The Feasibility of Behavioural Assessment and Treatment in Residential Homes for Children

by Derek Jehu

Professor, Department of Psychology and School of Social Work, University of Manitoba, Canada, and Visiting Professor, Department of Social Work, Monash University.

In two recent articles in this journal, a behavioural approach to childhood problems is discussed in the context of natural family situations (Griffin 1978, Herbert and O'Driscoll 1978). This paper extends the discussion to Residential Home settings, and can usefully be read in conjunction with the two earlier articles. It is based on our experience of implementing behavioural programmes of assessment and treatment with individual children living in the type of Residential Home that is administered by Social Services Departments in Britain, which I am told are very comparable to similar establishments in Australia. These Homes care for between 6 and 50 or more children, ranging in age from a few days to 18 years. The problems we have treated in such settings include nocturnal and diurnal enuresis, encopresis, self-care deficits in the retarded, and various forms of conduct disorder. The efficacy of this treatment is reported elsewhere (e.g. Jehu **et al** 1977), and the present discussion is restricted to its feasibility. Generally speaking, it appears to be a practicable and acceptable approach for the staff and children concerned, but inevitably there are certain obstacles and limitations which are outlined below. This concentration on sources of difficulty rather than strength, should not lead to an undue emphasis on the problems likely to be encountered or to any implication that these are insurmountable.

ASSESSMENT

Appropriateness of treating the child

Occasionally, a child's problem behaviour is more properly regarded as appropriate reaction to the adverse environment in which he is living, so that either the improvement of this environment or transfer to another placement are more desirable forms of intervention than any direct attempt to treat the problem behaviour **per se.**

More commonly, such direct treatment is contraindicated because the reactions of the adults to the behaviour are in some way inappropriate. Thus, their tolerance levels for that behaviour may be unusually low, or they may not know that it is only to be expected in view of the child's age. In such circumstances, any intervention is often more suitably aimed at modifying the reactions of the adults rather than the behaviour of the child.

Description of problem behaviour

One difficulty that is encountered repeatedly is a marked tendency for the staff concerned to describe a child's problem in terms of vague and global labels, rather than specifying the actual behaviour that is the subject of their complaint. For instance, the problem might be described as 'aggression', rather than in terms of specific forms of physical assault, verbal abuse or destructiveness.

This adherence to global labels entails several important disadvantages; for instance, they obscure the actual problem behaviour, and are used inconsistently both by different people and by the same person on various occasions. Consequently, the behaviour to be changed during treatment is difficult to identify with sufficient precision, and the reliability of its assessment and monitoring is considerably reduced. Such labelling tends also to overemphasize the generality of the problem behaviour in all circumstances, whereas it is usually much more specific to particular situations. Thus, a child may attack his peers in the presence of certain members of staff, but not when others are on duty, and simply to call him 'aggressive' serves to obscure the situation — specific nature of this behaviour which has significant implications for its

https://doi.org/10.1017/S1035077200901871 Published online by Cambridge University Press

assessment and treatment. Worse still, to label a child 'aggressive' is often thought to constitute a sufficient explanation of his assaultive, abusive or destructive behaviour, and yet it is this same behaviour that forms the basis for him being judged 'aggressive' in the first place. Such tautologous explanations only serve to obviate the search for a more adequate causal understanding of the problem as a basis for appropriate treatment.

Quality of recording

The records of the problem behaviour that are maintained by the staff at the request of a behavioural consultant are frequently of poor quality. Among the possible reasons for this are the numerous other children and responsibilities requiring the attention of the very busy residential staff, the multiplicity of staff involved, and the problems of co-ordinating and monitoring their recording because of their different part-time and duty periods. There is also the difficulty mentioned above that many residential staff have in specifying problem behaviour and in adhering to these definitions, together with their unfamiliarity with recording in terms of specific behaviour and its surrounding circumstances, rather than making global assessments of the children in their care.

TREATMENT

Adverse influences in the Home

Occasionally, there are general circumstances in a Home which constitute an impediment to treatment; for instance, marital discord between the houseparents, or a state of friction or rivalry within the staff group as a whole. More commonly, such impediments arise from more specific adverse influences on a client's problem behaviour, stemming from staff members or from other children in the Home. Often these individuals are quite unaware of the deleterious effect their behaviour is having on the client. For example, a busy member of staff might overlook mildly stated requests by a child and thus precipitate a temper tantrum, and this may establish a problem behaviour which might then be reinforced by the adult attending and giving in to the child. Similarly, a problem of non-attendance at school might be precipitated by bullying from other children, or the admiration and respect from peers might serve to reinforce a client's defiance of the staff.

The modification of such adverse influences on the problem behaviour are crucial to its improvement, but for any of the very many possible reasons discussed throughout this section, they do not always yield easily during treatment. This is particularly true, when it is the client's peer group that is eliciting or maintaining his problem behaviour.

Staff resources

The extent, supervision and co-ordination of staff resources for treatment constitute other sources of difficulty in some cases. We are constantly impressed by the range of domestic duties and child care responsibilities undertaken by few residential staff for quite sizeable groups of children. In some instances, a treatment programme relieves these very busy people by introducing more efficient ways of managing a particular child's problem behaviour, and sometimes produces a rapid improvement with an associated reduction in its demands upon staff time and energy. More usually, a programme involves additional burdens, which the staff are in some cases unable to carry because of the many other pressures upon them.

Even in the smaller Homes, there are several adults involved in the care of each child, and they are usually on duty at different times. Sometimes, a senior member of staff in the Home is able to supervise and co-ordinate the implementation of treatment by the multiplicity of staff, but in many cases these tasks present problems for a behavioural consultant who has responsibilities in many locations over a wide geographical area.

Staff attitudes

While the attitudes of the residential staff towards behavioural treatment are generally favourable, it is not unusual to encounter some ambivalence, concern or objection over a number of philosophical, professional and procedural issues. Among the philosophical issues sometimes raised are an alleged denial of individual freedom of choice and action in the behavioural approach; its supposed mechanistic and dehumanizing nature; and complaints that it is controlling, manipulative and coercive.

Other issues concern the perceptions by the residential staff of their own professional roles. Some members of staff adhere strongly to a 'parental' role and reject that of 'therapist'. Those who regard themselves purely as subsitute parents often consider their provision of a suitable climate of care and concern in the Home as sufficient to resolve the children's psychological problems in time, and they reject any need for the addition of specific treatment programmes within such a beneficial atmosphere.

Finally, issues are frequently raised concerning the utilization of procedures that involve (a) the reinforcement of good behaviour with rewards, especially those of a tangible kind, (b) any discomfort to the client, (e.g. in time out or response cost procedures), (c) any negative side effects on the client, such as possible embarrassment, (d) any negative side effects on other children, for instance, the feelings of inequity they may have if a client is singled out for special rewards, or the possibility of them emulating his

problem behaviour in order to gain similar rewards themselves.

Many such controversial issues are discussed extensively in the literature (e.g. Herbert 1978, Jehu **et al** 1972) and this is not the place to examine the evidence and arguments on both sides. However, it is important to recognize that the attitudes of the staff on these and other points can markedly affect the feasibility of treatment, therefore it is essential to take this into account when planning and implementing a programme.

ROLE OF RESIDENTIAL STAFF

We are particularly concerned to explore the role that the residential staff might play in utilizing behavioural programmes within the context of a Residential Home. One reason for this is that these programmes might prove more effective than the current strategies for dealing with the psychological problems of children living in such settings. Typically, the residential staff try to deal with these problems themselves by providing a generally therapeutic atmosphere and regime in the Home, which is sometimes supplemented by more specific methods of management, such as lifting at night or restricting fluids for enuretic children. However, while a therapeutic milieu of care and concern is a necessary condition for any more specific intervention, there is reason to think that it is not always a sufficient condition for therapeutic change, and that the more specific methods used by the residential staff are not always the best available. This is shown to be the case in respect of the alarm treatment of nocturnal enuresis in our own work (Jehu **et al** 1977), and there is growing evidence on the efficacy of the behavioural treatment of a wide range of childrens' problems by natural or substitute parents in family or residential situations (e.g. see reviews by Berkowitz and Graziano 1972, Burchard and Harig 1976, Cone and Sloop 1974, Herbert 1978, Johnson and Katz 1973 Mash **et al** 1976a, 1976b, O'Dell 1974, Wahler 1976). Thus, it may be that members of the residential staff could help some children more effectively if guidance were made available on the implementation of suitable behavioural approaches within a general context of care and concern.

Incidently, this strategy is also very much in accordance with what is currently thought to be good practice in child psychiatry. When a child's problem does not appear to be yielding to the therapeutic milieu and current management in one or more Residential Homes, he is often referred for psychiatric treatment. In more traditional form this commonly involves individual psychotherapy for the child, on a once weekly basis over a quite prolonged period, and conducted in a clinic setting. In contrast, several important developments in child psychiatric practice over the past 20 years seem to lead into the kind of therapeutic approach which is discussed in this paper. Thus, the following are among such developments recently described by Graham (1976): "(a) Increasing use of therapeutic techniques involving the whole family or at least both parents and the identified child. (b) Greater emphasis on brief, focused methods of therapy . . . (c) More interest in and use of a variety of behaviour modification techniques . . . (d) More emphasis on the use of psychiatric time for consultation with others rather than for direct clinical contact with children and their families . . . (g) Interest in the possibility that the social organization of treatment institutions for children alters their effectiveness. This has been followed naturally by attempts to deal with problems by better 'management' of the institution rather than by focusing on the individual child" (p. 97).

This last point constitutes another reason for exploring the use of the behavioural approach by residential staff in Residential Homes. As indicated earlier, there are sometimes general circumstances or specific influences operating in the Home which contribute to a child's problem behaviour or impede its successful treatment. Such adverse conditions are largely under the control of the staff concerned and only they are able to modify these conditions so that the child's problems can be ameliorated. Generally speaking, these staff members do not recognize any contribution from their own practices or the regime in the Home to a child's problem behaviour, which is more usually seen as arising entirely from his disturbed life history and family background, with their residual effects on his personality and attitudes. However, there is now appreciable evidence that the organization and practices in a variety of children's institutions are significantly associated with the development and behaviour of the residents (e.g. Cornish and Clarke 1975, Tizard **et al** 1975). It follows that an important focus of intervention should be on "reprogramming the social environment" (Patterson **et al** 1967) in the Home, a task which must inevitably be performed via the residential staff who contribute to and control this environment.

Fortunately, the residential staff are in a powerful position to undertake the behavioural assessment and treatment of a child in their care. A therapist who only sees the child in the clinic, or even one who visits the Home occasionally, may never have an opportunity of directly observing the problem behaviour and its surrounding circumstances, especially if it occurs infrequently and is relatively specific within the Home situation, whereas the residential staff who live with the child are much more likely to get such first hand experience. Admittedly, as discussed earlier,

there are limitations in their current abilities to specify and record their observations, but potentially they have an invaluable role to play in behavioural assessment. Similarly, their therapeutic potential is high; again, they spend a great deal of time with the child, and are likely to have a significant emotional relationship with him. Consequently, one might expect their therapeutic influence to be greater than that of a comparatively remote therapist whose contact with the child is relatively much less intensive and meaningful. For instance, many members of the residential staff are likely to be very potent sources of positive social reinforcers, such as attention, praise and approval, that are important in promoting and maintaining acceptable behaviour among children in their care. Thus, in this and many other ways, the residential staff are potentially very powerful therapeutic agents, although this capacity is not always fully realised for a variety of reasons discussed earlier.

Another potential advantage of treatment being implemented by the residential staff in the Residential Home is that this to some extent circumvents the common problem of transferring treatment effects from an artificial clinical situation to the natural real life environment in which the child lives. It still leaves, of course, the additional problems of maintaining any positive changes in the child's behaviour after the specific treatment intervention ends, and of transferring these changes to a fresh environment if the child is moved to another placement in care or returned to his own parents. As all behaviour is strongly influenced by the immediate social environment in which it occurs, it follows that any relevant change in this environment is likely to be accompanied by a change in behaviour. Thus, if the staff of a Home revert to their former methods of handling a child after treatment has ended, then he may lose any therapeutic gains and relapse into more problematic ways of behaving. Similarly, if the conditions in a fresh environment are conducive to such ways, then there may be a deterioration in more acceptable behaviour. Only if there is continuity of benign controlling conditions between different environments, is there likely to be a relatively automatic persistence of therapeutic gains. Such continuity or similarity is the exception rather than the rule, therefore it is usually necessary to make specific provision for the maintenance and transfer of treatment effects over time and across environments.

A final reason for exploring the implementation of treatment by residential staff in Residential Homes, is that this may serve to conserve and maximize mental health manpower resources that are in very short supply. The substantial number of children in care who exhibit psychological problems that have proved intractable to the care provided in Residential Homes, coupled with the shortage of psychiatrists, psychologists, and suitably trained social workers, who are available to undertake direct clinical work with these children, suggests strongly that this system of treatment delivery is likely to meet the needs of only a small proportion of the children concerned. Thus, the therapeutic impact of these scarce professionals might be maximized if they were to spend a substantial proportion of their time in an indirect consultancy role to members of the residential staff who would undertake the direct treatment of the children, in their care. Of course, as discussed earlier, there are limitations in the capacities of some residential staff to undertake such a therapeutic role, and all those who may be called upon to do so will require suitable training.

In order to be capable of conducting behavioural assessment and treatment procedures under the supervision of a consultant, the residential staff need to be introduced to the fundamental principles and concepts of the behavioural approach and to have ample opportunity to explore the controversial issues arising from them, examples of which were discussed above in the context of staff attitudes. More particularly, the staff need to be able to identify problem behaviour in children that might suitably be discussed with a consultant as possible cases for behavioural intervention; to specify such problems in terms of the actual behaviour involved and the circumstances that precede and follow its occurrence; to systematically observe and record that behaviour and its surrounding circumstance; and to implement appropriate treatment procedures under the supervision of a consultant. Such material could very usefully be introduced into the teaching on courses for residential staff. Certainly, one of the most pervasive constraints we experience is the virtually complete lack of accurate knowledge about the behavioural approach, together with widespread misunderstanding of its nature and scope. Suitable didactic instruction could improve this situation, and would at least sensitize residential staff to a possible source of effective help for some children, so that the staff are able and willing to refer them for behavioural assessment and treatment. Those staff members who might implement such programmes themselves would, of course, require supplementary training and supervision focused on the particular children concerned (Jehu 1976),

Suitable training may give residential staff the knowledge and skills they require to implement behavioural procedures under supervision, but there is still the vital issue of their motivation to undertake what is often a

https://doi.org/10.1017/S1035077200901871 Published online by Cambridge University Press

considerable addition to their already burdensome, not to say awesome, responsibilities. If such staff are to be willing to implement and continue these procedures, it is necessary for the consultant to try to minimize any disincentives and to maximize any incentives for them to do so. He or she can try to minimize disincentives in various ways, including tailoring treatment programmes to suit the individual people and particular situations concerned; so that the existing regimes and practices are disrupted as little as possible, any unnecessary clashes with the values or personal characteristics of the staff are avoided, and the programmes can be operated within the limitations imposed by any practical constraints such as staff shortages. In certain cases, the consultant may undertake a substantial part of the treatment in the Home. This relieves and supports the overburdened residential staff, to whom the treatment is gradually and slowly handed over whenever possible. Many negative or ambivalent attitudes towards the behavioural approach among the residential staff, are considerably modified in a positive direction as these staff members begin to know the consultant and to work with him or her. Clearly, a necessary condition for such attitude change, is a relationship of mutual consideration, respect, trust and confidence between the residential staff and the consultant.

Turning to the provision of incentives for the residential staff, among the ways in which this may be attempted are the achievement of a reduction in the client's problem behaviour. Clearly, this is a major incentive, for it entails considerable personal and professional satisfaction and pride in having been able to help the child on the part of the residential staff concerned, as well as relieving them of the worry and annoyance previously occasioned by the problem. There is however a footnote to be added to this last point. For a natural parent caring for a child in his own family, there is essentially no relief to be gained from any problem behaviour unless it remits spontaneously or can be successfully treated, and this provides a strong motive for the parent to implement and persist with such treatment. In contrast, if a child in a Residential Home becomes too troublesome to the staff, they can press for his removal to another placement, and we have encountered occasional cases where this was the course preferred by the staff, with consequent negative repercussions on their willingness to co-operate in a behavioural programme. A second and related incentive for the residential staff is their success in implementing such programmes. The satisfaction and pride this affords can encourage them to persist in their efforts long before these achieve any substantial reduction in the problem behaviour. The consultant can try to facilitate such success and encouragement by planning feasible programmes, and by providing prompt and frequent feedback to the residential staff on their performance in implementing them. Such performance can also be reinforced through the interest shown by the consultant and through his or her support and approval for the efforts being made by the residential staff. Again, the value of such interest, support and approval to the residential staff depends on the quality of their relationship with the consultant. Finally, he or she can try to ensure incentives for the residential staff by arranging or mobilizing many other potential sources of reinforcement. For instance, interest, support and approval can be elicited from more senior members of staff in the Residential Home or social service organization, and residential staff may be included in presentations of papers and in attendance at conferences with the consultant, as well as sharing in the authorship of published papers.

PROVISION OF BEHAVIOURAL PROGRAMMES IN SOCIAL SERVICE ORGANIZATIONS

The findings and arguments reviewed earlier in this paper suggest that consideration should be given to making the behavioural treatment of children more generally available in social service organizations. Such provision would be a supplement rather than an alternative to other social work resources, for the specific treatment of a particular form of problem behaviour is not a substitute for a more comprehensive programme of social work help for a child and his family. Without this, the target behaviour may be improved, but many of the other psychological and social problems that are common among children in care and their families may still remain. Conversely, a very satisfactory general programme of help may well not resolve particular psychological difficulties that require specific treatment procedures within the total intervention.

This leads on to the question of whether behavioural treatment could be implemented or supervized by field social workers in the course of their ordinary casework and other duties. We suggest that this would not generally be a feasible mode of delivery. In the first place, there are few field social workers who possess the knowledge and skills required to plan and conduct behavioural programmes without supervision from a consultant in this area. Moreover, even with this support, most social workers are unlikely to be able to devote the necessary time to such programmes. It is very apparent in our work that substantial demands are made upon the time of the therapist, and he must be able to give regular and intensive attention to each child under treatment. This heavy concentration of time on a small

number of children, without frequent disruption by crises and other urgent demands, does not accord well with the work patterns of most field social workers.

Another possible delivery system would be to establish some form of specialist behavioural resource within a social service organization, consisting perhaps of one or more suitably trained and experienced people. They might be drawn from the professions of social work, psychology or psychiatry, but would need to have a thorough training for behaviour therapy with children (Jehu 1976), as well as being experienced and personally acceptable people who could attract and retain respect, confidence, trust and co-operation of colleagues at all levels in the organization. It is envisaged that the tasks of a specialist behavioural resource would include a consultancy service to residential staff and field social workers who are considering referrals for behavioural assessment and treatment, or who are implementing such programmes themselves; the direct treatment of selected children, either in their natural environments or in a clincial setting, as appropriate in each case; and the continuous evaluation of behavioural programmes in the organization, so that their efficacy and feasibility can be progressively improved.

The performance of these tasks by the behavioural consultants is likely to be seriously impeded by any lack of familiarity with the organization and operation of a social service organization; including its statutory framework, its resources and who controls them, its channels of communication, and the individuals and processes involved in decision making. I would like to emphasize the importance of any behavioural resource staff acquiring such knowledge as quickly as possible. Their attention also needs to be directed towards the integration of their own specialist resource within the overall work of the organization, otherwise they will be isolated and rendered ineffective. Good communication, liaison, and collaboration are essential, if inefficiency, rivalry and incompatible goals are to be avoided.

REFERENCES

Berkowitz, B.P., and Graziano, A.M. (1972). Training parents as behaviour therapists: A review. **Behaviour Research and Therapy**, 10, 297-317.

Burchard, J.D., and Harig, P.T. (1976). Behaviour modification and juvenile deliquency. In H. Leitenberg (Ed.), **Handbook of Behaviour Modification and Behaviour Therapy.** Prentice-Hall, Englewood Cliffs, New Jersey, 405-452.

Cone, J.D., and Sloop, E.W. (1974). Parents as agents of change. In A. Jacobs and W. Spradlin (Eds.), **The Group as Agent of Change.** Behaviour Publications, New York, 277-328.

Cornish, D.B., and Clarke, R.V.G. (1975). **Residential Treatment and its Effects on Deliquency.** H.M.S.O., London.

Graham, P. (1976). Management in child psychiatry: Recent trends. **The British Journal of Psychiatry**, 129, 97-108.

Griffin, M.W. (1978). Behaviour modification with children in natural environment. **Australian Child and Family Welfare**, 3, 8-13.

Herbert, M. (1978). **Conduct Disorders of Childhood and Adolescence: A behavioural approach to assessment and treatment.** Wiley, London and Brisbane.

Herbert, M., and O'Driscoll, B. (1978). Behavioural casework: A social work method for family settings. **Australian Child and Family Welfare**, 3, 14-25.

Jehu, D. (1976). A note on teaching behaviour modification to social work students. **Bulletin of the British Association for Behavioural Psychotherapy**, 4, 21-24.

Jehu, D., Hardiker, P., Shaw, M., and Yelloly, M. (1972) **Behaviour Modification in Social Work**, Wiley, London and Brisbane.

Jehu, D., Morgan, R.T.T., and Turner, R.K. (1977). A controlled trial of the treatment of nocturnal enuresis in Residential Homes for children. **Behaviour Research and Therapy**, 15, 1-16.

Johnson, C.A., and Katz, R.C. (1973). Using parents as change agents for their children: A review. **Journal of Child Psychology and Psychiatry**, 14, 181-200.

Mash, E.J., Hamerlynck, L.A., and Handy, L.C. (Eds.) (1976a). **Behaviour Modification and Families.** Brunner Mazel, New York.

Mash, E.J., Handy, L.C., and Hamerlynck, L.A. (1976b). **Behaviour Modification Approaches to Parenting.** Brunner Mazel, New York.

O'Dell, S. (1974). Training parents in behaviour modification: A review. **Psychological Bulletin**, 81, 418-433.

Patterson, G.R. McNeal, S., Hawkins, N., and Phelps, R. (1967). Re-programming the social environment. **Journal of Child Psychology and Psychiatry**, 8, 181-195.

Tizard, J., Sinclair, I., and Clarke, R.V.G. (Eds.) (1975). **Varieties of Residential Experience.** Routledge and Kegan Paul, London.

Wahler, R.G., (1976). Deviant child behaviour within the family: Developmental speculations and behaviour change strategies. In H. Leitenberg (Ed.), **Handbook of Behaviour Modification and Behaviour Therapy.** Prentice-Hall, Englewood Cliffs, New Jersey, 516-546.

https://doi.org/10.1017/S1035077200901871 Published online by Cambridge University Press