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Fostering changes A cognitive-behavioural approach to help foster carers manage children

A project has been set up in a socially deprived inner-London borough to provide foster carers with practical skills in the management of child behaviour. **Clare Pallett, Stephen Scott, Kathy Blackeby, William Yule** and **Roger Weissman** discuss why the project was set up and consider how carers learn best. Social workers often provide good general support to carers and placements, but may not offer more specific practical advice in managing behaviour so well. A training course based on cognitive-behavioural theory is described and case examples given. The evidence presented shows significant improvements in carer-child interaction, child difficulty, specific child problems causing most worry to carers, and child emotional symptoms; insignificant improvements were seen in hyperactivity and conduct problems.

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Introduction

The number of children 'looked after' is growing steadily. In March 2000, 58,100 children were looked after by local authorities in England – an increase of five per cent on the previous year (Department of Health, 2001). This growth has been accompanied by shifts in philosophy and policy. Over the last decade there has been a move away from residential to fostering placements. Some of the most disadvantaged and vulnerable children are now cared for in family settings, by foster carers who very often have limited access to professional support and training networks. Research shows that these children have substantially higher rates of mental health difficulties than children in the general population (McCann *et al*, 1996), and an especially high incidence of behavioural problems (Dimigen *et al*, 1999). Other research suggests that the commonest causes of placement breakdown are a) child behaviour difficulties and b) foster carers' lack of confidence (Sinclair *et al*, 2000).

The Government has responded to concerns about the poor outcome of these children by launching a number of initiatives to enhance their quality of care. Quality Protects sets national objectives for children's services that are targeted to provide better protection, quality care and improved life chances for looked after children. The UK National Standards for Foster Care aim to raise and maintain the quality of care for children in foster placements by making the expectations on both carers and the agency more clear, and by providing a framework for effective resourcing and management. In addition to these initiatives, the Code of Practice on carers' assessment sets out to provide a more rational framework for the assessment of foster carers. It endeavours to define the basic areas of competence that carers should have (National Foster Care Association, 1999a, 1999b).

While all these developments are taking place, local authorities are experiencing a crisis in recruiting and retaining carers. This presents an enormous challenge for fostering teams to provide the kinds of resources and support that will attract new carers into fostering, maintain them in their role and equip them to carry out successfully what is a demanding and complex task.

How the project came into being

The National Specialist Adoption and Fostering Team at the Maudsley Hospital in south London is a multidisciplinary Child and Adolescent Mental Health Service (CAMHS) team that comes into contact with many foster carers in the course of its clinical work. Over the years, a number of carers have told the team that they receive good-quality emotional support from social workers, but do not always get the same degree of clear, practical advice on how to manage difficult behaviour. The research study, *Joining New Families: Adoption and fostering in middle childhood* (Quinton *et*

al., 1998) reached the same conclusion. It reported that foster carers frequently expressed the need for specific support in managing and controlling disruptive behaviours.

In response to local health and social services' concerns about the dearth of such support, joint funding was sought in 1998, and granted to provide a service offering practical advice and skills development for foster carers.

The training programme

Overview

We have been offering training to all foster carers in Southwark who have children in placement. We have two courses, one for carers of the under-12s and one for those looking after teenagers. The training group meets once a week for a three-hour session over ten weeks. Groups consist of between six to 12 carers, who are mixed in terms of experience and ethnicity. Sixty carers have completed our training to date. Of these, 47 per cent have been African-Caribbean in origin, 38 per cent white UK, 12 per cent black African and three per cent other. Ten per cent of those attending have been men. We meet in an adult education centre in the community that has crèche facilities.

Each course has four essential components:

1. introduction to social learning theory;
2. using positive strategies to encourage pro-social behaviour;
3. limit-setting;
4. additional issues, which include problem-solving and stress management.

Theoretical underpinning of the training

In developing our training we have drawn upon many exciting ideas from current parenting programmes that have proved to be effective (Webster-Stratton, 1992; Neville *et al.*, 1998; Sanders 1999; Sutton, 1999). These programmes are based on cognitive-behavioural and social learning theory. Social learning theory takes the viewpoint that most behaviours are learned, and that they can therefore be

unlearned, and new alternative behaviours mastered in their stead (Bandura, 1977). This approach has not always been popular with social workers, who sometimes regard it as rather mechanistic. These concerns may be allayed by developments in cognitive-behavioural theory, which place more emphasis on individuals' beliefs and the social context in which behaviour is learned. The individual is seen as more actively involved in judging and interpreting everyday events. Hence, during training we have the opportunity to explore with carers how the way they think about themselves or about a situation often affects how they feel and act. This framework is useful for carers in managing their own feelings, as well as for working with children in placement.

Attachment theorists believe that a secure base for relationships requires consistency, calm, sensitive responses and absence of hostility (Sutton, 1999). These are all skills or qualities promoted in the training programme. Therefore, as well as improving observable child behaviour, training may also improve attachment representations and relationships.

Engaging carers in training

From the start we have tried to consult with carers. Three focus groups were convened early on. Carers stated that they felt inadequately supported and that their basic training did not equip them to manage children with complex needs and disturbed behaviour.

The complexity of the fostering task should make training an essential part of the role and not an optional extra. However, anyone providing training for foster carers will recognise how difficult it can be to get them to attend the training on offer. There are many reasons for this. The practical demands of reviews, appointments, child sickness, childcare and travel arrangements can be major impediments. A research project in Scotland found that only around half of the carers came to the training that was offered (Minnis and Devine, 2001; Minnis *et al.*, 2001). Minnis suggests that carers' reasons for non-attendance are usually practical and relate to their fostering role.

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The home visit

One of the most important steps we have taken to overcome the barriers to attendance at training is to visit carers at home before the course. We introduced these visits after running our pilot group, as we realised it would be beneficial to have some prior knowledge of the carers' home situation and of the children in placement. Of the 60 carers we have visited, only three have failed to turn up for the subsequent course. A further four have dropped out during training, but in three of these cases this was due to major family illness or placement of a newborn baby.

The purpose of the home visit is at least two-fold. Firstly, we hope to engage carers, to give them information about the course and to arouse their interest and enthusiasm. Secondly, we obtain important information about their childcare experience, about any stresses in their home lives and about the child behaviours they are currently struggling with. This helps us to target our training to their specific needs.

During these visits, we are also able to discuss carers' previous experience of training. Sometimes they share their anxieties about being part of a group or going back into a 'learning situation'. Some have expressed resentment towards the local authority which, they feel, places ever-increasing expectations upon them. Our experience suggests that fostering teams need to work actively to enable carers to attend training. Carers may require convincing that it will be useful. They may need help to think their way around the practical arrangements of travel or substitute childcare, or it may be that they need personal reassurance and encouragement to actually just turn up. We have found that these visits have enabled us to build up a rapport between ourselves and the carers, to gain their commitment to attending the training as well as generating some optimism about the possibility of behavioural change.

Home visits are costly in terms of staff time, but this can be justified for a ten-week course. We have an average attendance rate of almost 80 per cent.

Creating a supportive group environment

As carers work from home, they can feel very isolated. Meeting with other carers for both training and support fulfils many different needs. It enables them to voice frustrations and anxieties, learn from each other, as well as from the group leaders, and to receive feedback and constructive criticism. It also provides immense relief for them to realise that other carers experience similar frustrations. This is empowering. At the end of our training course, carers unanimously report that their sense of confidence has increased. This is also evident in their demeanour as the training progresses. Several carers who expressed anxiety about being in a group became more outspoken and assertive. One woman reported that her confidence had so grown that she felt able to apply for a part-time job as a support worker in her foster son's school. Another carer felt spurred on to sort out a previously unresolved matter with social services. These examples illustrate the important point that for many carers, training experiences can be very positive and enabling.

Creating a learning environment

A review of a large body of evidence on parenting programmes suggests that providing both skills *and* emotional support are critical to improving child outcomes (Scott, in press). The aim of our training is to develop carers' skills in managing difficult behaviours, and to build positive relationships with the children and young people they care for. In order to achieve this, it is essential that we create the kind of emotional space where carers can learn.

Our approach to training

Webster-Stratton and Herbert (1994), refer to the 'collaborative mode' as the underlying helping process in their work with families. We have found this a useful idea to carry over into training:

Collaboration implies a non-blaming, supportive, reciprocal relationship based on utilising equally the therapist's knowledge and the parents' unique strengths and perspectives. (Herbert, 1996, p 27)

The trainer helps group members to share their experiences and discuss their ideas. The responsibility for thinking through issues and coming up with potential solutions is shared between the trainers and group members.

Guiding principles for learning

We have found the above ideas particularly useful in developing a style of training that engages carers not just at an intellectual level, but in a practical and often personal way. To tease these ideas out a little further, we have identified a number of guiding principles for us as trainers, for which we are indebted to the work of the Centre for Fun and Families (Neville, 1998). The principles are:

- *Respecting carers' experience* Carers bring their own experience to training and it is important that this is valued. We start the course with the carers identifying the qualities and skills of the children they care for, as well as their difficulties. It is essential that it is the carers who decide which problems they want to work on and which strategies they want to use.

- *Active learning* Carers are actively involved in practising skills both during the sessions and at home in between. For example, in the training carers will practise how to provide positive attention through play. This is called 'attending' (Webster-Stratton and Hancock, 1998). Group members take turns to be either the child playing or the adult attending. They then feed back what it is like to use this skill and to be on the receiving end.

- *Empirical learning* Carers are given a specific skill to try out at home each week to see if, and how, it works. We call this 'home practice'. The tasks carers carry out range from observation, targeted praise and using reward charts, to practising time out and applying logical consequences. At the beginning of each session carers give feedback on their home practice and they discuss their experiences with each other. If a group member is not successful in using a particular strategy, the group is there to problem-solve with them. What went wrong? What could have been done

differently to achieve a different outcome? Our aim is for carers to develop the confidence and skills to think flexibly and creatively about the problems they encounter, and to be prepared to try out a variety of new and different solutions.

- *Valuing carers* In terms of feeling valued, carers often feel at the bottom of the pile. In training it is important that they have an experience of being valued, respected and 'looked after'. We provide ring-binders for carers to keep their notes and home practice in. We write personally to them with details of the session if they are unable to attend, so that they do not feel left behind. We think carefully about what food to provide at break time. (This is a valuable social time when carers can get to know each other, share experiences more informally and forge important links with each other.) These are small details, but ones that help carers feel 'attended to' and valued.

- *Having fun* This is important. We have found that the more relaxed carers feel, the more open they are to learning. By making the learning fun, active and group oriented, we hope to engage carers in the process of learning so that they can learn about the children placed with them, and also discover elements about themselves.

The course falls roughly into four parts (see Table 1):

1. *Introduction* We provide carers with a framework for thinking about and understanding how behaviours are learned and maintained. We explore some of the key concepts which underpin the entire course. We start by looking at the language carers use to describe problematic behaviour. They may come up with descriptions such as 'He's lazy', 'attention-seeking', 'has tantrums'. The group then works on developing skills to define behaviour in terms that are more clear, specific and 'observable'. Once they have learnt this, they are in a better position to track behaviour at home, to record what happens and how often it occurs. They can then check out whether what they say and think about a particular child is borne out by their observations of their behaviour. Although observation

Table 1

Content of the ten-week course

<i>Base-line skills</i>	<ul style="list-style-type: none"> ● Describing behaviour clearly ● Observation ● Recording behaviour ● Analysis of antecedents, behaviour and consequences
<i>Encouraging skills</i>	<ul style="list-style-type: none"> ● Praise ● Attending ● Choosing alternative behaviour ● Tangible rewards ● Reward charts ● Token rewards
<i>Setting limits and providing consequences</i>	<ul style="list-style-type: none"> ● Ignoring ● Commands ● Family rules ● Directed discussion ● Natural and logical consequences ● Time out and quiet time
<i>Additional issues</i>	<ul style="list-style-type: none"> ● Problem-solving ● Enuresis and encopresis ● Beliefs and cognitions

may sound like a rather dry activity, it is the first essential step in working towards behavioural change. It provides a valuable opportunity for carers to stand back and just tune into the child and it often sensitises them to the needs, temperament and behaviour of the children in their care.

2. *Positives* Behaviour management needs a firm positive foundation on which to build. Therefore the first five sessions of the training concentrate on positives – how carers can develop an affirming and communicative relationship with the children they care for. We explore strategies which focus on the child's appropriate behaviours, and which provide the child with positive attention and opportunities for praise and reward. 'Attending' is an absolutely vital skill for carers that can help to build up more affectionate and intimate bonds between themselves and the children in their care.

3. *Limit-setting* In the latter half of the course we consider how carers can set limits for the children they care for, and manage situations where children are not compliant. These are the situations in everyday life which can easily escalate into nagging, criticism or accusation. They involve patterns of relating which

are damaging and compound the children's negative feelings about themselves and their relationships. They also encourage carers to give attention for misbehaviour, thus making it more likely to persist. Carers are often anxious about discipline and fearful of allegations being made against them. They need strategies for disciplining which they can see are effective without being abusive. An important aspect of our training is to help carers prepare for potential conflict situations, and to practise their responses in the safety of the group. Once they have a clear strategy for dealing with a particular situation, they generally feel less stressed and overwhelmed. They find that they are able to remain calmer and more rational, in what might otherwise be a fraught and upsetting situation.

4. *Additional issues* We also look at some specific issues in the course of the training. Our final session explores how carers manage stress and look after themselves. Another important area of skills development is negotiating and problem-solving. Problem-solving skills are useful for carers themselves, as well as for the children in their care. Carers can help children to learn how to think through conflicts in their lives, and to develop

skills in making more conscious and rational decisions about the events which affect them.

Flexible training

Each group has been remarkably different. We have needed to change the pace, methods and content of each course to match the needs and style of the particular group and the individuals in it. Colleagues using our materials with a group where no one had English as a first language had to make substantial changes to the language they used. This group found role play one of the most useful techniques for learning. In our last training group we had a number of carers with long-term and pre-adoptive placements. In this case we felt we needed to do more work on the carers' self-esteem, encouraging them to praise, value and reward themselves for their efforts and their achievements.

Building confidence

We aim to provide carers with a tool-bag of different strategies to use flexibly in different situations. These strategies are often remarkably straightforward, but need to be used with care and precision.

One of the specific skills that we teach is how to manage enuresis and encopresis. Wetting, in particular, is a problem that some carers accept and do not try to change, and which social services do not traditionally have the expertise to advise on. In the vast majority of cases, carers on the training course have been able to remedy these difficulties with relatively straightforward measures (Herbert, 1996; Yule, 1997). One seven-year-old boy who had older brothers in foster care who wet themselves at night, was excited and delighted when he became dry after two weeks of using reward charts and a pants alarm. Neither he nor his carer had thought it was possible, and his self-esteem rose considerably. When carers are given the tools for directly addressing behavioural problems, they realise that their children can learn new skills and that this helps the children feel more positive about themselves. Child improvement often has a knock-on effect on the carers, who feel more confident and energised as a result.

Results of training

It is encouraging for the group when carers feed back changes that have taken place in their own and in their children's behaviour. Individual carers vary in the extent to which they are able to, or choose to, implement the ideas and skills they learn about. Not surprisingly, it is those who go ahead and apply themselves to the home practice who invariably see the most dramatic changes in behaviour. We will describe some individual examples of change, before looking at the overall evaluative picture.

Qualitative narrative accounts

The training generated numerous examples of change:

- Shona had a seven-year-old boy, Ben. He was constantly distracted and fidgety and would wake in the morning any time from 5am and disrupt the entire house with his noise and activity. Shona started to record his behaviour in the mornings. She would lie in bed and write down what she could hear going on. On one occasion when Ben was quiet, she drew a smiley face on the observation chart, which she then stuck to the fridge door. When Ben learned why his carer had drawn the smiley face, he was over the moon to discover that he had done something that pleased her. Over the course of the next three weeks his behaviour totally changed. He would get up in the morning to go to the toilet, and then return to bed to either play quietly or go back to sleep. Shona would then have to make sure she woke him in time to get to school. Although this exercise started as an observation, it highlights the dramatic power of social rewards like praise. It also draws attention to how often adults fail to make their expectations about children's behaviour clear and specific. Once this little boy knew what behaviour his carer liked, he was only too happy to oblige.
- Marjorie cared for three nine-to-ten-year-olds who would lark around playing games after they had gone to bed in the evening. Scolding them did not improve the situation. Her evenings were transformed through a simple combination of strategies. She used a behaviour chart to

reward them when they went to bed quietly and she used strategic 'ignoring' while they were playing around. For these children this worked perfectly. Instead of rewarding their inappropriate behaviour with her attention, this carer targeted and encouraged desirable behaviour, for which she provided a tangible incentive.

- Hilda was looking after two refugee boys who had experienced war and bereavement. They had been quite reluctant to get involved in her family, who came from a very different culture from their own. They did not think Hilda had any right to expect them to help her around the home. Hilda used a strategy for providing positive, non-intrusive attention to these teenagers. She decided to sit with them quietly when they were watching films and videos about their home country. They soon wanted to share more with her about their own families, culture and circumstances. By going out of her way to spend time with them in activities that were important and meaningful to them, she gained their greater co-operation in household tasks. It led to what Hilda describes as 'greater mutual respect'.

- Improving carers' skills does not always prevent placement disruption. The reality is that fostering services are still under-resourced and under pressure. In these circumstances workers sometimes make inappropriate placements and place excessive pressure on carers. When Judy came on the course she was at the end of her tether and one of her placements was near breaking point. She had six children to care for at home: two of her own, two long-term placements, a premature baby and Diana. Diana was eight years old and had suffered horrendous neglect. She was stealing from the others in the foster home as well as annoying and bullying one of the girls. She would fly into a silent rage at the slightest hint of reprimand. During the course of training many aspects of Diana's behaviour improved and Judy felt much more optimistic about the prospect of the placement continuing. However, this was not to be the case. The combined stresses of caring for a number of children with complex and varying needs proved too much and Diana's

placement came to an end. Although the training improved the home situation in the short term, it was not able to prevent disruption. On the positive side, however, we learnt from the supervising social worker that the training enabled Judy to reach a more objective and less guilt-ridden decision about Diana moving on. This was based on a clear assessment of the girl's needs and the carer's own family situation.

Quantitative measures

Although our training programme was not set up as a formal research project, we used quantitative evaluation measures.

User satisfaction

At the end of training we used a 'participant satisfaction questionnaire' (Webster-Stratton, 1989). Carers scored teaching methods, subject matter, home practice and each trainer's performance on a scale from one to six. Sixty carers completed the training and 55 of these have returned their satisfaction questionnaires. Responses were very positive (see Table 2).

All said that they would recommend other carers attend the training, and 85 per cent of these stated that they would 'strongly recommend' it. This suggests that carers perceive the training to be relevant and useful.

In the focus groups, prior to training, lack of confidence had come up as a concern for carers. Table 2 also shows how carers scored their confidence about managing behaviour in the home after training, and how they scored improvement in child behaviour.

In addition, carers answered open-ended questions. The following responses are typical:

It was exciting and informative.

... made me feel stronger.

It has made me value more what I do as a carer.

This course has enhanced the way we care for young people.

I feel more positive and confident.

I listen more.

Table 2

User satisfaction questionnaire (N = 55)

Measure	Percentage of respondents answering 'definitely/a lot' or 'very/very much' (top 2 points on 6 point-scale)
Helpfulness of teaching methods	91%
Usefulness of programme subject matter	93%
Usefulness of home practice	84%
Effectiveness of trainers	100%
Appropriateness of cognitive-behavioural approach	95%
Amount of behaviour change in child	81%
Would you recommend programme to a friend?	97%
How confident do you feel about managing most child behaviour?	97%
Has the course improved your sense of confidence?	100%

... a very beneficial course – very supportive and lots to learn.

Some carers wished the course had been longer, but a few found the sessions and the entire course too long. Table 2 shows that most were very satisfied with the content of training, but a few have requested additional training on issues such as sibling rivalry, sexual abuse, bereavement, getting children to 'open up' and working with children with disabilities.

Carer behaviour

For the last two groups we ran (with ten participants) carers were asked to complete several short questionnaires including the Carer–Child Dysfunctional Interaction scale from the Parenting Stress Index (Abidin, 1995). Typical questions include 'My child rarely does things for me that make me feel good' and 'Most times my child does not like me and does not want to be close to me'. The results (Table 3) show a marked improvement. The table includes the calculation of an *effect size* for each of the different aspects assessed. This is a widely used measure in intervention trials that enables direct comparison of the size of change between the times at which assessments are made (it is the change in mean scores divided by the standard deviation). Conventionally, 0.3 is seen as small, 0.5 as moderate and 0.8 as a large change.

Child behaviour

Difficult child scale This is a scale from the Parenting Stress Index. Typical questions include 'My child turned out to be more of a problem than I expected' and 'My child makes more demands on me than most children'. The results (Table 3) show a large effect size or improvement.

Concerns about my child scale Participants in the last two groups we ran were asked to fill in a visual analogue scale (Scott *et al*, 2001). Carers identify three specific concerns and mark how severe they perceive these to be on a 10cm line, from 'not a problem' to 'couldn't be worse'. Examples were 'crying at strange moments', 'soiling' or 'lying when she has done something wrong'. The results show a very large improvement in the particular problems that carers were most concerned about.

Strengths and Difficulties Questionnaire

This a widely used questionnaire (Goodman, 1999), the main aim of which is to detect the presence of problems rather than be sensitive to change. Nonetheless the emotional problems scale showed a significant improvement. Hyperactivity and conduct problems revealed a minimal trend towards improvement, but this was not significant.

Table 3
Carer and child behaviour

Mean score (Standard Deviation)					
Measure	N	Before	After	Effect size	Significance of change (p value)
<i>Carer behaviour</i>					
Carer–Child Dysfunctional Interaction (PSI* subscale)	10	25.0 (9.2)	22.4 (8.7)	0.28	0.022
<i>Child behaviour</i>					
Difficult child (PSI* subscale)	10	35.5 (6.8)	29.2 (9.2)	0.93	0.037
Parent-defined problems (visual analogue scale)	36	6.8 (2.3)	3.6 (2.3)	1.40	<.0001
Emotional problems (SDQ*)	36	2.9 (2.2)	2.3 (2.3)	0.29	0.031
Hyperactivity (SDQ*)	36	5.6 (3.1)	5.4 (2.9)	0.06	0.574
Conduct problems (SDQ*)	36	3.5 (2.6)	3.2 (2.5)	0.11	0.485

PSI = Parenting Stress Index (Abidin, 1997); SDQ = Strengths and Difficulties Scale (Goodman, 1999)

Discussion

Our evaluation suggests that for many carers, this training brings about improvements in the emotions and behaviour of the children in their care, and a better quality of relationship and interactions with them. It also had a beneficial effect on carers' sense of confidence and self-efficacy. A controlled trial is now needed to check that these improvements were indeed due to the training, and would not have happened spontaneously anyway, and to see if they are maintained over time. It would be instructive to identify what processes were involved for those carers and children where improvements were minimal, and where disruption occurred. Nonetheless, given that Sinclair (in preparation) found that carer confidence and child problems were the best predictors of placement breakdown, this training is likely to promote stability of placement and help children form stable attachments through trusting relationships.

Looking ahead

Carers need a variety of different skills to work creatively and effectively with the children and young people in their care. Skills that derive from cognitive-behavioural theory are not the only tools they need, but our experience has been that carers find them relevant, valuable and empowering.

Our task is not only to bring training to

foster carers, but to try and ensure that the ideas and skills involved are assimilated within social work teams. Supervising social workers stand to benefit immensely from a working knowledge of cognitive-behavioural strategies. These will broaden the range of skills at their disposal and enable them to work with carers and their children in a flexible yet focused way.

One of the areas that we need to develop further is our link with social services. We have run workshops for social workers, to keep them abreast of the skills their carers are learning. These have been well received, but more can be done to share ideas and skills. We are learning to work increasingly flexibly and have found a range of ways of collaborating with colleagues. We are currently liaising with the local fostering support team to explore how we can take training to carers who live out of the borough. Work has also started on a trainers' handbook that we would like to see available for use by social workers in adoption and fostering teams.

If this kind of skills-based training for carers works as well for others as we have seen it working ourselves, we would be very keen to see other social services departments adopting or developing their own training and support programmes. However, fostering teams are under fairly relentless pressure to find placements for children, to recruit and retain carers and

to adapt to the needs of changing policy and priorities. Hence it is not always easy to take on new ideas and initiatives. We hope that all of this will help to get the ideas and skills involved owned by social workers and integrated within their knowledge base and practice.

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