

**Volume I:**  
**Research Component**

**Brief training for care staff who work with people with an intellectual  
disability and challenging behaviour**

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## **Overview**

This work was undertaken in partial fulfilment of a three year Doctorate in Clinical Psychology at the University of Birmingham that was completed in 2011. The thesis is comprised of two volumes.

Volume I is the research volume and consists of three papers. Paper one is a critical review of the recent literature on brief staff training for care staff who work with people with challenging behaviour in intellectual disability services. The second is an empirical paper that investigates a one-day training for care staff using principles of a Positive Behaviour Support approach. It examines the effects of training on staff attributions and attitudes relating to challenging behaviour and the impact of staff organisational culture upon changes in attributions and attitudes. The final paper is an executive summary of the findings from paper one and two.

Volume II is the clinical practice volume and includes five clinical practice reports. The first report (Psychological Models) describes a psychodynamic and cognitive-behavioural formulation of the difficulties of a 55-year old female with a diagnosis of anxiety and depression. Clinical practice report 2 (Single Case Experimental Design) details a cognitive-behavioural intervention with a 24-year old female with a diagnosis of Obsessive-Compulsive Disorder. The third report (Service Evaluation) presents an exploration of child and adolescent mental health service (CAMHS) staff views on training to aid their therapeutic work with a multicultural population. Clinical practice report 4 (Case Study) discusses an intervention with a man with learning disabilities

which integrates narrative and cognitive-behavioural therapy approaches. The final report (Oral Presentation) is presented here as an abstract, which describes a narrative therapy intervention with an older adult experiencing low mood and anxiety.

Names and identifying details were changed to ensure full confidentiality.

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## **Literature Review**

**What does the literature tell us about brief training for care staff who work with people with challenging behaviour in intellectual disability services?**

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## **ABSTRACT**

### **Background**

Staff training is considered vital in maintaining high quality services for people with intellectual disabilities. Recently, there has been a change in approach to training and it is essential for the effectiveness of these changes to be established.

### **Materials and Methods**

A systematic literature review on brief training for staff who work with people with an intellectual disability and challenging behaviour was conducted. PsycINFO and OvidMEDLINE were used along with a quality assessment tool to assess the methodological quality of studies.

### **Results**

In total, 11 articles were included. Studies indicated changes in knowledge, attributions, and confidence of care staff following training. However, numerous methodological issues were found.

## **Conclusion**

Further research is needed to confirm the effectiveness of recent approaches to training.

It would also be useful to ascertain the role of other factors impacting on staff gains made in training.

**Keywords: staff training, intellectual disabilities, challenging behaviour, cognitions**

## INTRODUCTION

High quality training for staff working with clients with challenging behaviour can be considered a vital requirement in services for people with intellectual disabilities.

Challenging behaviour has been defined as ‘culturally abnormal behaviours of such an intensity, frequency of duration that the safety of the person or others is likely to be placed in serious jeopardy, *or* behaviour which is seriously likely to limit use of, or result in the person being denied access to, ordinary community facilities’ (Emerson, 1995) and the percentage of people in intellectual disability services currently estimated to have challenging behaviour is 10-15% (Emerson, Kiernan Alborz, Reeves, Mason, Swarbrick, Mason and Hatton, 2001).

Providing effective services for those with complex needs including challenging behaviour is especially demanding for care staff (Campbell, 2011) and difficulties in doing so are a contributing factor to work place stress, a major problem in services for people with intellectual disabilities in the UK (Hatton, Rovers, Mason, Mason Kiernan, Emerson, Alborz, Reeves, 1998). Staff stress can lead to poorer quality interactions with clients (Rose, Jones and Fletcher, 1998), lowered job satisfaction, burnout, and higher sickness rates (Rose, 1995). Failures to provide staff with the relevant skills, knowledge and motivation in dealing with challenging behaviour is costly for the wellbeing of clients and staff alike (McKenzie, 2000), yet a gap has been noted between what is known to work in addressing challenging behaviour and what staff do in practice (Campbell, 2011). This indicates the need for a comprehensive training

approach to ensure all staff are updated with the approaches and techniques they require to work effectively and safely.

### **Background to recent developments in training for staff working with challenging behaviour**

There is a widespread belief in the benefits of staff training in improving staff performance (Campbell, 2007) and as a result, staff training has been used to educate and support staff who work with people with intellectual disabilities across a broad range of areas. For example, the literature has highlighted the benefits of training for staff in working with clients who have experienced sexual abuse (Hames, 1996), in increasing self determination (Wong and Wong, 2008), enhancing interactions with clients (Finn and Sturmey, 2009) and raising awareness of mental health problems amongst staff (Costello, Bouras and Davis, 2007; Tsiantis et al, 2004).

Over recent years, there have been significant developments in the approaches to training staff and this includes training for staff working with clients with intellectual disabilities who exhibit challenging behaviour. Previously, training focused on the management of challenging behaviour (Grey, Hastings and McClean 2007), on behavioural and physical interventions. One criticism however, was that this increased the use of aversive methods of behavioural management on people unable to consent, and that techniques could be implemented without proper understanding of the function of a person's challenging behaviour (Berryman, Evans and Kalbag, 1994). Ethical and legal concerns were expressed about pain-compliance methods (Allen and Tynan,

2000). Alongside this, it was raised that attending to skill acquisition may be insufficient to change staff performance (Wong and Wong, 2008).

Recently, staff training has developed to focus on understanding the cognitions and emotions of staff, e.g. how these may act as setting conditions for staff responses to challenging behaviour (Grey, Hastings and McClean, 2007). Weiner's work (1980, 1993), provided a basis for this, suggesting that care staff attributing greater control to a client were less sympathetic and less likely to help, than if they attributed challenging behaviour to be outside of the client's control. Research has supported the role of controllability attributions in helping behaviour (Dagnan, Trower and Smith, 1998; Hill and Dagnan, 2002), suggesting staff who hold negative perceptions are more likely to confront clients (Jahoda and Wanless, 2005) and that controllability attributions can be altered (Noone, Jones and Hastings, 2003). It would be useful to know how effective this change in training approach has been, particularly in terms of brief training e.g. up to five days, (as opposed to extended training e.g. up to two years). Training of a brief nature has the potential to improve staff performance more quickly and could also be considered representative of the length of training many staff receive.

### **Aims of the review**

This systematic review investigates the recent literature on brief training for care staff working with clients with an intellectual disability and challenging behaviour. The review examines what this literature tells us about the recent approaches to brief staff training, the overall quality of these studies and their resulting implications.

## METHOD

### Literature search

A literature search was conducted using the social science and medical databases PsychINFO, OvidMedline and EMBASE. Search terms were selected from reading relevant literature and these were combined to result in the literature for the review. These are provided in the table below.

Table 1: Literature search terms

'Intellectual disabilities'	Challenging behaviour	Staff training
'intellectual disab*'	'challenging behaviour*'	'staff training'
OR	OR	OR
'learning disab*'	'problem* behaviour*'	'training'
OR	OR	
'mental retardation'	'behaviour*'	

NB Use of \* allows for any words beginning with the search term to be identified e.g. intellectual disab\* enables articles with the words intellectual disability and disabilities to be identified

The search was restricted to articles in English, from peer reviewed journals, between the dates of 1984 and 2011. In an initial search, the earliest article dated back to 1994.

The main search was set from ten years before to ensure all recent work was identified.

The selected articles' references were also examined to see if there were any further relevant articles. Details of the articles obtained, along with the specific exclusion criteria are provided in table 2.

Table 2: Articles obtained and exclusion criteria

Identified Articles	Number of Articles
Total articles identified via search minus duplications	30
Number of articles excluded	25
<i><b>Exclusion Criteria</b></i>	
Training for clients not staff	4
Not focusing on challenging behaviour	6
Reviews	2
Training of 4 months or longer e.g. accreditation level	4
Study focused on training for working with children	2
Training focusing on teaching CBT to staff for specific issues e.g. anger	2
Not a study i.e. a resource pack, audit or policy	5
Remaining articles from search	5
Articles identified via reference search	6
<u>Total number of core articles reviewed</u>	<u>11</u>

### **Quality assessment tool**

The purpose of using a quality assessment tool was two fold. Firstly, it was to ensure that the methodological quality of studies was reviewed in addition to their content. In an evaluation carried out of 511 systematic literature reviews of non-randomised studies, only 33% assessed study quality (Deeks, Dinnes, D'Amico, Sowden, Sakarovitch, and Song, 2003). The second was to ensure that a standardised method of assessing study quality was utilised to ensure a level of objectivity to the process.

To select a relevant tool, the Health Technology Assessment (Deeks et al, 2003) was used. This reviewed 194 quality assessment tools used in systematic literature reviews and recommended six 'best tools' to use in reviewing randomised and non-randomised studies. Of the six 'best tools', the 'Quality Index' (Downs and Black, 1997) was chosen for its ease of use, psychometric properties and its comprehensive coverage of domains considered relevant in reviewing the methodological quality of studies by the health technology assessment.

There are 27 items in the Quality Index tool, and these relate to study quality on five domains: Reporting, External Validity, Internal Validity- bias, Internal Validity- confounding, and Power. The scoring criteria are provided in table 3.

Table 3: Quality Index scoring criteria (Downs and Black, 1997)

Criteria	Points		
	Yes	No	
<b>Reporting</b>			
1. Clear description of hypothesis / aims	1	0	
2. Main outcomes to be measured reported	1	0	
3. Characteristics of sample clearly reported	1	0	
4. Intervention clearly reported	1	0	
5. Principle confounders reported	2	1	0
6. Findings clearly reported	1	0	
7. Estimates of random variability provided	1	0	
8. Adverse events as consequence of intervention reported	1	0	
9. Details of participants lost to follow-up reported	1	0	
10. Actual probability values reported e.g. 0.035 not <0.05 except where less than 0.001	1	0	
<b>External validity</b>			
			Unable to determine
11. Sample representativeness of population	1	0	0
12. Participation representativeness of population	1	0	0
13. Ecological validity of intervention	1	0	0
<b>Internal Validity – Bias</b>			
14. Attempt to blind subjects to intervention received	1	0	0
15. Attempt to blind those measuring main outcomes	1	0	0
16. No unplanned statistical analyses	1	0	0
17. Adjustment for different lengths of follow-up	1	0	0
18. Appropriateness of statistical analysis	1	0	0
19. Compliance with intervention reliable	1	0	0
20. Outcome measures accurate (reliable and valid)	1	0	0
<b>Internal Validity Confounding (selection bias)</b>			
21. Participants recruited from same population	1	0	0
22. Participants recruited over same period of time	1	0	0
23. Participants randomised to intervention groups	1	0	0
24. Randomisation concealed to participants	1	0	0
25. Adjustment for confounding variables	1	0	0
26. Losses of patients to follow-up accounted for	1	0	0
<b>Power</b>			
27. Sufficient power to detect clinically significant effect	1	0	0

NB Number 5 awards 2 points if the study provided a full list of principle confounders and 1 point if confounders are partially described

## **RESULTS**

In order for the evidence of the studies to be considered more easily in terms of their potential reliability and validity, studies were grouped into three categories based on the total number of points obtained when the tool was applied.

These categories were:

- Most methodologically robust studies (scores 19 - 28)
- Medium methodologically robust studies (scores 10 - 18)
- Least methodologically robust studies (scores 0 - 9)

Each category will be discussed in turn, beginning with high scoring studies. Table 4 (see appendix 7) outlines the total scores obtained and how these were achieved across the five quality domains. A brief summary of the content of the articles is provided in table 5 and methodological aspects, including areas of strengths and limitations identified by the Quality Index tool are outlined in table 6.

Table 5 –Summary of CONTENT of articles

AUTHOR	Main focus of research (Effect of training upon...)	Training length and content	Details of sample *	Main finding
van Oorsouw, Embregts, Bosman and Jahoda (2010)	<i>Knowledge</i> of challenging behaviour and <i>quality of physical intervention</i> techniques	5-day programme on causes of challenging behaviour, signs of escalation, symptoms of trauma and physical intervention training	n = 70 (experimental group n = 35 control group n = 35)	Significant increase in knowledge of challenging behaviour and quality of physical interventions techniques in experimental group. Scores remained above pre-test levels at follow-up
Allen and Tynan (2000)	<i>Knowledge</i> of reactive behaviour management and <i>confidence</i> in working with aggression	3-day Management of Aggression Training Program. Introductory theory day then 1- 2 days physical intervention practice	n = 109) (already trained group n = 51 untrained group n = 58)	Significant increase in knowledge of reactive behaviour management and confidence in working with aggression found in untrained group
Tierney, Quilan and Hastings (2007)	<i>Self-efficacy, emotional reactions</i> and <i>causal beliefs</i> of challenging behaviour	3-day training including behavioural and functional assessment, de-escalation of challenging behaviour and managing stress	n = 48	Significant increases in perceived self-efficacy but no significant changes in emotional reactions or causal beliefs at 3-month follow-up
Kalsy, Heath, Adams and Oliver (2007)	<i>Knowledge</i> and <i>attributions</i> of controllability in working with people with down syndrome, dementia and challenging behaviour	4-hour workshop including knowledge of aging and dementia, disease course and interventions	n = 97	Significantly increased knowledge and lowered controllability attribution ratings

Table 5 –Summary of CONTENT of articles contd

McKenzie, Sharp, Paxton and Murray (2002)	<i>Knowledge</i> about challenging behaviour, <i>attributions</i> regarding the cause of challenging behaviour and <i>staff practice</i>	1-day training on topics such as recording and assessing behaviour, basic behavioural and positive programming approaches	n = 39 (staff practice group n = 14)	Staff rated their knowledge as higher. No significant changes in attributions. Significant changes found in staff practice at 16 and 20 week follow-up
Dowey, Toogood, Hastings and Nash (2007)	<i>Staff talk</i> and <i>causal explanations</i> of challenging behaviour	1-day training. Lectures included quality of life issues, community participation and an introduction to Applied Behavioural Analysis.	n = 54	Staff explained challenging behaviour less with emotional and organic reasons. There was a significant increase in the use of both correct and incorrect behavioural explanations
Gentry, Iceton and Milne (2001)	<i>Knowledge</i> and <i>skills</i> in nonphysical methods	3-day 'Interactive Staff Training'. Involved discussion of challenging behaviour, analysis, behaviour guidelines and organisational issues	N = 101	Significant improvements in staff knowledge of nonphysical methods and development of management guidelines for challenging behaviour
McKenzie, Paxton, Patrick, Matheson and Murray (2000)	<i>Knowledge</i> about challenging behaviour	As per 2002 study	N =132 (trained group n = 59, control group n = 73, follow-up group 3-6 months n = 12 and 6-12 months n = 15)	Significant increase in knowledge about challenging behaviour in experimental group. Knowledge scores maintained at 3-6 and 6-12 months

Table 5 –Summary of CONTENT of articles contd

Berryman, Kalbag and Evans (1994)	<i>Attributions</i> regarding causes of challenging behaviour <i>attitudes</i> towards clients with a disability and <i>treatments</i> proposed	1-day training on positive behavioural interventions. Non-aversive training emphasised quality of life. Traditional training emphasised decreasing or increasing a target behaviour	n = 74 (non-aversive group n = 29, traditional group n = 45, follow-up n = 36 )	Significant reductions in the selection of emotional and intrinsic reasons for challenging behaviour and significant increases in the need for tangible reinforcement or escape avoidance reasons selected in the non-aversive group. Significantly more staff in this group recommended teaching clients new skills and writing a functional analysis plan
McDonnell (1997)	<i>Knowledge, confidence</i> and <i>skills</i> in the management of challenging behaviour	3-day training including understanding the law and non-violent methods of managing challenging behaviour	n = 21	Significant increase in confidence and non-significant increase in knowledge. All participants passed a restraint role play test
Smidt, Balandin, Reed and Sigafoos (2007)	<i>Beliefs</i> about challenging behaviour, <i>communication interactions</i> with clients, <i>levels of challenging behaviour in clients</i>	4 x 2½h MOSAIC training package focusing on analysis of communication behaviours and developing communication goals	n = 18	Increase in staff augmentative communication behaviours, decrease in inappropriate language. Decrease in clients levels of challenging behaviour. Increase in staff beliefs that challenging behaviours are learned or due to emotional reasons.

Table 6 –Summary of METHODOLOGICAL aspects of the literature

AUTHOR	Design	Measures	Areas of strengths and limitations identified using the Quality Index tool and total points awarded *		
			Strengths	Limitations	Score
Van Oorsouw, Embregts, Bosman and Jahoda (2010)	Quasi-experimental pre-test-post-test control group design	<i>Knowledge:</i> Challenging behaviour knowledge questionnaire <i>Quality of Physical Interventions:</i> Video analysis	Clear reporting. Robust design. Confounding variables identified. Outcome measures valid and reliable	Did not use randomisation or blinding procedures	22
Allen and Tynan (2000)	Mixed design	<i>Knowledge:</i> Reactive Strategies Questionnaire <i>Confidence:</i> The Confidence in Coping with Patient Aggression Instrument (Thackery, 1987)	Attempt to blind those measuring outcomes Confounding variables accounted for	Did not use randomisation. No follow-up	19
Tierney, Quilan and Hastings (2007)	Pre and follow-up within participants design	<i>Self-efficacy:</i> Staff efficacy scale <i>Emotional reactions:</i> Emotional Reactions to Challenging Behaviour Scale (Mitchell and Hastings, 1998) <i>Causal beliefs:</i> Challenging Behaviour Attributions questionnaire (Hastings, 1997)	Clear reporting. Follow-up used	No randomisation, blinding or control conditions. No immediate post-training data collected	14

\* The maximum number of points that can be awarded is 28.

Table 6 –Summary of METHODOLOGICAL aspects of the literature contd

Kalsy, Heath, Adams and Oliver (2007)	Mixed factorial design	<i>Knowledge:</i> Knowledge of aging and intellectual disability questionnaire <i>Attributions:</i> Controllability Beliefs Scale (Dagnan et al. 2004)	Some areas of clear reporting	* No follow-up. Characteristics of participants not fully described. No adjustment for confounding variables	14
McKenzie, Sharp, Paxton and Murray (2002)	Pre and post and follow-up within participants design	<i>Knowledge:</i> Self-assessment visual analogue scale <i>Attributions:</i> Open ended questions and bi-polar visual analogue scale <i>Staff practice:</i> Tasks based on Periodic Service Review (La Vigna et al (1994)	Ecological validity of staff practice follow-up arm of study	Two of the main outcome measures lacking in validity and reliability. Small number in staff practice group (n = 14) too small to detect clinically significant effect	12
Dowey, Toogood, Hastings and Nash (2007)	Pre and post within participants design	<i>Causal explanations:</i> Subscale of Self-Injury Behavioural Understanding Questionnaire (Oliver et al. 1996)	Some areas of clear reporting	No follow-up. No adjustment for confounding variables. The measure used was not consistent with the overall rationale of the study and properties of the modified questionnaire were not reported	11

\* None of the following studies used randomisation or blinding procedures.

Table 6 –Summary of METHODOLOGICAL aspects of the literature contd

Gentry, Iceton and Milne (2001)	Pre and post within participants design	<i>Knowledge:</i> Questionnaire about challenging behaviour, functional analysis and other aspects of incident management <i>Skills:</i> Role play evaluation	Some areas of clear reporting	Measures were ‘ad hoc’ with no reliability or validity data. No follow-up	11
McKenzie, Paxton, Patrick, Matheson and Murray (2000)	Mixed design using follow-up groups.	<i>Knowledge:</i> Questionnaire about defining an intellectual disability, challenging behaviour and duty of care	Use of control group. Some consideration of confounding variables	Follow-up groups contained different staff members and were relatively small (n = 12 and 15) to detect clinically significant effect. Areas of unclear reporting e.g. statistics	12
Berryman, Kalbag and Evans (1994)	Mixed design with follow-up	<i>Attributions:</i> Causal attributions for Challenging Behaviour Scale (Berryman, 1991) <i>Attitudes:</i> Attitudes Towards Disabled Persons Scale – Form A (Yuker, Block & Young, 1966) <i>Treatments proposed:</i> Discussion and selection from a list (information not provided on the list)	Follow-up conducted at 9 months post training	No adjustment for confounding variables. Areas of unclear reporting e.g. main outcomes to be measured and characteristics of sample	9

Table 6 –Summary of METHODOLOGICAL aspects of the literature contd

McDonnell (1997)	Pre and post within participants design	<i>Knowledge:</i> Violent Incident Knowledge Test <i>Confidence:</i> Managing Challenging Behaviour Confidence Scale <i>Skills:</i> Restraint Role Play Test	Course aims clearly reported	No follow-up. No adjustment for confounding variables Several areas of unclear reporting e.g. no information on recruitment of participants	8
Smidt, Balandin, Reed and Sigafos (2007)	Multiple baseline design	<i>Beliefs:</i> Challenging Behaviour Attributions questionnaire (Hastings, 1997) <i>Communication interactions:</i> Video analysis of augmentative communications, praise and inappropriate language of staff <i>Levels of challenging behaviour in clients:</i> Client incident forms	6 and 12 month follow-up. Ecological validity of training and methods of assessment	Validity of study due to low overall levels of challenging behaviour before study. Training focused on 3 clients and results may not generalise to other clients. Several areas of unclear reporting e.g. no statistical analyses were reported	7

### **Most methodologically robust studies (scores 19- 28)**

Two studies achieved scores that placed them in this category (Van Oorsouw et al. 2010 and Allen et al. 2000) and both examined the effects of training on staff knowledge and quality of their physical interventions in response to challenging behaviour. Their impetus for addressing staff knowledge was similar; that staff lacking in knowledge were more likely to be negatively affected by challenging behaviour and improving knowledge may lead to a reduction in the likelihood of challenging behaviour occurring (van Oorsouw, 2010). The relevance of focusing on developing staff ability to undertake physical interventions was to reduce the likelihood of injury for clients and staff and because if staff do not feel safe, they will be unlikely to implement other behavioural or communicative strategies effectively (Allen, 2000).

Van Oorsouw et al. (2010) adopted a quasi-experimental control group design consisting of two experimental groups (n = 35) and two control groups (n = 35) to investigate the impact of a five-day training programme for staff working with clients with challenging behaviour. The training took place one day a week for five weeks and consisted of 25½ hours teaching on the causes of challenging behaviour, early signs of escalation and caring for colleagues involved in incidents and 7½ hours teaching on physical intervention skills. An exclusion criteria was used to ensure that none of the staff had participated in any comparable training for at least two years and groups were matched in terms of their professional role, severity of challenging

behaviour worked with and gender. Staff in the control group received the training once the study was completed.

Following the training, a significant improvement was found in the levels of knowledge of staff and in the quality of their physical interventions. Demonstrations of physical intervention techniques were videoed and analysed using a standardised observation manual developed by the authors. Inter-rater reliability between the ratings of the two authors of the 12 observations demonstrated a kappa co-efficient of 0.93. Clinical validity of the manual was ascertained by observations being assessed by three experienced trainers and correlated with the scores of the authors (Pearson's  $r$  of 0.59). In addition, knowledge and physical intervention scores remained significantly higher at three-five month follow-up in the intervention group than pre training scores. No significant differences were found in the control group pre and post training. However, staff knowledge and physical intervention scores at follow-up in the intervention group were significantly smaller than post training scores. This suggests that maintenance of high levels of knowledge and physical interventions in care staff may not be automatic and may require additional input (i.e. from managers or services providing training). It may have been useful if a follow-up measurement of knowledge and skills had been undertaken in the control group to see if any increases in scores would have taken place over time independent of training. However, this may have resulted in the control group waiting longer for training which may have been unethical given possible safety implications for clients or staff.

Allen and Tynan (2000) utilised a mixed design to compare a training programme in two groups of staff; one who had previously received the training (n= 51) and another who had not (n = 58). Training was carried out using the 'Management of Aggression Training Program', previously developed by the authors. The main emphasis of the programme was the development of preventative approaches to challenging behaviour through antecedent or ecological change (altering aspects of the environment that may trigger challenging behaviour). It consisted of an introductory theory day followed by one to two days physical intervention practice according to need. Staff who had previously undertaken training were randomly selected from attendance lists from past trainings and the 'untrained' staff group comprised of staff who requested training. Participants in both groups were blinded as to the purpose of the study, which was also to find out if training could increase staff confidence in their ability to cope with challenging behaviour. Following training, a significant improvement was found in the levels of knowledge and confidence in the 'untrained group' (who were now trained). However, staff in the 'trained group' achieved significantly higher scores on both measures than the 'untrained' group scores post training. It is possible that pre-existing differences found between the groups (including length of service and nature of challenging behaviour experienced by the staff) may have accounted for this variation. Matching participants in the two groups in this study would have addressed this issue and further increased the validity of the findings.

There are some other limitations to these studies. Neither used an RCT design to randomly allocate participants to experimental conditions, though in the Allen study this may have required a more complex design that may have been difficult to

implement. Neither measured the effects of the training on staff practice and both studies accept this as a limitation, recognising a difference in staff possessing knowledge and skills and utilising these in highly charged emotional situations (van Oorsouw, 2010). In addition, no follow-up was conducted in Allen's study. A follow-up would have made an interesting comparison to the van Oorsouw study which found that scores in knowledge and skills significantly reduced three to five months after training. As there was a greater emphasis within the 'Management of Aggression Training Approach' on proactive methods including environmental and antecedent change, it may have provided some indication if these methods were employed by staff, influencing how they perceived reactive behaviour management over time. Despite these limitations, both studies obtained relatively high ratings on the Quality Index tool and this was due to their experimental designs, attention to confounding variables and clear reporting style. This suggests that the studies possess good reliability and validity and provides some evidence that staff training is an effective intervention to improve care staff knowledge of challenging behaviour and physical interventions. These studies could also be seen to set a benchmark as to a standard of research attainable.

### **Medium methodologically robust studies (scores 10- 18)**

These studies investigated the impact of brief staff training on a variety of different cognitive and emotional dimensions of staff. These were staff attributions, knowledge, emotional reactions and self-efficacy, as well as implementation of behavioural plans for challenging behaviour and other aspects of staff practice.

The area most frequently researched was that of staff knowledge. McKenzie et al. (2002), McKenzie et al. (2000), Kalsy et al. (2007), and Gentry et al. (2001) examined the effects of brief training on enhancing staff knowledge. With the exception of instruction in physical interventions, the basic content of training appeared similar to that of training in the most methodologically robust quality studies (i.e. causes of challenging behaviour, signs of escalation and preventative strategies). Apart from Gentry et al. (2001) who assessed a three-day training, these studies assessed one-day training.

McKenzie et al. (2000) investigated the impact of training on the knowledge of staff relating to challenging behaviour. The study consisted of a training group (n=59) and a control group (n=73) who did not receive the training. Knowledge was measured with a questionnaire concerning the criteria for a learning disability, defining and managing challenging behaviour and duty of care. Following the training, significant increases were found in the knowledge of the trained group in relation to defining a learning disability, duty of care and defining challenging behaviour but not the management of challenging behaviour. The authors suggest that this may be because staff felt the production of behavioural guidelines and functional analysis were outside the remit of their work. Follow-up data demonstrated that their overall scores remained significantly higher at six months (n=12) and twelve month (n=15) than at pre training. The control group showed no increases in knowledge. This study was later replicated with 36 staff who also reported significant increases in knowledge (McKenzie et al. 2002). It was not specified by the authors however, whether the staff

who participated in this study were a distinct group from the previous study and this is a key weakness in terms of the study's reporting.

Gentry et al. (2001) investigated a three day 'Interactive Staff Training' (IST) on levels of staff knowledge. The IST approach was developed by Corrigan and McCracken (1997) originally for use in psychiatric settings and was different to the other training in attending to organisational and motivational barriers to the implementation of new knowledge and skills. Key features of the IST approach were to train staff as a whole group (including managers), obtaining administrative support for changes, assessing staff needs prior to training, and forming a committee responsible for decision making regarding the organisation of the training. In addition to the topics typically covered, the training also included sessions on the organisational barriers to implementing strategies and practical implications of management guidelines. Significant improvements in staff knowledge were found following training, although no follow-up was conducted to know if improvements were maintained.

A study by Kalsy et al. (2007) examined if a four hour workshop could improve the knowledge of staff who worked with clients with down syndrome, dementia and challenging behaviour. In total, 97 staff attended the workshop which consisted of teaching on the disease course of dementia, health problems, behavioural descriptors, assessment and intervention options. Detailed workshop information was not provided. Significant increases in knowledge were found following the training,

though the measure related to aging and intellectual disabilities not specifically to challenging behaviour.

A second area investigated by several studies was that of attribution change, relating to the recognition that addressing staff appraisals can have a positive effect on how staff behave towards clients (Ager and O'May, 2001). As a result, studies have used a variety of means to assess whether staff appraisals can be altered by training.

Berryman et al. (1994) was the first study to address staff attributions of challenging behaviour and move beyond a traditional behavioural focused approach. Berryman et al. (1994) evaluated the effects of two types of one day training. One group received training in traditional behaviour management (n=45), whilst a second group received training in understanding behaviour in relation to a person's past experiences and social context, including teaching on functional alternatives in communication and improving quality of life (n=29). The results indicated that in the latter group, staff showed a significant increase in attributions to external reinforcers such as escape-avoidance processes and tangible reinforcement and a significant reduction in the selection of categories of internal reasons such as clients' emotions and low self-esteem as causes of challenging behaviour (measured by the Causal Attributions for Challenging Behaviour Scale). This was significantly different from the traditional behavioural management trained group, who tended to attribute clients' challenging behaviour to their emotions. Differences were maintained at nine month follow-up suggesting that staff who received the latter training continued to go beyond attributing clients' behaviour to their emotions - "He destroys property because he is

angry” to think about the reasons why this may be (Berryman et al. 1994). The study also assessed how the training influenced behavioural plans developed by staff and significant differences were found between the two groups, with no significant changes found in the intervention plans of staff in the traditional behaviour management group where as the latter group demonstrated a greater emphasis on helping clients to achieve new skills and undertaking a functional analysis.

Significant changes in attributions were also found by Kalsy et al. (2007) who also investigated attributions in addition to knowledge following a four hour training session. The Controllability Beliefs Scale (Dagnan et al. 2004) was used to assess how much control care staff believed clients with down syndrome and dementia had over challenging behaviour. The study also assessed optimism of staff who were asked to rate their agreement with two statements about the likelihood of change in challenging behaviour. Following the training, staff demonstrated significantly lower controllability attribution scores, meaning that significantly less control was attributed to clients over challenging behaviour. However, no correlation was found between the lowered controllability attribution scores and levels of optimism in staff. The authors highlight that this result does not support Dagnan et al’s (1998) suggestion that attributions of controllability are a precursor to optimism. However, these results cannot be taken to refute Dagnan et al’s suggestion either, because there is nothing to verify the accuracy or sufficiency of the method used to assess optimism in this study. Another possible explanation for these findings is that following training, staff attributed the cause of the challenging behaviour more to the dementia than perceiving that the person was engaged in challenging behaviour by choice, but

because of the enduring nature of dementia, may not have felt optimistic about change.

Two studies did not find any changes in attribution. Tierney et al. (2007), assessed changes in attributions, emotional reactions and feelings of self-efficacy of staff after attending a three-day training on understanding challenging behaviour and stress. The training included teaching on behavioural and functional assessment, using a 'Positive Behavioural Support Plan', coping with stress and provided techniques from the 'Non Violent Crisis Intervention Training Programme'. The programme centred on crisis development and appropriate interventions during and following challenging behaviour. The training was attended by 48 staff. Attributions were measured by the Challenging Behaviour Attributions Scale (Hastings, 1997), emotional reactions by the Emotional Reactions to Challenging Behaviour Scale (Mitchell and Hastings, 1998) and self-efficacy by a 5-item likert scale. Following training, there were no significant changes in either attributions or emotional reaction scores but a significant increase was found in staff ratings of self-efficacy. Tierney et al. (2007) had wanted to establish whether a 'typical staff training approach' (i.e. fairly standard material being covered e.g. causes of challenging behaviour, functional analysis, importance of communication, precipitating factors to challenging behaviour) could lead to cognitive and emotional changes in staff. Their findings could be taken to suggest that a 'typical' training may be sufficient to improve staff feelings of self-efficacy but insufficient to alter their cognitions or negative emotional reactions to challenging behaviour and that a more targeted approach may be needed. The efficacy scale, which measured staff confidence, control, satisfaction, difficulty in dealing with

challenging behaviour and feeling of having a positive impact, may have also have been more compatible with a 'typical training approach'. Methodological weaknesses may also be responsible for some of these results.

McKenzie et al. (2002) also measured attributions in addition to knowledge, and in a small subgroup (n=14), staff practice. Attributions were measured using two methods. The first was a bipolar scale based on 4 attributional dimensions suggested by Munton et al. (1999) which were internal-external, controllable-uncontrollable, stable-unstable and global-specific. The second was open ended questions about the causes of challenging behaviour, which were scored using Bromley and Emerson's (1995) categories which included a wide range of possible causes such as internal psychological state, environment, stimulation, communication, medical, mental illness or escape (McKenzie, 2002). Practice was assessed in a four hour assessment of a series of tasks set in relation to a selected client in accordance with the Periodic Service Review (PSR, La Vigna et al. 1994). Examples of PSR tasks were the correct recording of the client's behaviour, reactive strategies and treatments selected, and appropriate use of reinforcement. Immediately after the training and at eight weeks follow-up, no significant changes were found in staff ratings on attributional dimensions but a significant decrease was found in the selection of the category of 'communication deficit' at follow-up than pre training though the reason for this is uncertain. Significant changes were also found in staff practice following training. Therefore the authors concluded that attributional change does not play a key role in changing staff practice.

One other study investigated whether a one-day workshop could alter staff causal explanations (n=54) of challenging behaviour (Dowey et al. 2007). This study was also interested in whether 'working culture' and in particular 'staff talk' (the way staff talk to each other about challenging behaviour) as a factor of organisational culture could be changed to increase receptivity to a later skills based training. The workshop was presented as a pre training for later skills based training. Lectures, vignettes and role play exercises were used to teach staff about the causes of challenging behaviour, including the role of the environment in shaping behaviours and aspects of Applied Behavioural Analysis. The training also consisted of a lecture on quality of life issues such as choice, respect, community presence and participation. Changes in attributions were measured using a modified subscale of the Self-Injury Behavioural Understanding Questionnaire (Oliver et al. 1996). This required participants to read 11 scenarios and select from four possible explanations for the challenging behaviour that reflected behaviourally correct, behaviourally incorrect, internal emotional or internal organic explanations. Following training, there was a significant increase in the use of behavioural explanations compared to explanations relating to the emotional or organic state of the client. However, the increase in behavioural explanations consisted of a significant increase in both behaviourally correct and behaviourally incorrect explanations. This study implies that training can change causal thinking about challenging behaviour and that staff may have gained a general understanding that challenging behaviour can be related to environmental and situational reasons but one day may not have allowed enough time for staff to develop their thinking to answer questions correctly. Another drawback to this study was that it did not measure whether these changes influenced 'staff talk' and the authors did

not report on the skills based training and whether staff were more positive towards this.

On face value, these medium score studies seem to demonstrate some consistent support for staff training improving staff knowledge, whilst suggesting a mixed picture with regards to the efficacy of training in changing staff attributions. However, when the Quality Index tool was used, a number of methodological issues within these studies were revealed suggesting a lack of robustness to the findings.

Methodological weaknesses were consistently identified across four of the five Quality Index domains. Only on domain five (*power*), did the studies score comparably to those in the high quality category because of their reasonable sample sizes. Overall, there was a lack of clear *reporting* with regard to the populations from which the sample was recruited, numbers prepared to participate compared to the numbers of staff invited to training or the participants lost to follow-up. None of these studies obtained points on the *external validity* domain, often because it was questionable as to how generalisable their results were to the general care staff population. *Internal validity* scores (both on the *bias* and *confounding* domains of the Index) were also low due to an absence of blinding procedures, collection of follow-up data or consideration of factors that could confound the results e.g. whether staff had recently attended other challenging behaviour training. Another *internal validity* issue frequently identified was the accuracy of the main outcome measures used. For example, the measure used in Gentry et al's (2001) study that detected highly significant increases in staff knowledge scores, was an 'ad hoc' measure with no detail about its structure, development, reliability or validity. Psychometric properties

are also not reported for the 20-item knowledge quiz used in the study by Kalsy et al. (2007). McKenzie et al (2002) employed a self-assessment visual analogue scale on which staff were required to rate how much they believed their knowledge of challenging behaviour had changed following training. Therefore, subjective perceptions about improvements in knowledge, not actual changes were obtained.

While there appeared to be a greater use of standardised tools for the measurement of attributions, there are still some considerations. Tierney et al. (2007), who found no changes in staff attributions following a three-day training, used the CHABA to measure attributions and the authors themselves highlight the low levels of internal consistency of the CHABA on several sub scales. They assert that a more psychometrically robust measure may have detected changes in attributions. Another issue was that post training scores were only gathered after three months and so their conclusion that training did not significantly change staff attributions may be inaccurate, as a better design incorporating both immediate and follow-up data collection may have shown that changes in attribution scores occurred but were not maintained at follow-up.

### **Least methodologically robust studies (scores 0- 9)**

Mc Donnell (1997) investigated a three-day course which aimed to increase understanding of challenging behaviour, teach skills in defusing situations and restraint and increase confidence of care staff. At the end of the course a significant increase in self confidence was found (measured by the 15 item Managing

Challenging Behaviour Confidence Scale), but no significant difference in knowledge (measured by the Violent Incident Knowledge Test). All 22 participants also demonstrated competence in physical restraint.

Smidt et al. (2007) found that after the implementation of four, two and a half hour training sessions using a 'MOSIAC' package (Model of Interaction for the Analysis of Interaction and Communication), there were some initial increases in the use of augmentative communication skills by staff (n=18) and some small changes in attributions (measured by the CHABA). However, this was only maintained at follow-up (six month and 12 month) by one organisation out of three. There was also little impact on challenging behaviour recorded by staff which was ascertained through an audit of clients' incident forms.

While these studies make a contribution to research on brief training, there are issues that impede their validity (in addition to the problems identified for studies reviewed to this point). Mc Donnell (1997) found that a large number of staff attributed their increase in confidence to the role play exercises but there are concerns about the generalisability of this to working directly with clients. Smidt et al. (2007) assessed staff practice but the frequency of challenging behaviour of the clients was initially low (in organisation three, only one incident was recorded during the 18 months of the study). Secondly, only one type of challenging behaviour was measured and it is unknown whether there was any increase in other forms of challenging behaviours. Thirdly, training effectiveness was judged on the findings relating to just one resident per organisation and it was not defined how this resident was selected.

## **DISCUSSION**

This paper reviewed the recent literature on brief training for care staff who work with people with an intellectual disability and challenging behaviour. Overall, this literature suggests that brief training may have a role to play in increasing staff knowledge, for example of intellectual disabilities, challenging behaviour, proactive and reactive strategies and other issues such as choice and community participation. The effectiveness of training in altering knowledge of staff is consistent with the wider literature on the impact of staff training. The literature reviewed also suggests that training can change staff attributions relating to challenging behaviour, e.g. implying that following training, staff give more consideration to reasons external to the person (i.e. environmental or situational) as causes of challenging behaviour and less focus on internal reasons (e.g. people's organic or emotional state). The literature also implies that training can improve staff confidence, the quality of physical intervention techniques and some other aspects of staff practice such as the development and implementation of behavioural guidelines.

The Quality Index tool (Downs and Black, 1997) enabled the literature to be examined in a more comprehensive manner and a variety of methodological weaknesses were exposed, indicating that their research findings are not as robust as they initially appear. Key difficulties include inadequate experimental designs, not using standardised measures, failure to account for confounding variables and a lack of description of aspects of the study. Just two studies were designated scores that achieved a "most methodologically robust" rating in this review and this was due to

their relatively good research designs, attention to a range of confounding variables and clear reporting style.

It was recognised that there were some limitations to using the tool. The Quality Index was not specifically designed for reviewing literature about intellectual disabilities or training. Therefore, studies which used multiple methods to examine the effects of training including assessing staff practice (McKenzie et al, 2002; Berryman et al, 1994; Smidt et al, 2007), could not be awarded extra points.

Investigating the effects of training on staff practice could be considered an important aspect of such research but was an overall omission from the studies reviewed. Points could also not be awarded for the clinical significance of the study or if something conceptually new was added to the literature (e.g. Dowey et al, 2007 and Gentry et al, 2001 aimed to change aspects of organisational culture and this added a different dimension to the research). There was an indication that the broader the focus of the study (conceptually or methodologically), the less methodologically robust the study.

Given the methodological issues raised, the review confirms the suggestive but not definitive nature of the findings. For example, there is also some indication from the studies that a 'typical training approach' may be sufficient to change levels of knowledge but insufficient to change staff attributions or emotional reactions, even where training is three days long rather than a single day. This indicates that a more targeted approach which addresses values and beliefs of staff may be required for changes in these variables. However, this is a tentative indication because it was difficult to separate when findings of studies were related to the nature of the training

approach adopted as opposed to the methodological quality of a study. A further difficulty was identifying how much the results of any training were attributable to characteristics of the trainers i.e. their personal style and way of conveying material to staff in a way that was meaningful to their work setting, or the particular formats they used. One study has linked training effectiveness with formats used by the trainer, including mixed formats for teaching, ensuring verbal feedback and praise and setting clear goals (van Oorsouw, Embregts, Bosman and Jahoda, 2009) and it is possible that these also related to the success of some studies.

### **Clinical implications**

Both of the “most methodologically robust studies” (partially supported by studies in the “medium” category) found that training was a useful tool for increasing staff knowledge. Increasing staff knowledge may alter the way staff approach clients, which could reduce the chances of incidents occurring (van Oorsouw, 2010). It is recognised that in care services there are often poor levels of knowledge but all staff require the necessary knowledge to work with people with challenging behaviour (Ball, Bush and Emerson, 2004). All staff should have access to such training.

Taking into consideration the limitations of the studies, the findings suggest a role for training that addresses staff attributions. That studies often demonstrated a shift from ‘internal’ to ‘external’ explanations for challenging behaviour following training is clinically relevant because it may mean that staff will be more aware of the reasons for challenging behaviour, including how their own behaviour could precipitate and

maintain challenging behaviour. Attributing less control to clients over challenging behaviour may mean staff are more sympathetic and helpful (Weiner, 1980; 1993). It could be hypothesised changes in attributions of controllability could lead to better relationships with clients, if staff do not feel that a person is using challenging behaviour purposely against them. Perhaps this may reduce negative perceptions towards clients, which has been associated with staff taking a confrontational approach (Jahoda and Wanless, 2005). Hence, if changes in attributions may lead to changes in staff behaviour, this may reduce the escalation of challenging behaviours. Sufficient time should be designated to address the values and attitudes of staff.

There is also some indication within the research that it could be beneficial for training to take account of team factors when undertaking training. Recognising the impact of organisational barriers on new learning, Gentry et al. 2001; Dowey et al. 2007, used approaches that addressed aspects of organisational culture.

Individualising training for a team may improve the likelihood of training having an impact, by increasing the contextual fit between the taught ideas and their acceptability (Grey et al. 2007).

It seems a reasonable assumption that there is a role for staff training and this leads to the implication of how services can ensure that all staff become trained. At present, training is not mandatory and there is a need for services to work collaboratively to address training needs. It could be beneficial for a strategy to include a system of monitoring staff performance to ensure that staff are regularly updated and those who require further training are identified. In the study by Berryman et al. (1997) changes

in attributions were maintained at nine month follow-up and the authors describe the use of biweekly supervision. This also implies the role of supervision as part of an overall strategy to maintain improved staff performance. It has been recognised that there is variation in what staff as well as service employers deem to be the remit and responsibilities of their jobs (Campbell, 2010) but for a multifaceted strategy to work, value must be placed on staff development by all involved.

### **Research implications**

The literature highlights a number of implications for future research. In particular, the methodological limitations of the studies elucidated by the Quality Index tool, provide some clear indicators for the design of future research. For instance, there is a need for future studies to use validated and reliable measures that are sensitive to the changes that can occur and to take better account of confounding variables. This could be addressed by using randomised control designs, applying a double-base line assessment to detect changes in the dependent variable occurring prior to training, and by ensuring that either exclusion criteria or statistical analysis is used to take account of staff who may have previously attended training. Several of the studies focused on the immediate gains following training and there is a need to investigate the sustained benefits, as well as how changes in knowledge, cognitions or emotions lead to enhanced staff practice. Further research is also warranted into staff variables which have so far received less attention i.e. self-efficacy, optimism, attitudes and emotional reactions. In seeking to understand the benefits of addressing different variables of staff and how they interrelate, a balance must be struck between adopting a comprehensive approach to assessment and protecting the wellbeing of staff so they

are not exhausted by questionnaires. With the number of staff variables that can be researched, the formation of more up to date psychological models to guide this research would also be timely. In addition, future research into staff training may also want to evaluate different and more modern approaches to training, such as Positive Behavioural Support.

The literature also suggests that advances in the research should not be confined to improved replications of the studies already conducted, but should continue to look beyond training itself to other factors that may impact upon staff learning and retention of changes. One factor implied by the research is that of organisational culture. A number of studies in this review drew attention to the significance of organisational and contextual barriers in the implementation of learning from training and two studies attempted to address aspects of organisational barriers. However the nature of the relationship between organisational culture and the gains staff make and retain when they attend training is not well defined. The review highlights that it would be beneficial to empirically investigate this link.

Another area that may benefit from further research is staff experience of training and of being invited / encouraged to attend training. Mixed results as to the effectiveness of training, small sample sizes in some studies and unreturned questionnaires in others, may indicate issues around the acceptability, accessibility or compatibility of training for staff. Qualitative methodologies could also be utilised in future studies to enhance understanding of staffs' subjective experience of training.

## **CONCLUSION**

There is a paucity of research looking at brief staff training for care staff working with clients with challenging behaviour in intellectual disability services. The literature so far indicates a potential role for staff training as an intervention to improve staff responses to challenging behaviour and consequently improve services for clients with intellectual disabilities. However, there are a number of methodological flaws in the research and further research, with a more robust approach is needed to clarify training effectiveness. It is also the time to take a more comprehensive look at other factors which impact on staff gains in training and their maintenance. Doing so may require greater investment of resources but may lead to a more effective training strategy along with meaningful and enduring changes in the workplace.

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**Empirical Paper**

**Staff training in Positive Behavioural Support: Impact of organisational culture  
on changes in attributions and attitudes**

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## **ABSTRACT**

### **Background**

There is a paucity of research on brief training for staff who work with people with an intellectual disability who display challenging behaviour and on the influence of organisational culture on staff learning.

### **Materials & Method**

A one-day challenging behaviour training was investigated. Staff attributions and attitudes were measured at four time points. Organisational questionnaires were also administered to assess if changes in attributions and attitudes were related to staffs' organisational cultures.

### **Results**

Following training, significant changes in staff attitudes were recorded. Staff attributions of controllability were not significant when double base line scores were accounted for. No associations were found between changes in attitude and attributions scores and ratings of organisational culture.

## **Conclusions**

Further investigation is required to assess the effects of brief training on staff attributions and attitudes and the relevance of organisational culture.

**Keywords:** intellectual disabilities, challenging behaviour, staff attributions, staff attitudes and organisational culture

## INTRODUCTION

Challenging behaviour is a common concern in intellectual disability services, estimated to be expressed by 10-15% of people with an intellectual disability (Emerson et al. 2001). Challenging behaviours include aggression to others, self-injurious and destructive behaviour and its occurrence is associated with a range of negative outcomes such as physical injury (for the person, staff or others), social exclusion, isolation and neglect, as well as abuse from caregivers (Emerson, Robertson, Gregory, Hatton and Kessissoglou, 2000).

Vital to the management of challenging behaviour are front-line care staff who work directly with people with intellectual disabilities who work to prevent and manage challenging behaviour, whilst helping people develop and sustain fulfilling lives (Jahoda and Wanless, 2004). Being the interface between policy and practical action (Hatton et al. 1998) and key agents in implementing behavioural strategies (Dench, 2005), it is essential that they are given adequate support and training to equip them with the values, skills and knowledge to work with challenging behaviour (Department of Health, 2009).

### **Recent approaches to staff training**

Approaches to staff training for those who work with people with an intellectual disability and challenging behaviour have seen much change over recent years. Ethical and legal concerns stemming from a recognition that traditional approaches

can increase the use of aversive methods with people with intellectual disabilities (Berryman, Evans and Kalbag, 1994), have led those working with care services to seek other approaches to training. Simultaneously, there has been a move from behavioural to cognitive-behavioural theories in understanding people and their behaviour. With the publication of key government papers such as the Mansell Report (2007) and Valuing People Now (DoH, 2009) drawing attention to issues surrounding the rights and needs of people with intellectual disabilities and recommending improvements to service, there has been increased emphasis on the provision for effective staff training for all staff. Over the past 10 -15 years, staff training has turned its attention to focus on the cognitions of staff, including beliefs about challenging behaviour (Grey, Hastings and McClean, 2007). In addition, Positive Behavioural Support (PBS) has been promoted as a key intervention ‘that is both ethical and effective’ (Allen, 2005, p2) and it is argued that more staff should be trained in PBS (Allen, James, Evans, Hawkins and Jenkins, 2005).

### *Staff attributions*

Stemming from a cognitive-emotional model of helping behaviour proposed by Weiner (1980, 1993), there is a recognition of the relevance of understanding staff attributions. Weiner’s model linked staff attributions about the level of control they believed a client had over their challenging behaviour with the nature of response they exhibited. It predicted that staff are more likely to express negative emotions and be less helpful if they attributed challenging behaviour to be within a client’s control, and be more sympathetic and helpful, if they attributed challenging behaviour to be outside of a client’s control. The model stipulated that attributions of controllability

will influence emotional reactions which will in turn influence how staff behave. A number of studies have supported this model (Dagnan, Trower and Smith, 1998; Hill and Dagnan, 2002; Stanley and Standon, 2000; McGuinness and Dagnan, 2001), informing us that attributions may be akin to rules which potentially govern behaviour (Hastings & Remington, 1994). A further suggestion is that beliefs about the causes of challenging behaviour and how it is best reduced, may be a contributing factor to the failure of staff to implement robust evidence-based therapies (Campbell and Hogg, 2008).

A series of studies has explored the modification of staff attributions through training. These have investigated both longer term i.e. six months to two years in duration and brief training i.e. one to five days. Longer term training studies found significant changes in staff attributions following training (e.g. Mc Gill, Bradshaw and Hughes, 2007; Mc Clean et al. 2005), though results were not always maintained (Lowe et al. 2007). Research into brief training has however, elicited a mixed picture. Kalsy, Heath, Adams and Oliver (2007), found that following a four hour training session, staff attributed less control to clients over challenging behaviour than before training. Berryman, Kalbag and Evans (1994) found that a brief training led to a change in what staff believed to be the reasons for challenging behaviour. After the training in non-aversive behaviour management, there was a significant reduction in the degree to which staff saw client emotions or low self esteem as the cause for their challenging behaviour and a significant increase in the degree to which they perceived tangible reinforcement or the need to escape or avoid situations as reasons. Others studies have not shown any significant changes (McKenzie et al. 2002; Tierney et al.

2007). Another study found whilst training had a significant impact on shifting staff attributions about the causes of challenging behaviour from emotional or intrinsic to behavioural explanations, there was also a significant increase in the number of incorrect behavioural explanations staff selected from a list of options in addition to correct explanations (Dowey Toogood, Hastings and Nash, 2007). However, numerous methodological limitations within these studies, i.e. suitability of outcome measures, lack of attention to confounding variables or follow-up assessment, have made determining the efficacy of staff training in changing staff attributions difficult.

### *Staff attitudes*

Whilst it is recognised that less positive attitudes often exist towards clients with challenging behaviour and that negative attitudes actually increase the probability of challenging behaviour (Embregts, Didden, Huitink and Schreuder, 2009), this is a factor that has received even less attention and clarity in studies of staff training.

For instance Berryman et al. (1994) found changes in staff attitudes in addition to attributions following training. However, this was towards people with intellectual disabilities in general, not specifically towards people also with challenging behaviour and the experience of challenging behaviour may lead to the development of a different set of attitudes towards clients and towards working with them. Other studies have used the term attitudes but this has been in a broader sense, referring to communicative behaviours (Smidt et al. 2007), attributions and emotional responses (Lowe et al. 2007), role clarity and confidence in managing challenging behaviour (Gentry, Icton and Milne, 2000). As attitudes ‘generally imply the valuing or

devaluing of specific aspects of a person' (Farrel, Shafiei and Salmon, 2010, p1646), the consequences of negative attitudes towards clients with challenging behaviour could be severe. There is an indication that both counter-habilitative attitudes and staff attributions towards clients must be addressed if training to be effective (Duff, Redhead, Paxton, Icton, Rochester, 2006).

### ***Positive Behavioural Support***

Originating in the early 1980's (Carr et al. 1999), PBS has been described as:

“...educational, proactive and respectful interventions that involve teaching alternative skills to problem behaviours and changing problematic environments. It blends best practices in behavioural technology, educational methods and ecological systems change with person-centered values in order to achieve outcomes that are meaningful to the individual and to his or her family”

(Bambara, Koger, Katzer, & Davenport, 2004)

PBS approaches are considered the most ethically stringent, evidence-based intervention for people with intellectual disabilities and challenging behaviour (Allen et al. 2005), in one major review reducing challenging behaviour in between one-half and two-thirds of cases (Carr et al. 1999).

Studies of extended training in PBS have shown significant changes in the beliefs and knowledge of staff, in addition to improvements in the quality of life and reduction of

challenging behaviour for service users (McClean, Grey and McCracken, 2007; McGill, Bradshaw and Hughes, 2007; Lowe et al, 2007; McClean et al. 2005; Dench 2005). These studies highlight a need to translate best practice into everyday practice (McClean et al, 2005). However, training will often take place over a six month – two year period, which is unrepresentative of the training many care staff can easily access. Too few staff are trained in PBS (Allen, 2005) and it seems that further work to understand how it can be easily disseminated to staff working in a range of settings with clients with varying severity of challenging behaviour would be beneficial.

### **Organisational culture**

Organisational culture is a concept which has many definitions. A well known definition is by Schein (1990), who proposed organisational culture as:

“A pattern of basic assumptions, invented, discovered or developed by a given group as it learns to cope with its problems of external adaptation and internal integration, that has worked well enough to be considered valid and therefore is to be taught to new members as the correct way to perceive, think, and feel in relation to those problems”.

(Schein, 1990, p111)

Furthermore, organisational culture emerges from what is shared between colleagues, including beliefs, attitudes, values and norms (Davies, Nutley and Mannion, 2000)

and indicates what is behaviour is successful or not in an organisation (Witte and van Muijen, 1999).

The importance of understanding the influence of organisational culture in intellectual disability services has been recognised (see Hatton et al, 1999). Organisational characteristics (including formal and informal culture) are just as important as individual staff characteristics in determining the behaviour of staff (Hastings, Remington and Hatton, 1995) and have been associated with a range of outcomes (Hatton et al. 1998). These include the provision of assistance for service users to engage in active support and meaningful activity (Mansell, Beadle-Brown, Whelton, Beckett and Hutchinson, 2008) as well as high stress (Hatton and Emerson, 1993) and burnout (Blumenthal, Lavender & Hewson, 1998).

Emerson, Hastings and McGill (1994), highlight how informal rules held by a team (including peer groups definitions of what should be done and monitoring others performance) can also act as powerful barriers against “external” initiatives.

Consequently, organisational culture has also been found to affect the acceptability of behavioural interventions (Ager and O’May, 2001), attitudes towards external professionals (Rose, Ahuja and Jones, 2006) and the use of information and communication technology (Parsons, Daniel, Porter and Robertson, 2008).

Given staff beliefs about challenging behaviour are likely to be affected by their staff group (Hastings and Remington, 1994) and that organisational culture guides behaviour (Witte and van Muijen, 1999), we may expect organisational culture to

affect their response to another form of “external” initiative. That is, their response to staff training provided and in particular, changes they make when they attend training. The urgency of examining this relationship has been previously asserted (Hastings et al. 1995) but so far, little systematic research has been undertaken. Two studies have attempted to influence staff culture as part of staff training (Dowey et al. 2007; Gentry, Iacono and Milne, 2001) but these have not led to any conclusive findings about the role of organisational culture in staffs’ response to training. Dowey et al. (2007) aimed to change one aspect of staff culture ‘staff talk’, via a pre-training day, in order to increase staff receptivity to a consequent skills-based training. Whilst positive changes in staff causal explanations of challenging behaviour were found following the pre-training, the results of the skills-based training were not reported and the impact of the pre-training on ‘staff talk’ itself was not measured.

It has been argued that psychologists should actively measure collective as well as individual phenomena because of their relevance for team working and for success (Anderson and West, 1996). Organisational barriers have been suggested to impede the implementation of new learning (Corrigan and McCracken, 1995) i.e. through the threat of exclusion when taking learning back to organisations (Brookfield, 1994). Given that shared perceptions are co-constructed by the interactions between individuals (Anderson and West, 1998) it is possible that when staff return to their organisations following training, interactions influenced by shared perceptions within a team about people with intellectual disabilities and challenging behaviour reconstruct the ideas staff initially took from training. In this way, the nature of the organisational culture of a team may also influence the learning retained by staff.

## AIMS AND HYPOTHESES

This study aims to examine whether a one-day staff training using principles of Positive Behavioural Support can be effective in changing staff attributions and attitudes towards people with an intellectual disability and challenging behaviour and towards their work. The study also investigates whether any changes in staff attributions and attitudes that occur and are maintained are related to the organisational culture of the team to which staff belong.

*This study examines six hypotheses:*

- 1) Residential care staff will demonstrate lower attributions of controllability i.e. how much they attribute control to individual for his or her challenging behaviour, following a one-day challenging behaviour training using principles of Positive Behaviour Support.
- 2) Residential care staff from intellectual disability services will hold more positive attitudes towards working with individuals with an intellectual disability who have challenging behaviour following a one-day challenging behaviour training using principles of Positive Behaviour Support.

- 3) The amount of change found in care staff attributions between immediately before and after training will be directly related to the organisational culture of their team i.e. with greater reduction in attributions of controllability correlating with more favourable ratings of organisational culture.
- 4) The amount of change found in staff attitudes between immediately before and after training will be directly related to the organisational culture of their team, with greater increases in attitude scores correlating with more favourable ratings of organisational culture.
- 5) The degree of maintenance of changes in staff attributions measured at follow-up will be directly related to the organisational culture of their team, with smaller increases in attributions of controllability correlating with more favourable ratings of organisational culture.
- 6) The degree of maintenance of changes in staff attitudes measured at follow-up will be directly related to the organisational culture of their team, with smaller decreases in a positive attitudes correlating with more favourable ratings of organisational culture.

## **MATERIALS AND METHODS**

### **Design**

This study utilised a mixed-methods design. A within-subjects design was used to examine staff attribution and attitude change across four time points (one week pre-training, immediately pre and post training, and at two months follow-up). A between-subjects design was used to examine staff changes in attribution and attitude scores in relation to their ratings of the organisational culture of their team. It was recognised that an RCT would have been the ideal experimental design but a mixed design was chosen as a compromise to enable the effective comparison between a treatment and control period. Knowing the likely sample size that could be achieved within the period available for the project and the numbers required to achieve sufficient power to conduct an effective analysis, this approach was taken as a pragmatic solution that would enable the hypotheses to be investigated in a thorough manner as possible.

### **Participants**

Following approval from the University Ethics Committee and local Research and Development department, participants were sought from the population served by a local intellectual disability service based in an urban metropolitan borough. Participants were care staff who worked closely with individuals with an intellectual disability in a residential setting (private, voluntary, or statutory) who had been invited to attend a one-day challenging behaviour course. Staff were required to have

worked at their organisation for at least six months and to have not attended any other challenging behaviour training within the last six months.

Based on undertaking a regression analysis, using Cohen's (1988) conventions, it was calculated that approximately 40 participants were required to demonstrate a medium experimental effect (with power =0.8, alpha = 0.05).

Staff from 36 residential homes were invited to attend. In total, 101 staff booked onto the training and 91 staff agreed to participate in the study. Of these, 69 staff actually attended for the training (a participation rate of 69.7 %) working across a total of 13 different organisations. Due to four participants not completing a large proportion of the questionnaires i.e. more than 20%, the final number of participants in the analysis was 65. Of these 65 participants, due to staffing issues, shift patterns or absences, it was not possible to collect time point one data (one week prior to training) and time point four data (follow-up) for all 65 participants in the study. Therefore, there were 65 staff for whom data was gathered at time points two and three, 41 at time points one, two and three, 48 at time points two, three and four, and 37 at time points one, two, three and four.

In addition, Intensive Support Team staff based at the local intellectual disabilities service, also participated in the study order to provide an additional rating of organisations. The Intensive Support Team is a specialist service that provides assessment and intervention advice based on a model of Positive Behavioural Support, to care organisations and carers regarding the management of challenging

behaviour. Having worked closely with a number of services across the borough, the Intensive Support Team have a good knowledge of a variety of residential services. Intensive Support Team staff were required to have been working with the organisation for a least six months. There were six Intensive Support Team members who took part.

## **Measures**

The following questionnaires were used to collect demographic, attribution, attitude and organisational data. Questionnaires were selected according to their psychometric properties and brevity.

### **Staff characteristics**

#### ***Demographic information form***

An 8-item demographic information form was used to obtain general demographic characteristics about residential staff, such as age, gender, length of time working in their profession and current job, and whether they worked full or part time.

#### ***Controllability Beliefs Scale (CBS; Dagnan et al., 2004)***

The CBS (see Appendix 4) measures the extent to which a carer attributes an individual to be in control of his / her challenging behaviour. It comprises of a 15-item scale, which requires an individual to indicate how much they agree with statements about challenging behaviour, by marking a 5-point Likert scale which ranges from 'strongly disagree' to 'strongly agree'. The CBS included statements

such as ‘They are trying to wind me up’ and ‘They have chosen to behave this way’. A higher score indicates higher ratings of controllability. Item-correlations analysis demonstrated that the CBS has high internal consistency and also good internal reliability (Cronbach’s alpha = 0.89).

***The Five Minute Survey (adapted from Hardy, 2006)***

The Five Minute Survey (see Appendix 4) was based on a scale originally developed by Hardy (2006) to assess the attitudes of General Practitioners towards treating patients with an intellectual disability. This scale contained statements which relate to attitudes towards the provision of services to adults with an intellectual disability, for example ‘Individuals with an intellectual disability are most effectively treated with medication’.

For the purpose of this study, the questionnaire was modified to refer to challenging behaviour and shortened to consist of 13 statements to increase the ease and speed of completion for staff. To ensure that internal consistency of the measure was maintained, statistical analysis was conducted on the 13-items, which demonstrated a Cronbach’s alpha of 0.718. This indicates a high level of internal consistency. Given that previous validity and reliability statistics of the measure were good, further statistical analyses were not undertaken (Cronbach’s alpha = 0.824; Test retest reliability Pearson’s  $r = 0.810$ , Rose, 2010).

Of the 13 statements, 10 are worded with a negative bias and 3 with a positive bias. Participants are required to express how much they agree or disagree with statements

by placing a mark on a visual analogue scale (a 20-point Likert scale ranging from 0.25 to 5.00). A higher score indicates a more positive attitude.

### **Organisational characteristics**

#### ***The Team Climate Inventory (TCI; Anderson and West, 1994)***

The TCI is a multidimensional measure of team climate and group processes that assesses the overall strengths and weakness of teams. It has a four factor structure focusing on team vision, group participation and safety, support for innovation and task orientation. The structure was determined theoretically and this was confirmed with factor analysis. Participants are presented with 44 statements relating to the atmosphere of an organisation, nature of people's interactions, team objectives and support given for implementing new ideas. Participants are required to indicate on a 5-point Likert scale the extent they feel each statement reflects their organisation. The TCI has reliability data which demonstrate good internal consistency ( $\alpha = 0.84$  to  $0.94$ ) and it has been extensively validated with a number of reference groups which include NHS teams (Anderson and West, 1994).

#### ***The Service System Assessment (SSA; Allen 1999)***

The Service System Assessment is a measure of organisational functioning, designed to assess organisational issues in relation to challenging behaviour in services for adults with intellectual disabilities. The SSA is a 22-item scale, comprising questions regarding the social and physical environment, supervision and individual care planning. All items require a yes/no response. The internal reliability has been

identified to be good and levels of inter-rater and test retest reliability acceptable (72.0% and 80.2% respectively) (Allen 1999).

## **Procedure**

Information about the study was provided to the training liaison officer at the local intellectual disability services, who then emailed an information sheet about the study to residential staff in the borough alongside information about the training. The information sheet described the purpose of the study and a contact number for further details. Residential staff were required to indicate on the reply slip if they wished to participate in the study or not, or wanted more information. Staff who requested further information were contacted by telephone. There were a possible 13 dates staff could attend training.

A pack was issued to staff who wished to be involved in study approximately two weeks before they attended training. This consisted of another copy of the information sheet, a consent form and the first set of questionnaires (the CBS and The Five Minute Survey). The purpose of issuing questionnaires at this stage was to provide a baseline in order to detect any changes in staff attributions and attitudes prior to receiving the training and for this to be considered in the statistical analyses. These questionnaires were either collected or returned when staff attended the training. Questionnaires took approximately 10 minutes to complete.

When staff attended training, they were asked to complete a Background Information Questionnaire, TCI, CBS and The Five Minute Survey. The latter two questionnaires were distributed to staff again immediately after the training and on a final occasion approximately two months following training. Intensive Support Team staff were also provided with an information sheet about the study and on request, verbally given further details. Those who were interested in participating were given a consent form to complete and asked to fill in the SSA for organisations with which they had worked. Each Intensive Support Team member filled in two SSAs apart from one who filled in three SSAs.

All participants in the study were given at least 48 hours to decide if they wanted to be involved and a coding system allowed all questionnaires in the study to be completed and stored anonymously but enabled the researcher to match forms had been completed by each participants.

### **A.B.O.U.T training**

Training took place at the local intellectual disability centre and was carried out by a clinical psychologist, who delivered the training to groups of four to ten staff. The training was entitled 'A.B.O.U.T', and its aims were focused around the following areas. *Attitude*: having a positive, respectful and understanding attitude in working with clients and recognising the importance of communication, having a sense of power, a fulfilling life and positive emotional experiences. *Behaviour*: Knowing what factors lead to challenging behaviour, how this will be personal to each individual and

how to clearly describe behaviour. *Observation*: Knowing how to objectively observe, record, measure and summarise behaviour for others. *Understanding*: Understanding behaviour how behaviour is a powerful means of communication and working out what the person is communicating and what can be done to help them express themselves in other ways. *Techniques*: Having a non-confrontational philosophy and working effectively as team to promote non-challenging behaviour and manage challenging behaviour.

The overall training was embedded within a PBS approach involving teaching on preventive approaches to challenging behaviour and helping clients develop alternative means to express themselves. Throughout the sessions, a mixture of individual, small group exercises and guided discussion were used. A course handbook also accompanied the training. More detailed course information can be found in Appendix 6.

## **RESULTS**

### **Demographics of the sample**

Of the 65 care staff for whom questionnaires were used in the analysis, 41 were female (63.1%) and 24 were male (36.9%). The sample comprised 51 support workers, 10 senior support workers and four managers, and 50 participants (76.9%) worked full time. The mean age group of participants in this study was 31-35 years old, the mode was 21-25 (29.2%) and the median age group was 26-30 years old.

In terms of the length of time worked in their present job, the mean duration was 2 years 5 months (SD = 3 years). The mean duration of working in the field was 4 years 6 months (SD = 5 years 2 months). Of the sample, two participants had received no training during their present job (3.1%), three had received between 1-6 hours (4.6%), 16 had received between 1-4 days (24.6), 17 had received 1-4 weeks of training (26.2%) and 27 had received more than four weeks of training (41.5%). Additionally, 19 participants (29.2%) had caring responsibilities outside of work.

### **Preliminary analysis**

To analyse the data for normality and homogeneity of variance, a Kolmogorov-Smirnov test was undertaken. The analyses indicated that the main scales were all normally distributed. Therefore all further analysis was undertaken using parametric tests. Descriptive analyses were also carried out to establish means and standard deviations of the study variables. These are presented in Table 7.

Table 7. Mean attribution and attitude scores at time points 1- 4 and their standard deviations

Measure	Mean	SD	N
<u><i>Controllability Beliefs Scale</i></u> <u><i>(Attributions)</i></u>			
Pre-training (1)	21.62	9.36	42
Pre-training (2)	23.55	9.42	65
Post-training (3)	20.62	10.03	65
Follow-up (4)	20.55	9.39	49
<u><i>The Five Minute Survey</i></u> <u><i>(Attitudes)</i></u>			
Pre-training (1)	42.49	8.00	41
Pre-training (2)	41.89	8.56	65
Post-training (3)	46.00	9.55	65
Follow-up (4)	46.89	8.33	48

NB Lower attribution scores indicate lower controllability attributions. Potential scores range from 0 to 60. Higher attitude scores indicate more positive attitudes. Scores range from 0 to 65.

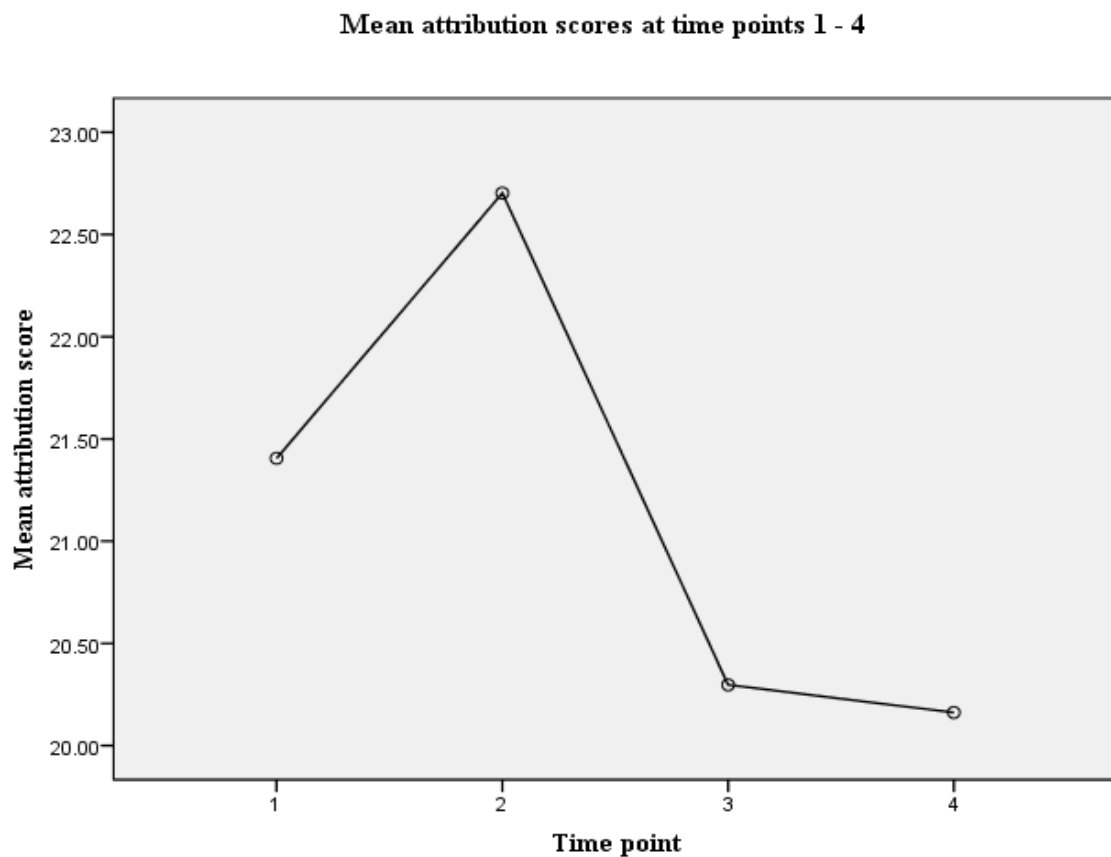
### **Staff changes following training**

#### ***Attribution change***

The first hypothesis was that staff attributions towards clients with challenging behaviour would change following the training. Scores on the CBS were compared across the time points using a repeated measures analysis of variance. This showed a

significant difference in staff attributions of controllability over the four time points ( $F(1, 36) = 356.8, p < 0.01$ ) in the graph below.

Figure 1. Mean attribution scores at time points 1- 4



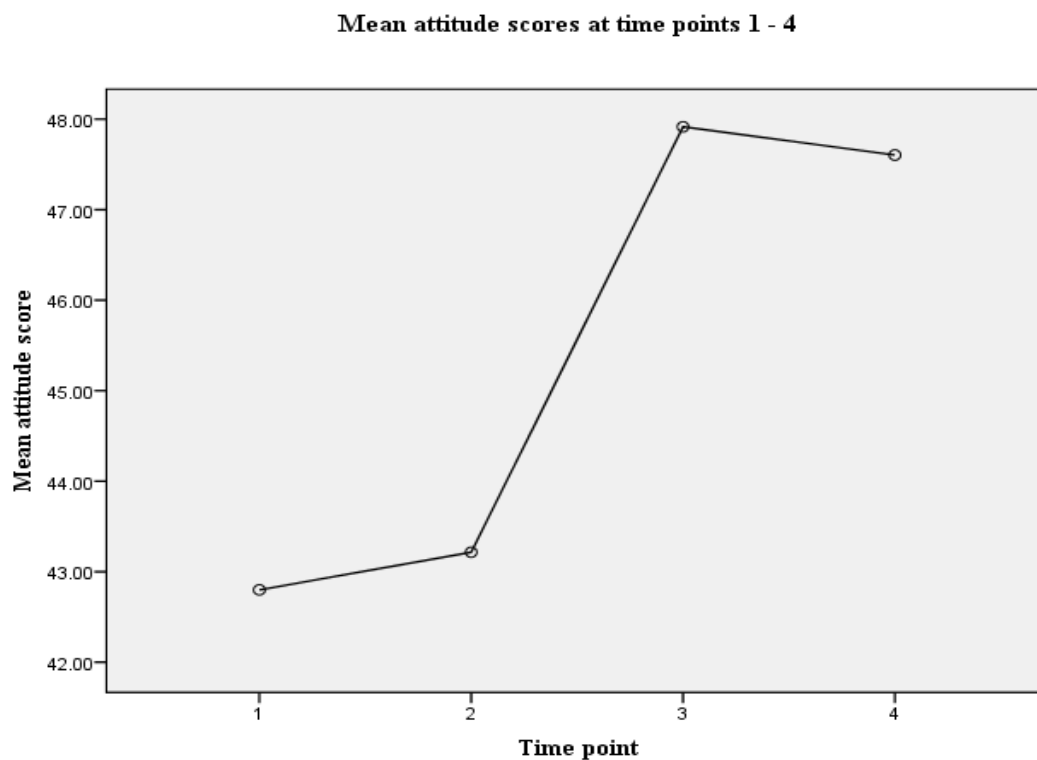
To examine this further, in particular between which time points a significant difference was occurring, paired-samples *t*-tests were used. The results demonstrated insignificant changes between time points one (one week prior to training) and two (pre-training) ( $t(41) = -1.137, p < 0.26$ ), a significant reduction in controllability attributions ( $t(64) = 1.967, p < 0.05$ ) between time points two (pre-training) and three

(post-training), and an insignificant change between time points three (post-training) and four (follow-up) ( $t(48) = 0.089$ ,  $p = 0.93$ ). However, overall change in attribution scores between time points one and four proved to be insignificant ( $t(36) = 0.718$ ,  $p = 0.48$ ).

### ***Attitude change***

It was also hypothesised that staff attitudes towards working with clients with challenging behaviour would change following training. Scores on The Five Minute Survey were compared across time points using a repeated measures analysis of variance. This showed a significant difference in attitudes over the four time points ( $F(1, 35) = 1242.7$ ,  $p < 0.01$ ) in the graph. This is represented in the graph below.

Figure 2. Mean attitude scores at time points 1 - 4



When differences between time points were explored further using paired-samples  $t$ -tests, an insignificant change was found between time points one (one week prior to training) and two (pre-training) ( $t(40) = -0.697$ ,  $p = 0.49$ ), a significant increase in attitude ratings between time points two (pre-training) and time three (post-training) ( $t(64) = -5.126$ ,  $p < 0.01$ ) and no change between time points three (post-training) and four (follow-up) ( $t(47) = 0.810$ ,  $p = 0.42$ ). Furthermore, a paired samples  $t$ -test examining participants' overall change in attitude score between time points one and four, was also significant ( $t(35) = -4.749$ ,  $p = 0.01$ ). This indicates that the training resulted in more positive staff attitudes towards people with intellectual disabilities with challenging behaviour and that staff attitudes remained significantly more positive two months after receiving the training.

### **Organisational culture and changes following training**

Hypotheses three and four stated that the degree of attribution and attitude change of staff would be directly related to the organisational culture of the staff team.

Hypotheses five and six stated that the degree of maintenance of attribution and attitude change would be directly related to the organisational culture of the staff team.

To investigate these relationships, the difference in each staff member's attribution and attitude scores between pre and post training, and between post training and follow-up, were calculated and the resulting variable was correlated with ratings on

the TCI subscales and SSA using Pearson's Correlations (r). The results are presented in Table 8.

Table 8. Correlations between attribution and attitude changes and the TCI subscales and SSA

Measure	<u>Relationship with change</u>		<u>Relationship with maintenance</u>	
	<i>Attributions (n=65)</i>	<i>Attitudes (n=65)</i>	<i>Attributions (n=49)</i>	<i>Attitudes (n=48)</i>
	Pearson's (r)	Pearson's (r)	Pearson's (r)	Pearson's (r)
TCI participant safety	0.097 ns	0.214 ns	0.051 ns	0.009 ns
TCI support for innovation	0.061 ns	0.141 ns	0.080 ns	0.126 ns
TCI vision	0.184 ns	0.065 ns	0.0230 ns	0.140 ns
TCI task orientation	0.157 ns	0.031 ns	0.269 ns	0.206 ns
SSA	0.004 ns	0.168 ns	-0.101 ns	-0.108 ns

As can be seen above, no correlations were found between any of the TCI subscale or SSA scores and attribution and attitude change immediately following training. There were also no correlations found between these scores and attribution and attitude changes between post training and follow-up.

### ***Organisational culture and attribution change***

To further explore the relationship between organisational culture and attribution change, a linear multiple regression analysis was conducted using the 'Enter' method. TCI subscale and SSI scores were entered as independent variables. The results are presented in Table 9.

Table 9. Regression analysis of relationship between organisational culture and attribution change

<b>Attributions (n= 65)</b>				
Measure	<i>b</i>	<i>Std Error</i>	<i>β</i>	Sig.
TCI participant safety	.716	.870	.139	ns
TCI support for innovation	-2.108	1.989	-.220	ns
TCI vision	1.010	.785	.251	ns
TCI task orientation	.528	1.620	.056	ns
Service System Assessment	-.095	.380	-.031	ns

This regression also showed that there was no significant contribution to the variance of any of the TCI subscales or SSA ratings on attribution change ( $F(4,60) = .874$ ,  $p < 0.49$ ). Analysis showed that these factors accounted for just 5% of the variance in attribution score change ( $R=2.35$ ,  $R^2=0.55$ ).

### ***Organisational culture and attitude change***

A multiple linear regression analysis was conducted using the 'Enter' method to further explore the relationship between organisational culture and attitude change. The results are presented in Table 10.

Table 10. Regression analysis of relationship between organisational culture and attitude change

Measure	<b>Attitudes (n= 65)</b>			
	<i>b</i>	<i>Std Error</i>	$\beta$	Sig.
TCI participant safety	.636	.468	.230	ns
TCI support for innovation	.096	1.070	.019	ns
TCI vision	.251	.422	.057	ns
TCI task orientation	-.522	.871	-.110	ns
Service System Assessment	-.291	.201	.179	ns

This regression showed that there was no significant contribution to the variance of any of the TCI subscales or SSA ratings on attitude change ( $F(4,60) = .824, p < 0.52$ ). Analysis showed that these factors accounted for just 5% of the variance in attitude score change ( $R=.228, R^2=0.52$ ). Therefore, the findings of these analyses are not supportive of the hypotheses that attribution and attitude changes demonstrated by

staff on receiving training or the durability of those changes are related to the organisational culture of staff teams.

A further analysis was conducted to see if staff ratings of their organisational culture would correlate with external professionals' ratings of organisations. A Pearson's Correlation (r) was conducted. Table 11 presents the correlation coefficients and significance levels of the sample.

Table 11. Correlations between TCI subscale and SSA ratings

<b>TCI Subscales</b>	<b>Pearson's (r)</b>
TCI participant safety	0.240
TCI support for innovation	<b>0.355**</b>
TCI vision	0.129
TCI task orientation	-.045

\*\*p<0.01

A positive significant correlation was identified between external professionals' ratings of the organisation (measured by the SSA) and care staff ratings of the support for innovation scale on the TCI. No other subscales correlated with SSA scores. This suggests that staff and external professionals may share views about the quality of an organisation in terms of the support available for innovation but not about other areas of team functioning.

## DISCUSSION

The aims of this study were to investigate the effects of a one-day training using a principles of Positive Behavioural Support on staff attributions and attitudes towards clients with an intellectual disability who display challenging behaviour and towards their work. A longitudinal design consisting of data collection at four time points, including two measurements prior to training, one week apart was also used.

### **Staff changes following training**

#### *Attribution change*

A significant difference was found between staff attribution scores immediately before and after training. This means that after the training, staff judged challenging behaviour to be less under clients' control than they had prior to the training. Changes in attributions are consistent with findings by Berryman et al. (1997), Kalsy et al. (2007) and Dowey et al. (2007). In accordance with Weiner's model (1980, 1993), we would expect a corresponding increase in the helping behaviour of staff towards the clients they work with. Follow-up data collection showed that staff controllability scores two months after training were also lower than immediately post training, suggesting that training continued to have an effect when staff returned to their organisations. However, this study also incorporated a double-baseline assessment into its design and when analysis took into consideration the variability in scores between first and second baseline, the result lost its significance. This indicates that there may be problems with the test-retest reliability of the Controllability Beliefs

Scale or this result may be due to the loss of data at different time points with different subsets of staff contributing to the analysis at different times. This may suggest that a larger sample size is required to investigate this hypothesis and further exploration of the psychometric properties of the CBS is needed.

### *Attitude change*

Following training, staff also demonstrated significantly more positive attitudes towards working with people with intellectual disabilities and challenging behaviour. Furthermore, staff attitude scores did not significantly decrease at follow-up, meaning that staff retained a more positive attitude in their work with clients with intellectual disabilities who displayed challenging behaviour. Further to this, the analysis showed little difference in staff attitude scores between baseline time points one and two and so the significance of the results were maintained.

These findings provide support for the role of staff training in changing the attributions and attitudes of care staff towards clients with challenging behaviour. Whilst designed as a basic training for educating front-line staff on the principles of PBS, it resulted in a positive impact on staff attributions and attitudes. This finding is different to Dowey et al. (2007), whose one-day training resulted in changes in staff attributions from ‘internal’ to ‘behavioural’ explanations for challenging behaviour but not necessarily a correct understanding of the reasons for challenging behaviour. Tierney et al. (2007) found a three-day training (incorporating a PBS plan) was insufficient to alter attributions.

Several reasons pertaining to the approach and methodology of the training may help to explain the findings of this study. Firstly, enabling staff to develop the right attitude in working with clients with an intellectual disability and challenging behaviour was considered fundamental by the A.B.O.U.T trainer and so there was a significant emphasis on thinking about attitudes. There was also an emphasis on normalising challenging behaviour, by encouraging staff to think about how they themselves would feel in a situation where they were unable to communicate. This task of ‘putting oneself in their shoes’ may have increased staffs’ understanding and empathy towards people with intellectual disabilities and challenging behaviour, contributing to a change in attitudes and attributions. In addition, the numbers of staff trained during each session was relatively small (between four and ten) meaning the trainer’s attention could be offered to all staff who attended. The methodology of the training was also participative and reflective, rather than didactic and group exercises, discussions and a workbook provided opportunities for staff to reflect on the material and upon their own beliefs and attitudes. Furthermore, this emphasis on participation and reflection may have aided the retention of material, hence the positive results at follow-up.

### **Relationship between organisational culture and attribution and attitude change**

In this study, no significant relationships were discovered between the changes found in staff attributions or attitudes, and ratings of organisational culture by staff or external professionals. With regards to both attributions and attitudes, ratings on the TCI accounted for just five percent of the variance of between changes in staffs’

scores across time points one to four. Additionally, no significant relationships were found between the maintenance of attribution and attitude scores and either care staff or external professionals ratings of organisational culture. On one hand these findings suggest that the training was effective regardless of the organisational culture of the team to which staff belong. Alternatively, these results may reflect methodological issues concerning the organisational culture data gathered. For example, the sample in this study may have comprised staff who were motivated or confident to attend training (of 36 homes contacted, staff from just 13 homes booked onto training and of the 13 homes, not all staff attended). Therefore, the full spectrum of organisational cultures may not have been captured and consequently this may have impacted on the variability of organisational culture ratings gathered. Another issue may be the concept of organisational culture and its measurement. This study assumed that all participating care homes possessed an organisational culture. It has been asserted however, that in order for organisational cultures to form, a group of people must have had enough stability and due to reasons such as a frequent turnover of members, some organisations may have no overarching culture (Schein, 1990). Given the mean duration that staff worked in their organisations was 2.4 years, it is possible that some care homes where there was a large turnover possessed no clear organisational culture which could be measured.

In terms of the association between staff ratings of organisational culture (measured by the four subscales of the TCI) and external professional ratings (measured using the SSA), a Pearson's correlation analysis revealed no significant correlations, apart from the support for innovation subscale and the SSA. This could suggest that

organisations may have been perceived very differently by the care staff who work within them compared to external professionals. Alternatively, the measures may have tapped into quite different concepts, with little overlap apart from support for innovation. The SSA is also a relatively untested measure (Dilworth, Philips and Rose, 2011) which may require further testing to assess the reliability and validity of its psychometric properties.

### **Strengths, methodological limitations and future research**

#### ***Strengths***

A strength of this study was its experimental design which included both follow-up and double-baseline data collection. Of the brief staff training studies conducted, this is the first to have used a double-baseline and as far as can be ascertained, contains the largest follow-up sample ( $n = 49$ ). The largest so far was Tierney et al. (2007) ( $n = 43$ ).

#### ***Methodological limitations***

There are some limitations to this study that need to be taken into considered. The first is the sample size for which data was gathered for all four time points ( $n = 37$ ) which may have influenced the findings. To have expanded the sample size may have required extending the time for data collection, which was beyond the scope of the study. The study could have used a more rigorous RCT design but given the time constraints, obtaining a control group would have impacted on the numbers in the study group and the numbers required to achieve sufficient power for the analysis

may not have been reached. A third limitation relates to the length of time after which follow-up data was obtained. Two months is a relatively short period and it is impossible to know whether attribution and attitude changes would have been maintained in the longer term. A follow-up of two months may have been insufficient to fully test hypotheses five and six because it may not have been enough time for staff to become re-immersed in their organisational cultures and their attributions and attitudes influenced by this. Further exploration of this could be beneficial. Another limitation was although demographic information about previous training was gathered, staff were not specifically asked about any prior challenging behaviour training they had attended during their career which also may have impacted on the results. Another drawback is that this study did not measure changes in actual staff behaviour and it cannot be assumed that changes in attributions and attitudes automatically improved staff practice. This is a frequent issue in brief training studies (see Campbell, 2011; Grey, et al. 2007) and evaluating staff behaviour as well as service user behaviour change has been regarded as essential in evaluating training in PBS (Hastings, 2005). A final limitation to the study is that clustered TCI scores were used in the analysis of the relationship between changes in scores in attributions and attitudes and organisational culture. Whilst the use of group scores is the recommended methodology of the TCI, the result of adopting this methodology was that the analysis did not reflect individual variability between participants' scores.

### ***Future research***

It is recommended that further research in this area either utilise an RCT or conduct a double-base line measurement. The findings of this study indicated the relevance of

taking a rigorous approach to the measurement of change and doing so would reduce the risk of Type 1 errors being made. Where possible, further studies should measure changes in staff practice and wait longer before collecting follow-up data. Future research could also be carried out to better understand the relationship between organisational culture and staff training. Qualitative methodologies could be considered, suited for exploring an individual's personal beliefs and opinions which could complement quantitative approaches in increasing understanding of organisational culture (Scott et al. 2003). Such approaches could also be used to understand staff subjective experiences of attending training.

### **Clinical implications**

The results of this study suggest that the principles of a PBS approach can be disseminated in a brief training format and this may provide a foundation upon which further work with staff could be undertaken. Further attention to staff attributions and attitudes may be required. Refresher sessions, supervision and managers supporting staff to hold the right attitude are all applicable. Supervisor workshops are also suggested as a way to maintain effectiveness in PBS (Dench, 2005). As only 13 of 36 homes invited chose to attend the training, this raises a question regarding the possible attributions and attitudes of staff who did not attend. Prompt attention may need to be paid to this. It has been suggested that staff have different ideas about their responsibilities (Campbell, 2011) and there can be numerous disincentives such as resources to attend, feelings of inadequacy relating to literacy levels and fears of a hidden agenda in being sent for training (Huda, 1996). Addressing these barriers by

working in partnership with managers of local residential homes may be important in if a consistent standard of care amongst all staff is to be ensured.

## **CONCLUSION**

This study found that a one-day training utilising principles of Positive Behavioural Support did impact upon the attributions and attitudes of care staff towards clients with an intellectual disability and challenging behaviour and towards their work. However, given changes in staff attribution scores prior to attending training, findings needs to be taken with caution and further research may be needed to clarify the effects of staff attending training on their attributions. This research also found no link between the type of organisational culture that staff came from and their changes in attributions and attitudes. Undertaking this study revealed some of the complexities of measuring organisational culture and given the methodological issues in this study, further research into how organisational culture may impact on staff training should not be ruled out. Continuing to embrace the complex and dynamic issues concerning staff learning and maintenance of learning, is important if staff training is to be a meaningful and durable intervention.

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## **Executive Summary**

**An investigation into brief training for care staff who work with people with an  
intellectual disability and challenging behaviour**

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## ***Background***

Challenging behaviour is a frequent occurrence in intellectual disability services and vital to its prevention and management are front-line care staff. Front-line care staff work both with the challenging behaviour (commonly aggressive, destructive or self-injurious, Emerson et al. 2001) and with the person exhibiting it in to help them sustain a meaningful and fulfilling life. Therefore, it is imperative that front-line care staff are provided with the right training and support to do their job safely and effectively and in manner of feeling informed and positive about their work.

Approaches to training staff who work with people with an intellectual disability and challenging behaviour have seen much change over recent years, broadening beyond a focus on behavioural and physical interventions. Training now also addresses how staff feel and think about challenging behaviour and this has been the focus of most research studies over the past 10-15 years (Grey et al. 2007). However, the effectiveness of recent approaches to training is still unclear. In particular, it would be useful to establish the effectiveness of brief training (1-5 days) because this is more typical of the kind of training staff would be likely to access.

Research has also been carried out into factors external to the individual staff member which influence their practice. One such factor is the organisational culture of the team to which a staff member belongs and it has been suggested to be just as important as an individual's characteristics in determining behaviour (Hastings et al. 1995). Organisational factors has been linked with numerous outcomes including staff stress (Hatton and Emerson, 1993), burnout (Blumenthal, Lavender & Hewson, 1998) and assistance given to service users to engage in meaningful activity (Mansell et al.

2008). However, no research has investigated how a staff member's organisational culture may influence what they gain and retain when they attend training.

### ***Literature review***

A review of the recent literature on brief training for staff who work with people with an intellectual disability and challenging behaviour was carried out. In total, eleven studies were reviewed and attention was given to both the content and the quality of the studies. A quality assessment tool was selected to help thoroughly examine the studies. The findings of the literature review were that training frequently improved staffs' general knowledge about intellectual disabilities and challenging behaviour. However, there were mixed results with regards to the effectiveness of training in helping staff think more broadly about the causes of challenging behaviour i.e. to also think about reasons such as communication, reinforcement, self stimulation, and the need to escape situations, in addition to internal reasons such as clients' organic or emotional state. There was some indication that a 'typical training approach' may be insufficient to address beliefs about challenging behaviour. However, these findings must be taken with caution because the quality assessment tool revealed a number of issues with these studies. These included problems with the measures used to assess changes following training, a lack of consideration to factors that could affect the results i.e. whether staff in the study had recently been on any other training and a lack of follow-up data gathered to know if any changes in beliefs were maintained. This indicated that further research was required which adopted a more thorough approach to the investigation of staff training.

### ***Aims***

The aim of the study was to examine a one-day training course using principles of a Positive Behavioural Support approach and whether it was effective in changing staff beliefs about their work with challenging behaviour and about those who exhibit it. The second aim of the study was to investigate whether changes in the above were related to the organisational culture of the teams to which staff belong.

### ***Method***

A questionnaire based study involving 65 care staff who attended a one-day A.B.O.U.T training was carried out. Questionnaires on staff beliefs were administered at four points in time (one week before training, immediately before and after training and approximately two months after training). An organisational measure was given when staff attended the training and also to external professionals to provide an additional rating of organisations.

### ***Results***

After the training, there were significant increases in staffs' attitude scores regarding working with clients who displayed challenging behaviour and these changes remained at two months follow-up. Staff also believed clients to have less control over challenging behaviour, though when variability between the double-baseline scores were accounted for, this change was not significant. No relationship was found between these changes and staff ratings of organisational culture.

### ***Limitations***

Although immediate pre and post data was gathered for 65 staff, there were only 37 staff for whom data was collected at all four time points. This may limit the reliability and generalisability of the findings. Also, of 36 care homes invited to the training, only 13 attended and therefore the full range of organisational cultures may not have been represented in this study, which may have impacted on the findings. Another limitation is that impact of training on staffs' daily practice was not assessed.

### ***Clinical Implications***

The findings of this study indicate that the A.B.O.U.T training does influence staff attitudes and beliefs towards their work with clients with an intellectual disability and challenging behaviour. However, additional support in the form of further training, refresher sessions or managerial support i.e. through supervision may be required to further increase positive attitudes and to address beliefs about the causes of challenging behaviour. Attention may also be warranted to issues relating to staff attendance at training.

### ***Conclusion***

Further investigation into brief staff training and the relationship between training outcomes and factors which influence these outcomes is needed if researchers intend to maximise the impact and longevity of training efforts.

## ***References***

Blumenthal, S., Lavender, T. & Hewson, S. (1998). Role clarity, perception of the organisation and burnout amongst support workers in residential homes for people with intellectual disability: a comparison between a National Health Service trust and a charitable company. *Journal of Intellectual Disability Research*, 42, 409-417.

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Grey, I.M., Hastings, R. S. & McClean, B. (2007). Editorial- Staff Training and Challenging Behaviour. *Journal of Applied Research in Intellectual Disabilities*, 20, 1-5.

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**Appendix 1**  
**Instructions to Authors for Submission to the Journal of Applied**  
**Research in Intellectual Disabilities**

## **Appendix 2**

### **Participant Information Sheets**

## **Participant Information Sheet (PIS) for Participants attending training**

### ***Staff Training in Positive Behavioural Support: Impact of Organisational Culture on Changes in Attributions and Attitudes***

You are being invited to participate in a research study about the above topic. This information sheet will provide you with some details about the research and what will be involved if you decide to take part.

#### **What is the purpose of the study?**

The purpose of the study is to understand more about the gains that staff make from attending training in working with clients who have a learning disability and whether this is related to the organisational culture of their staff team. The researcher would like to find out more about how you benefit from staff training. The study is being undertaken as part of an academic qualification.

#### **Why have I been chosen?**

You have been chosen to participate in this study because you work with people with learning disabilities.

#### **Do I have to take part?**

You are under no obligation to take part in this study. You will be given this information sheet to keep and at least 48 hours to consider whether you would like to take part in the study. You are free to withdraw from the study without giving any reason.

#### **What will happen to me if I take part?**

If you decide to take part in the study, you will be issued with a consent form and 2 brief questionnaires to fill in around one week before you attend the training (these will take up to 10 minutes to fill in).

#### **What do I have to do?**

When you attend the training, you will be given a brief background questionnaire followed by 3 other questionnaires, which will take a maximum of half an hour to fill in. These questionnaires ask a number of questions about your experience and views of challenging behaviour and about the culture of the team in which you work. Views of team culture will also be gathered by members of the Intensive Support Service. There are no right or wrong answers and your responses will be kept confidential.

After the training, you will be asked to fill in 2 of the questionnaires again and this will take approximately 10 minutes. You will be asked to fill in these questionnaires a final time two months following the training. These will be posted to you with a stamped address envelope for their return. A summary of the research will be sent to you once the research is completed. If you wish to have a copy of the full research report, this will be sent at your request.

### **What are the possible disadvantages and risks of taking part?**

It not anticipated that there will be any disadvantages or risks to taking part in the research. You will not be disadvantaged by filling in the questionnaires in terms of missing out on training as time has been built into the training for this. In addition, it is unlikely that undertaking the questionnaires would cause any emotional distress. However, if this were to occur, you will be able to talk the chief investigator (Abigail Gallivan – see below for contact details) or to John Rose (see below for contact details), who is a psychologist with experience of working with this client group, if you so wish to discuss any further issues.

Please note that if you were to disclose any instances of malpractice, the investigator would have to report this to the appropriate authorities.

### **What are the possible benefits of taking part?**

Taking part in the research will give you an opportunity to share your views and for these to be considered by other people. You will not be financially reimbursed for taking part in this study.

### **What happens when the research study stops?**

If the research were to stop, participants will be contacted and informed of this by the researcher. A report will be written once the research is finished.

### **What if there is a problem?**

If there are any problems, or you have any concerns about the research, you should contact the researcher who will try to answer your questions (see contact details below). If you were to lose capacity during the course of the research, your data will be destroyed and will not be included in the final study.

Please remember that you can withdraw at any time if you wish and any information relevant to you will be destroyed.

### **Will my taking part in the study be kept confidential?**

All information during the course of the research will be collected and kept in a confidential format. The questionnaires will be stored confidentially and identifiable information will not be shared or included in any report. Verbatim quotes will be used in the final report, but again these are anonymous. The NHS Trust for audit purposes may request information from the study but if were to occur, questionnaires data would not be identifiable. The only people who will see unedited data will be members of the research team. In the circumstance that a staff member disclosed a protection issue, this information would need to be shared with the relevant parties. All material will be destroyed ten years after the research is completed.

### **Contact Details:**

If you have any further questions about the study, please contact:

**Abigail Gallivan** (*Principal Investigator*) or **John Rose** (*Research supervisor*) at:

University of Birmingham,  
Edgbaston,  
Birmingham,  
Tel: 0121 414 2640

**Participant Information Sheet (PIS) for Intensive Support Team staff**

***Staff Training in Positive Behavioural Support: Impact of Organisational Culture on Changes in Attributions and Attitudes***

You are being invited to participate in a research study about the above topic. This information sheet will provide you with some details about the research and what will be involved if you decide to take part.

**What is the purpose of the study?**

The purpose of the study is to understand more about the gains that staff make from attending training in working with clients who have a learning disability and whether this is related to the organisational culture of their staff team. The researcher would like to ask you to rate the organisational culture of the staff teams who attend the training. The study is being undertaken as part of an academic qualification.

**Why have I been chosen?**

You have been chosen to participate in this study because you work with staff who work with people with learning disabilities.

**Do I have to take part?**

You are under no obligation to take part in this study. You will be given this information sheet to keep and at least 48 hours to consider whether you would like to take part in the study. You will then be asked to give your written consent to participate in the research. You are free to withdraw from the study without giving any reason.

**What will happen to me if I take part?**

If you decide to take part in the study, you will be given two questionnaires to fill in.

**What do I have to do?**

Your involvement in the study will require filling in a brief background questionnaire followed by one other questionnaire. This will take a maximum of 10 minutes to fill in. This questionnaire will ask about your views of the organisational cultures of different services with which you work. There are no right or wrong answers.

Your ratings will be collated with the ratings given by care staff about their organisational culture, which will be collected when they attend training on Positive Behaviour Support. Both sets of ratings will be analysed in relation to the results of attribution and attitude questionnaires that staff are requested to fill in before and after the training.

A summary of the research will be sent to you once the research is completed. If you wish to have a copy of the full research report, this will be sent at your request.

**What are the possible disadvantages and risks of taking part?**

It not anticipated that there will be any disadvantages or risks to taking part in the research. You will not be disadvantaged by filling in the questionnaires in terms of missing out on training as time has been built into the training for this. In addition, it is unlikely that undertaking the questionnaires would cause any emotional distress. However, if this were to occur, you will be able to talk the chief investigator (Abigail Gallivan – see below for contact details) or to John Rose (see below for contact details), who is a psychologist with experience of working with this client group, if you so wish to discuss any further issues.

Please note that if you were to disclose any instances of malpractice, the interviewer would have to report this to the appropriate authorities.

### **What are the possible benefits of taking part?**

Taking part in the research will give you an opportunity to share your views and for these to be considered by other people. You will not be financially reimbursed for taking part in this study.

### **What happens when the research study stops?**

If the research were to stop, participants will be contacted and informed of this by the researcher. A report will be written once the research is finished.

### **What if there is a problem?**

If there are any problems, or you have any concerns about the research, you should contact the researcher who will try to answer your questions (see contact details below). If you were to lose capacity during the course of the research, your data will be destroyed and will not be included in the final study.

Please remember that you can withdraw at any time if you wish and any information relevant to you will be destroyed.

### **Will my taking part in the study be kept confidential?**

All information during the course of the research will be collected and kept in a confidential format. The questionnaires will be stored confidentially and identifiable information will not be shared or included in any report. Verbatim quotes will be used in the final report, but again these are anonymous. The NHS Trust for audit purposes may request information from the study but if were to occur, questionnaires data would not be identifiable. The only people who will see unedited data will be members of the research team. In the circumstance that a staff member disclosed a protection issue, this information would need to be shared with the relevant parties. All material will be destroyed ten years after the research is completed.

### **Contact Details:**

If you have any further questions about the study, please contact:

**Abigail Gallivan** (*Principal Investigator*) or **John Rose** (*Research supervisor*) at:  
Address provided, or Department of Clinical Psychology,  
University of Birmingham,  
Edgbaston,  
Birmingham, Tel: 0121 414 2640

### **Appendix 3**

### **Participant Consent Forms**

**CONSENT FORM for participants attending training**

**Title of Project:** *Staff Training in Positive Behavioural Support: Impact of Organisational Culture on Changes in Attributions and Attitudes*

**Name of researcher:** *Abigail Gallivan*

**Please tick box**

- |   |                          |
|---|--------------------------|
| 1. I confirm that I have read the Participant Information Sheet for the above study and have had the opportunity to consider the information, to ask questions about the research and have had these answered satisfactorily.   | <input type="checkbox"/> |
| 2. I confirm that my participation in the research is voluntary and that I understand that I am free to withdraw, without giving a reason and without my legal rights being affected.   | <input type="checkbox"/> |
| 3. I confirm that I understand that should I choose not to be involved in the research, my opportunity to receive the training will not be affected in any way.   | <input type="checkbox"/> |
| 4. I agree to direct quotes being used.   | <input type="checkbox"/> |
| 5. I understand that the data collected during the study may be looked at by Individuals from the University of Birmingham, regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my study data. | <input type="checkbox"/> |
| 6. I understand that any data collected will remain confidential. Unless child or adult protection issues arise, in which case the researcher will be obliged to report this.   | <input type="checkbox"/> |
| 7. I agree that information and resultant data collected may be published providing it is anonymised.   | <input type="checkbox"/> |
| 8. I agree to take part in the above study  | <input type="checkbox"/> |

Name of participant	Signature	Date
---------------------	-----------	------

Name of person taking consent

Signature

UNIVERSITY OF  
BIRMINGHAM  
BIRMINGHAM

**CONSENT FORM for Intensive Support Team staff**

**Title of Project:** *Staff Training in Positive Behavioural Support: Impact of Organisational Culture on Changes in Attributions and Attitudes*

**Name of researcher:** *Abigail Gallivan*

**Please tick box**

- |   |                          |
|---|--------------------------|
| 2. I confirm that I have read the Participant Information Sheet for the above study and have had the opportunity to consider the information, to ask questions about the research and have had these answered satisfactorily.   | <input type="checkbox"/> |
| 2. I confirm that my participation in the research is voluntary and that I understand that I am free to withdraw, without giving a reason and without my legal rights being affected.   | <input type="checkbox"/> |
| 3. I understand that the data collected during the study may be looked at by Individuals from the University of Birmingham, regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my study data. | <input type="checkbox"/> |
| 4. I understand that any data collected will remain confidential. Unless child or adult protection issues arise, in which case the researcher will be obliged to report this.   | <input type="checkbox"/> |
| 5. I agree that information and resultant data collected may be published providing it is anonymised.   | <input type="checkbox"/> |
| 6. I agree to take part in the above study  | <input type="checkbox"/> |

-----  
Name of participant

-----  
Signature

-----  
Date

-----  
Name of person taking consent

-----  
Signature

-----  
Date

## **Appendix 4**

### **Questionnaires**

**Background information Questionnaire**

Please indicate:

1. Your profession/job:.....

2. What is your age?

☐ -21      ☐ 21-25      ☐ 26-30      ☐ 31-35      ☐ 36-40

☐ 41-45      ☐ 46-50      ☐ 51-55      ☐ 56-60      ☐ 61+

3. Your gender:    M      F

4. How long have you been working in this job?.....

5. How long have you been working in your profession?.....

6. Do you work:

☐      ☐  
Part time      Full time

7. In the last 2 years, how much training have you had in supporting people with a learning disability?

☐      ☐      ☐      ☐      ☐  
None      1-6 hours      1-4 days      1-4 weeks      4 + weeks

8. Do you have any responsibilities as a carer outside of work?

☐      ☐  
Yes      No

Thank you

## Thoughts about challenging behaviour

Listed below are thoughts that people may have when dealing with a person with learning disability and challenging behaviour. Think about challenging behaviour that you have experienced from a client recently. For each thought please put a tick in the box that shows how much you agree with each statement.

	Agree strongly	Agree slightly	Unsure	Disagree slightly	Disagree strongly
They are trying to wind me up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They can't help themselves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They are doing it deliberately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They know what they are doing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They have no control over their behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They could stop if they wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They are trying to manipulate the situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They can think through their actions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They don't mean to upset people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They are in control of their behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They mean to make me feel bad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They have chosen to behave in this way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They are not to blame for what they do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They know the best time to challenge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They don't realise how it makes me feel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Dave Dagnan 2001

## Staff Attitudes Questionnaire

### Adults with a Learning Disability and Challenging Behaviour



#### The Five Minute Survey



We would like to ask you about your thoughts of working with individuals who have a learning disability and challenging behaviour. All responses are confidential.

#### INSTRUCTIONS:

Mark the oval on the rating scale to indicate the extent to which you may agree or disagree with the statement.

#### EXAMPLE:

If you tend to agree a lot with the statement, you may want to place a mark as follows:

**DISAGREE**

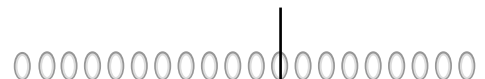
**AGREE**



Alternatively, if you tend to disagree slightly with the statement, you may want to place a mark as follows:

**AGREE**

**DISAGREE**



Please rate the following statements:

AGREE

DISAGREE

1. In a 'cash-strapped' service where resources have to be prioritised it is not always possible to provide comprehensive care to individuals who have a learning disability and challenging behaviour.

000000000000000000000000

2. I am more likely to get abuse from an individual who has a learning disability and challenging behaviour than from an individual who does not.

000000000000000000000000

3. I would always try to explore the challenging behaviour of an individual who has a learning disability by communicating with the individual, rather than solely asking another carer.

000000000000000000000000

4. I would not mind having to spend time ensuring individuals with a learning disability understand their challenging behaviour.

000000000000000000000000

5. I am not adequately trained to deal with the challenging behaviour of individuals with a learning disability.

000000000000000000000000

6. Individuals with a learning disability and challenging behaviour are most effectively treated with medication.

000000000000000000000000

7. I would not spend time explaining treatment/care plans to a person with a learning disability and challenging behaviour, as they would not understand.

000000000000000000000000

8. An individual with a learning disability and challenging behaviour would be more easily distressed or upset compared to individuals who do not have a learning disability.

000000000000000000000000

9. Individuals with a learning disability and challenging behaviour are more difficult to support, as they do not comply with requests.

000000000000000000000000

10. Due to a lack of resources and heavy workloads, my service is unable to deliver appropriate services to individuals with a learning disability and challenging behaviour.

000000000000000000000000

11. I am cautious about approaching an individual with a learning disability and challenging behaviour as they may become aggressive.

000000000000000000000000

12. I would not expect an individual with a learning disability and challenging behaviour to benefit from counseling and talking therapies.

000000000000000000000000

13. I have the necessary skills and training to manage individuals with a learning disability and challenging behaviour.

000000000000000000000000

## **SERVICE SYSTEM ASSESSMENT**

### **SERVICE SETTING:**

Thank you for filling in this questionnaire. Your responses will be kept confidential.  
Please tick as appropriate.

1. Are adequate staff resources available to meet clients' needs?

Yes ☐ No ☐

2. Do staff display positive attitudes towards clients?

Yes ☐ No ☐

3. Do staff have sufficient 'energy levels' to implement intervention recommendations?

Yes ☐ No ☐

4. Is the physical environment appropriate for the clients (i.e. adequate personal space, light, ventilation etc.)?

Yes ☐ No ☐

5. Is the social environment (amount of staff contact, assistance, interaction style etc.) appropriate to the needs of the clients?

Yes ☐ No ☐

6. Are day service resources provided separately to the residential team?

Yes ☐ No ☐

7. Is the placement generally permanent (as opposed to being emergency, short-term etc.)?

Yes ☐ No ☐

8. Are high rates of relief staff used?

Yes ☐ No ☐

9. Are staff deployed to work at times when they are most needed?

Yes ☐ No ☐

10. Are weekly staff meetings held?

Yes ☐ No ☐

11. Do staff receive regular supervision from their manager?

Yes ☐ No ☐

12. Do staff receive on the job training from their own organisation?

Yes ☐ No ☐

13. Do staff receive in-service training from their own organisation?

Yes ☐ No ☐

14. Is the training provided relevant and appropriate?

Yes ☐ No ☐

15.

16. Is the physical environment well maintained?

Yes ☐ No ☐

17. Are the administrative systems effective?

Yes ☐ No ☐

18. Are there systems for recording clients' participation in activities?

Yes ☐ No ☐

19. Are there systems for recording clients' development (e.g. in learning new skills)?

Yes ☐ No ☐

20. Are there systems for recording clients' challenging behaviour?

Yes ☐ No ☐

21. Are there effective individual planning systems?

Yes ☐ No ☐

22. Does the overall approach to delivering care seem well-structured?

Yes ☐ No ☐

TOTAL SCORE ☐☐

**Appendix 5**  
**Ethical Approval letter**

## **Appendix 6**

### **Course Information**

# **“ABOUT Challenging Behaviour”**

**Is a one-day basic introduction to the key knowledge and skills in relation to challenging behaviour**

The course will be run by the Behavioural and Psychology Adult Learning Disability service for staff members who work with adults whose behaviour challenges services.

ABOUT stands for :

***Attitude    Behaviour    Observation    Understanding    Techniques***

The specific content for each of these key areas is outlined below.

## ***Attitude***

- ❖ Having the ability to see the world from a service user's point of view.
- ❖ Recognising how important being able to communicate with others is; having a sense of power; having a fulfilling life; and having positive emotional experiences is to all of us.
- ❖ Interacting with service users as we would hope people would interact with us.
- ❖ Making sure that everything we do helps service users to be seen positively by ourselves, and by other people.

## ***Behaviour***

- ❖ Being able to describe behaviour clearly.
- ❖ Knowing what it is that leads to a behaviour being described as “challenging”.
- ❖ Knowing the key factors that influence challenging behaviour to occur.
- ❖ Recognising that there will be personal factors for each individual.

## ***Observation***

- ❖ Knowing how to make objective observations of a person's behaviour.
- ❖ Keeping accurate records of behaviour.
- ❖ Knowing how to measure behaviour.
- ❖ Summarising and presenting recorded information to other people.

## ***Understanding***

- ❖ Using behaviour records to understand a person's behaviour.
- ❖ Recognising that challenging behaviour is a powerful means of communication.
- ❖ Working out what the person is communicating through challenging behaviour.
- ❖ Understanding what you can do to help the person express themselves in other ways.

## ***Techniques***

- ❖ Effective teamwork.
- ❖ Strategies to promote non-challenging behaviour.
- ❖ Having a non-confrontational philosophy and approach.
- ❖ Managing incidents of challenging behaviour.

<b>Training Dates Available:</b>	<b>Friday 23 July 2010</b>
	<b>Wednesday 28 July 2010</b>
	<b>Friday 30 July 2010</b>
	<b>Friday 06 August 2010</b>
	<b>Wednesday 25 August 2010</b>
	<b>Friday 27 August 2010</b>
	<b>Friday 03 September 2010</b>
	<b>Friday 10 September 2010</b>
	<b>Wednesday 15 September 2010</b>
	<b>Friday 24 September 2010</b>

**The course will start at 9.30 so please arrive by 9.15 am and will finish at 4.30 pm.**

Venue: The address of the local learning disability service was stated

***Liquid refreshments are provided, however lunch is not.***

To secure a place on **ONE** of the above dates, please complete the attached application form and return to the training liaison officer at the local learning disability service. *Please photocopy the enclosed application form if extra copies are required.*

Training Department- Address, email, telephone and fax numbers were provided

As part of the development of the service, a research project is going to be conducted looking at the effectiveness of staff training and organisational culture. The title of the project is 'Staff Training in Positive Behavioural Support: Impact of Organisational Culture on Attributions and Attitudes'.

In being involved, all you will need to do is fill in some brief questionnaires which will be provided to you. Your questionnaires will remain anonymous and confidential. (Please see the attached information sheet for details about the research). All you need to do to let me know, is to tick the application form whether you would like to be involved. My contact details are below should you wish to find out more or ask any questions.

Abigail Gallivan (Trainee Clinical Psychologist) E-mail: [REDACTED]  
Address and telephone number was provided

## FORMAT FOR DELIVERY



<b>Session 1: Attitude</b>	<p>Show slides 1-8</p> <p>Individual exercise: Receiving poor service</p> <p>Show slide 9</p> <p>Group exercise: Characteristics of bad attitude</p> <p>Show slides 10-19</p> <p>Individual exercise: Examples of the right attitude</p> <p>Show slide 20</p>
<b>Session 2: Behaviour</b>	<p>Show slides 1-4</p> <p>Individual exercise: Describing behaviour clearly</p> <p>Show slides 5-10</p> <p>Group exercise: Factors influencing challenging behaviour</p> <p>Show slides 11-13</p> <p>Give handout: Factors influencing challenging behaviour</p> <p>Show slides 14-15</p>
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<b>Session 5: Techniques</b>	<p>Show slide 1-4</p> <p>Group exercise: Key areas of effective teamwork</p> <p>Give handout: Elements of effective teamwork</p> <p>Show slide 5</p> <p>Give handout: Strategies that promote non-challenging behaviour</p> <p>Show slides 6-7</p> <p>Group exercise: Recognising confrontational and non-confrontational philosophies and approaches</p> <p>Show slides 8-14</p> <p>Give out course evaluation sheet</p> <p>Give out participant handbook</p> <p>Give out attendance certificate</p>

## COURSE HANDBOOK

### Introduction

This handbook accompanies the course "A.B.O.U.T. Challenging Behaviour", which is a basic introduction to the key knowledge and skills in relation to challenging behaviour.

"A.B.O.U.T." stands for:

Attitude

Behaviour

*Observation*

*Understanding*

*Techniques*

The specific content for each of these key areas is outlined below.

### Attitude

- ❖ Having the ability to see the world from a service user's point of view.
- ❖ Recognising how important being able to communicate with others; having a sense of power; having a fulfilling life; and having positive emotional experiences is to all of us.
- ❖ Interacting with service users as we would hope people would interact with us.
- ❖ Making sure that everything we do helps service users to be seen positively by ourselves, and by other people.

### Behaviour

- ❖ Being able to describe behaviour clearly.
- ❖ Knowing what it is that leads to a behaviour being described as "challenging".

- ❖ Knowing the key factors that influence challenging behaviour to occur.
- ❖ Recognising that there will be personal factors for each individual.

### **Observation**

- ❖ Knowing how to make objective observations of a person's behaviour.
- ❖ Keeping accurate records of behaviour.
- ❖ Knowing how to measure behaviour.
- ❖ Summarising and presenting recorded information to other people.

### **Understanding**

- ❖ Using behaviour records to understand a person's behaviour.
- ❖ Recognising that challenging behaviour is a powerful means of communication.
- ❖ Working out what the person is communicating through challenging behaviour.
- ❖ Understanding what you can do to help the person express themselves in other ways.

### **Techniques**

- ❖ Effective teamwork.
- ❖ Strategies to promote non-challenging behaviour.
- ❖ Having a non-confrontational philosophy and approach.
- ❖ Managing incidents of challenging behaviour.

### **Session 1: Attitude**

Attitudes are important, since they are a reflection of how we see the people and things around us. Our attitudes indicate the value or importance we place on individuals, groups of individuals, or the things around us. Our attitudes will also influence how we behave or interact in many instances.

When we are on the receiving end of a negative attitude from other people, it tends to have these effects on us:

- ❖ Makes us feel angry, annoyed, frustrated, helpless, not in control, etc.
- ❖ Likely to lead us to view the other person negatively.
- ❖ Likely to lead to us interacting or engaging with the person from this negative perspective.
- ❖ May create a "cycle of conflict", where on-going interactions become more-and-more negative.

When we are on the receiving end of a positive attitude from other people, it tends to have these effects on us:

- ❖ Makes us feel respected, valued, in control etc.
- ❖ Likely to lead us to see the other person positively.
- ❖ Likely to lead to us interacting or engaging with the person from a positive perspective.
- ❖ Creates a "cycle of mutual respect", where on-going interactions become more-and-more pleasant.

Exactly the same processes that happen in daily life happen within services for people who have a learning disability. When we as staff have a negative attitude towards the people who use our services, this is likely to lead to a "cycle of conflict". When "cycles of conflict" have been created in services, it increases the likelihood that challenging behaviour will occur as a manifestation of this conflict.

However, when we as staff show positive attitudes towards the people who use our services, it is more likely that we help create "cycles of mutual respect", which in turn help minimise occurrences of challenging behaviour.

A number of key areas are important in ensuring positive attitudes and "cycles of mutual support". These are as follows:

- ❖ Treating the person with dignity and respect.
- ❖ Really listening to what the person is telling you (through their words or their behaviour).

- ❖ Taking what the person is communicating seriously.
- ❖ Giving the right amount of assistance and support. Giving more assistance and support than an individual needs could lead to the person losing their skills and feeling disempowered. Giving less assistance and support than an individual needs can lead to the person not developing their independence skills, and having to depend on others for things to happen.
- ❖ Offering people choices - from day-to-day matters to important life decisions. Respecting the choices and decisions that people make. And remember that all of us can change our minds from time-to-time.
- ❖ Ensuring the person has lots of opportunities for a fulfilling life. This is more than just having activities to do to pass the time.
- ❖ Ensuring the person has positive emotional experiences - a sense of joy and something to look forward to in life.
- ❖ Seeing and respecting the person as an individual.
- ❖ Supporting the person to have a range of relationships - from having acquaintances, to friendships, to closer relationships.
- ❖ Supporting the person to be a valued member of their community.

The better you and your colleagues are at showing a positive attitude to the people you support, the less likely you are to create the type of situations where challenging behaviour can occur.

## ***Session 2: Behaviour***

The most important starting point in talking about challenging behaviour is being able to describe a specific behaviour ***in clear terms***. The description needs to be one where everyone can actually see the behaviour occurring, and agree that it is happening. As a rule of thumb, if the description you use to describe a particular behaviour was written on a piece of paper, and shown to 6 different people and asked to role-play what was written on the paper, you will have come up with a really clear description if all 6 people behave ***exactly the same way*** in the role-play.

<p><b>Some examples of clear and vague descriptions</b></p>
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Clear	Vague
Paul punched Peter twice in the face.	Samantha had a temper tantrum this morning.
Will through an empty cup at the wall.	Daniel was winding other people up all day.
Amy hit her head three times with her clenched fist.	Frank was in a bad mood all morning.
Judith took Simon's hamburger from off his plate and ate it.	Andy was self-harming for almost an hour.
Steve bit his right arm causing it to bleed	Tony behaves inappropriately towards young women.
	Helen upset Jo earlier today.

Emerson *et al* (1987) have offered a definition of challenging behaviour:

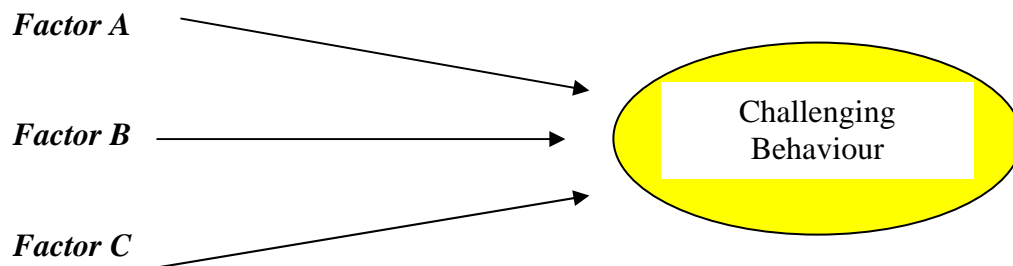
**"By severely challenging behaviour we mean behaviour of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour which is likely to seriously limit or deny access to the use of ordinary community facilities".**

***"challenging" will require consideration of four key areas:***

- 1. The strength of the behaviour (frequency, duration and intensity).***
- 2. The context in which it occurs (where and at what time).***
- 3. The age or developmental status of the person.***
- 4. The likely consequences of that behaviour (for the person, for others, and for the environment).***

*There is no single cause for challenging behaviour. Whilst it seems sensible to want to know the cause for a person's challenging behaviour, it is better to look at factors associated with the occurrence of challenging behaviours.*

*One way of representing this is as follows:*



*It is important to remember that different factors will affect different people in different ways.*

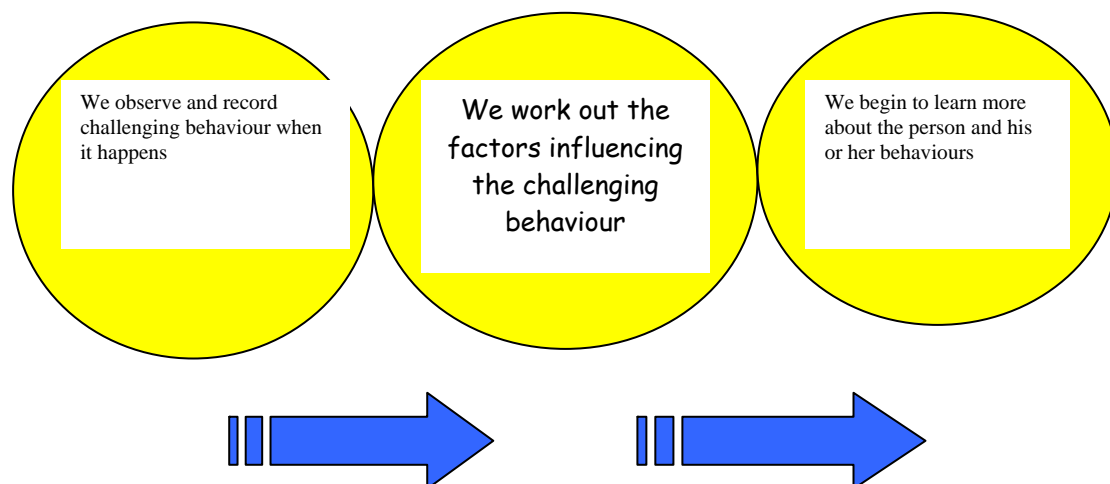
*The factors fall into two broad areas of Personal factors and Environmental factors. These are outlined on the next page.*

*The challenge for us is to work out which particular factors are influencing individuals when their behaviour is challenging. Sometimes, if we as staff members change what we do with and for the person, the person's challenging behaviour will reduce or stop.*

*The process involved in understanding challenging behaviour can be represented as follows:*



By severely challenging behaviour we mean behaviour of behaviour which is likely to seriously limit or deny access to the use of ordinary community facilities".



### Session 3: Observation

There are a number of important reasons for recording instances of challenging behaviour. These are:

- ❖ To have an accurate picture of how often the particular challenging behaviour is occurring over time.
- ❖ To identify any patterns to the occurrence of challenging behaviour.
- ❖ To be able to evaluate the effectiveness of strategies you use in relation to the challenging behaviour.

In order to observe and record incidents of challenging behaviour, there are a number of important steps.

- ❖ Develop a really clear description of the challenging behaviour you want to observe and record.
- ❖ Know exactly which aspect of the challenging behaviour you want to record. This might be frequency (how often the behaviour happens), duration (how long the behaviour lasts), or intensity (the impact of the behaviour for the person and/or the environment).
- ❖ Design a recording sheet that will help you easily record the behaviour you are observing.

There are many different formats for recording behaviour. There is no such thing as **THE** best format - it will depend on how many behaviours you are recording, the strength of the behaviour, and which aspect of the behaviour you are recording.

It is not enough to simply record occurrences of specific behaviours. You also need to look at these and summarise them at frequent intervals. This will help with looking at the trend of the behaviour over time (e.g. is it occurring more often? Less often?), and will also help identify patterns as to when the behaviour is occurring.

Examples of recording sheets and summarising records are on the following pages.

## Summarising Behaviour Records

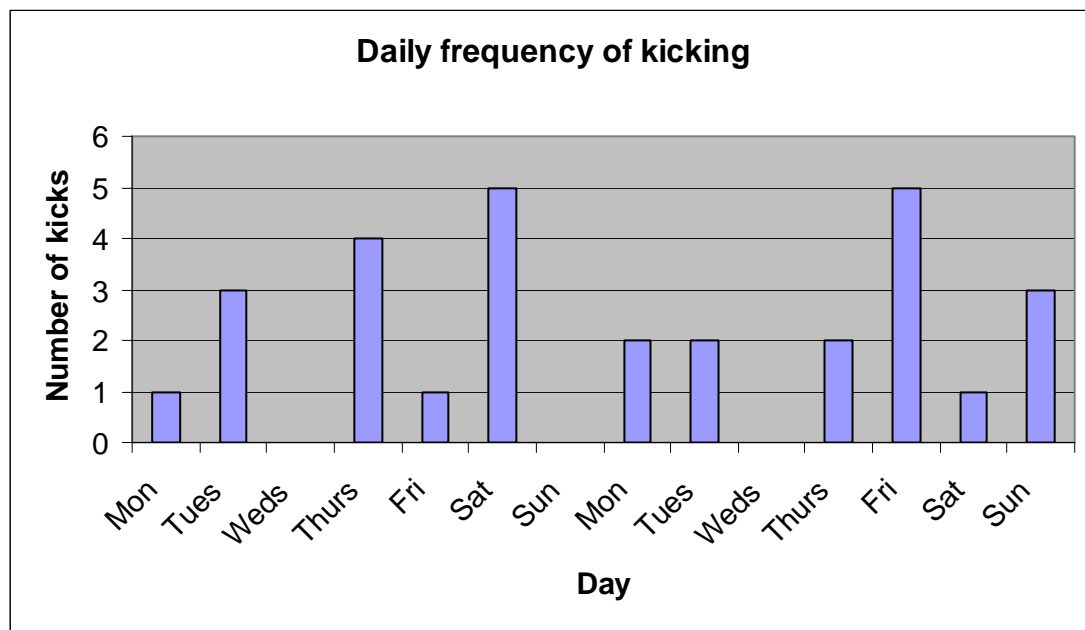
In this example, the number of times Teresa kicked other people was recorded over a two-week period.

The record looked like this:

### Number of times Teresa kicked other people

Mon	Tues	Weds	Thurs	Fri	Sat	Sun
1	3	0	4	1	5	0
Mon	Tues	Weds	Thurs	Fri	Sat	Sun
2	2	0	2	5	1	3

This is then converted into a graph:

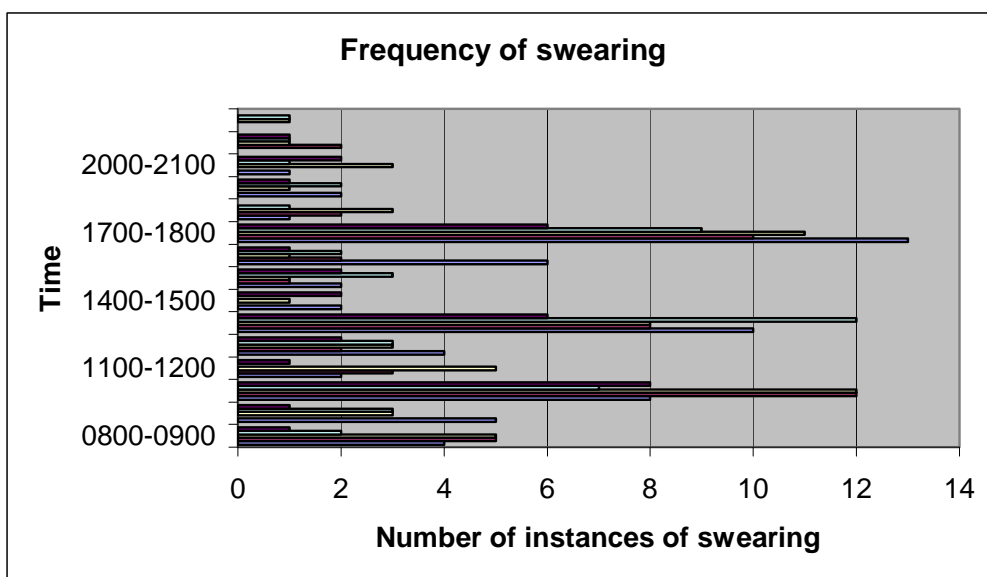


In this example, the number of times Robert swore during each hour was recorded over 5 days.

The record looked like this:

	Day 1	Day 2	Day 3	Day 4	Day 5
8am-9am	4	5	5	2	1
9am-10am	5	0	3	3	1
10am-11am	8	12	12	7	8
11am-12pm	2	3	5	0	1
12pm-1pm	4	2	3	3	2
1pm-2pm	10	8	8	12	6
2pm-3pm	2	0	1	0	2
3pm-4pm	2	1	1	3	2
4pm-5pm	6	2	1	2	1
5pm-6pm	13	10	11	9	6
6pm-7pm	1	2	3	1	0
7pm-8pm	2	0	1	2	1
8pm-9pm	1	0	3	1	2
9pm-10pm	0	2	1	1	1
10pm-11pm	0	0	1	1	0

When this is graphed out, it can be seen that a pattern emerges in that the highest frequency of swearing occurs between 10am-11am, 1pm-2pm, and 5pm-6pm.



## Session 4: Understanding

It is important to remember that challenging behaviour, like virtually every other behaviour, has been learnt. The reason that individuals may continue to behave in ways that challenge others over time is because it's effective (at least some of the time) to the person in achieving the desired outcome the person wants.

Challenging behaviour serves a ***purpose*** for the individual. It is a very powerful means of communication. It is usually the most effective way some people have to communicate to the people around them how they feel about themselves; how they feel about other people (and what those people do or don't do); and how they feel about their current circumstances and life in general.

When people behave in ways that challenge others, they may actually be communicating things like:

- ❖ "I'm bored!"
- ❖ "I want you to spend time with me!"
- ❖ "I want something!"
- ❖ "I don't want to do this!"
- ❖ "I'm scared!"
- ❖ "I don't like what you're doing to me!"
- ❖ "I'm hurting!" (This could be physical or emotional hurt).
- ❖ "I don't understand you - I'm confused!"
- ❖ "I feel let down!"

This is not an exhaustive list.

In order for us to work with the person so that they have different and better (but just as effective) ways of communicating with us, we really need to observe, "listen", and really ***understand*** what the person is telling us through the behaviour that we are finding challenging.

In order for us to ***understand*** what the person is telling us, there are some important steps:

1. We need to observe and record instances of clearly defined challenging behaviour whenever it occurs.
2. It's not just enough to just record *when* it occurred, *where* it occurred, how *often* it occurred, or how *long it lasted*. We need to know exactly what was happening before the challenging behaviour occurred, and what happened or changed as a result of the behaviour occurring. Since challenging behaviour is a means of communication, we need to know the **context** in which the communication is being made in order to fully understand it. The phrase "*You're pulling my leg!*" is communication. Without having an idea of the context, we don't know whether the person uttering this phrase: a) Perceives that they are being teased by whoever they are with at the time, or b) Having an extremely unpleasant appointment with their physiotherapist!! The context is crucial in helping us understand what the person is communicating.
3. Challenging behaviour is ***always*** telling us something, and the challenge to us is working out what the person is ***telling*** us.
4. Once we understand what the person is telling us through their behaviour, we can support the person to learn other ways of communicating this that are just as effective from the person's point of view, but that does not involve challenging behaviour.
5. In some instances, once we understand what the person is telling us through their challenging behaviour, if we change what happens ***to*** or ***around*** the person so that life is better for the person, or we are supporting people in the best way for them as individuals, then the person no longer needs to use challenging behaviour to communicate with us.

There are a number of important things that ***you*** can do to understand what people are telling you through their challenging behaviour:

1. Get better and better every day at ***"listening"*** to what the person is telling you through his or her behaviour.
2. Put yourself in ***"that person's shoes"*** to help you understand what the person might be communicating.

3. Make sure that as a staff team you are really good at recording occurrences of challenging behaviour, and what is happening before, after, and as a result of the challenging behaviour occurring.

### ***Session 5: Techniques***

In working with people who behave in ways that challenge services, a staff team should aim to be:

- ❖ The type of team who work well together, and...
- ❖ Are able to use strategies that promote non-challenging behaviour...
- ❖ Within the context of a non-confrontational philosophy and approach...
- ❖ And who can manage incidents of challenging behaviour effectively.

There are a number of important elements to effective teamwork. These elements come under the headings of:

- ❖ Good communication and support.
- ❖ Agreed aims and values.
- ❖ Shared knowledge.
- ❖ Routine evaluation.

Some examples under each of these headings are shown on the next page.

There are a number of strategies that can be used to promote non-challenging behaviour. These are:

- ❖ Acknowledge non-challenging behaviour.
- ❖ Support the person to communicate in non-challenging ways.
- ❖ Acknowledge effective coping and tolerance.
- ❖ Support the person to have a good quality of life on his or her own terms.

Some examples of use of these strategies are detailed after the next page.

The approaches to managing or responding to instances of challenging behaviour can be categorised into two types of philosophies and approaches:

1. Confrontational philosophies and approaches.
2. Non-confrontational philosophies and approaches.

Confrontational philosophies and approaches:

- ❖ Tend to be associated with escalation of challenging behaviour.
- ❖ Tend to be based on staff team attempts to "control" behaviour.
- ❖ Tend to be based on a service or staff based, rather than a person centred, perspective.
- ❖ Creates tension and an unpleasant atmosphere.

Non-confrontational philosophies and approaches:

- ❖ Tend to emphasise keeping calm, rather than provoking the situation further.
- ❖ The approach aims to help the person regain control of their emotions as quickly as possible.
- ❖ Recognises the legitimacy, if not the form, of the communication.
- ❖ Allows the possibility to put "giving in" ahead of "getting hurt".

The most common approaches to managing incidents of challenging behaviour are medication (PRN), redirection/distraction, and physical interventions (restraint). Each of these has their place, but it is generally better to...

## **AVOID INCIDENTS HAPPENING IN THE FIRST PLACE!!**

There are a number of things that can be done to avoid incidents occurring in the first place.

- ❖ Spend time getting to really know the person.
- ❖ Document the situations and factors associated with the occurrence of challenging behaviour for each individual.

- ❖ Do everything you can to predict, avoid, or support the person through the situation when you know it is potentially a high-risk situation.
- ❖ Document the "early warning signs" that someone is not happy, or is becoming agitated or distressed.
- ❖ As soon as you notice these, interact with the person in whatever way is helpful. It might be asking the person if they are OK; asking if there's anything you can do; asking if they want to go and do something that you know they enjoy.
- ❖ Make sure you have a non-confrontational approach.
- ❖ Remember that it is easier to calm a situation before, or as it starts, rather than once it has already started.
- ❖ Listen to the person (or "listen" to their behaviour).
- ❖ Try to work out what the person wants, how the person is feeling, what they are not happy with, and do your best to put this right.

We hope that you have found this course useful and enjoyable. We hope it has given you ideas about things you can do on a day-to-day basis that will support the work you do in relation to challenging behaviour and **helps you make a positive difference to people's lives.**

## A.B.O.U.T. Challenging Behaviour



## A.B.O.U.T. Challenging Behaviour

- Attitude
- Behaviour
- Observation
- Understanding
- Techniques

## Attitude

- Having the ability to see the world from a service user's point of view.
- Recognising the importance of being able to communicate with others; having a sense of power; having a fulfilling life; having positive emotional experiences.
- Interacting with others as we would want people to interact with us.
- Making sure we present people positively.

## Behaviour

- Being able to describe behaviour clearly.
- Knowing what it is that leads to behaviour being described as "challenging".
- Knowing the key factors that influence challenging behaviour to occur.
- Recognising that there will be personal factors for each individual.

## Observation

- Knowing how to make objective observations of a person's behaviour.
- Keeping accurate records of behaviour.
- Knowing how to measure behaviour.
- Summarising and presenting recorded information to others.

## Understanding

- Using behaviour records to understand a person's behaviour.
- Recognising that challenging behaviour is a powerful means of communication.
- Working out what the person is communicating through challenging behaviour.
- Understanding what you can do to help the person express themselves in other ways.

## Techniques

- Effective teamwork.
- Strategies to promote non-challenging behaviour.
- Having a non-confrontational philosophy and approach.
- Managing incidents of challenging behaviour.

## Attitudes

Individual Task



# Attitudes

## Group Task



## The importance of attitudes

- Our attitudes reflect how we see things in life in general.
- This in turn will indicate the value or importance we place on things.
- Our attitudes will also influence our behaviour.

## How negative attitudes affect us

- Make us feel angry, annoyed, helpless, frustrated, not in control, etc.
- Likely to lead us to view the other person negatively.
- Likely to lead to us interacting or engaging with the person from this negative perspective.
- May create a “cycle of conflict”.

## How positive attitudes affect us

- Make us feel respected, valued, in control, etc.
- Likely to lead us to see the other person positively.
- Likely to lead us to interacting or engaging with the person from a positive perspective.
- Creates a “cycle of mutual respect”.

## Attitudes within services

- All of the things that have been said previously about positive and negative attitudes equally apply to services.
- When we show a bad attitude towards the people who use our services, this is likely to lead to a “cycle of conflict”.
- A “cycle of conflict” sows the seeds for the occurrence of challenging behaviour.

## Attitudes within services

- When we show a positive attitude towards the people who use our services, this is likely to help create a “cycle of mutual respect”.
- When services are good at creating and maintaining “cycles of mutual respect”, challenging behaviour is less likely to occur.

## Positive attitudes and “cycles of mutual respect”

A number of key areas are important:

- Treating the person with dignity and respect.
- Really listening to what the person is telling you (through words or behaviour).
- Taking what the person communicates seriously.
- Giving the right amount of assistance and support – not too much, and not too little.
- Offering choices and respecting decisions.

## Positive attitudes and “cycles of mutual respect”

- Ensuring the person has lots of opportunities for a fulfilling life.
- Ensuring the person has positive emotional experiences.
- Seeing and respecting the person as an individual.
- Supporting the person to have a range of relationships.
- Supporting the person to be a valued member of their community.

## Demonstrating *you* have the right attitude

Individual exercise



## Think of a person who uses your service...

- Give examples in as many of the circles as you can of things that you have done that show the positive attitude to the individual person.

## Closing remark

- The better you and your colleagues are at showing a positive attitude to the people you support, the less likely you are to create the type of situations where challenging behaviour can occur.

## A.B.O.U.T. Challenging Behaviour

### Session 2



## Behaviour

- Being able to describe behaviour clearly.
- Knowing what it is that leads to a behaviour being described as “challenging”.
- Knowing the key factors that influence challenging behaviour to occur.
- Recognising that there will be personal factors for each individual.

## Describing behaviour

- The most important starting point is being able to describe a behaviour ***in clear terms***.
- The description needs to be one where everyone can actually see the behaviour, and agree that it is happening.

## Individual exercise



## What makes a behaviour *“challenging”*?

Any judgement we make about behaviour will reflect:

- The strength of the behaviour (frequency, duration and intensity).
- The context in which it occurs (where and at what time).
- The age or developmental status of the person.
- The likely consequences of that behaviour.

## A definition

- *“By severely challenging behaviour we mean behaviour of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour which is likely to seriously limit or deny access to the use of ordinary community facilities”.*

(Emerson et al, 1987)

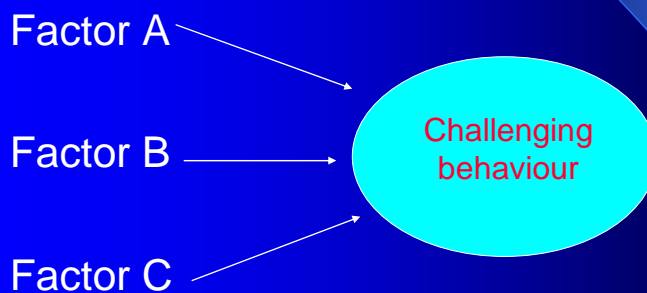
## Examples

- Physical aggression towards other people.
- Self-injury.
- Damage to materials or property.
- Sexually inappropriate behaviour.

## Key factors influencing challenging behaviour

- There is no single cause for challenging behaviour.
- Whilst it seems sensible to want to know the cause for a person's challenging behaviour, it is better to look at factors associated with the occurrence of challenging behaviours.

## Factors influencing challenging behaviour



## Group exercise



## Factors influencing challenging behaviour

### Personal Factors

- Physical or psychological.
- Personality and personal characteristics.
- Sense of self.
- Communication difficulties.
- Basic needs and abilities.
- Psychological difficulties due to previous abuse.

## Factors influencing challenging behaviour

### Environmental Factors

- Quality of the physical environment.
- Quality of the social environment.
- Being in a position of powerlessness.
- Unpredictable occurrences.
- Other people's high expectations.
- Communication difficulties.
- Responses to challenging behaviour.

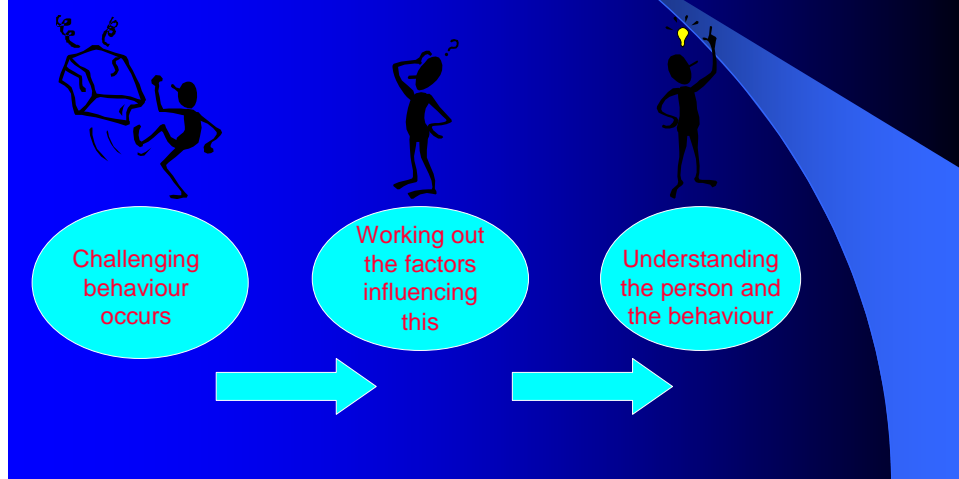
## Factors influencing challenging behaviour

- See the handout for some more specific details.

## Important points to remember

- Different factors will affect different people in different ways.
- The challenge for us is to work out which particular factors are influencing each individual when their behaviour is challenging.
- Sometimes, if **we** change what we do with and for the person, the person's challenging behaviour will reduce or stop.

## The process



# A.B.O.U.T. Challenging Behaviour

## Session 3



## Observation

- Knowing how to make objective observations of a person's behaviour.
- Keeping accurate records of behaviour
- Knowing how to measure behaviour.
- Summarising and presenting recorded information to other people.

## Recording behaviour

- In most services, there is some system for documenting challenging behaviours shown by individuals.
- Sometimes these are recorded in a daily report or in a diary.
- And sometimes they are like this...

## Daily report on John S.

Monday a.m.	Played up in the morning, went out for a walk. Aggressive on return,
Monday p.m	Winding staff and residents up. Was in a foul mood all shift.
Tuesday a.m.	No behaviours all shift.
Tuesday p.m	Good until after tea-time.
Thursday a.m.	Got out of wrong side of bed this morning. Showed behaviours +++
Thursday p.m.	He's been fine with me all shift.



## Reasons for recording challenging behaviour

- To have an accurate picture of how often the particular challenging behaviour is occurring over time.
- To identify any patterns to the occurrence of challenging behaviour.
- To be able to evaluate the effectiveness of strategies you use in relation to the challenging behaviour.

## How to observe and record

- Develop a really clear description of the challenging behaviour you want to observe and record.
- Know exactly which aspect of the challenging behaviour you want to record.
- Design a recording sheet.

## Which aspect to record?

- Frequency?
- Duration?
- Intensity?

## Group exercise



## Formats for recording

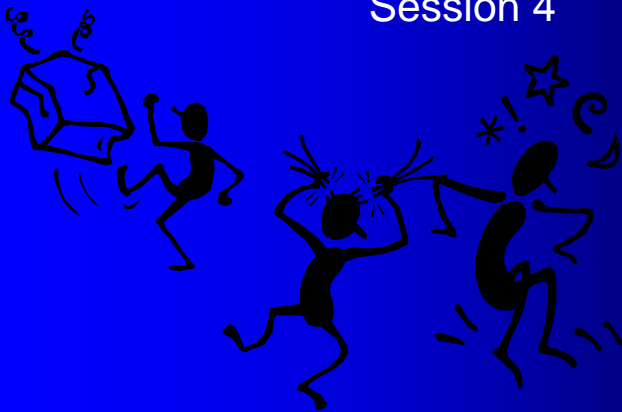
- There are many different formats for recording behaviour.
- There's no such thing as **THE** best format – it will depend on how many behaviours you are recording, the strength of the behaviour, and which aspect of the behaviour you are measuring.
- There are some examples in the handout.

## Summarising and presenting recorded information

- It's not enough to simply record occurrences of specific behaviours.
- You also need to look at these and summarise them at frequent intervals.
- They help with looking at the trend of the behaviour over time, and help identify patterns to when the behaviour is occurring.
- There are examples in the handout.

## A.B.O.U.T. Challenging Behaviour

### Session 4



## Understanding

- Using behaviour records to understand a person's behaviour.
- Recognising that challenging behaviour is a powerful means of communication.
- Working out what the person is communicating through challenging behaviour.
- What you can do to help the person express themselves in other ways.

## Important Points

- Challenging behaviour has been learnt.
- Challenging behaviour serves a purpose for the individual.
- Challenging behaviour keeps occurring because it's effective (at least some of the time) to the person in achieving the desired outcome the person wants.

## Communication

- In virtually every instance, challenging behaviour is a very powerful means of communicating.
- It is usually communicating something important about how the person feels about him or herself, how they feel about other people, and how they feel about life in general.

## Challenging behaviour may be saying...

**I'm bored!**

**I want you to  
spend time  
with me!**

**I want  
something!**

**I don't want to  
do this!!**

**I'm scared!**

**I don't like  
what you're  
doing!**

**I'm hurting!**

**I don't  
understand  
you!**

**I feel let down!**

## Understanding Behaviour

- In order to understand what someone's behaviour may be communicating, we need to observe and record what is happening around the time that the behaviour occurs.
- We need to observe and record what happened just before, the behaviour occurred, and what happened or changed as a result of the behaviour.

## Recording behaviour

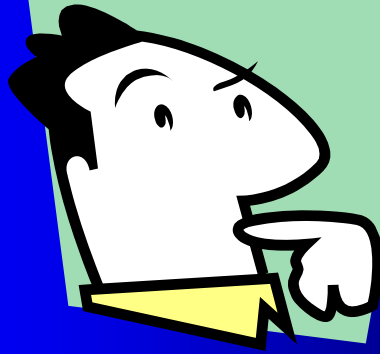
- It is important to define the behaviour you want to record.
- It is important to write down what happened just before, and just after the behaviour.

## A bad example...

What happened just before the behaviour?	What was the behaviour?	What happened or changed after the behaviour?
<i>No thing</i>	<i>Playe d up – re ally aggre s s i v e .</i>	<i>We nt to be droom.</i>



## Group exercise



## Final **IMPORTANT** points...

- Challenging behaviour is ***always*** telling us something.
- What we need to do is ***work out*** what the person is ***telling*** us.
- And support the person to be able to ***tell us this, but in a different way.***

## Final **IMPORTANT** points...

- Sometimes, if we **change** what happens **to** or **around** the person so that life is better for the person, the person no longer needs to use challenging behaviour to communicate with us.

## What **YOU** can do...

- Get better and better every day at “**listening**” to what the person is telling you through his or her behaviour.
- Put yourself in “**that person’s shoes**” to help you understand what the person might be telling you.
- Make sure that as a staff team you are really good at recording occurrences of challenging behaviour.

# A.B.O.U.T. Challenging Behaviour

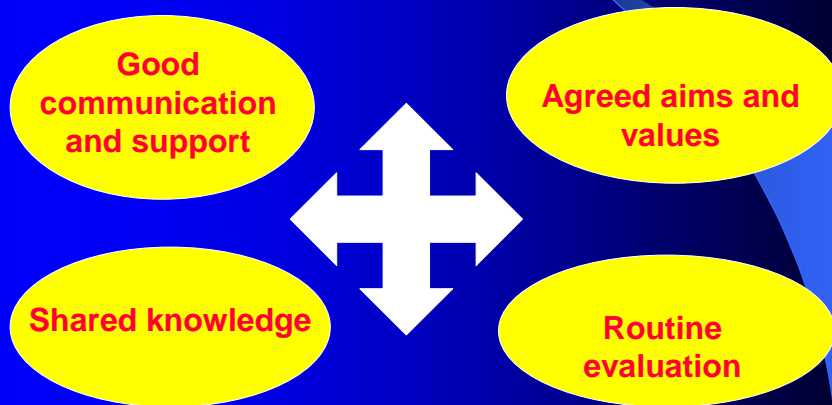
## Session 5



## What to aim for...

- Being the type of team who work well together, and...
- Are able to use strategies that promote non-challenging behaviour...
- Within the context of a non-confrontational philosophy and approach...
- Who can manage incidents of challenging behaviour effectively

## Elements of effective teamwork



## Group exercise



## Strategies to promote non-challenging behaviour

- Acknowledge non-challenging behaviour.
- Support the person to communicate in non-challenging ways.
- Acknowledge effective coping and tolerance.
- Support the person to have a good quality of life on their own terms.
- See Handout for some examples.

## Having a non-confrontational philosophy and approach

- What do you think “a non-confrontational philosophy and approach” is?
- Why do you think such a philosophy and approach is important in relation to challenging behaviour?

## Group exercise



## Confrontational philosophies and approaches

- Tend to be associated with escalation of challenging behaviour.
- Tend to be based on staff team attempts to “control” behaviour.
- Tend to be based on a service or staff based, rather than a person-centred perspective.
- Creates tension and an unpleasant atmosphere.

## Non-confrontational philosophies and approaches

- Tend to emphasise keeping calm, rather than provoking the situation further.
- The approach aims to help the person regain control of their emotions as quickly as possible.
- Recognise the legitimacy, if not the form, of the communication.
- Allows the possibility to put “giving in” ahead of “getting hurt”.

## Managing incidents of challenging behaviour

The most common approaches are:

- Medication (PRN)
- Redirection/distraction
- Physical intervention/restraint
- Each of these have their place, but it is generally better to...

**Avoid incidents  
happening in the first  
place!!**

### **How to avoid incidents occurring in the first place**

- Spend time getting to really know the person.
- Document the situations and factors associated with the occurrence of challenging behaviour for each individual.
- Do everything you can to predict, avoid, or support the person through the situation.

## How to avoid incidents occurring in the first place

- Document the “early warning signs” that someone is not happy, or is becoming agitated or distressed.
- As soon as you notice these, interact with the person in whatever way is helpful. It might be asking the person if they are OK; asking if they want to go and do something that you know they enjoy.

## How to avoid incidents occurring in the first place

- Make sure you have a non-confrontational approach.
- Remember that it is easier to calm a situation before it starts, than once it has started.
- Listen to the person (or “listen” to their behaviour).
- Try and work out what the person wants, how the person is feeling, what they’re not happy with.



**The End!!**  
Hope you  
enjoyed this  
course...

**Appendix 7**  
**Total and individual domain scores achieved by studies in the review**

Table 4: Total and individual domain scores achieved by studies in the review

	Total	Reporting	External validity	Internal validity-bias	Internal validity confounding	Power
Top score possible	28	12	3	7	6	1
<b>High (19-28)</b>						
van Oorsouw, Embregts, Bosman and Jahoda (2010)	22	11	2	5	4	1
Allen and Tynan (2000)	19	10	1	4	3	1
<b>Medium (10-18)</b>						
Tierney, Quilan and Hastings (2007)	14	8	0	4	1	1
Kalsy, Heath, Adams and Oliver (2007)	14	7	0	4	2	1
McKenzie, Sharp, Paxton and Murray (2002)	12	4	0	4	2	0
Dowey, Toogood, Hastings and Nash (2007)	11	5	0	3	2	1
Gentry, Icton and Milne (2001)	11	6	0	2	2	1
McKenzie, Paxton, Patrick, Matheson and Murray (2000)	10	5	0	2	2	1
Berryman, Kalbag and Evans (1994)	10	6	0	2	1	1
<b>Low (0-9)</b>						
McDonnell (1997)	8	5	0	2	1	0
Smidt, Balandin, Reed and Sigafos (2007)	7	4	1	1	1	0