

Promoting Verbal Reports and Action Plans by Staff during Monthly Meetings

in a Japanese Residential Home

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Abstract

We examined factors leading to the successful implementation of behavioral programs by staff caring for children in a Japanese residential home. We used a multiple baseline design across three units of residential homes to assess the effects of two interventions. The primary dependent measures were staff verbal reports (e.g., descriptions of antecedents, behavior, and/or consequences) and action plans (instructions for intervention). Our results indicated that, the use of quantitative data (e.g., frequency of behaviors) increased the percentage of time spent engaged in verbal reports while the use of qualitative data (e.g., A-B-C recording) increased the percentage of action plans. In conclusion, our intervention promoted effective verbal reports and action plans. Using these tools, staff in residential housing facilities may be able to improve support delivered to children in Japanese residential programs. Future research may help to verify whether similar effects can be achieved in other settings.

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Among the total population of children who need protection against abuse or maltreatment in Japan, about 12% live in foster care, relative to about 77% of such children in the United States (Kaihara, Kikuchi, Yuzawa, Takahashi, Hirata, Komatsu, Mori, Kotani, & Jin, 2009). In Japan, most of children who need protection against abuse or maltreatment are placed in residential homes. It has been suggested that many of these children suffer from emotional and behavioral problems (Tsuboi, 2005). Additionally, approximately 92% of the staff members in such residential homes report having difficulty delivering treatment for the children who have such problems (Ito, 2003). Kato (2006) suggests that several factors underlie these feelings, such as difficulty understanding why the children have emotional and behavioral problems and lack of concrete intervention methods. By addressing these variables, it may be possible to improve support for staff members in residential homes for children, thus increasing the efficiency and efficacy of treatment.

The use of behavioral method and objective data has been noted as a key factor in promoting effective treatment by staff (Burns, Peters, & Noell, 2008; Deno, 2005; Todd,

Horner, Newton, Algozzine, Algozzine, & Flank, 2011). For example, Todd et al. (2011) developed the Team-Initiated Problem Solving (TIPS) training program, which emphasize the use of data to define behavior and develop treatment plans. TIPS programs often collect quantitative data via a recording tool (e.g., School-Wide Information System; SWIS). Staff members then review these data during meetings to precisely identify and define behavior, and develop appropriate interventions. While the use of data about the children during meetings has been found to improve treatment delivered, previous studies have not examined the specific meeting contents (Fienup, Luiselli, Joy, Smith, & Stein, 2013). Thus, the variables that encourage staff members to make verbal reports and action plans during meetings are unclear.

In addition to the TIPS, functional behavior assessments (FBAs) have been used to promote problem identification and facilitate the design of interventions (McNeill, Watson, Henington, & Meeks, 2002). Descriptive analysis (often called “A-B-C recording”), which is a type of FBA, involves the observation and documentation of behavior and environmental events that co-occur (Lerman, Hovanetz, Strobel, & Tetreault, 2009). Data obtained via descriptive analysis may be qualitative.

In this study, we examined whether use of a recording tool and set of guidelines that we developed promoted staff to make verbal reports of behavior in A-B-C format and

to develop treatment plans regarding interactions with children in a Japanese residential home. Moreover, we compared two types of data collection to examine which most strongly promoted staff verbal reports and action plans.

Methods

Participants and Settings

Between four and six direct care staff from each of three units within a Japanese residential home (herein titled A, B, and C) participated in this study (15 in total). The residential home housed children aged 3 to 18 years, with about 10 children each in Units A and C, and seven children in Unit B during the time of this study. The age distribution of the children in each unit was comparable, and staff members typically cared for the children in shifts that did not overlap.

Unit A had six staff (three men and three women, although one woman retired during the course of this study) and 10 children. The average age of the staff in Unit A was 33.3 (range, 22–51 years old), and the mean length of service was 6.8 years (range, 0–11 years). Unit B comprised four staff (two men and two women) and seven children. The average age of the staff in Unit B was 26.3 (range, 24–28 years old), and the mean length of service was 2.7 years (range, 0–5 years). Unit C had five staff (two men and three women; however, one woman was absent from work during the course of this study)

and 10 children. The average age of the staff in Unit C was 32.0 (range, 23–39 years old), and the mean length of service was 6.0 years (range, 1–13 years).

Staff within each unit collectively chose one child who required a high level of support. Staff in Unit A chose an eighth-grade boy with Attention Deficit Hyperactivity Disorder (ADHD), staff in Unit B chose a second-grade boy with ADHD and Autism Spectrum Disorders, and staff in Unit C chose a twelfth-grade boy with intellectual disability. The support target for each child was adjusted based on the contents of a monthly meeting.

We obtained consent from the facility director and staff regarding the collection and use of data for this study. In addition, this study was carried out following approval by the Research Ethics Committee at the Faculty of Human Sciences, University of Tsukuba.

Procedure

Experimental Design. We used a multiple baseline design across the three units of the residential home to assess the effects of the two interventions on staff member verbal reports of behavior and action plans.

Baseline. We conducted a routine support meeting once per month in each unit, from March through December in 2013. The goal of each meeting was to supervise the

development of treatment and implementation methods for each child. Because the staff members worked in shifts in the residential home, the meetings were subject to participation by multiple staff members. We asked those present at each meeting to share the contents of the meeting with the absent staff members.

During these support meetings, the primary author of this study served as the facilitator. Each meeting progressed through two stages: (1) staff verbal reports for support targets and methods, (2) staff treatment planning implementation for the next month. In stage 1, the primary author asked a staff member to describe the progress history for specific support targets and asked other staff members to share their opinions. In stage 2, the primary author asked all of the staff at the meeting to plan support targets for the upcoming month, as well as methods for implementation. During this stage, the primary author told the staff that, as they would be responsible for implementation, they should develop the treatment plan.

When verbal reports produced no response after 10 seconds, the primary author asked staff whether they had other reports or opinions to share (e.g., “Is there anything else you think we should talk about?”) Then the meeting progressed to the next stage. Upon the completion of stage 3, the meetings ended. During the meetings, the primary author did not provide advice to staff regarding support targets or methods for each child.

We asked that staff input information about daily progress with respect to support targets via an existing electronic case record system that was already in place in the residential home prior to the study. Daily completion of this record had already been compulsory at the end of each shift.

Intervention 1. We developed a Goal Evaluation Tool (GET) for use during Intervention 1 and added it to the existing case record system in the residential home. The GET, which was developed using Windows Office Excel 2007[®], was used to confirm regular and simple achievements with respect to implementations the support plans. The tool included a column in which staff members were asked to record the data. A function within the GET allowed users to generate a graphic feedback that showed the implementation of plans based on the number of circles or crosses recorded. We asked staff to complete an entry in each GET column (either a circle or cross) after they made the required entry in the existing case record system at the end of each shift. The primary author printed the master GET record before each support meeting, and started the meeting after each participant confirmed that they had completed their entries.

We developed a Problem-Solving-Chart (PS-Chart) to consistently track progress. The PS-Chart showed examples of solutions depending on the characteristics of different problems, and served to facilitate the progress of each meeting. The PS-Chart was printed

on A4 paper and presented to staff during each meeting. The primary author facilitated the meeting by highlighting the phases currently under discussion. Therefore, the PS-Chart was expected to serve as a discriminative stimulus that would result in the staff to verbal reports of behavior.

Intervention 2. For Intervention 2, we added columns to the GET in which the staff members were asked to state the “Antecedents (A),” “Behaviors (B),” and “Consequences (C)” of behavior with the child for whom they had generated action plans. Each column was presented so that definitions were shown when clicked by staff. We asked the staff members to complete an entry in A-B-C columns after they recorded the success of the support targets via either a circle or cross. The primary author input a sample to demonstrate an entry example for the A-B-C columns. Otherwise, Intervention 2 contained the same procedures as in Intervention 1.

Dependent Measure

We used two dependent measures to evaluate the versatility of the problem-solving skills exhibited by the staff. The percentage of time spent engaged in verbal reports involving a description of support situations was calculated as the rate of verbal reports based on the contingencies of support situations during each meeting. We classified the verbal reports given by staff during each meeting into the following three categories: (1)

Antecedents that described the situations preceding the target behaviors; (2) Behaviors that described the occurrence or non-occurrence of the target behaviors; and (3) Consequences that described changes in the environment or the after-treatment of staff following the target behaviors. Other verbal reports were not evaluated. The primary author defined “Behavior” in operational terms for the month during which the support target was set with low concreteness. The percentage of time spent engaged in action plans was calculated as the rate of the statements based on the contingencies of target behaviors. We classified the statements of staff during each meeting as either (1) Antecedents that described the new support method preceding the target behaviors, or (2) Consequences that described the new support method following the target behaviors. These dependent measures were evaluated using a 30-second partial interval method for assessment of the meeting data, which was captured via a voice recorder. These measures were calculated by dividing the number of intervals comprising each statement by the total number of intervals during which a given staff member spoke, multiplied by 100.

Following the completion of interventions, we evaluated the social validity of the study with respect to each staff member. This evaluation comprised 12 questions regarding the validity of the intervention targets, procedures, and effects. Each item was evaluated using a 6-option Likert scale, where 1 corresponded to “I do not think so at all”

and 6 to “I think so very much.”

Interobserver Agreement

We calculated the interobserver agreement for the dependent measures. With the support of the primary author, a graduate student studying behavior analysis (who did not participate in this study) evaluated the data. They found that the percentage of agreement was about 30% for each dependent measure. The percentage of agreement for each statement made during the meetings was calculated by dividing the number of agreement intervals by the total number of intervals, and then multiplying this value by 100. The percentage of agreement regarding the verbal reports during the meetings was 95.9% (range, 94.8–96.8%), and the percentage of agreement regarding action plans during the meeting was 97.6% (range, 95.8–98.6%).

Results

Verbal Reports

Figure 1 shows the data for verbal reports during the meetings. During Baseline, the percentages of verbal reports of antecedents and consequences were low; 15% or less in all units. For example, staff often stated that difficult behavior exhibited by a given child resulted from previous abuse or maltreatment. The percentage of verbal reports for behaviors was greater than 15% in Unit B in May only, and otherwise low. During

Intervention 1, the verbal reports for antecedents and behaviors increased in Units A and B. For example, staff described situations (e.g., when, where, or with whom) preceding the behaviors after they reviewed the GET during the meetings. However, the verbal reports for antecedents did not increase in Unit C, although the verbal reports for behaviors increased during September in this unit. During Intervention 2, the verbal reports for consequences increased in October and November for Unit B during Intervention 2, but the results for the other two units were similar to those from Intervention 1.

Action Plans

Figure 2 shows the percentages of action plans given during the meetings. During Baseline, the percentage of action plans for antecedents and consequences control was low, 15% or less in all units. For example, staff members often stated that they thought the staff should develop attachment relationships with the child. During Intervention 1, the percentage of action plans for antecedent control increased in July in Unit A only. For example, staff often stated that they thought they should distribute the child's daily medicine accompanied by a glass of water to improve treatment compliance, which was an activity that only some staff had reported engaging in during Baseline. However, the percentage of action plans did not increase in Units B and C. The percentage of action

plans for antecedent control (e.g., “Children are approached beforehand to get ready for supper”) increased in Unit B during Intervention 2. For example, staff often stated that they thought they should decrease the amount of food given to the child for dinner after the GET showed a cross and the following A-B-C record: “He piled a lot of food on his plate (A), he was late (B), I scolded him (C).” However, the percentage of action plans was low during both the baseline and Interventions in Unit C. Moreover, we did not observe an increase in the percentage of action plans for consequences in any units.

The results of the social validity questionnaire completed by 12 staff members suggested that the intervention had high social validity for the verbal reports and action plans.

Discussion

In this study, we introduced the GET and PS-Chart into a Japanese residential home. We considered whether these tools promoted verbal reports and action plans, and which type of data (e.g., qualitative or quantitative) best promoted verbal reports and action plans made by staff. As a result, verbal reports of antecedents and behaviors increased in two out of three units during Intervention 1. This result indicates that graphic feedback regarding the quantitative data (e.g., frequency of behavior) via the GET might have served as a discriminative stimulus for the behaviors that the staff described with respect

to the support situations. For instance, the staff members who viewed the graph in the GET that showed which support targets were not achieved were able to recall those situations and speculate about why they happened during the meetings. However, the rate of verbal reports of consequences was low in all units except for Unit B. This suggests that verbal reports for antecedents or behaviors and those for consequences might be controlled by different variables.

The rate of action plans did not increase during Intervention 1 except in Unit A. This result suggests that the graph provided information about whether the support target was achieved, but did not provide information about how the plan could be improved. Conversely, action plans increased in Unit B during Intervention 2, as did A-B-C recording. This result suggests that the A-B-C recording enabled the arrangement of information recorded by staff members, while the PS-Chart produced rules to prevent the contingency of support targets that were not achieved, and to establish the contingency of support targets that were achieved. Thus, staff were able to state the next plan based on the provided rules. For example, staff viewed the antecedents of the A-B-C record “He piled a lot of supper on his plate” via the GET in October in Unit B, and the facilitator pointed out the “Adjustments in environment” section of the antecedents part of the PS-Chart. In response, the staff generated the plan that “The amount of supper given to the

child for dinner should be decreased in advance,” corresponding with the qualitative data of the A-B-C record. In summary, quantitative data involving the frequency of behaviors tended to promote verbal reports for support situations, and the qualitative data in the A-B-C recording tended to promote action plans for support during monthly meetings.

In conclusion, the GET and PS-Chart effectively promoted verbal reports and action plans. Moreover, because this study included children from a variety of age groups, our results indicate that staff might be able to improve support for people of different ages (not just children) with different support requirements using these tools. However, this study had limitations which require further clarification. Future research should investigate the following four points. First, we found that action plans in Unit C did not increase. This may have been because of the low rate of recording in the GET. Because a low rate of recording might not produce adequate feedback for improved support behaviors, future investigations about facilitating recording behaviors are needed. Second, studies that compare verbal reports and action plans for each participant are needed. Third, future studies should examine intervention procedures by which staff can solve problems independently, for instance, by nominating a staff member as the facilitator (i.e., without the use of an outside supporter). Finally, it is necessary to verify the generalizability of our findings in other welfare facilities or

education. Nonetheless, service provision in Japanese residential homes could likely benefit greatly by adopting procedures to promote accurate reports of behavior on the part of staff and to develop tangible action plans for addressing behavior problems.

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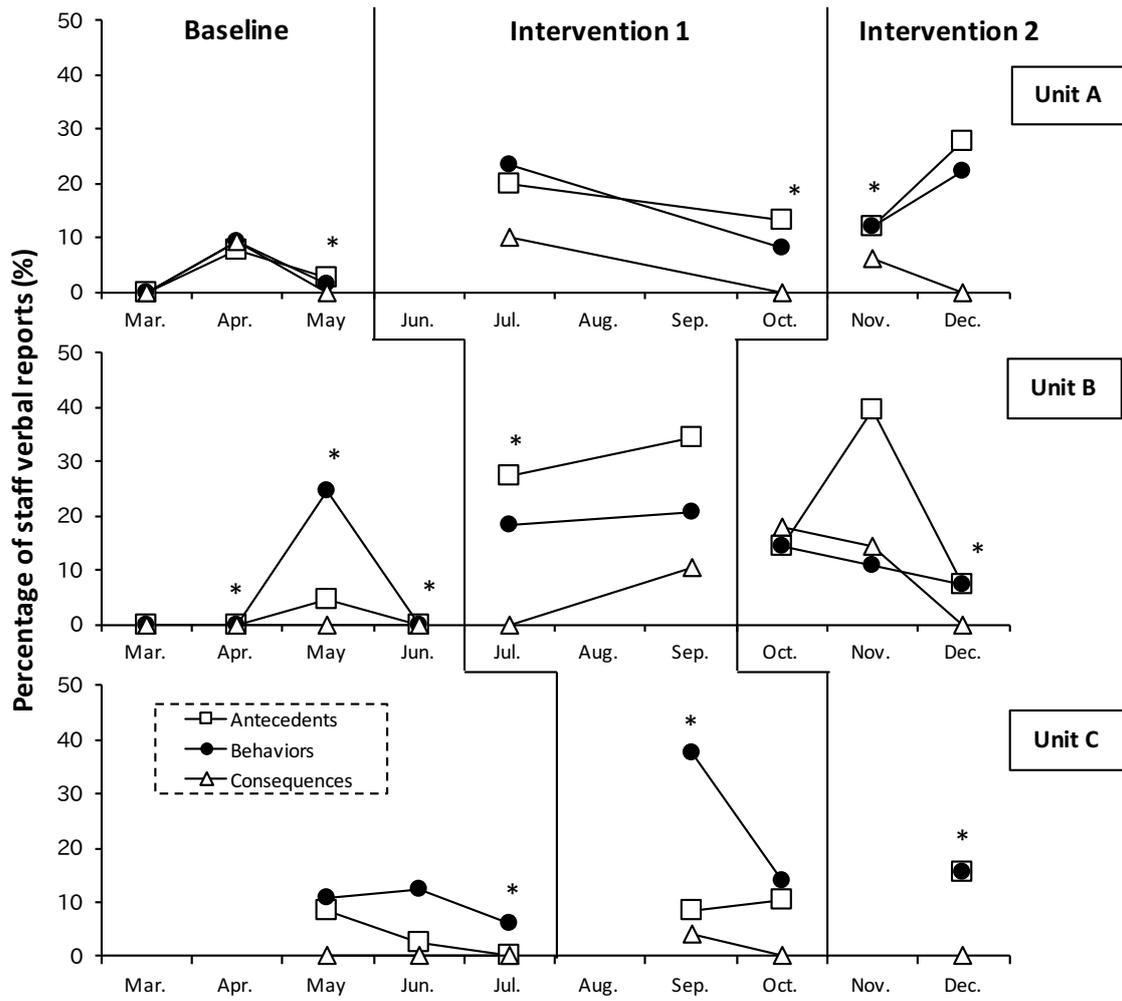


Figure 1. Percentage of verbal reports. White squares show verbal reports for antecedents, black circles show verbal reports for behaviors, and white triangles show verbal reports for consequences during the meeting. The asterisk (*) indicates when a support target was changed during the meeting.

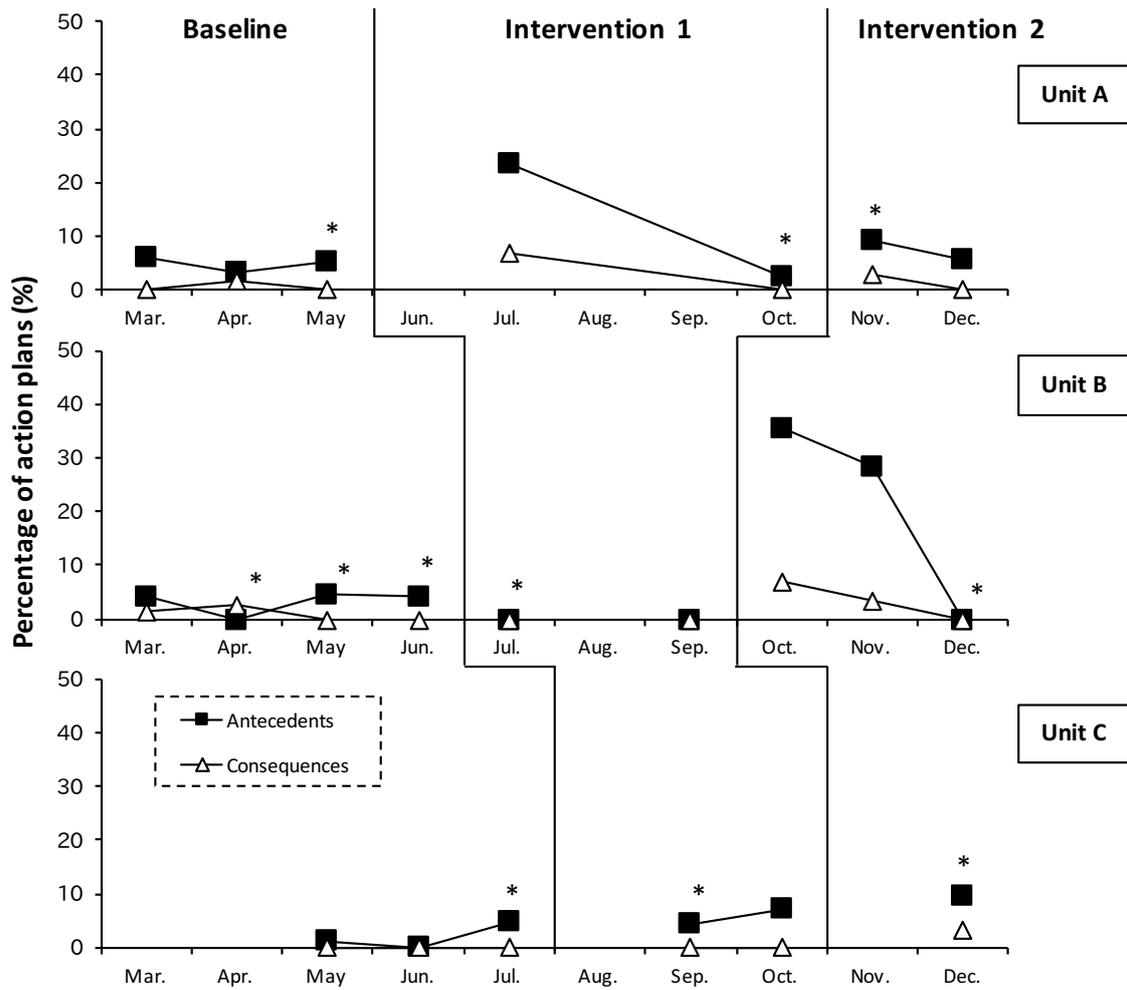


Figure 2. Percentage of action plans. Black squares show action plans for antecedent control and white triangles show action plans for consequence control during the meeting. The asterisk (*) indicates when a support target was changed during the meeting.