address the key themes of the child’s skill development, preventive strategies, coping with crisis, strategies for problem-solving and whole systems work.

In all components of the training the emphasis was on problem-solving methods. Clear and easy-to-follow flow-charts, on one side of A4, had been developed in order to support the foster carers to collate information and think through possible actions in a step-by-step way. Foster carers were encouraged to try to distance themselves a little in using these methods, in order to understand the dynamics of behavioural patterns, and to be clear about interventions which could sometimes appear counter intuitive. A recurrent theme of the course was an emphasis on involving the whole system wherever possible. A frequent refrain was the need for carers to involve significant others and to have shared de-briefings where possible after incidents, so that the complexity of triggering events could be identified and managed better in the future. Foster carer social workers and the children’s social workers were briefed before and after the training and given copies of the training materials. To achieve best results foster carers were encouraged to attend with partners in order to support consistency of behavioural management at home.

Carers and the children
Full data sets were obtained for what we term here the ‘main carers’ – those who were most involved in the day-to-day care of the children. This yielded 106 foster carers: 53 looking after children in the intervention sample and 53 in the comparison sample. A similar range of ages was represented by foster carers in each sample, with most aged between about 30 and 58 years, averaging in the mid-40s.
No significant difference between the two samples was found in this respect. The designations (and income) of carers varied across participating authorities, but none were ‘relative’ or ‘respite’ carers. While some were termed specialist carers many were described as mainstream carers who, like others (see Minnis and Devine, 2001, p 51), were caring for children whose history of abuse or neglect was considered the root of much difficult behaviour.

The majority of carers in both groups were women and they were the main carers in households. Most were married and living with spouses. Just under a half in each group had a paid job outside the home, mainly part-time work. Some two-fifths held an occupational qualification (GCSE or higher) and around one-fifth held a professional or vocational qualification. Most had experience of bringing up their own children.

Previous experience as foster carers ranged from four months to 27 years, with an average of 6–7 years. A mean of 11.8 and 14.7 children had been fostered, respectively, by the intervention and comparison groups. Around 50–60 per cent of each group stated they had received training in challenging behaviour in the last three years. However, exposure to training differed markedly within and across authorities, and it was not possible to establish a reliable history or uniform baseline of previous instruction.

Our 106 carers looked after 103 children and young people who were defined as exhibiting challenging behaviour. Of these children, 54 were assigned to the intervention sample and 49 to the comparison sample. Care was taken to try and preserve the balance between the two groups of children with respect to age, gender and reported level of challenge. Overall, males predominated – 59 per cent in the intervention sample and 67 per cent in the comparison sample. A Mann-Whitney U test found no significant difference between the two samples in age, with both having an average age of ten years and ten months, ranging from under four years to just under 18 years. Level of competence was assessed on items from the Child Behaviour Checklist (Achenbach and Edelbrock, 1986). Here, no significant differences between the intervention and comparison samples were found, with 61 per cent and 50 per cent, respectively, rated as average for their age in sports, hobbies, clubs and chores; 29 per cent and 40 per cent rated as average in social relationships; and 32 per cent and 35 per cent rated as average in academic performance. The vast majority of the remaining proportions of both samples were rated as below average in all these respects. Half of each sample were in receipt of some remedial service, while just under half (48 per cent and 44 per cent, respectively) were said to have a disability. Most of each sample (82 per cent and 85 per cent) were said to experience academic or other problems in school. Ninety-eight per cent of the population were white British.

The training
Our training programme, designed in collaboration with local authority support staff, sought to provide carers with skill development, clear plans for coping with emergencies when they occurred and a proactive strategy aimed at smoothing the fit between the person and the environment. The training was delivered to groups of carers over a period of three days. There was a ‘follow-up’ day some three to four weeks later to discuss progress. Local authority support staff received pre-training materials and a training manual providing information, guidance and examples demonstrated in the training.

In the development of the training course, to ensure good attendance and participation, particular attention was paid to the training schedule. One month prior to the start of the course, a letter was sent to participants describing course content and outcomes, and practical arrangements like timings and venues. A further reminder was sent just prior to the course starting. The three core elements of the course were delivered over three days at weekly intervals. The course was spread in this way to enable participants to try things out as the course proceeded, and to report back on any problems or successes that they may have experienced.
Each day’s training started at 10am and finished at 2.30pm with a brief break for lunch. These timings were used in order to fit in with childcare arrangements. A final fourth session was held a fortnight later and served as an opportunity for participants to revise the course principles and do some joint problem-solving on their own examples.

The training process was informed by the belief that foster carers who support children who challenge are typically experienced in behaviour management. Thus, while some examples were included in the training materials, foster carers were encouraged to offer their own examples for the group to work on and to reflect on ways in which things might have been handled differently. In light of this, the trainer needed to be able to manage group interaction as well as deliver the training content. This meant ensuring equal participation and involvement, and approaching the training as a mutual learning experience. This process was further supported by the group size, which we wanted large enough to promote diversity of contribution but small enough to be manageable – between ten and 12 attendees was deemed appropriate.

A core element of the course was to support foster carers in reflecting on their own behaviour and how it might be making matters worse rather than better. Exercises incorporated in the training materials helped the participants to do this but it was not a painless process, and it was therefore particularly important that individuals felt safe and comfortable in the group environment. For the trainer this meant not only negotiating ground rules with the group, but also being vigilant in seeing that these were followed.

**Training evaluation: measurement, procedure and analysis**

Key outcome measures for children assessed general ability and participation outside the home and behavioural problems. For carers, the key outcome measures were their reactions to children who challenge, their beliefs about causes of challenging behaviour, their analytical understanding of such behaviour, and their emotional well-being. Two main sets of measures were used: detailed child profiles were collected for each child in the intervention and comparison samples, by interview with the foster carer; and carer profiles were obtained for each participating carer in both samples. In addition, a short questionnaire was designed for the study to elicit the views of the intervention carers on various aspects of the training they received.

General ability was measured on items from the Child Behavior Checklist (Achenbach and Edelbrock, 1986) for ages four to 16. This measures the child’s general level of competence by asking carers to compare the child with others of the same age with respect to the quality and amount of involvement in hobbies, sports, clubs and chores, how well the child gets on with peers and siblings, how well the child works alone and the level of performance in academic subjects. The scale was administered by interview with carers at baseline only. Participation outside the home was measured by a modified version of the Index of Community Integration (Raynes et al., 1989), extended to incorporate items relevant to children and young people, and an exclusion rating. The Index comprised a list of 17 types of community facility. Carers were asked how often the child had used each facility in the previous month and to what extent the child’s behaviour limited access. This scale was administered at baseline and at post-intervention.

Behavioural problems were assessed on a measure designed for this study, based on a modified version (Felce et al., 1994) of a section in the Disability Assessment Schedule (Holmes et al., 1982). The original list comprised 13 behaviours, modified to give separate ratings for each behaviour on the frequency of its occurrence and the severity of management problem presented. This list was extended to 48 behaviours in this study, to include the wide range of behaviours cited for the children during the initial identification exercise. The scale was employed at baseline and post-intervention.

Carer profiles included information on age, gender, relationship and status of carers, occupation, qualifications, child-rearing experience, description of the...
household, experience of fostering, challenging behaviour and training, emotional responses to and beliefs about challenging behaviour, emotional and physical well-being, self-evaluation, and insight into behavioural responses. Carers’ reactions to challenging behaviours were assessed on the Emotional Responses to Challenging Behaviour Scale (Hastings and Remington, 1994). This is a 15-item scale comprising a list of negative emotions typically experienced by caregivers when working with children who display severely challenging behaviour. Carers were asked to complete this scale at baseline and after intervention.

The Challenging Behaviour Attribution Scale (Hastings, 1997) was used to measure carers’ beliefs about the causes of challenging behaviour. This comprises a 33-item list of possible causes for challenging behaviour. The items are classed under five sub-scales to represent five causal models: learned behaviour (positive and negative), biomedical factors, emotional factors, stimulation, and physical environment. Carers were asked to complete this scale at baseline and post intervention. Emotional and physical well-being was measured on the Malaise Inventory (Rutter et al., 1979). It is a short checklist of 24 items relating to typical health and emotional problems associated with high stress levels. It was self-completed by all carers at both phases of the study.

A short questionnaire was designed for the study to assess to what extent carers had an analytic understanding of behaviour. The questions covered their description of a recent behavioural incident presented by the foster child, their understanding of what may have led to the behaviour, what motivated the child, what the child achieved, what the consequences were, how the carer responded, if the carer could have reacted differently or prevented the behaviour, and how the carer would respond in the future. Answers were noted by the interviewer and later rated by the clinical psychologist (who designed and conducted the training). This was administered by interview at baseline and post intervention with all carers for each child in the study.

Two main statistical techniques were employed in the analysis of data (Siegel, 1956). The Mann-Whitney U test (two-tailed) was used to compare the distribution of scores obtained for the intervention and comparison groups. The Wilcoxon Matched-Pairs Signed-Ranks test (two-tailed) was used to investigate the differences between pre-test and post-test scores.

**Key findings**

Overall, there was a lack of measurable effects attributable to the training. Further analysis of the data in relation to selected child and carer characteristics (eg age of child, experience of carers) showed no significant differences. We were unable to analyse the possible impact of factors such as trauma, learned behaviours and disability because reliable information was not available for the whole sample; such histories are likely to mediate the way behaviour management techniques impact (Baumeister, 1989).

The key findings based on the above measures post training are briefly summarised as follows:

- No significant difference was found in the number of exclusions from community facilities over time between children in the intervention group and comparison group.
- While there were changes in the severity of presenting behaviours, the number and frequency of presenting behaviours did not differ significantly between both groups.
- Carers’ emotional response to challenging behaviour incidents decreased across both groups.
- In respect of challenging behaviour attributions by carers, there were significant differences in some sub-scales, with the intervention group giving more credence to emotional and biomedical factors. But no significant changes across total scores occurred for both groups.
- Carer stress changed over time. Patterns did not differ between intervention and control group.
Carer capacity to identify a range of variables across challenging behaviour and to demonstrate insight into their own responses did not differ significantly post training.

These findings suggested to us that the training had no impact in relation to the measures applied. However, they contrasted strongly with carer satisfaction with the training. Thus, as with the Minnis and Devine study (2001, p 52), there was strong approval for the training and satisfaction ratings showed that 93 per cent found it useful and 96 per cent said they would apply the techniques learned. On follow-up, 93 per cent said that they had applied techniques learned.

The post-training measures were applied some five to seven weeks after training and perhaps a longer time lapse of three to six months was needed. However, we note the limited evidence of training impact in the Minnis and Devine study (2001, p 47) at nine months and would agree with Lowe et al (1996) that there are no proven indicators for appropriate time lapse in relation to training interventions of this kind.

Experience of delivering the training
The training was delivered by a consultant clinical psychologist with considerable experience in working with adults and children who challenge, and their carers. The experience of delivering the training was very positive according to carer feedback. However, it was apparent during the course that there were at least four factors that seemed to militate against training alone being effective in producing behaviour change. Firstly, there was the predictable issue that many of the children supported in foster care placements had chronic and longstanding problems and had a history of multiple placements. Indeed, in some of our training groups foster carers had supported children who were now in the care of another family in that same group and were able to share experiences. Group discussions also suggested that many of these children were likely to have additional undiagnosed difficulties like mild learning disabilities and dyslexia that needed to be taken into consideration in providing support.

A second factor that would undermine the impact of training was the evident paucity of information given to foster carers about behavioural dynamics associated with the child or young person. It was clear from discussions that lessons learned from one placement about behavioural management were not passed on to subsequent placements, and so systemic knowledge about useful approaches was not built up. Recording systems were reported to be inadequate in respect of behaviours and focused on risk management rather than on preventive approaches and learning loops about interventions that work best.

Thirdly, there were no coherent models for supporting the children who challenge across service components. Training in a model that works best in a consistent environment will be less effective where significant others in a child’s life use different approaches. For example, incidents were described during training where approaches taken by schools unintentionally undermined approaches taken at home. Thus, key players jointly training in, or at least adopting, shared responses to challenging behaviour was seen by carers as a measure likely to impact positively. Some carers also reported frustration with child and adolescent mental health services where interventions seemed to be based on inadequate histories, and where confidentiality about clinical assessment and intervention was seen as impeding the sharing of information that could be useful for both carer and child. However, only a small proportion of carers (5 per cent) and children (15 per cent) had any contact with psychologists or behavioural specialists. Most support came from foster carer supervising social workers, most of whom were not trained in behaviour management. The absence of a supportive environment that can understand and help reinforce the messages of training is not conducive to effective management of challenging behaviour.

Fourthly, a key component of the training was about planning, intervening and then de-briefing to learn from the
way incidents had been managed. Similar systems across the four authorities for sharing information and joint working were sometimes evident, but this was not necessarily the norm, and foster carers often reported that in professional systems their knowledge and input did not seem to be valued.

Making training more effective
Foster carers were asked to give feedback on how training might be improved. Comments were made about the importance of group management so that individuals were not allowed to monopolise the conversation, and there were helpful suggestions about how exercises could be organised to use the time more efficiently. Overall, the foster carers viewed the training very positively and there were no drop-outs from the course. Anecdotally, participants indicated that the problem-solving models helped them think more clearly about their own behaviour, as well as that of the foster child, and at times helped them acknowledge that behaviour management might be a better goal than behaviour change.

However, if training courses such as this are to demonstrate significant outcomes for the children, changes at a ‘system’ level are crucial. Key areas for action might include:

- joint training for foster carers, social services staff and teachers (and family members where appropriate);
- shared information on specific behavioural dynamics (ie behavioural triggers and approaches that are likely to respond well) and changes in those dynamics;
- recording systems to log and update this information so that key players can access and inform practice accordingly;
- structured post-incident debriefing to make sure preventive plans are in place next time;
- involving key players in clear plans describing short-, medium- and long-term responses to known dangerous behaviour.

Further evaluative studies should focus on systems which seek to deploy an holistic approach to challenging behaviour and to examine training outcomes in relation to system elements.

Conclusion
Foster carers represent a vital part of the service delivery system for looked after children, but their parenting skills are increasingly under pressure from the behavioural demands posed by the children and young people to whom they offer a home. Supporting a child with challenging behaviour in a family setting is extremely demanding and foster carers need a scheme of training which builds on their existing skill base and is tailored particularly to the work that they do. Achieving a good result for the child depends on the actions of a range of service components including education, health and social services, and each has a particular contribution to make. However, a preventive approach to supporting children who challenge relies on these components working together and sharing information about the management of behaviour so that the child experiences a consistent and coherent environment. Within this context the training of people to use specific problem-solving models about behaviour change is likely to have more impact. Training foster carers in ways to manage challenging behaviour is an important investment, but this needs to be supported by a more determined ‘system’ orientation to information sharing and intervention if training is to maximise its potential.

Acknowledgements
We wish to acknowledge the support of the Wales Office of Research and Development in funding the study and we extend our thanks once more to the many foster carers and local authority staff who participated in the project.

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