



Student Number: 0745475

**Challenging behaviour in people with learning disabilities:
The goodness of fit of Positive Behavioural Support Plans**

Samantha Woolls

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**Dissertation submitted in partial fulfilment of the requirement for the degree
of DClinPsy at Cardiff University and the South Wales Doctoral Programme in
Clinical Psychology**

DECLARATIONS

This work has not previously been accepted in substance for any degree and is not concurrently submitted in candidature for any degree.

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DEDICATION

For Seth

ABSTRACT

Challenging behaviour in individuals with a learning disability can significantly impair the health/quality of life of the person themselves, those who care for them and those who live or work in close proximity (Emerson, 2002). Appropriate and ethical management of these behaviours is important for the well-being of both the individual and direct-care staff. Positive Behavioural Support (PBS) is a values-based behavioural technology that has been found to be effective in supporting people with learning disabilities and challenging behaviour and increasing their quality of life (e.g. Carr *et al.* 1999). However the application of PBS to real-world settings does not feature strongly in the research and therefore specific factors that contribute to the successful implementation of PBS have not been identified through research. Direct-care staff are crucial to implementing behavioural interventions with people with learning disabilities, yet their perspective is neglected in the literature. The main aim of the present study was to use qualitative methodology to explore the perspectives of direct-care staff working with PBS of what helps the successful implementation of PBS with people with learning disabilities and challenging behaviour. The perspectives of clinicians working with direct-care staff were also explored with the aim of identifying the extent of agreement between direct-care staff and clinicians. This study used semi-structured interviews with direct-care staff, and a focus group with clinicians. Verbatim transcripts were then analysed using a Grounded Theory approach. From the analysis, six core concepts emerged. These were, 'Service delivery', 'External support', 'Internal Support', 'Mediators' and 'Delivery of PBS', all of which combined to affect the 'Goodness of Fit' of PBS. Some factors were considered more important than others, such as the relationship between clinician and direct-care staff, the commitment of the organisation to PBS and the attitude of direct-care staff. The factors were diverse and highlighted the complexity of implementing PBS in community settings. The implications of the study for both services and clinical practice were discussed and recommendations made.

Challenging Behaviour and People with Learning Disabilities: The Goodness of Fit of Positive Behavioural Support Plans

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Chapter 1

INTRODUCTION

1.1 OVERVIEW

This chapter introduces the topics and research relevant to the current study. Initially, definitions and descriptions of learning disability and challenging behaviour will be provided, as this study holds at its focus these individuals and the services provided for them. The rationale and history of the use of behavioural approaches will be presented, along with discussion of the effectiveness and current usage of such approaches. Positive Behavioural Support will be described, including the rationale for its development and the research accounting for its effectiveness. The literature pertaining to barriers to behavioural plan implementation will be discussed, including a number of factors related to direct-care staff, as well as features of the organisation and the behavioural plans themselves. Finally, the aims and objectives of the current study are presented.

1.2 LITERATURE SEARCH

The search engines PsycINFO and Google were used and the following terms used to search for relevant papers: “learning disability”; “mental retardation”; “intellectual disability”; “challenging behaviour”; “staff”; “staff team”; “staff stress”; “staff turnover”; “attribution”; “positive behavioural support”; “applied behavioural analysis”; “behavioural approaches”; “barriers”. Well-known authors were searched for, including ‘Allen’, ‘Carr’, ‘Emerson’, ‘Hastings’ and ‘Hatton’. Peer-reviewed journals were also scanned for known papers that had not been discovered by the PsycINFO search engine including ‘*Journal of Intellectual Disability Research*’, ‘*Journal of Applied Research in Intellectual Disability*’, and ‘*Journal of*

Applied Behavioural Analysis'. Allen and Hastings were also contacted directly for key recommended papers.

1.3 DEFINITIONS AND EPIDEMIOLOGY

1.3.1 Learning Disability

While definitions and criteria are presented here, it is important to note that people with learning disabilities do not represent a homogenous group, however there is a need to classify for the purposes of identifying need and access to appropriate services. The World Health Organisation (1992) defines a learning disability as 'a state of arrested or incomplete development of mind'. According to the Professional Affairs Board of the British Psychological Society (Learning Disability: Definition and Contexts, 2000), there are three core criteria for defining learning disability:

- Significant impairment in intellectual functioning;
- Significant impairment of adaptive/social functioning;
- Age of onset before adulthood.

All three criteria must be met for a person to be considered to have a learning disability. These criteria represent common features of learning disabilities that have gained widespread international acceptance across professional boundaries (e.g. American Association on Mental Retardation, 1992; World Health Organisation, (ICD-10), 1992; American Psychological Association, (DSM IV), 1994; Department of Health, 1998).

In terms of impaired intellectual functioning, people with learning disabilities have a reduced ability to understand new or complex information or to use new skills (Kerr, 2007). The term 'adaptive functioning' describes the collection of conceptual, social and practical skills that have been learned by people in order to function in their everyday lives, including effectively and independently taking care of themselves and interacting with other people

(Harrison & Oakland, 2003). Individuals with learning disabilities have impaired adaptive functioning and require varying degrees of support depending on the severity of their learning disability.

The third necessary requirement to meet the criteria for a learning disability is that impairments in intellectual and adaptive functioning occur in the developmental period of life (i.e. in childhood, before the age of 18 years). This distinguishes learning disabilities from conditions which are acquired in adulthood that result in similar impairments, such as acquired brain injuries and strokes (British Institute of Learning Disabilities, 2008).

The term 'service user' will be used throughout this study to refer to people with learning disabilities who receive a service via care staff, who will be referred to as 'direct-care staff'.

1.3.2 Challenging behaviour

Challenging behaviour refers to:

"Culturally abnormal behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities" (Emerson, 1995).

This definition implies that challenging behaviours are defined by their impact and will vary widely as to their form and those psychological or biological processes that underlie them. According to the document 'Challenging Behaviour: A Unified Approach (Royal College of Psychiatrists, British Psychological Society & Royal College of Speech and Language Therapists, 2007), the term challenging behaviour is used to transfer the demands for change from the individual to the organisation around them. The 'challenge' therefore, is for carers, services and professionals to find more effective ways of meeting the individual's needs by understanding the origin and meaning of behaviours. Examples of challenging

behaviour include physical and verbal aggression towards others, destruction of property, self-injurious behaviour and stereotypy or withdrawal.

Challenging behaviour is also said to be a social construction, so that the same behaviour may or may not be perceived to be challenging according to the observer, culture or environment (e.g. Emerson, 2001). Thus the nature, severity and frequency of behaviour may remain unchanged but can cease to be seen as challenging when carers, services and professionals are able to respond in positive, inclusive and enabling ways.

Challenging behaviours have a number of detrimental personal and social consequences that impact upon the individual themselves and those around them. For example, they can increase stress in family carers (Quine & Pahl, 1989), make people more likely to be placed in residential care (Quereshi, 1995) and increase staff turnover in services (Felce *et al.* 1993). Further known consequences can be the breakdown of placements, people being placed long distances away from their family and being admitted to segregated specialist treatment facilities (e.g. Allen *et al.* 2007). People with challenging behaviours have also been shown to be at increased risk from abuse, neglect and deprivation (Emerson *et al.* 1994). Behaviours that cause management problems, such as aggression, property destruction, sexually inappropriate behaviour, over-activity and being socially disruptive often result in people being referred for specialist intervention or service placement (Lowe *et al.* 1995). Behaviours such as extreme withdrawal or social avoidance may not be given sufficient attention despite the detrimental impact on the person's development and quality of life (Lowe *et al.* 1995).

1.3.3 Prevalence of people with learning disabilities and challenging behaviour

Challenging behaviour is a sizeable challenge for people with learning disabilities, their families and carers, services and commissioners. Estimates of prevalence will vary according to definitions used. However figures tend to show that between 10% and 15% of people

who are supported by learning disability services display behaviours that are considered to be a challenge; that is cause a serious management problem, or would do were it not for the implementation of effective behaviour management strategies (Emerson *et al.* 1997a, b). A recent epidemiological study of individuals with learning disabilities and challenging behaviour carried out in South Wales (the geographical region covered by this study) showed that 10% of the learning disability population were rated as 'seriously challenging' (Lowe *et al.* 2007). This was consistent with other epidemiological studies carried out in the UK (e.g. Harris, 1993, Emerson *et al.* 2001). However, Lowe and colleagues (2007) also identified substantial numbers of additional people reported as presenting challenging behaviours with lower degrees of severity. The implication for this was of major clinical significance and highlighted the need for services to meet the challenge at primary, secondary as well as tertiary levels of care.

1.4 BEHAVIOURAL APPROACHES TO MANAGE AND MODIFY CHALLENGING BEHAVIOUR IN PEOPLE WITH LEARNING DISABILITIES

1.4.1 The origins of Applied Behavioural Analysis

Behavioural principles are based on the concept that behaviour is a learned or 'conditioned' response to recognisable internal and external environmental stimuli. Skinner (1953) proposed a particularly influential theory known as operant conditioning, whereby a new behavioural response could be established by reinforcing desired emergent behaviours through the manipulation of environmental factors. This theory was put into practice during the 1960s and 1970s and became known as Applied Behavioural Analysis (ABA). The intention in using these behavioural principles was to reduce undesired or challenging behaviours, and increase desired behaviours. Baer *et al.* provided an account of the nature of ABA as it should be practised (Box 1.1)

Box 1:1 Baer *et al.*'s (1968) account of ABA as it should be practised.

- Applied: in that the behaviours and events studied should be of importance to society
- Behavioural: in that studies should be concerned with what people do
- Analytic: in that studies should provide a 'believable demonstration of the events that can be responsible for the occurrence or non-occurrence of the behaviour, usually by the demonstration of experimental control'.
- Technological: in that techniques used are identified and described in a manner that allows replication.
- Conceptually systematic: in that the procedures used are shown to be relevant to basic behavioural principles.
- Effective: in that socially significant changes in behaviour are achieved.
- General: in that the behavioural change 'proves durable over time...appears in a wide variety of possible environments or...spreads to a wide variety of related behaviours'.

ABA has been used in other fields such as acquired brain injury (e.g. Feeney & Ylvisaker, 1995) and in addressing social problems, for example to promote seat belt usage (Williams *et al.* 1989). In the field of learning disabilities, ABA sought to reduce challenging behaviours and to increase more acceptable behaviours. However, it also focused on the development of skills. Many studies have demonstrated the success of the approach in teaching skilled behaviour to people with severe learning disabilities (e.g. Azrin & Armstrong, 1973; O'Neil & Bellamy, 1978) and to people with mild learning disabilities (Didden *et al.* 2006).

1.4.2 Effectiveness of Applied Behavioural Analysis

Since ABA has been put into practice, a large body of literature has shown the successful use of ABA-based procedures to reduce problem behaviour and increase appropriate skills for people with learning disabilities. Several review articles have been published summarising the literature. These reviews show the efficacy of ABA-based procedures in the assessment and intervention with people with learning disabilities and challenging behaviour, and also autism and related difficulties (e.g. Campbell, 2003; DeMeyer *et al.* 1981; Herbert *et al.* 2002; Hingtgen & Bryson, 1972; Kahng *et al.* 2002; Matson *et al.* 1996; Sturmey, 2002). Research into the effects of behavioural methods appears to fit well with a robust experimental design. However, many early studies were criticised for their lack of external validity, often because they took the individual concerned out of their usual environment in order to conduct a brief intervention on a specific behaviour and in an unnatural context (Carr *et al.* 1999).

Scotti and colleagues (1991) produced the first comprehensive meta-analysis of ABA-based intervention with people with learning disabilities and challenging behaviour. Their overarching conclusion was that the available empirical evidence supported the effectiveness of interventions based on ABA principles for reducing serious challenging behaviour in people with learning disabilities. Their report also noted inconsistent research practice and omissions in the available evidence. These omissions included the reporting of relevant independent variables and service user information, use of aversive interventions, availability of alternative positive interventions and degree to which interventions were associated with unintended side-effects, as well as the clinical significance or meaningfulness of reported benefits (Helmstetter & Durand, 1991; Meyer & Evans, 1993; Voeltz & Evans, 1982 cited in Scotti *et al.* 1991). The article contained recommendations for improving research practice to ensure that published interventions could provide the information needed for evaluating intervention strategies and verifying particular protocols. Of particular importance, Scotti *et al.* emphasised the need to report collateral change (both positive and negative behaviours) and the need for longer baseline and intervention phase data.

In an updated meta-analysis of research over the previous five years (Scotti *et al.* 1996), research practice appeared to have improved though problems with the generalisation of the results of studies were still evident. For example, many studies relied on the use of single-case design, albeit with an experimental method, and primarily with people with profound and severe levels of learning disability and/or autism. These individuals were more likely to be supported in institutional settings, of which few remain today, and segregated settings, thus limiting the ability to generalise the findings to community settings.

A review of eighty studies between 1980 and 2005 concerning people with mild learning disabilities found that challenging behaviour was effectively reduced using predominantly ABA-based methods and, to a lesser extent, cognitive-behavioural packages, such as anger management (Didden *et al.* 2006). This finding was similar to a previous meta-analysis (Didden *et al.* 1997), and the authors note similar limitations for both. For example, there was a prominence of children and adolescents and residential settings, and few studies of adults and family and day service settings. There were also few studies of more internalising challenging behaviour, such as withdrawal, anxiety and depression (Didden *et al.* 2006).

The most recent meta-analysis looking at the efficacy of ABA-based procedures included 72 articles published between 1988 and 2006 (Harvey *et al.* 2009). The results affirmed the findings of Scotti *et al.* (1991) and other reviews that behavioural intervention, compared to no intervention, “*can clearly reduce even the most severe challenging behaviour*” (Harvey *et al.*, 2009).

Despite the methodological limitations of such research, the large body of literature reviewed in these studies appears to provide empirical evidence indicating that procedures developed using ABA-based principles are effective at assessing and intervening with a variety of behaviours shown by people with a variety of difficulties and diagnoses. However, the lack of external validity in many studies examining ABA means that translation into

practice is not clear-cut and invites interpretation as to how to use such technology in real-life settings.

1.4.3 Ethical concerns of Applied Behavioural Analysis

According to the principles of ABA, strategies can include methods for changing behaviour through both non-aversive and aversive methods. An aversive method in behavioural terms indicates something that happens to a person that they find unpleasant, and that they therefore seek to avoid. This may also be termed 'punishment'. Types of aversive interventions found in the literature include electric shocks, forced body movement and contingent removal of preferred items and activities (Scotti *et al.* 1991).

Matson and Taras (1989) found that 76% of studies published over the previous two decades concerned aversive interventions, showing just how widespread the use of such interventions was. Lennox *et al.* (1988) reported similar findings and Scotti *et al.* (1991) found that aversive interventions increased throughout the 1980s.

1.4.4 Origins of Positive Behavioural Support

Positive Behavioural Support (PBS) emerged as a response to concerns about the extent and nature of the use of aversive interventions with people with learning disabilities and challenging behaviour. PBS has three main influences: ABA; Normalisation and Social-Role Valorisation; and Person-centred planning.

1.4.4.1 Applied Behavioural Analysis

ABA appears to be an effective technology for intervention, and the definition and evidence-base are discussed above. However, Emerson and McGill (1989) note that ABA is not aligned with a guiding values base governing how it should be used. Given the findings on the use of

aversive interventions, it would be reasonable to assume that there is a strong potential for abuse. PBS draws upon the technology provided by ABA.

1.4.4.2 Normalisation and social role valorisation

Another major theoretical influence over services that emerged from the early 1960s was that of normalisation, which originated in Denmark as part of the 1959 Mental Retardation Act. Normalisation advocated that people with learning disabilities should be allowed to access normal patterns of living (Emerson, 1992). In the USA during the 1970s and 1980s, Wolfensberger (cited in Emerson, 1992) developed a more elaborate definition of normalisation, which he termed social-role valorisation (SRV). Wolfensberger emphasised the importance of how disadvantaged people are portrayed or perceived by the public and went on to redefine the aims of normalisation in terms of socially valued roles rather than culturally normative practices (Emerson, 1992). Williams (1995) proposed that social-role valorisation is fundamentally about improving the relationships of people with learning disabilities with others in society, to counteract processes of social devaluation.

Emerson and McGill (1989) also highlighted that normalisation and SRV had inadequacies; that is it had a strong values base but lacked an accompanying technology to put the values into practice. It therefore seemed an obvious solution to combine both approaches, creating a new values-led technology to achieving behavioural change; thereby combining ABA as the technology, and SRV and normalisation as the values base.

1.4.4.3 Person-centred planning

PBS also adopts the process of person-centred planning, which is the process of identifying goals and implementing an intervention plan (Kincaid, 1996; O'Brien *et al.* 1991; Smull & Harrison, 1992; Vandercook *et al.* 1989). The idea of person-centred planning is that services should be created, developed and tailored according to the specific needs and goals of the

individual. This is in contrast to traditional planning, which attempts to meet the needs of the individual with pre-existing services (Beadle-Brown, 2006)

A central influence of person-centred planning is that of the five service accomplishments (O'Brien & Tyne, 1981), namely, 'Choice', 'Community Presence', 'Competence', 'Respect' and 'Community Participation'. Since the introduction of the five service accomplishments by O'Brien and Tyne in 1981 there has been a steady stream of policy and legislative documents that have influenced service provision for people with learning disabilities. For example, in 1989 the White Paper 'Caring for People' confirmed the Government's commitment to the development of locally based health and social care services. Later, the Government introduced 'The NHS and Community Care Act' (1990) to provide the necessary support structures to enable people, when possible, to remain in their own homes, thereby reducing the demand for long-term care. These structures included an increase in the range of services that service users could access, including the promotion of independent care options. In keeping with the five service accomplishments, these services aimed to be tailored to the needs of the individual. PBS incorporates these principles into its approach and therefore should resonate and 'fit' with the values of contemporary services.

1.4.5 Positive Behavioural Support: Definition

Positive Behavioural Support (PBS) can be defined as:

"An applied science that uses educational methods to expand an individual's behavioural repertoire, and systems change methods to redesign an individual's living environment to achieve first, an enhanced quality of life and, secondarily, to minimise problem behaviour" (Carr, et al. 1999)

The first definitive account of the principles of PBS was presented in a seminal paper by Horner and colleagues (1990). The key features of PBS were outlined by Allen *et al.* (2005) and are shown in Box 1.2

Box 1.2 Key features of PBS, as outlined by Allen *et al.* (2005).

Key Features of PBS

- It is values-led, in that the goal of behavioural strategies is to achieve enhanced community presence, choice, personal competence, respect and community participation, rather than simply behavioural change in isolation
- It is based upon an understanding of why, when and how the behaviours happen and what purposes they serve (through the use of functional analysis)
- It focuses on altering triggers for behaviour, in order to reduce the likelihood that the behaviour will occur
- It uses skill teaching as a central intervention, as lack of critical skills is often a key contributing factor in the development of behavioural challenges
- It uses changes in quality of life as both an intervention and an outcome measure
- It achieves reductions in behaviour as a side-effect of the above
- It has a long-term focus, in that challenging behaviours are often of a long-term nature and successful interventions therefore need to be maintained over prolonged periods
- It has a multi-component focus, reflecting the fact that challenging behaviours are often multiply-determined and that users typically display multiple forms
- It reduces or eliminates the use of punishment approaches
- It includes both proactive strategies for changing behaviour and reactive strategies for managing behaviour when it occurs, because even the most effective change strategies may not completely eliminate risk behaviours from behavioural repertoires (LaVigna *et al.* 1989; Horner *et al.* 1990; Carr *et al.* 1990).

1.4.6 Positive Behavioural Support in practice

It is useful to outline what 'tools' may be used to put PBS into practice. Such tools may include altering known conditions that increase the probability of challenging behaviour

occurring, such as altering environmental factors (e.g. space, light, etc.), social factors (e.g. number of people in a setting), programmatic factors (e.g. activity levels), and intra-personal factors (e.g. mental health needs or drug regimes). Other tools might be the teaching of new competencies to enhance independence and self-esteem, the use of positive reinforcement for behaviours that do not challenge, and reactive strategies (e.g. distraction, evasion and minimal restraint) if challenging behaviour does occur. It is also important to consider possible strategies that may address the need for changes in staff behaviour and in systems of service delivery. It is therefore by no means a straightforward add-on to service delivery, but encompasses a whole approach or framework for a service to adopt.

1.4.7 Positive Behavioural Support summary

In summary, this approach combines the effectiveness of behavioural approaches with an ethical values base and delivered within a person-centred framework. It does not only seek to reduce the frequency, severity and duration of challenging behaviour, but takes a holistic approach to enhance the quality of life of those individuals. Unlike previous behavioural approaches that addressed strategies to manage behaviour after its occurrence, PBS aims to understand why the behaviour occurs in the first place and what purpose it serves, and therefore reduce the triggers for the behaviour. It also uses skill teaching as a central intervention to enhance independence of service users.

1.4.8 Effectiveness of Positive Behavioural Support

PBS was not widely used until the mid-to-late 1980s (Marquis *et al.* 2000). However a substantial evidence-base for PBS has developed that appears to indicate its effectiveness as a model of support for individuals with challenging behaviour (Donellan *et al.* 1985; Grey & McClean, 2007; McClean *et al.* 2005).

Carr *et al.* (1999) conducted a meta-analysis of studies between 1985 and 1996 that included 220 participants with mostly severe and profound learning disabilities, but reasonable numbers of participants with mild and moderate learning disabilities. They concluded that the intervention of PBS was considered successful in almost two thirds of cases and that success rates almost doubled when interventions were based upon prior functional analysis. PBS was also considered effective when typical agents and typical settings were used, which demonstrated the social validity of PBS. However these were mostly in institutional settings, with few community-based settings. Outcomes that were described in this meta-analysis included changes in positive as well as challenging behaviour, stimulus transfer across both people and behaviours, maintenance of gains over time, impact on lifestyle change, and stakeholder views on the social acceptability and effectiveness of the intervention. However, the data on maintenance of gains over time diminished as the duration of follow-up was lengthened. Also, while there are demonstrations of successful lifestyle change, one of the key features of PBS, and good social validity, these data are reported only for a small minority of studies.

More recently, McClean *et al.* (2007) evaluated PBS for people with very severe challenging behaviour in community settings. They found that the implementation of PBS was associated with substantial reductions in challenging behaviour. Also, for most of the service users, significant reductions in the frequency of challenging behaviour were observed within either one or two months of implementation of PBS. For those service users who received psychotropic medication, medication rates dropped by 66%. Psychiatric symptomatology was also reduced. These findings questioned the levels of medication being used with the service users in this study, and supported a previous finding that medications can be successfully reduced and removed when appropriate behavioural interventions are introduced (McClean *et al.* 2007). Furthermore, this study showed that three out of five service users improved their quality of life scores from below the 1st percentile to above the 50th percentile. However, the sample size of this study was very small (five) and therefore caution must be exercised in drawing conclusions. It did demonstrate that PBS can be

effectively used in the community with people with severe challenging behaviours, and in this case, five individuals with the 'most severe challenging behaviours in a county'.

There are several issues when attempting to review the literature on PBS. One of these is the overlap with other approaches, including ABA. As Marquis *et al.* (2000) point out, reviews related to the issue of remediating problem behaviour have usually combined the analysis of PBS with the analysis of non-PBS approaches, or they have reviewed only a subset of PBS procedures (Didden *et al.* 1997; Lancioni & Hoogeveen, 1990; Lennox *et al.* 1988; Matson & Taras, 1989; O'Brien & Repp, 1990; Vollmer & Iwata, 1992). Also, despite the apparent focus on PBS, Carr and Sidener (2002) and Mulick and Butler (2005) note that the majority of studies included in the meta-analyses described above were published in the ABA literature. This overlap makes the distinction between ABA and PBS less obvious.

An additional complication in evaluating PBS is that it has been described by Sailor and Paul (2004) as "*flexible in its engagement of scientific procedures*". According to these authors, PBS studies often show considerable variability in methods. For example, evaluations of PBS are often more descriptive than experimental and often involve subjective personal impressions (e.g. anecdotal reports) and indirect measures of behaviour (e.g. interviews, checklists and rating scales) rather than direct objective measurement methods. There are also problems with the omission of data on successful and unsuccessful cases (Sailor & Paul, 2004).

A further difficulty with assessing the evidence-base is the potential for bias depending on the individuals selected to be included in research. As Durand and Rost (2005) point out, following their review of studies related to PBS approaches that had been published in the *Journal of Applied Behavior Analysis* between 1968 and 2001, few studies (26%) mention how they selected those included in their research and fewer still mention whether they used procedures to reduce selection bias. Almost none of the studies (3%) show whether

participants dropped out of the intervention prematurely. Detailed information on such characteristics would extend the knowledge available to include situations and characteristics of intervention implementers (carers/staff) as well as those of individual service users that could describe where PBS is more or less effective. It is therefore with caution that positive outcomes from studies of PBS are generalised across contexts and individuals.

These methodological issues make it difficult to determine the critical features and effects of PBS, particularly in comparison to studies focused on ABA. However, the list of key features of PBS (Box 1.2) includes many facets of PBS that are perhaps more difficult to assess in line with robust research procedures, and it therefore increases the likelihood that 'success' can be interpreted in many different, and subjective, ways. At present, the meta-analysis of PBS studies serves as the best indicator as to the effectiveness of PBS, showing positive outcomes for the majority of studies, with caution as to the generalisation across contexts and individuals.

1.5 CURRENT USAGE OF BEHAVIOURAL APPROACHES WITH PEOPLE WITH LEARNING DISABILITIES

The previous section indicates that behavioural approaches can be effective, however despite this there is evidence that very few people who could benefit from such interventions are in receipt of such support (Harris & Russell, 1989; Oliver *et al.* 1987; Qureshi, 1994). These studies showed that as few as two to twenty per cent of people with learning disabilities and challenging behaviour received behavioural support of any description, with even fewer receiving support closer to the ideals of ABA (Allen *et al.* 2005).

Other approaches tend to be favoured over developing and implementing behavioural interventions (Allen *et al.* 2005). For example, despite the lack of supporting data for the efficacy of psychotropic medication for challenging behaviour (Brylewski & Duggan, 1999),

50-60% of people with learning disabilities who challenge will be in receipt of such medication (Keirnan *et al.* 1995; Fleming *et al.* 1996). Also, 50% or more will be regularly restrained (Emerson, 2002) despite the risks associated with inappropriate restraint being well-documented (Leadbetter, 2002; Paterson *et al.* 2003). Allen and colleagues (2005) summarised this situation:

"We are currently failing to provide people with learning disabilities and challenging behaviour with effective support. What works best is used least and what works least is used most. The gap between the rhetoric and the reality of evidence-based practice for this group of service users is both stark and alarming" (Allen *et al.* 2005, p.8).

The next section will explore the possible reasons for the poor levels of implementation of behaviour plans.

1.6 BARRIERS TO THE IMPLEMENTATION OF BEHAVIOURAL INTERVENTIONS

During the early stages of ABA, Tharp and Wetzel (1969) recognised and discussed various organisational 'resistances', which may impede the implementation of ABA-based approaches. It was at this time that a triadic model of intervention in natural environments was described, in which behavioural consultants worked to influence and shape the behaviour of mediators (carers/staff) who, in turn, influenced and shaped the behaviour of target individuals. Consultant skills could be 'given away' to individuals in close daily contact with individuals displaying behaviours of concern, thus making good use of scarce professional resources by delivering interventions via people who had natural relationships with service users in naturalistic settings (Allen, 1999).

It is not uncommon for interventions to be only partially successful or not successful at all when attempting to implement interventions with people with learning disabilities (McGuire

& McEvoy, 2007). It is of note that while difficulties may arise from the clinical problem itself, more often difficulties arise from the consultant's contribution or because of difficulties with the implementers (carers/staff) (McBrien & Candy, 1998). Common problems associated with the consultant and mediators are listed below:

Problems with the consultant:

- *Inadequate information about the specific clinical problem or setting*
- *Not hearing the viewpoints of important stakeholders*
- *An overly theoretical approach*
- *An overly complex intervention*
- *Failure to monitor and follow up on intervention*

Problems with the mediators

- *Poor communication among team members*
- *Lack of staff and other resources*
- *Disaffected staff and poor morale*
- *Lack of knowledge and/or experience*
- *Conflicting attitudes or beliefs*

Clinicians working to achieve service user behaviour-change in staffed settings need to share skills with staff and be confident that problem-solving can go on in their absence (Hill-Tout, 1992). However, it has often been noted that staffed settings are not receptive to psychological interventions and remain often uninfluenced and probably unimpressed by

them (Smyly, 2006). Smyly (2006) found that despite clinicians spending a lot of time trying to explain a psychological perspective and their point of view about a client's problem and the possible solutions to staff teams, nothing seemed to change. Woods and Cullen (1983) concluded that there was no simple explanation for the determinants of staff behaviour change, and so working to change the behaviour of staff is a complex issue. From a broad behavioural systems approach, it is important to understand the factors responsible for staff behaviours that may maintain challenging behaviours (Hastings & Brown, 2000; Hastings & Remington, 1994a).

Today there are many theories about the possible reasons for this resistance to professional advice and implementation of behavioural approaches with people with learning disabilities and challenging behaviour. Such barriers include aspects of the service, the nature of the behavioural intervention, staff stress, staff turnover, staff attitudes and beliefs, and lack of training. These factors are outlined in the following section. As mentioned earlier, there is an overlap between ABA and PBS literature and so this section considers behavioural interventions in general. The ways in which PBS attempts to address these barriers is discussed in Section 1.7.

1.6.1 The importance of staff as agents of change

It is now widely accepted that direct-care staff play a vital role in the provision of high-quality services for people with learning disabilities. As Hatton *et al.* (1999) state:

"Staffing issues should be central to anyone interested in developing high-quality services for people with learning disabilities (Reid et al. 1989; Rice & Rosen, 1991; Emerson et al. 1995). Staff provide the interface through which national, regional and organisational philosophies and policies are translated into practical action directly affecting the lives of people with learning disabilities" (Hatton et al. 1999, p253).

Staff behaviour, in the forms of assistance and positive contact, has a direct impact on improving the quality of life of service users (Felce & Emerson, 2001). Staff behaviour in the form of absenteeism and turnover has an indirect impact on the quality of life of service users by reducing organisational efficiency, the continuity of care for service users and the skills and experience of the workforce (Hatton, 1999). As has been previously stated, the detrimental costs of challenging behaviour have been well documented, however it is increasingly understood that these consequences largely result from the nature and quality of the support provided, rather than the behaviour itself (Lowe *et al.* 2007).

The implementation of behavioural approaches often requires staff to change their own behaviours in relation to the service user, and this can be the crucial element that can lead to the success of any behavioural intervention. It has been suggested that change in staff behaviour can be effectively managed by top-down management that is committed to change, constructive engagement of all staff in reasons for change and increasing staff knowledge and skills to implement changes (Ashbaugh, 2008).

1.6.2 Staff stress and emotional responses

The evidence suggests that workplace stress can be a major problem in services for people with learning disabilities. High staff stress and poor morale are widespread in such services (Hatton *et al.* 1999), with around one-third of staff reporting levels of stress indicative of mental health problems (Hatton *et al.* 1995; Hatton *et al.* 1998). Results from similar surveys with other groups put these high levels into context. For example, stress levels in services for people with learning disabilities are higher than staff working in a general health service (27%; Borrill *et al.* 1996) and are twice as high as the UK adult population (16%; Bennett *et al.* 1995). These high levels of stress in such services have implications for poor staff performance (Rose *et al.* 1994) and staff absenteeism and turnover (Hatton & Emerson, 1993; Rose, 1995; Hatton *et al.* 1997).

Staff psychological well-being is of great importance, not only for the well-being of staff, but the well-being and quality of life of those service users in their care. Few studies have been conducted in this area, but those that have found that staff under stress are less likely to engage positively with service users (Lawson & O'Brien, 1994; Rose *et al.* 1998a,b). However, relationships between psychological well-being and behaviour are well-established in other fields. For example parents who are depressed may interact less positively with their children, which has long-term negative consequences for children's development, including development of psychopathology (e.g. Goodman & Gotlib, 1999; Lovejoy *et al.* 2000). This finding could indicate that staff who are depressed may interact less positively with service users, with negative effects for the service user and the potential for an abusive relationship.

It is clear that challenging behaviours may elicit strong emotional responses amongst staff working with people displaying these behaviours (Allen, 1999). Hastings (2002) reviewed the literature on the relationship between challenging behaviour and staff stress and concluded that there is a significant and reasonably strong association between staff exposure to challenging behaviours and staff stress. Hastings went on to suggest that the impact of challenging behaviour on staff can vary from minor irritation to debilitating fear and anxiety. Staff may wish to be relieved from working with a particular service user who displays such behaviours, or may even cite problems coping with challenging behaviour as a reason for seeking alternative employment.

Jenkins *et al.* (1997) found that residential staff supporting individuals with challenging behaviour were significantly more likely to be anxious, to feel less well supported and to have lower levels of job satisfaction. Cottle *et al.* (1995) found that anxiety levels increased by statistically significant levels following violent incidents, and returned to baseline within a month, although major individual differences were observed in this respect. Over 56% of

staff made critical or hostile comments about the service user concerned following the incident; this figure rose to over 66% after a month.

Hastings (1995) suggested that over time as staff habituate to service user behaviours, such emotional responses may diminish. However, in Bromley and Emerson's (1995) study, the wearing nature of challenging behaviour over time was identified as the most significant cause of carer stress (reported by 75% of all carers). Lack of effective intervention strategies for the behaviour, its unpredictability and carers' inability to understand why the behaviour was occurring were all significantly greater sources of stress than the threat of injuries or concerns about the physical strength of the client. Other sources of stress in this study were concerned with deficiencies in resources and staff skills, and systems problems, such as a lack of communication between staff.

The list of factors contributing to staff stress can be long, and Hatton and colleagues (1999) attempted to group them into several domains according to current organisational theories (Arnold *et al.* 1995; Cooper & Payne, 1988). These are outlined below.

1.6.2.1 Within-staff factors

These include younger staff age (Razza, 1993), personal health (Power & Sharp, 1988), staff beliefs about, and emotional reactions to, challenging behaviour (Bromley & Emerson, 1995). Other factors can be coping strategies used by staff to deal with workplace problems, particularly emotion-focused coping strategies such as wishful thinking (Hatton & Emerson, 1995; Thompson, 1987).

1.6.2.2 Characteristics of service users

These focus on challenging behaviours shown by service users (Bersani & Heifetz, 1985; Rose, 1993; Bromley & Emerson, 1995; Jenkins *et al.* 1997) with staff reporting high levels of stress related to their difficulty in understanding the behaviour, the apparent unpredictability of the behaviours, and staff not knowing how the behaviours can be intervened with or managed (Bromley & Emerson, 1995). There is also some more direct evidence suggesting that those staff exposed to more frequent, and more severe challenging behaviour are at increased risk of stress, burnout and mental health problems (Cottle *et al.* 1995; Freeman, 1994; Hastings & Brown, 2002b; Jenkins *et al.* 1997). Poor service-user skills are also implicated here (Zaharia & Baumeister, 1978; Dyer & Quine, 1998).

1.6.2.3 Factors intrinsic to the job

Factors here include work overload (Power & Sharp, 1988; Razza, 1993; Rose, 1993), a lack of job variety (Allen *et al.* 1990; Hatton & Emerson, 1993), low income (Bersani & Heifetz, 1985) and the emotional impact of working with people with learning disabilities (Hatton *et al.* 1995).

1.6.2.4 Social support

These include feedback on job performance (Hatton & Emerson, 1993), and both practical and emotional support from colleagues, supervisors and managers (Dyer & Quine, 1998; Hatton & Emerson, 1993; Hatton *et al.* 1995; Razz, 1993; Rose, 1993, 1995; Rose & Schelewa-Davies, 1997;).

1.6.2.5 Career development

Factors in this area include lack of job security (Rose, 1995), lack of promotion prospects (Hatton & Emerson, 1993) and lack of further training and skill development (Hatton & Emerson, 1993; Rose, 1995).

1.6.2.6 Role in the organisation

Factors in this area include role ambiguity (i.e. being unclear about what the job entails), (Blumenthal *et al.* 1998; Dyer & Quine, 1998; Hatton & Emerson, 1993) and role conflict (i.e. receiving conflicting demands), (Allen *et al.* 1990; Dyer & Quine, 1998; Hatton & Emerson, 1993; Razza, 1993).

1.6.2.7 Organisational structure and climate

Factors in this area include hierarchical organisational structures (Hatton & Emerson, 1993), lack of participation in organisational decision-making (Blumenthal *et al.* 1998; Dyer & Quine, 1998; Hatton & Emerson, 1993), commitment to the organisation, particularly in terms of alienation from the organisation (Hatton & Emerson, 1993) and lack of person-organisation 'fit' (Hatton *et al.* 1999; Whybrow, 1994). Robertson and colleagues (2005) found that a third of staff were likely to seek new employment within the following year due to job insecurity and poor pay.

1.6.2.8 Work-home interface

Some work has suggested a link between high staff stress and conflicting demands between work and home (Hatton *et al.* 1995; Rose, 1995).

1.6.3 Attitudes and beliefs

Hastings and Remington (1994a) argued that direct-care staff beliefs about the causes of challenging behaviour (i.e. the causal attributions that they make – conceptualised as rules governing staff behaviour) are highly influential over staff behaviour that reinforces the challenging behaviour. Allen (1999) reviewed the literature regarding staff attributions and the impact of these on staff behaviour, and found that a consistent theme appeared to be the variables over which staff could exert some control (e.g. communication). These were viewed as less likely causes of challenging behaviour than those over which they had little or no influence (e.g. internal factors and general environmental factors). This could lead staff to feel that there was nothing that they could do to influence such behaviours, a state which Seligman (1975) described as ‘learned helplessness’. The impact of any attempts at intervention via staff under such circumstances would obviously be greatly reduced as a consequence of lowered motivation (Allen, 1999).

The evidence for the causes of challenging behaviour suggests that the behaviour often serves as a function to escape from a variety of aversive staff demands (Carr *et al.* 1994; Durand, 1990; Emerson, 1995; Whittington & Wykes, 1996) and/or as a means to gain access to something desirable. The high frequency with which staff believe behaviour is driven by internal causes and is therefore ‘uncontrollable’ is in conflict with the evidence and the behavioural model in general. Allen (1999) suggests that in the face of such a mismatch of views (staff attributions focusing primarily on internal causation versus behavioural practitioners’ attributions focusing primarily on environmental causation), it is clear why staff beliefs may present as a barrier to the implementation of behavioural plans.

1.6.4 Staff training

A natural solution to the barriers discussed so far might be the implementation of training for staff. Staff working with people who have challenging behaviour in learning disability services need to be good at what they do and to believe that what they do brings about

therapeutic change (Campbell, 2007). Skills and awareness, as well as appropriate value and knowledge bases, are essential for this very difficult work (Campbell, 2007). It has been noted that some staff lack the training to do the job properly (NHS Quality Improvement Scotland, 2006; Smith *et al.* 1996).

Cullen (1988) wrote that staff training has not been shown to be a sufficiently powerful factor in changing staff behaviour, and the current general consensus is that simply training direct-care staff is an ineffective strategy for change (Clements, 1993). However, according to Campbell (2007), there continues to be a basic belief that staff training will improve staff performance.

It is perhaps the nature of the training that is important. Although some training has been found to be effective in increasing staff knowledge and impacting on practice (Allen *et al.* 1997; Berryman *et al.* 1994; Dench 2005), other investigators have concluded that staff training alone is insufficiently powerful to achieve enduring change (Ziarnik & Bernstein, 1982; Cullen, 2000). Academic or theoretical instruction delivered in a classroom, although often necessary, has been shown not to impact on staff performance when used alone (Lattimore *et al.* 1984; McBrien & Foxen, 1987). Indeed Stokes and Baer (1977) termed such traditional organisational training approaches as inadequate 'train and hope' strategies, that is, train staff in a classroom setting and hope that skills are generalised to the workplace.

It would seem that combining a variety of different training techniques and reinforcing this with ongoing management attention is a more effective way of changing staff behaviour and maintaining improved methods of working (Lowe *et al.* 2007). Indeed, the key role held by managers is emphasised in many studies, while others also highlight the need to provide in situ training in the workplace, as well as ongoing management attention (Anderson, 1987; Jones *et al.* 1987; Page *et al.* 1982; Risley & Favell, 1979). Such training would need to take place within the context of a supportive management system and one that provides staff

with clear models in terms of first line managers who will act as 'practice leaders' (Mansell *et al.* 1994; McGill & Bliss, 1993). An intensive training package implemented by Lowe and colleagues (2007) yielded positive results in terms of short-term impact on staff attitudes and attribution, however these tended to be of a temporary nature. This training included an ongoing assessment, which resulted in a BTEC qualification, and this aspect appeared to aid the maintenance of increased knowledge, which was accompanied by training in situ.

1.6.5 Aspects of services

There is literature that implicates aspects of services and institutions as central factors as to why behavioural programmes may not work. One difficulty is the lack of available resources (Corrigan *et al.* 1992). These include a shortage of equipment, sources of appropriate reinforcement, staff shortages and high staff turnover and they have all been shown to be important factors (Burdett & Milne, 1985; Emerson & Emerson, 1987; Repucci & Saunders, 1974). However, it can often be the case that viewing the need for extra resources as a barrier can be a 'red herring' and that if the resource problem was solved, there may well be another barrier (Hill-Tout, 1992). This suggests that extra staff alone is likely to be insufficient to produce change.

Organisational structures that involve high levels of bureaucracy and administrative barriers may create interference. Decisions that are made in other parts of a service, such as staff allocation, may also affect programmes (Hall & Baker, 1973). Organisational rules and regulations have been identified as counter-habilitative (Ferguson & Callari, 1983; Holburn, 1990; Meinhold & Mulick, 1990). Non-person-centred approaches, where the organisation dictates daily routines, are also likely to restrict opportunities for implementing aspects of a behavioural programme, such as increasing participation in daily activities (Woods & Cullen, 1983).

Motivation for implementing the plan is also a factor that can affect the implementation of a behavioural programme. Organisational culture has been shown by organisational psychology to influence important aspects of staff behaviour and motivation (Hatton *et al.* 1999). Research has found that staff often do not receive support for their efforts from other staff groups (Burdett & Milne, 1985; Corrigan *et al.* 1992; Emerson & Emerson, 1987; Hall & Baker, 1973; Woods & Cullen, 1983). Staff may not be rewarded for good work and may not be held accountable for improvements in the behaviour of service users, or lack of such improvements, which is highly likely to affect their motivation to follow a behavioural plan (Hatton *et al.* 1999).

1.6.6 Nature of behavioural programmes

Behavioural programmes themselves can have several difficulties. The small, slow changes in behaviour often produced by programmes may not be enough to maintain good staff practice (Hastings & Remington, 1993). Programmes can be intrusive for implementers (Walker *et al.* 1985), perceived as inflexible (Backer *et al.* 1986), and may not match up with current service approaches or goals. Programmes can fail to be implemented appropriately as the staff who implement them are often not the professionals who have designed them (Bernstein, 1982).

A criticism of the evidence that supports ABA-based approaches in particular is that much of the evidence comes from researchers successfully demonstrating the application of a single intervention (Carr *et al.* 2002). This research demonstrates effective science but poor ecological validity (Carr *et al.* 2002). Frequently, these studies have been characterised by the involvement of researchers and psychologists, not otherwise expected in the service user's context, working in atypical settings, such as clinics and institutions, carrying out brief interventions that often last only 10 to 15 minutes, in highly circumscribed venues (e.g. only one situation out of many that may be associated with behaviours that challenge) (Carr *et al.* 1999). It is therefore likely that translating such practice into real-life settings had proven problematic. Indeed, Horner and Carr (1997) state that it is the comprehensive approach

involving multi-component intervention that is necessary to change the many facets of an individual's living environment, which is problematic.

1.6.7 Summary of barriers

Direct-care staff are the key agents delivering behavioural interventions in services for people with learning disabilities, however it appears that staff are often not receptive to such interventions. The reasons are unclear although there are a number of issues that appear to be linked. Staff stress and emotional responses to working with people with learning disabilities and challenging behaviour could be reasonably assumed to play a part in potential barriers to behavioural intervention. Research has found a number of contexts and individual characteristics that would indicate increased likelihood of direct-care staff reacting negatively within their work, such as style of coping, work overload, ineffective support and lack of clarity in job role. Attitudes towards and beliefs about challenging behaviour can also affect staff behaviour and influence their feelings of 'learned helplessness'. Staff training that combines a variety of techniques seems to be the most successful in influencing staff behaviour change. Organisational cultures and motivation can be a strong influence over staff behaviour, and high levels of bureaucracy, rules and regulations and non-person centred approaches can all interfere with the successful implementation of behavioural programmes. Finally, the nature of behavioural programmes can in themselves be complex and lack 'fit' with the organisation, staff team and service user(s).

1.7 POSITIVE BEHAVIOURAL SUPPORT AS A SOLUTION TO THESE BARRIERS

The combination of values and technology that makes up PBS offers a relatively new approach to supporting people with learning disabilities and challenging behaviour. It has attempted to embrace the criticisms of past approaches, that is, by combining the technology of ABA with a values base of SRV and person-centred planning. This reduces the potential for the use of aversive behavioural interventions and offers a holistic framework

within which to address the goal of increasing service-user quality of life. The values are also consistent with those promoted in government policy and legislation (e.g. Valuing People, Department of Health, 2001; Fulfilling the Promises, Welsh Assembly Government, 2001; Human Rights Act, Department of Health, 1998), which have had a major influence over the values espoused by services. The behavioural approach has also been adopted by relevant bodies such as the National Care Standards Commission in England (2003), who issued guidance on best practice in registered homes for people who challenge. They specify that services must have in place a behaviour plan for their service users and this must include a functional analysis report, baseline data on behavioural frequency and duration, and both proactive and reactive behavioural support plans (Wing & Connor, 2003). This consistency of values between PBS and services, and the behavioural approach advocated by relevant bodies, suggests that the approach should not run into difficulty in fitting into existing service values.

PBS attempts to address some of the potential barriers linked to direct-care staff factors. It recognises the need for a competency-based approach, in that it involves training to increase staff knowledge and understanding of challenging behaviour and of PBS principles. It also emphasises the importance of focusing on a collaborative relationship between professionals on the one hand and support staff and other relevant stakeholders on the other (Carr *et al.* 2002). Collaboration needs to occur with respect to case formulation, goal-setting, intervention selection and ongoing programmatic change. Training, therefore, is not viewed simply as a transfer of strategic information from experts to providers but rather as a process of mutual education involving capacity-building that ultimately results in systems change as opposed to narrowly defined changes for a particular individual (Carr *et al.* 2002).

PBS also recognises the need not only to assess the functions of the behaviour of the individual to inform an intervention, but also for clinicians to assess the relative strengths and needs in association with ability to implement PBS effectively, which can be accounted for when developing a PBS intervention. Such tools include a mediator analysis (exploring

strengths and needs of the implementers, e.g. direct-care staff) (Allen, 1999) or assessing for 'goodness of fit' (Albin *et al.* 1996) with the environment, which may include other service users, community access and facilities and aspects of the physical environment in the home. External professionals are tasked with carrying out a detailed assessment of the behaviour and to co-develop with staff a PBS plan. Sustainable change is more likely when such plans are developed in ways which maximise their 'goodness of fit' with key aspects of the context in which they are to be implemented (Albin *et al.* 1996). The 'goodness of fit' aims to account for, amongst other potential issues, level of staff experience and motivation, available resource, and other service users. This attempts to eliminate unrealistic expectations of staff capabilities by assessing the staff team's strengths and needs, with the potential to address those needs. Therefore a systems focus is maintained, with the ultimate goal of tailoring the system to meet the needs of the individual within realistic goal-setting.

1.8 AIMS AND OBJECTIVES OF CURRENT STUDY

As the above discussion demonstrates, direct-care staff are critical for affecting many aspects of the lives of people with learning disabilities and challenging behaviour in receipt of direct-care. This includes the responsibility for supporting the individual with their challenging behaviour that also promotes the values of normalisation and SRV. Staff behaviour also impacts directly on service user quality of life, with both positive and negative outcomes (e.g. Felce & Emerson, 2001; Hatton, 1999).

The literature has shown that there can be numerous barriers to the successful implementation of behavioural interventions by direct-care staff. Issues such as staff stress, staff turnover, lack of clarity and unhelpful attitudes and beliefs about challenging behaviour can all have a negative impact on direct-care staff and also impact negatively upon the service-user's quality of life. There can be a cyclical relationship between negative staff experiences and challenging behaviour. The implementation of behavioural plans can be a way to break this cycle with the ultimate outcome that the service user's quality of life

is increased, and, in turn, the challenge for direct-care staff is lessened. There is evidence that suggests that behavioural interventions can reduce challenging behaviour and increase quality of life for service users (e.g. Carr *et al.* 1999). The role that direct-care staff play in implementing behavioural plans is of crucial importance to their success, and therefore ultimately has a major influence over service user quality of life.

PBS has been presented as an approach that addresses some of the barriers that have been discussed, such as having a values base consistent with existing services, but particularly its attention to staff needs. This makes PBS, in theory, more likely to be implemented successfully as opposed to ABA. The lack of ecological validity in the evidence-base means it is unclear whether PBS can be successfully implemented in community settings. Furthermore, there has been no research to date that explores with staff their perspective about what is needed for a successful PBS intervention. The importance of staff perspectives has been largely neglected in the research. This negligence may mirror the 'expert' stance taken by professionals and researchers that fail to take into account the importance of the staff perspective.

The overall aim of the current study is to develop a model for understanding the factors that can contribute to the successful implementation of Positive Behavioural Support with people with learning disabilities and challenging behaviour. One objective to achieve this aim is to explore direct-care staff perspectives and experiences of implementing PBS. It is likely that direct-care staff participants will provide new insights into the factors that facilitate or hinder the implementation of behavioural support plans within a PBS model. Their solutions to the barriers will also be explored as a valuable perspective for clinicians working with staff teams.

It is considered important to triangulate the data to enhance confidence in any resulting model and therefore a further objective is to also explore the perspectives and experiences

of clinicians supporting direct-care staff to implement PBS. This will give clinicians the opportunity to make clear their perspectives on the factors that affect the implementation of behavioural plans. It is possible that perspectives between the two sets of participants will differ, and any differences found in the data may provide an understanding of the breadth of relevant factors contributing to the successful implementation of PBS.

The results will directly inform clinicians' practice when working with staff teams using a PBS model. This will increase the likelihood that PBS interventions are implemented, thereby increasing the likelihood of an increased quality of life for service users in their care.

Chapter 2

METHODOLOGY

2.1 OVERVIEW

This chapter will describe the design and procedure of the study. The rationale for a qualitative design and grounded theory will be presented. Guidelines for conducting qualitative studies will be outlined with examples of how the researcher addressed these. The process of recruitment and data collection is presented, along with descriptions of the participants. The use of grounded theory to analyse the current study is also described.

2.2 DESIGN

The current study utilised a qualitative approach to explore the views and experiences of direct-care staff and clinicians working to implement Positive Behavioural Support in community residential settings with people with learning disabilities and challenging behaviour (service users). The researcher carried out semi-structured interviews with direct-care staff, and conducted a focus group with clinicians. In particular, the researcher sought to explore:

- What facilitates effective implementation of Positive Behaviour Support (PBS)
- What barriers exist to the effective implementation of PBS
- How to overcome any barriers identified

Data collection and analysis was guided by the principles of grounded theory. For Part A of the study, eight face-to-face interviews were conducted, with participants recruited from

residential settings where they use PBS to support service users. Of these eight interviews, four were conducted with staff in NHS-managed Specialist Residential Services (SRS), and four were conducted with staff in social-care residential settings. In Part B of the study a focus group was conducted with six members of staff from the Specialist Behavioural Team (SBT), (four behaviour specialists and two clinical psychologists), to explore their perspectives. The themes arising from the focus group were compared to the themes arising from the interviews.

2.2.1 Rationale for a qualitative design

Researchers employing qualitative methods are interested in how individuals experience their world and so the research is led by the participants. This allows participants to raise topics that may not have been anticipated by researchers. Fielding (1994, cited in Duffy *et al.* 2002) stated that the qualitative interview allows respondents to use their own way of defining the world; assumes that no fixed sequence of questioning is suitable to all respondents; and allows respondents to raise issues not previously considered by the interviewer.

Barker *et al.* (2002) suggested that qualitative approaches allow discovery-orientated exploration of areas where there is a dearth of existing literature. As outlined in Chapter 1, the literature pays little attention to the perspectives of direct-care staff tasked with implementing PBS plans, and no research in this area has been conducted to date. Therefore, a qualitative methodology was considered appropriate for the exploration of this area.

2.2.2 Grounded theory

2.2.2.1 Introduction to grounded theory

Grounded theory is a process by which researchers begin with a number of open and general research questions. They then collect the relevant information and analyse this in such a way that theory can emerge. Grounded theory is iterative, in that it involves a continuing interaction between concepts and data. Grounded theory emphasises the need for theory to be grounded in reality hence the need for researchers to get out 'into the field' and actually experience the phenomena being studied.

It can be argued that the process of subjectively analysing the data alters the nature of the emergent theory. This interplay between a researcher and the data is acknowledged by qualitative methodologies. Henwood and Pidgeon (2003) described the conflict between a scientific process, where the data reflects the participants' views, and an acceptance of the constructionism inherent in the approach. That is, theory cannot simply emerge from the data, because interpretation and analysis is always carried out from a conceptual position adopted by a researcher. Qualitative researchers require theoretical sensitivity (i.e. an ability to recognise important data and understand their meaning), which is achieved through a grounding in relevant literature, personal/professional experience of the phenomena, and continued immersion in the data. Layder (1993) argued that data should guide but not limit theorising. Therefore the term "generation of theory" rather than "discovery of theory" may be more accurate (Henwood & Pidgeon, 2003). The method can provide a process by which a level of objectivity is obtained, through a researcher's acknowledgement of their subjectivity.

2.2.2.2 Grounded theory procedure

There are well-established principles for guiding grounded theory research (Strauss & Corbin, 1998; Willig, 2008). This involves the 'coding' of themes within a data source; themes that share central features or characteristics with one another. These themes are

coded at increasingly higher levels of abstraction and the researcher uses constant comparative analysis, by reviewing new data to link it and integrate it with data collected earlier in the study. The method of 'constant comparison' ensures that the coding process maintains its' momentum by moving back and forth between the identification of similarities and differences between basic data, emerging categories and theoretical propositions (Willig, 2008). The aim is to capture all variation within a category, and the complexity can be used to promote conceptual and theoretical development (Henwood & Pidgeon, 2003).

'Theoretical sampling' refers to the process of collecting further data in light of the categories that have emerged (Willig, 2008). This process enables researchers to continue checking the emerging theory, so that it can be changed or explored further as new data is collected. 'Theoretical saturation' is the point at which no new categories can be identified, and instances of variation cease to emerge. It is at this point that researchers cease sampling and coding. However while saturation remains the aim, modification or changes in perspective are always possible. The resultant grounded theory is therefore always provisional (Willig, 2008).

Researchers should keep a written record of all aspects of their study throughout this process, which includes notes on the progression of the analysis and also their reflections, reactions and interpretations of the data. There is an ongoing evaluation of the research questions, and these evaluations can evolve or change as the analysis progresses. The written record can provide direction for theoretical sampling and enable researchers to organise their thoughts.

2.2.2.3 Why grounded theory?

As a method, grounded theory represents a more validated and well-established qualitative methodology. Typically, grounded theory is used to investigate new areas of research as a

means of developing a theory when little is known about a subject or problem area (Willig, 2008). Further insight into the factors that affect the implementation of PBS plans is needed, as highlighted by Chapter 1. Grounded theory also enables a researcher to develop a theory that directly informs clinical practice, with subjectivity reduced as much as possible.

2.2.3 Ensuring quality and rigour in qualitative research

Qualitative research has attracted criticism regarding a potential lack of rigour and this has been a matter of some debate (e.g. Mays & Pope, 2000). In an attempt to standardise qualitative research, Elliott *et al.* (1999) developed guidelines on how to maintain credibility, validity and reliability when conducting qualitative research. These guidelines are outlined below, along with explanations of how each guideline was addressed in the current study.

2.2.3.1 Situating the sample

The reader of any study should be able to assess the range of persons and contexts to which the findings might be relevant. To aid this, the researcher in this study sought participant information prior to each interview and the focus group and presented the information in Section 2.4.3

2.2.3.2 Accomplishing general versus specific research tasks

Researchers need to make the aims of their study clear for the reader. If the aim of the study is to create a general understanding of a phenomenon then an appropriate range of people should be sampled. However, if the intention is to describe a specific instance of a phenomenon, to develop a deeper understanding, then the data should be analysed systematically and comprehensively. The purpose of the current study was not to generalise, but to develop a detailed understanding of the key factors that influence the effectiveness of PBS in community residential settings. The aims for the current study have been addressed using grounded theory techniques, which are systematic and

comprehensive. The data has been presented and discussed (Chapter 3) enabling the reader to be clear about the outcomes of the analysis. The limitations of this methodology have been discussed in Section 4.4.

2.2.3.3 Grounding in examples

Examples of the data should be presented for the reader to assess the fit between the data and the interpretation. In the current study, participant quotes were used to illustrate categories and concepts derived from the data (see Chapter 3).

2.2.3.4 Providing credibility checks

Checking the credibility of categories or constructs ensures that a researcher's analysis accurately reflects the data. In the current study, the data analysis was checked by both the researcher's academic and clinical supervisors who collectively have extensive knowledge and experience of the subject area and methodology. The researcher met with both supervisors regularly during data analysis, and received feedback on the verification of emergent categories and concepts and later on the development of the grounded theory.

2.2.3.5 Coherence

Researchers need to describe their data, analysis and findings in a coherent narrative and/or map or framework for the phenomenon to be understood. In this study the researcher presented the findings in both verbatim and diagrammatic form in the Results section (see Chapter 3). Additionally, the coherence was supported and checked by both supervisors.

2.2.3.6 Resonating with readers

Information should be presented in such a way that allows readers to identify with the subject matter, and to clarify or deepen their understanding of the phenomenon. Repeated checks of drafts of the study with both supervisors helped the researcher in this study to maintain consideration of the reader and how the study may be received.

2.2.3.7 Awareness of one's own perspective

It is important that researchers recognise their own values, assumptions and interests, and the role that these play in data collection and analysis. It is recognised and accepted that researchers will be influenced by their own philosophical stance, experiences, values and priorities (Henwood & Pidgeon, 2003). By accepting the limits of their own perspective, researchers are enabled to see beyond their own concepts and to use them in new ways (Henwood & Pidgeon, 2003). Elliott *et al.* (1999) recommend that researchers specify their own theoretical orientation and expectations, both in advance and as they become apparent, and this needs to be made transparent. The researcher in this study therefore kept a reflective journal throughout data collection, analysis and write-up, an excerpt from which can be found in Appendix F. Appendix E provides an account of the researcher's background, and a disclosure of the values and assumptions held which may have influenced the researcher's interpretation of this study.

2.2.4 Rationale for the use of semi-structured interviews (Part A of the study)

Semi-structured interviewing can enable participants to talk about their experiences in their own words, which can empower participants to feel they are being listened to and that their contributions are valued (Del Busso, 2004). The interview can also be a "conversation with a purpose" (Marshall & Rossman, 2006), which enables researchers to explore a few general topics and help uncover participants' views.

The researcher was keen to hear from direct-care staff their honest perspectives and experiences of PBS and felt that this could be compromised in anything but a one-to-one interview. However, the researcher was aware of potential limitations such as participants feeling uncomfortable about sharing their experiences or offering responses thought to be desired. The researcher needed to maintain flexibility and to refrain from asking leading questions. Awareness of any biases, however, can be acknowledged and accounted for during data collection and analysis (Pidgeon & Henwood, 2003).

2.2.5 Rationale for the use of a focus group (Part B of the study)

Focus groups are essentially an organised group discussion centred on a single theme or specific set of issues (Krueger, 1988). Focus groups have been especially popular in health-related research, and can be a valuable method for the exploration of knowledge, beliefs and experiences (e.g. Murray *et al.* 1994; Ritchie *et al.* 1994). This popularity can be attributed to the cost-effective nature of focus groups (Greenbaum, 1998), and also their ability to generate rich data on various levels of understanding, i.e. what people think, how they think it and why they think it (Kitzinger, 1995). Focus groups can be particularly useful in exploring group norms or workplace cultural values, as the group interactions of the focus group reveal areas of consensus and dissent (Kitzinger, 1995). It has also been noted that focus groups are a useful method for facilitating the expression of criticism (Watts & Ebutt, 1987). Additionally, focus groups offer the basis for exploring different types of solutions, which is invaluable in research that aims to improve services (Kitzinger, 1995).

The researcher was mindful that the data generated by a focus group may represent the interaction between specific individuals involved, rather than gaining authentic individual perspectives. Whilst individual interviews can elicit perspectives, experiences and feelings of a more personal nature, the dynamics of a focus group can draw out new ideas within its participants, and consequently can open up new channels for exploration. It was felt that using a focus group with SBT clinicians could help generate solutions and ideas for overcoming barriers that were identified during the interviews with direct-care staff, and

also the realistic possibilities of these. This was important because of the relevance of the outcome of the interview data to SBT working practices, that is, developing and implementing PBS plans with direct-care staff. The focus group gave participants the opportunity to discuss the aims of the study from their perspective. Ultimately, this gave the researcher the opportunity to compare themes from the interviews with those from the focus group. If differing perspectives were identified, this could be discussed as a potential barrier in itself, and broaden the remit of the study. The recommendations arising from the data collected would be well-informed and directly service-related.

2.2.6 Development of research questions

Part A: A small number of themes, with a series of prompts, were used as the basis for individual interviews. The themes were developed using the researcher's professional training and experience of working with staff to develop and implement PBS, and also the reading of relevant literature. The researcher also consulted with supervisors, both of whom have extensive experience in the use of PBS and working with staff teams, and have published in the area. An original interview schedule can be found in Appendix I. It should however be noted that in accordance with the grounded-theory approach, interview questions were guided by themes arising from previous interviews, therefore subsequent interviews varied in their emphasis and direction.

The interview schedule was based around four themes, namely:

- Understanding of PBS
- Impact of PBS model of working
- Skills/training/support required
- Challenges to working in a PBS model

Typical stem questions were:

- What is your understanding of PBS?

- What are your experiences of implementing a PBS plan?
- Have you felt adequately supported to implement PBS plans?
- What are the biggest challenges to working in this model?

Part B: When developing questions for the focus group, the researcher was guided by the research aims, as well as the themes arising from the interviews. In particular, the focus was on what helps the effective implementation of PBS plans, and what solutions can be used to overcome any barriers.

2.3 ETHICAL CONSIDERATIONS

2.3.1 Ethical scrutiny

Ethical approval was sought from the South West Wales Local Research Ethics Committee and was granted in August 2009 following presentation of the research to the committee (Appendix C). Approval was also sought from two local NHS Research and Development Committees and this was granted in July 2009 (Appendix A and B).

2.3.2 Informed consent

The researcher obtained verbal and written consent from participants during recruitment and data collection. The researcher ensured that consent was informed by meeting with participants prior to any data collection, explaining the research and inviting questions. The details of the research were also outlined in a participant information sheet given to participants upon the first meeting with the researcher. Potential participants were invited to consider carefully the information presented before completing the consent form if they wished to participate. The participant information sheet contained the contact telephone numbers of the researcher and supervisors should potential participants have any further questions.

The researcher reiterated the aims of the research prior to the interviews and focus group, and checked that participants were happy to continue. They were reminded that they could withdraw at any time with no consequences.

2.3.3 Confidentiality and anonymity

The interviews and focus group were audio-recorded and transcribed by the researcher. Any identifying information contained in the transcripts, such as reference to service users, other staff members, professionals involved, or the setting, was removed. Each participant was allocated an interview number for the purposes of analysis, and given pseudonyms during the write-up of the results. Only anonymised data was viewed by the researcher's supervisors.

2.4 PARTICIPANTS

2.4.1 Deciding on a sample

The researcher discussed inclusion criteria with supervisors. The Specialist Behavioural Team clinicians were invited to participate due to their Team objective of increasing the quality of life for service users within a PBS model. The focus on PBS is therefore more acute than more generic clinicians.

In terms of direct-care staff, it was agreed that staff should be included who worked in the NHS-managed Specialist Residential Services (SRS). Staff in these settings had undertaken significant amounts of training, including completing qualifications in PBS, over the previous seven years. SBT played a key role in developing the skills of staff to implement PBS during this time. The researcher felt that interviewing these staff about their experiences of implementing PBS, given the intensity of training and support they had received, as well as the length of time that they had been working with PBS, could be crucial to identifying key factors for effective implementation and discovering how barriers can be overcome.

However, SBT form part of the management structure of SRS and therefore the training and support offered, as well as the relationships between SBT and SRS staff, was not representative of how SBT work with other organisations to deliver and implement PBS. The researcher therefore felt that barriers may not be identified that might otherwise be found when the SBT work with other organisations. This would have limited the applicability of the findings. Therefore, it was decided to include staff in social-care settings to enhance generalisability. In addition, any differences that were found between the SRS and social-care residential settings could serve to further highlight the key factors that influence the effectiveness of PBS.

2.4.2 Inclusion and exclusion criteria

Part A: Potential participants were eligible for inclusion if they were staff members supporting service users on the caseload of the SBT, and had been involved in the implementation of PBS plans for the service users they supported for longer than one year. Potential participants were sought from NHS-managed SRS or social-care residential settings. Participants were excluded if they did not work in residential settings, worked in settings where there were no service users who exhibited challenging behaviour, or had no involvement with the SBT. Participants were also excluded if they had no experience of working with service users who exhibited challenging behaviour.

Part B: Participation in the focus group was dependent upon participants being clinical psychologists or behaviour specialists of the SBT who were involved in the development of PBS plans in *both* SRS and social-care settings. This was to ensure that all participants were able to discuss themes emerging across settings.

2.4.3 Description of participants

Part A: The researcher interviewed 6 females and 2 males. With regard to job titles, various titles are used across settings and organisations and the meaning of the titles may also vary. The researcher has recorded job titles in the terms used by the interviewee. The number of years of experience working with this client group ranged from 17 months to 26 years.

Names have been changed for the purposes of confidentiality and some information regarding past work experience has been anonymised or omitted if there is the possibility that it can identify the person.

Barbara

Barbara was a qualified nurse working in a specialist residential setting. She had worked with this client group for 20 years, which included working in a learning disability hospital prior to the current setting.

Kelly

Kelly was a 'staff nurse' in a SRS setting. She had eight years of experience working with people with learning disabilities and challenging behaviour. Kelly was a 'primary nurse' for one of the service users in the setting.

Nadine

Nadine was a 'nursing assistant' working in a SRS setting. She had been in post for 26 years, 19 of which were spent working with service users in a learning disability hospital. Nadine was part of a 'core group' for one particular service user in the setting (i.e. worked closely with the 'primary nurse' for that service user).

Sandra

Sandra was a 'registered nurse' working in a SRS setting. She qualified in 1979 and had worked in two different learning disability hospitals prior to the current setting. She had spent a total of 24 years working with people with learning disabilities and challenging behaviour. Sandra was a 'primary nurse' for one of the service users in the setting.

Paula

Paula was a 'clinical support worker' working in a social-care setting that specialised in supporting people with learning disabilities and challenging behaviour. She had been in post in this setting for five years.

Derek

Derek worked in a residential social-care setting as a 'senior support worker'. He had been in this post for 10 years, and for four years previous to this he worked in another company as a support worker with service users with challenging behaviour. As a senior support worker, Derek held 'key worker' responsibility for one of the service users in the setting.

Leanne

Leanne was a 'support worker' in a residential social-care setting and had been in post for 17 months. She had no prior experience of working with people with learning disabilities and challenging behaviour. Leanne was a 'key worker' for one of the service users residing at the setting.

Mark

Mark was a 'deputy manager' for a residential social-care setting. He had been in this role for two years, but had previous experience of working with people with learning disabilities and challenging behaviour in the NHS-managed SRS. In total he had 10 years of experience with this client group.

Part B: The researcher held a focus group with four behaviour specialists and two clinical psychologists from the SBT. Due to the small number of people in SBT who met the inclusion criteria, it was felt necessary, to protect anonymity, to present only broad statements of demographic information.

The participants ranged in their number of years working for SBT, and this was between 18 months and 11 years. All participants had previous experience of working with people with learning disabilities and challenging behaviour. For most participants this was in a direct-care role (e.g. nursing, support work). For other participants this was in a psychology role (e.g. assistant psychologist, trainee clinical psychologist). One participant had both direct-care and psychology experience with this client group prior to working with SBT. Previous experience ranged from three years to 19 years.

For the purpose of reporting the results, pseudonyms will be used. These are:

Helen

Vera

Sally

Teresa

David

Karen

2.5 PROCEDURE

2.5.1 Recruitment of participants

Part A

Recruiting from Specialist Residential Services

The researcher randomly selected two settings from which to seek participation. Following agreement from the lead manager, the researcher contacted the two setting managers to discuss staff participation in the study. The researcher gained permission from the setting managers to meet with staff. During these meetings, the researcher explained the study, presented staff with participant information sheets, consent forms, stamped addressed envelopes and offered them the opportunity to ask questions. If staff were interested in participating, they were asked to complete and sign the consent form, which they gave to the researcher at the time, or returned in the stamped addressed envelope. Once consent had been received, appropriate times and locations were arranged with each participant to carry out the interview.

Recruiting from social-care settings

The researcher met with the team manager for the SBT and requested assistance in identifying potential participants from social-care settings. The SBT discussed this at a meeting and presented the researcher with eight social-care settings that met the inclusion criteria. From this list of eight, the researcher randomly selected two settings. The Team manager contacted the settings on behalf of the researcher and the researcher received permission to contact the setting managers directly.

The researcher then followed the same procedures for recruitment as had been followed for recruiting from SRS.

The researcher received consent from eleven members of staff in total, across both SRS and social-care settings. It was not considered necessary to interview all eleven participants therefore the researcher used 'theoretical sampling' to select which participants to interview. The decision was based upon where they worked (i.e. to avoid over-sampling of one setting), and their experience and involvement with working with PBS plans. The aim was to gain a breadth of data across settings, levels of experience and amount of involvement with the development of PBS plans, based upon emerging themes and theory. Participants who volunteered but were not chosen for interview were thanked for their interest.

Part B: The researcher again sought assistance from the SBT manager. The researcher gained permission to meet with SBT staff who met the inclusion criteria. During this meeting, potential participants were offered information about the study, and the opportunity to participate. Four behaviour specialists and three clinical psychologists met the criteria, however one clinical psychologist could not be involved in the focus group due to other commitments. Of the remaining potential participants, all signed consent forms to participate in the focus group, and an appropriate date and location was agreed.

2.5.2 Procedure of semi-structured interviews

Interviews were arranged with participants at a location of their choice. All participants chose their place of work as a convenient location, where a private room was made available. Prior to starting the interview, the researcher assured participants that they did not have to answer any questions they felt uncomfortable about, that they could stop the interview at any time for a break or to withdraw their participation. They were also assured that in the case of withdrawal, any interview data would not be used in the analysis. All interviews lasted an hour and were audio-recorded using a digital recorder. Information about demographics was gained prior to the interview and was not audio-recorded.

The researcher aimed to touch upon the four main themes in the interview schedule. However the schedule was used flexibly by the researcher, allowing interviewees to discuss those issues they felt important. The researcher encouraged interviewees to reflect on their experiences and also followed avenues of exploration that the researcher was curious about. Tentative questioning was used about the participants' knowledge of the experiences of others, and also their thoughts and ideas about the issues that the study was exploring.

2.5.3 Procedure of the focus group

The time and date for the focus group was arranged with consideration for the convenience of the participants, at a location easily accessible to all of them. The researcher introduced the participants to the aims of the research and invited questions prior to the start of the focus group. It was also made clear that participants could withdraw from the study at any time, and that all data would be kept confidential and anonymous.

The focus group discussion lasted for an hour and 45 minutes. It was audio-recorded and led by the researcher, who set out the purpose of the focus group and the 'ground rules'. The researcher then facilitated discussion around three main themes consistent with the aims of the study. Questions were asked about what helps in the process of developing and implementing PBS plans, what are the barriers, and what needs to happen to overcome the barriers. Themes arising from the interviews were also presented to the focus group at a half-way point, giving participants the opportunity to discuss these in light of the issues they had identified, and to discuss realistic solutions for overcoming barriers that could directly inform service recommendations.

2.6 DISSEMINATION OF RESULTS

It is anticipated that the researcher will formally present the content of the study to local learning disability services, as well as write for publication with support from the academic

and clinical supervisors. The researcher will also provide a summary sheet of results and service implications to all participants who had requested it.

2.7 DATA ANALYSIS

Data was analysed according to the Grounded Theory as described in Section 2.2.2

2.7.1 Analysing the interviews and focus group

2.7.1.1 Cyclical process of data collection and management

Central to grounded-theory methodology is that analysis is concurrent with data collection, which allows emergent theory to inform subsequent data collection (Duffy *et al.* 2002). The researcher was aware of emerging themes and areas requiring further investigation during the interview-data collection phase. Following each interview and the focus group, and also during the transcription process, the researcher noted memos and themes that arose, and kept a reflective journal throughout these processes (see Appendix F for excerpt from reflective journal). These notes informed additional questioning and the validation of ideas for subsequent interviews.

2.7.1.2 Coding interview and focus group transcripts

The coding process started with the researcher transcribing, reading the transcripts and highlighting pieces of text, which were coded with low level descriptions. During subsequent interviews, the researcher was mindful of emerging themes and areas for exploration. Following each interview, and during transcription, the researcher noted reflections and themes that arose. Open, axial and selective coding was used interchangeably until 'theoretical saturation' was achieved (see below).

Following the interviews, a summary of the main themes emerging from the coding of transcripts was presented to the focus group. The transcripts from the focus group were also analysed using the same coding procedure.

Further description of the coding procedure and how it was applied in the current study is outlined below.

2.7.1.3 Open coding

According to Strauss and Corbin (1998), open coding is the analytical procedure whereby concepts are identified and their properties and dimensions are discovered in the data. This allows data with similar meaning to be grouped together under a descriptive label (code), which captures the essence of a segment (Willig, 2008). In the current study, the researcher noted codes next to the highlighted transcript segment. These were then translated into a list of codes, allowing the researcher to relate them to other transcripts and inform new lines of enquiry for subsequent interviews.

2.7.1.4 Axial coding

Axial coding entails linking categories to their sub-categories according to their properties and dimensions, which acts as a means of grouping concepts and further defining codes under abstract categories (Strauss & Corbin, 1998). In the current study, axial coding was achieved by constant comparison of emerging codes and concepts and observation of conceptual similarities and differences, and noting possible relationships between codes. Categories were developed by querying the properties and dimensions of the phenomena, and the variety of conditions, actions/interactions and consequences associated with them. Sub-categories were then developed through attempts to identify how concepts might relate to each other.

2.7.1.5 Selective coding

Selective coding involves integrating and refining categories with the aim of organising them around a central explanatory framework. In the current study, this process was used to develop core concepts, to which all other categories, sub-categories and concepts could be linked and understood. An emerging and tentative explanatory framework was developed following the fourth interview. During the fifth and sixth interviews, the researcher remained open to new concepts as these were in a different setting, but was mindful of the initial framework. The framework was further developed and the latter two interviews were used to fully explore and saturate categories. The developing theory was presented to supervisors and was further refined and validated by comparing it back to the raw data.

Chapter 3

RESULTS

3.1 OVERVIEW

The following chapter is presented in two parts. The main results of the study are in Part A, which presents the results from the analysis of the interview data. The data was analysed and organised into core concepts, categories and sub-categories.

Part B presents the results of the focus group with the intention of referencing a comparison with the interview data. The data was analysed in the same way as the interviews and is therefore also organised into core concepts, categories and sub-categories. The data from the focus group shows potential barriers if the perceptions of facilitative factors relevant to the implementation of PBS are different between direct-care staff and SBT clinicians.

A diagrammatic model of the resulting grounded theory is presented at the end of the results section.

A3.2 PART A - RESULTS OF THE INTERVIEW DATA ANALYSIS

A3.2.1 Categorisation of data

The interview data was analysed and organised into core concepts, categories and sub-categories. Each core concept, category and sub-category is defined and presented together with illustrative quotes. **CORE CONCEPTS** will be written in **BOLD UPPER CASE** font. **Categories** will be written in **Bold lower case** font. *Sub-categories* will be written in *bold italic lower case* font.

A3.2.2 Coding/Anonymity

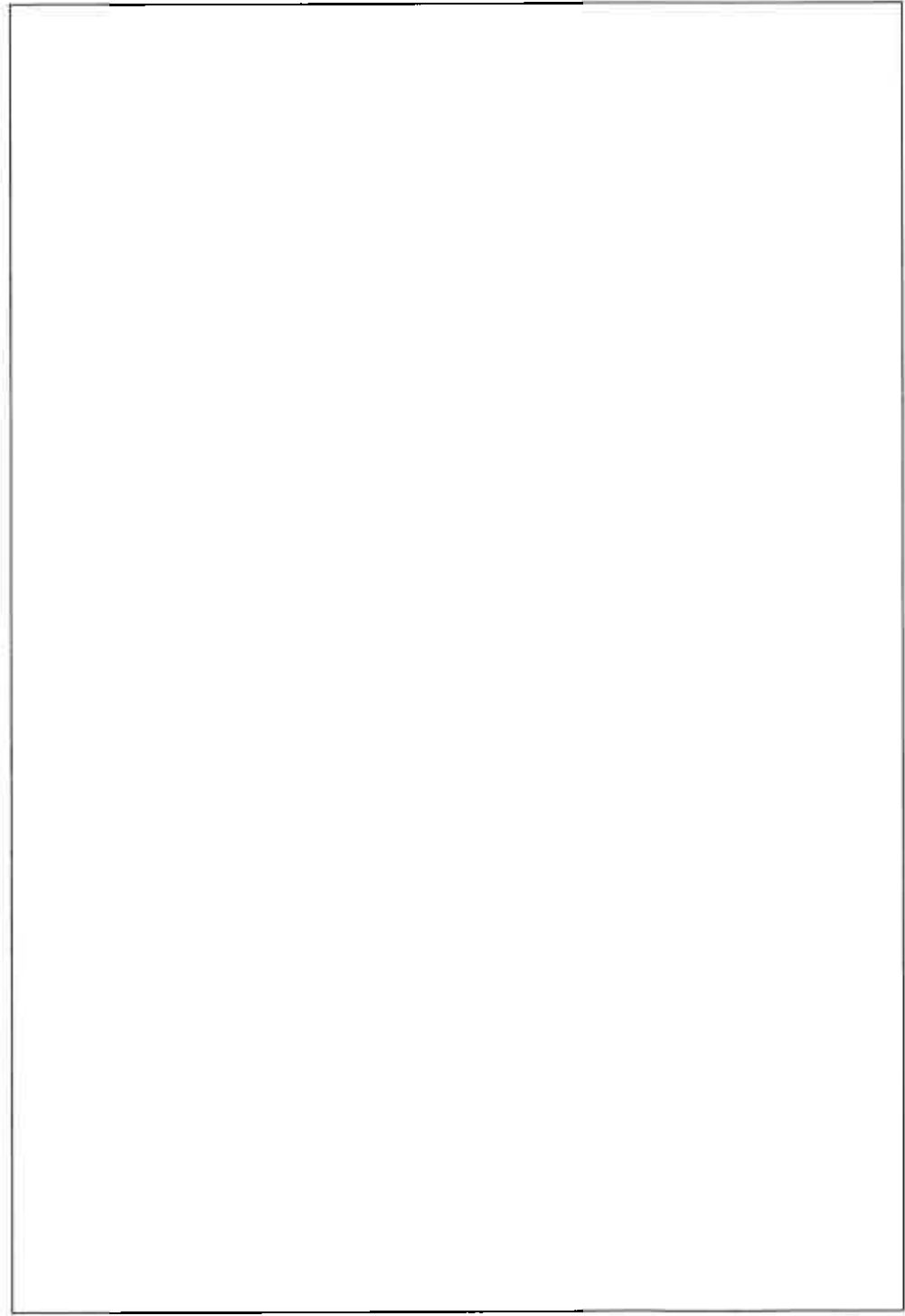
The names assigned to all participants are pseudonyms. The place of work is represented by abbreviations. Names of participants working in Specialist Residential Services will be followed by '(SRS)' and for participants working in Social Care, their names will be followed by '(SC)'.

To protect the identity of people mentioned during the interviews, they are referred to by their role and within square brackets (e.g. [SBT member]).

A3.2.4 Overview of interview results

The figure below shows the four **CORE CONCEPTS** and their component **Categories** representing the themes that emerged from the interviews with staff members.

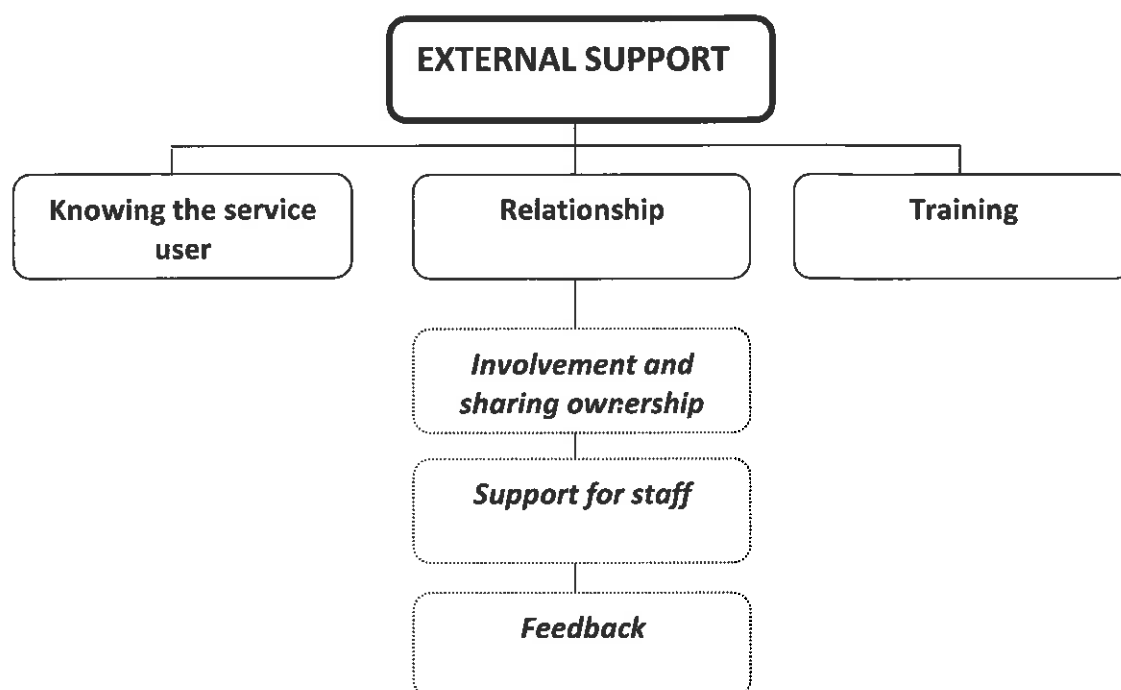
Figure 3.1 Key factors identified that influence the success of Positive Behavioural Support plans: A diagrammatic summary of **CORE CONCEPTS** and **Categories**



A3.3 CORE CONCEPT: EXTERNAL SUPPORT

Definition: This concept encompasses factors that relate to the approach of SBT and the impact of this.

Figure 3.2 Diagrammatic representation of the core concept **EXTERNAL SUPPORT**



A3.3.1 Category: Knowing the service user

This category refers to the SBT clinician getting into the staff context as much as possible to develop their knowledge of the service user. Seven out of eight participants talked about this issue. Participants in SRS highlighted the importance of knowing the service users and did not perceive a problem in this respect. However, participants in social care who talked about this issue felt that SBT clinicians did not know the service users well enough. They perceived that SBT clinicians were not present in the setting enough to know the service users, and placed an importance on clinicians being more present more often so that they could develop a deeper understanding of the service users and the difficulties for staff. The

same participants expressed frustration with having SBT clinicians present (e.g. assistant behavioural specialists) who were not the same people who would be developing the plan.

Kelly (SRS) felt it was particularly important to know the service users well to be able to develop and implement preventative strategies: *"I think you've got to know the people you're caring for extremely well to know the preventative stuff and you've got to build a really good picture of them"*.

Paula (SC) spoke of the importance of clinicians being seen more often: *"We need to see them more often, they need to see the guys more often, they need to be much more involved with each individual client"*. Paula (SC) further talked about the need for clinicians to be present at certain times of the day: *"They were here for a while, but not at times when it mattered, like 7 o'clock or 6 o'clock in the morning when the behaviours were displayed. [Service user] was waiting for staff to come in and exposing himself at the windows and throwing things at you and spitting. But that's when SBT need to be here is when it matters, not at tea-time when they've been chilled and they're all sleepy and waiting for their tea"*.

Mark (SC) acknowledged the difficulty that clinicians face in trying to get to know service users: *"It's hard for them because they have a snapshot of an assessment"*, but he believed that clinicians' awareness of the issues facing staff would increase if they worked alongside staff: *"If you're going to come in here and work with these people and tell them how to do it you need to roll your sleeves up, get in there and you need to start working. 'Do it this way, I'm going to show you'. I believe very much in lead by example"*.

Derek (SC) perceived that clinicians who were writing the plans were not present enough and wanted consistency between clinicians who were present in the setting, and the clinician developing the plan: *"They've sent assistant behaviour specialists to do the job and*

not the people writing the plans". He also commented that clinicians could do more direct work with the clients, which would help their knowledge of service users: *"On paper they may do but they don't know the individual people"*.

A3.3.2 Category: Relationship

This category covers the relationship that SBT have with staff members that they are working with to develop and implement PBS plans. Sub-categories include ***Involvement and sharing ownership***, ***Support for staff***, and ***Feedback***

A3.3.2.1 Sub-category: Involvement and sharing ownership

This refers to the need for SBT to involve staff in the development of PBS plans. Staff need to feel that their contribution is valued and that the resulting PBS plan is a product of the knowledge and experience of both SBT and the staff member/team. The degree to which participants felt involved and listened to affected how they felt about SBT and the relationship they had with them. On the whole, where participants felt involved, their feelings towards SBT were more positive. The importance of involvement was emphasised by Paula (SC) who felt that the lack of involvement staff had with a recent PBS intervention had been key to its being unsuccessful: *"It's so frustrating sometimes when you think 'Well you don't know what's going on'"*.

Also, the more participants were involved, the more their knowledge and understanding of PBS was increased and the easier it was for them to implement the PBS plan, as Kelly (SRS) commented: *"I think because we were writing them, not that the nursing aids¹ didn't have any input, but because we were actually up here writing them it was probably easier for us to take on board than the NAs"*. It appears that this involvement promotes an ownership for staff that increases their confidence to work with PBS.

¹ 'Nursing aids' are nursing staff that are unqualified. Also referred to as 'nursing assistants' or 'NAs'

The level of involvement varied according to the staff member's role. Qualified participants, or participants who were key-workers for service users, were directly involved in developing the PBS plans. Participants who were unqualified or were not key-workers for service users and had less direct involvement in developing PBS plans found that their involvement was useful for them to be able to share their knowledge of being in direct contact with service users on a daily basis.

A key difference between SRS and social care should be noted here. Qualified staff in SRS have been supported by SBT to develop and write their own PBS plans with the aim that they will be able to take on this role without SBT support in the future. This is not the usual approach by SBT as it is normally SBT clinicians that write and develop PBS plans using input from the staff team supporting the service user.

Barbara (SRS) talked about the need to be persistent to be heard: *"We've had little problems with things and we might have said in one meeting and it hasn't gone in and we've kept going and [he/she] took it on board then"*.

Nadine (SRS) felt that she could be more directly involved with ongoing reviews and Multi-Disciplinary Team (MDT)² meetings, rather than going through the qualified staff: *"We are the ones working with them all the time. We're the ones that take them out and see the things that upset them. We are relating it to them then they are coming up and relating it to the MDT when I think we could be more involved in that"*.

²Muti-Disciplinary Team (MDT) meeting is a meeting that is held monthly and attended by a team of different disciplines, such as psychology, psychiatry, speech and language etc, along with key members of staff from the residential setting. The PBS plan is discussed at these meetings and changes may be agreed.

While Leanne (SC) felt that clinicians in SBT did involve staff on the whole, she also felt that sometimes she was not listened to: *“I think sometimes the SBT do tend to overlook what we are saying. We are with the service users twenty-four seven and I do think sometimes we are overlooked”*.

Derek (SC), a senior support worker, talked about the process of involving staff, and although he felt that all staff should be involved and meeting with SBT clinicians, he was unsure if this was happening: *“I think we’re doing the care plan for the new client, although I think I’ve met with them once in 6 months”*.

A3.3.2.2 Sub-category: Support for staff

All the participants talked about the support they received from SBT. This included talking about the relationship between themselves and the individual clinician(s), and the approach taken by clinicians and how this made them, and the staff team, feel towards SBT clinicians.

Where participants felt well supported in implementing PBS plans, feelings were positive towards SBT. Two participants in social care (in the same setting) felt less well supported and correspondingly felt negative towards SBT.

Sandra (SRS) felt that the support her staff team received from clinicians in SBT helped them with their confidence: *“Once we started working and having the support from outside, behavioural specialists, we did have the skills, we just didn’t know it”*. Sandra (SRS) also commented that she found it useful to check if they were along the right lines when developing their PBS plans, rather than struggle.

Leanne (SC) noted the importance of the SBT clinician being approachable: *“The one that I deal with [he/she] is always saying ‘Just give me a ring, I’ll come down’, things like that. [He/she] makes you feel at ease even though [he/she] knows that you’re not experienced, and [he/she] is just lovely and does make you feel you can approach [him/her] very much”.*

Paula (SC) talked more negatively about the relationship with SBT clinicians and did not feel that staff were well supported: *“These people come in and they tell us you can do this and this is what we’re going to do and we’re going to try this, this and this, and then they leave us to it and you’re like ‘Well hang on a minute, this isn’t going to work and this clearly isn’t working”.*

Derek (SC) revealed the feeling amongst staff about clinicians in SBT: *“Not a lot of faith is put in SBT by staff. They’re not held in a very good light. Clueless, words like that might be bandied around. I’m sure they mean well but they’re just not...”.*

A3.3.2.3 Sub-category: Feedback

This category captures elements regarding the importance of feedback and how it reflects or affects the relationship between staff and SBT. All participants felt comfortable giving feedback to SBT clinicians regarding the PBS plan, whether this was to state that they agreed, disagreed or were giving feedback on the progress of the implementation of the PBS plan. Barbara (SRS) felt that receiving positive feedback from clinicians made her feel more motivated, and Kelly (SRS) liked the fact that the staff team she worked with consistently received positive feedback.

Sandra (SRS) felt that the staff team she worked with should have had more recognition for their efforts to develop and implement PBS plans: *“We should have had a little bit more recognition of the work and effort that we put into it”.*

Derek (SC) talked about the lack of feedback from SBT clinicians: *"We've been doing positive monitoring³ for about three or four months now and I haven't seen any feedback from it. [Manager] might have done but I don't think staff have heard anything. It seems to have died a death"*. Further, Derek (SC) felt that feedback on a recent episode of a PBS plan being ineffective would have been useful from SBT clinicians: *"What makes it worse is that there was no feedback on what went wrong and what could be learnt from it, it's just swept under the carpet and never mentioned again. The staff team went through a lot of training and difficult situations with the client and it didn't work and there's no 'Oh we got it wrong', none of that"*.

A3.3.3 Category: Training

The category of training concerns whether or not participants felt that they had the skills and training needed to be able to implement PBS, and also what they remember of their training and how they felt about it, both at the time of the training and since. All participants felt that they had received sufficient training and had developed the skills to be able to implement PBS plans. Two participants who worked in SRS spoke about the length of time between completing one stage of their BTEC qualification and starting the next. Barbara (SRS) and Sandra (SRS) both felt that the gap had been too long and that refresher training in between would have been useful. Five participants spoke about how the size of the plans made it difficult to learn and remember them as Paula (SC) remarked: *"When I first arrived, I sat down here for a week reading. I didn't take any of it in!"*. It could also feel like an unmanageable task as Barbara (SRS) commented: *"You can't sit down every day and read your 50 or 60 pages of paperwork, you can't do it"*.

³ Positive Monitoring is a means of observing how a PBS plan is being implemented by individual members of staff. It can be carried out by either SBT clinicians or the organisation's managers or senior staff. It acts as a method for feeding back to staff their performance.

There are often a number of service users that have PBS plans in place, which made remembering them more difficult, as Paula (SC) described: *“When I started reading all these plans and then I’d have to come back to them because I’d be working with one of them and I’d be thinking ‘Oh which one is this now?’ and I’d have to come back and get the plan out and flick through it and ‘Ah yes, that’s right’. I did a lot of that, going back and forth to plans”*.

Some participants were aware of SBT making changes to the plans to condense them and make them more manageable, and some comments referred to this. Some participants described methods that helped them to retain the information in the plans, such as being tested or going back to the plans to check. Leanne (SC) talked about the monthly tests that her staff team are subjected to, and how useful this was to keep staff up to date and knowledgeable about the PBS plans.

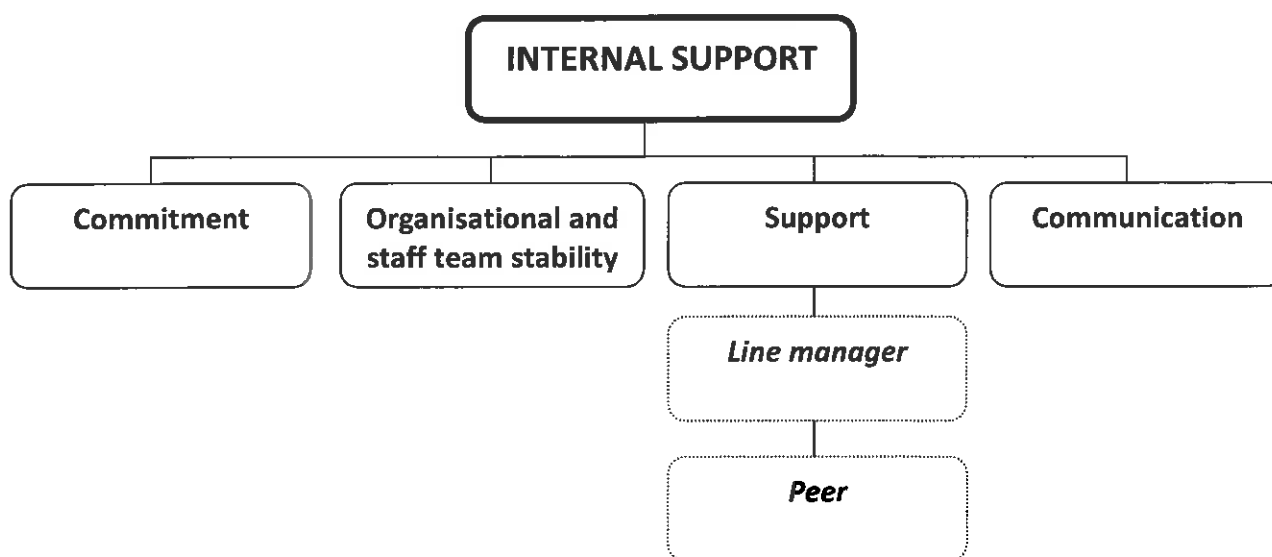
Kelly (SRS) commented in favour of condensing the plans: *“Very often if you’ve got a thick plan it’s putting people off from the get go and a lot of it is repetitive in all the other plans. I think the new ones are good. The old ones were very very detailed and lengthy”*.

Nadine (SRS) talked about the impact of being tested on her knowledge of PBS plans: *“When we had to come up here and answer questions on the plans, we’d all be nervous wrecks...you know them inside out but it was just being put on the spot...I think it was a good thing because it made you read the plans and keep updated on them and know all about things, like they’d say name three triggers. You know it every single day but it makes you think about it”*.

A3.4 CORE CONCEPT: INTERNAL SUPPORT

This concept refers to the organisational aspects that relate to individual staff members.

Figure 3.2 Diagrammatic representation of the core concept **INTERNAL SUPPORT**



A3.4.1 Category: Commitment

This refers to the organisation's commitment to delivering PBS within its service and how this is demonstrated. Seven out of the eight participants commented on how PBS is viewed and supported within their organisation. The researcher interpreted an organisation's commitment to delivering PBS through the methods of training they used. Differences were found between organisations as to how much emphasis they appeared to place upon training their staff in PBS.

Kelly (SRS) described how they were trained in PBS, *"I think originally when we first started writing them and what we did, we did teaching sessions on people's plans, each primary nurse would sit down with perhaps three members of staff during the handover, we'd go through the plan and we'd do that for a number of weeks. Sometimes the same people would be on and you'd go through it again with them. I think that was the only way of drumming it into us in the beginning"*.

Paula's (SC) comment reflected the difference between SRS and social care in their approach to training and their support of ongoing learning in PBS. Paula (SC) described the training of new staff in PBS plans as being *"sat down here and told to read"*. Paula (SC) also commented that 'shadowing' was the main form of training where she worked.

Mark (SC) provided insight from a deputy manager perspective in a social care setting that places importance on training staff in PBS: *"I pull the staff team out and I stay here and run the house...they're also tested on their knowledge"*.

Working according to a PBS model can represent a change to how staff members have worked previously. The level of commitment demonstrated by the organisation can affect the individual staff member's motivation to change their working practices. There is a difference between participants working in SRS and social care, in that the staff in SRS are required to work with PBS and gain relevant qualifications as part of their job. The extent to which this approach is advocated in social care varies. Staff in SRS commented on the impact of their new job requirements upon their motivation.

Barbara (SRS) commented that: *"It's part of the job, it's got to be done and that's it"*.

Sandra (SRS) said that her motivation for getting through the difficulties that she had with PBS was *"because we had to"*.

A3.4.2 Category: Organisational and staff team stability

This relates to the stability of the organisation and staff team to work with PBS. Staff shortages and turnover were described as a challenge with far-reaching implications, for example on the ability of staff to carry out activities detailed in service user's PBS plans.

Additional demands were placed on staff, and also there were the implications of the use of agency staff. Generally, more issues of shortages due to sickness and holidays were found in the Specialist Residential Services, and more issues of lack of staff due to high turnover, and use of agency staff, were found in social-care residential settings.

Sandra (SRS) described the impact of staff sickness on service user activities: *"If we've got one off sick and you need two staff to go with that one person, you can't leave one on the bungalow with the other four so then the activity gets cancelled"*. Sandra (SRS) also described the effect of staff shortages on the demands placed upon staff: *"You don't always find time to get on the computer and do what you're supposed to do. The paperwork is the first thing that goes"*.

Paula (SC) spoke of the effect of activities having to be cancelled on service users and staff: *"There are times due to staff shortages when that's not going to happen and we get blamed for it then. We get 'Why can't I go out?' because we're the ones that are here so we have to take all the flak. It's more stressful in a place like this with guys who like consistency and like to know what they're doing and like to go out every day and get upset when they can't"*. Paula (SC) provided insight into the effects of agency staff working with service users: *"It's very unsettling for the guys. They don't know the member of staff, the staff don't know them"*.

Derek (SC) also commented regarding agency staff: *"A lot of agency staff have no idea about PBS, and they probably never will because they may work here two to three months and not come again"*.

Mark (SC) referred to the effect of turnover of staff on the service users: *“Service users don’t like it. You get behaviours if you’ve got new staff coming back and forth, staff that are not here enough”*.

A3.4.3 Category: Support

This category refers to the support available for staff from within the organisation and can be broken down into sub-categories of **‘Line manager’** and **‘Peer’**.

A3.4.3.1 Sub-category: Line manager

Five out of the eight participants across both SRS and social care commented that they felt well-supported by their line manager. Being supported by their line manager appeared to help the participants to develop within their role, for example learning to develop and write PBS plans through receiving advice or feedback, but also feeling that they could approach their manager with other difficulties.

Barbara (SRS) spoke about the importance of having an approachable line manager and thus getting issues resolved: *“If we’ve got a problem with anything [manager] says her door is always open. So I’ll go and ask. I’d rather ask for help than look a fool, and in this job you can’t afford to make a mistake”*.

Nadine (SRS) felt supported enough to be able to talk about things that might have upset her: *“We’re always encouraged if there’s anything you want to say. We’ll have supervision if we’ve got anything we don’t like or something’s upset us”*.

Mark (SC) felt that the presence of management was important for staff to feel supported and that management understood the issues they faced: *“As a manager you have to be on the floor, work with these plans”*.

A3.4.3.2 Sub-category: Peer

Five out of the eight participants commented on the support they felt they received from the team within which they worked, and the importance of working as a team, particularly in order to promote consistency in the implementation of the PBS plan. Most of these participants were from SRS and all felt that they worked within a good staff team.

Barbara (SRS) talked about the familiarity amongst the staff team and how this helped them to support each other: *“You can tell when somebody’s having a bad day or have had a bad day before they come in and you say something and they bite your head off and I just brush it off and either shut up or walk out because you know people”*.

Kelly (SRS) reflected on the dynamics of the team where she worked, and how this helped to overcome inconsistency in implementing the PBS plan: *“I do think we’ve got a good bunch here. Us girls have got quite a good relationship with each other and will just quietly... no-one takes offence at people picking up on things, ‘Did you see what you did then?’. Nothing seriously, not giving someone a row just pinpointing, ‘You didn’t even realise you did that then’*”.

A3.4.4 Category: Communication

This encapsulates the importance of communication within an organisation, although some reference is made to communication between staff/organisation and SBT. Difficulties were noted in the communication of changes made to the PBS plan to the staff team, as Kelly

(SRS) commented: *“There have been things that have come up in the MDT and have gone into the plan and perhaps haven’t been communicated as well, and you’re finding out second hand off somebody”*. While participants could recall examples of where communication channels were ineffective, they were unable to give examples of how these could be improved. Sharing knowledge of the service user and also difficulties with the plan were discussed as key to developing an effective PBS plan. The implications of ineffective communication with regard to changes made to the PBS plan resulted in inconsistency amongst the staff team, and therefore a barrier to the effectiveness of the PBS plan. Nadine (SRS) had experienced this difficulty in communication: *“You might be doing something that was in the plan and something might have changed and you’d be ‘Well I haven’t been told’”*.

Mark (SC) described the channels for communication that had been set up: *“Each service user here has a core team that would be involved in any changes to the PBS plan. I expect them to talk to the other staff members around meetings, or on shift, when they know when their review is coming up to see if anyone can throw anything into the hat about how it can be improved”*.

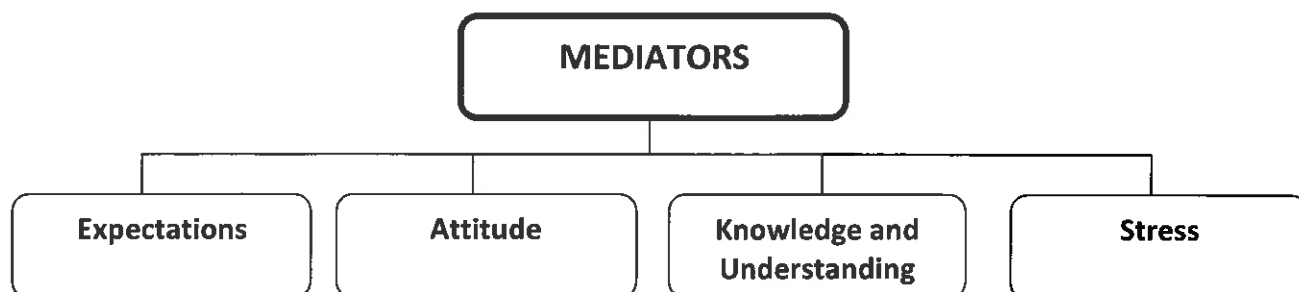
Nadine (SRS) spoke of the importance of communicating her knowledge of the service users to others: *“We’re the ones that take them out and see the things that upset them. So yes, bringing it back and discussing it”*.

Leanne (SC) described how useful she found meeting with clinicians from SBT on a monthly basis: *“They’re really good. I’m really enjoying these meetings every month. It’s nice that they’re listening”*.

A3.5 CORE CONCEPT: MEDIATORS

This core concept encapsulates the key intra-personal factors of staff members that affect the effectiveness of PBS plans and how they work with them.

Figure 3.3 Diagrammatic representation of the core concept **MEDIATORS**



A3.5.1 Category: Expectations

This category relates to the expectations or apprehension of staff about working in a PBS model, and how consistent these expectations were with the reality of working in a PBS model. This was discussed by a significant minority of participants who all worked in SRS.

Kelly (SRS) talked about the experience of having PBS introduced to the service: *"It was a bit daunting to start off with"*.

Barbara (SRS) reflected on how she felt when she started working in a PBS model, and how this changed over time: *"Oh god I said 'I can't stick this', you just didn't know what you were doing, but then you get it, and it didn't take long"*.

Sandra (SRS) spoke of negative feelings felt by her and the staff team when they learnt about the introduction of PBS to the service: *"At first it was resentful, it was 'Oh god here comes more paperwork, haven't we got enough to do?' It was better than what I thought it*

was going to be. Most of the staff here are old school, not that we're afraid of change, but we're old school so of course when this came in it was 'Oh god can we do this?' and it was a frightening thought. It slowly fell into place and it wasn't as difficult as what we thought it was going to be".

A3.5.2 Category: Attitude

This category captures elements of the interviews that refer to the participants' attitude towards PBS. All participants offered their opinion on PBS and all were positive towards the principles of PBS. There was an acceptance that sometimes the PBS plan may not be effective for one reason or another, but there seemed to be a consistency between the values of PBS and the values of the participants. Witnessing the benefits of PBS for service users appeared to have a positive effect on participants' attitudes towards PBS, as Nadine (SRS) commented: *"If we followed the plan and it wasn't working we'd think these plans are rubbish"* and Kelly (SRS) felt similarly: *"If I could see the benefits I would change in a second. If there are positives for changing, I can't see how people couldn't change".*

Mark (SC) emphasised the importance of staff attitude for implementing a PBS plan effectively: *"It's all about the staff, their approach, their psyche I suppose. If they're willing to embrace it and work with it it's one hundred times easier to implement it".*

Sandra (SRS) spoke about the change in her attitude towards PBS and what made the difference for her: *"You can see why and you can see how it's going to work so it's not a case any more of 'Oh god another piece of paperwork', OK initially it is but I think it was just a natural progression going from 'Oh I've got to do this', doing it, seeing it working, 'Oh well it wasn't so bad after all'. It was just a natural progression going from there to 'Oh it does work'".* However, she also reflected that sometimes things written in the PBS plan may not work in practice: *"I think it's a good idea but putting it into practice is the hard part. It's nice you've got everyone singing from the same hymn sheet for a change no matter where you*

go you've got the same principles in place⁴ but actually carrying those principles out is harder than it looks".

A3.5.3 Category: Knowledge and understanding

All participants were asked about their knowledge and understanding of working in a PBS model. Most participants talked about the key characteristics of PBS plans.

Kelly (SRS) felt that the preventative strategies were key to PBS plans. Kelly (SRS) also talked about the tailored nature of PBS plans: *"PBS plans are a care package to focus on primary preventions in quite a detailed and quite specialist in that I think they identify people's problems and are quite individualised plans. They're in-depth and with the aim of preventing rather than reacting to behaviours"*.

Nadine (SRS) talked about the person-centred nature of PBS, and also highlighted that it was about looking at staff behaviour as well as service user behaviour. Nadine (SRS) found that being consistent was particularly important because of the effects of inconsistency on service users: *"You've all got to be working the same. Like I say, consistent and...if they see us, well she deals with it that way, she deals with it that way, that's not fair on them. And when you're dealing with challenging behaviour, I think you've got to be the same because it's all too confusing for them"*.

Similarly, Paula (SC) felt that consistency was the most important factor when working with PBS plans. She also emphasised the focus on preventative strategies in managing challenging behaviour: *"It's helping them to live their lives without any, I don't know, hurdles*

⁴

Sandra is referring to PBS having been implemented across all settings in SRS

really, and helping them to be...keep them at baseline and not to get them agitated and to help them be happy”.

Nadine (SRS) reflected that having the reasoning behind some strategies used in PBS helped her to understand the PBS plans better: *“We might say ‘I don’t think that’s right’, but then it’s explained to us and we can see that it is right, just putting it all into perspective. And everyone sees things differently, so I might think something and someone explains it to me and you think ‘Oh they are right’”.*

A3.5.4 Category: Stress

The category of stress incorporates those elements that staff find difficult or stressful.

All the participants talked of situations and/or parts of their job that was a stressor to them, and most participants talked about the effect this had on them and how they felt. Stressors included other staff not following the PBS plan, as Barbara (SRS) stated: *“It’s so frustrating that somebody else is doing something different, and I’m thinking ‘You know you shouldn’t be doing that’, and it’s like banging your head against a brick wall”.*

Other stressors were demands of the job and competing demands, which could make reading and learning about the PBS plans more difficult, as found by Nadine (SRS): *“If we were nights they’d say we’ll leave this for you to have a look at. That’s the thing, you haven’t got time”*, and also Sandra (SRS): *“Time was the factor right across the bungalows. You were set a time of two weeks to get this done and more often it wasn’t”.*

Feeling negative about management could affect morale and act as a stressor, which Barbara (SRS) found difficult: *“It can be quite demeaning sometimes, when you feel you’re doing a good job and then there’s someone coming in and pushing the pace. It can be*

frustrating because perhaps you've just sat down. Some days, like today, it's hectic and we're trying to sort it all out and you're trying to write a report and then you've got somebody asking you to do something with somebody, and I'm thinking 'Let me out of here, I'm doing my job!'"

Characteristics of the service users were felt to be a stressor. Kelly (SRS) felt that the unpredictability of service users was a particular stressor: *"It can be stressful, yes, but I think that's because... it's just the complex people that we're looking after"*. Leanne (SC) felt that the complexity of the service users she supported was difficult: *"We have one gentleman with us who is really complex and his triggers are all over the place at the moment and I think just not knowing sometimes what is actually setting off the behaviour...I think that is the key thing. Some of them are so complex we'll never know what the triggers are for some of them"*.

On the whole it seemed that staff working in SRS had more demands placed upon them than staff in social care with regard to developing PBS plans, completing their BTEC qualification and also keeping up to date with producing monthly reports. A significant minority of participants commented that working according to a PBS plan had a beneficial effect on their stress levels through the reduction of challenging behaviours displayed by service users. Consistency amongst the staff team about how to prevent and manage these behaviours, i.e. knowing what to do, also contributes to lowered stress.

The potential effects of staff stress is that the PBS plan does not get implemented as Sandra (SRS) described: *"It's a case of 'Oh I forgot to do that'. We've been rushed off our feet and short-staffed and we've agreed without thinking"*.

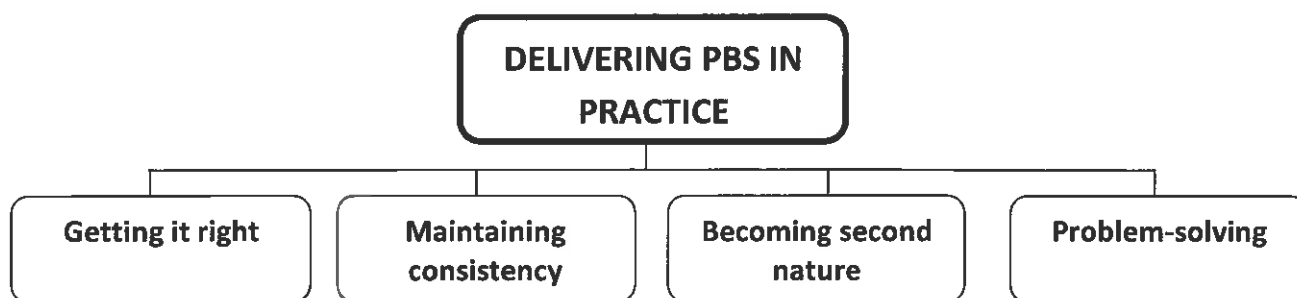
The lack of awareness of the impact of stress was spoken about by Barbara (SRS): *“On our BMF⁵ forms it says on there about post-incident support but everybody always ticks no because at the time you don’t feel you that you were that stressed but looking back.... With [service user] we had some horrendous incidents and I went home and thought ‘I can’t move my neck’, feeling really pent up and you’re realising why then”.*

Barbara (SRS) commented on her coping strategies for stress: *“You sound off against other people. We all bounce off one another here, so that’s a de-stressor. Have a moan about something and then I walk out there and think ‘I’m going to shut up now because it doesn’t get you anywhere’. Just have a moan and get it off your chest”.*

A3.6 CORE CONCEPT: DELIVERING PBS IN PRACTICE

This concept refers to the implementation stage of PBS plans.

Figure 3.4 Diagrammatic representation of the core concept **DELIVERING PBS IN PRACTICE**



⁵ BMF or Behaviour Monitoring Form is a form that is completed by staff following an incident of challenging behaviour. It includes what happened before and during the incident and the steps that staff took to deal with the incident. There is the option on these forms for staff to tick that they would like post-incident support.

A3.6.1 Category: Getting it right

This category refers to the initial stages of implementing a PBS plan, and how staff and SBT clinicians need to work together to ensure it is effective. Six out of eight participants talked about the need for making changes to the plans and the process of trial and error.

Barbara (SRS) talked about the tailoring of PBS plans, once staff had the knowledge and understanding to work flexibly with them: *“We tweaked everything and when we got to realising what we were using and how to use it, and then you’ve obviously got to tweak it to suit each individual”*.

Nadine (SRS) felt that trying strategies out was the only method for discovering whether a strategy for managing behaviour was going to be useful or not, and therefore involving people and trying out their ideas was beneficial for the development of effective plans. She reflected on the process: *“We had to go through that learning time, try this, that didn’t work. I think we had to go through that to get the plans we’ve got today. I think it was a lot of trial and error and trying things out but I think any team has to go through that period to get a good quality plan”*.

Sandra (SRS) talked about the process of getting to know a new service user, whilst implementing a PBS plan with them: *“We expected teething problems and we’ve had teething problems. I expect there will always be some problems, but hopefully not as big as when she first came”*. Sandra (SRS) also spoke about trying out community activities that were written into the PBS plan before knowing if they were appropriate or not: *“It was a barrier. Though there are lots of activities we could be doing we’ve got to look at our service users and their needs and capabilities and it’s not as easy as it looks on paper”*.

It appeared that on occasion there are differences of opinion between SBT clinicians and staff members about what will be effective in the PBS plan. Two participants spoke about trying out SBT clinician suggestions when staff have not agreed with it.

Leanne (SC) described the process of trial and error and the difficulties of dealing with a difference in opinion between staff and SBT: *"The PBS plan is effective now, but it wasn't when he first came here... I was explaining to [SBT clinician] we know these signs and we withdraw otherwise it's going to escalate. [SBT clinician] was saying 'Well go in there every five minutes and try and interact'. I didn't agree. If you go in too early it's going to escalate. We tried it and it did escalate"*.

Derek (SC) spoke about the problems of trying out PBS plans that staff felt would be ineffective at the request of SBT: *"There've been quite a few things that have gone wrong in their plans. They've implemented certain plans that have been big failures and it's hard to get back on track. Certain revolutionary quote plans that were obvious they weren't going to work and they never did work and it caused problems for the client and for staff"*.

A3.6.2 Category: Maintaining consistency

Consistency was discussed by staff as a key element to the implementation of PBS plans, and therefore any barriers to this would need to be overcome. Seven of the eight participants spoke on this issue and there were no differences to the approach taken between SRS and social care.

Some participants commented on how difficult it was to maintain consistency and also possible reasons for this, such as PBS representing a change to previous working practice. Sandra (SRS) commented on the experience of a change to her working practice: *"Oh yes I slip back, like put her socks on for her, but you shouldn't be doing. Yes it is hard when you've*

worked to a hotel model⁶ all your life". Kelly (SRS) felt: "I think it's hard to get out of that way of working if you've worked like that for so long", and Nadine (SRS) felt this was about a person's mindset: "Their mind might be set in one way and they're asked to do it a different way".

Most participants dealt with inconsistency by telling the staff member that they had done something that they should not have, as Paula (SC) described: *"They normally get pulled up by other staff. It does get noticed and it does get back and people do get pulled up over it and told to read the plan".* Sandra (SRS) finds promoting the rationale for the PBS plan helpful to maintain consistency: *"You have to remind them that it's for her benefit, not theirs".* Participants who worked in SRS felt particularly comfortable with pointing out where staff were not following the PBS plan, as it was accepted as necessary and they worked well together as a team, which Kelly (SRS) commented on: *"Each of us pick each other up ten times a shift. I don't think any of us takes things personally, we're so used to picking each other up".*

Leanne (SC) and Mark (SC) reflected on the reasons for inconsistency, which might be that everyone works differently, or that the staff member is tired and as Mark (SC) said, may be looking for the *"easy route"*. As a deputy manager, Mark (SC) described how he dealt with inconsistency: *"If somebody is not doing something right you can say 'Well I work to that plan and I do it that way, what makes you different, why do it that way?', and they have no answers".*

⁶ Hotel model refers to a method of working where staff support service users by doing things for them, rather than supporting service users to do things for themselves.

A3.6.3 Category: Becoming second nature

This category relates to staff working with PBS plans in such a way that the strategies and methods become automatic and habitual. Six out of eight participants talked about working automatically. A longer length of time working with the plans was a factor contributing to the practices becoming 'second nature', as Kelly (SRS) comments: *"We've been using them for so long, they're second nature now. Because we do things proactively, every single day we come here, it's become second nature. You do it without even realising you're doing it. It's part of your work, that's how you work and that's that"*. Working 'automatically' meant that staff did not have to think about what they were doing. Participants talked about this in a positive way, which helped them to be confident that they knew what they needed to do.

Derek (SC) found the automatic nature of working made it difficult to describe to the researcher what working in a PBS way meant: *"I suppose it's difficult to break down because we do it all the time. When you put it on paper, and ask people to explain, it's difficult. I find it difficult too, because I've been here too long, you just do what you do"*.

A3.6.4 Category: Problem-solving

The category of problem-solving encapsulates how individual staff members, the team and the organisation solves problems, such as dealing with staff shortages and low morale, ensuring planned activities can go ahead, coping with stressors and dealing with a PBS plan that is ineffective. Half of the participants spoke about how problems are dealt with.

Sandra (SRS) talked about the dedication of staff in ensuring that planned activities could go ahead, and their need to be flexible in this capacity: *"Staff will come in later, or they'll even come in earlier, most of the class activities start at 1 o'clock and we don't actually come on shift until ten past one but a lot of our staff will come in half past twelve to take them rather than have our morning staff stay on until 3 o'clock"*.

Barbara (SRS) also talked about dealing with low morale: *"I'll say to people on shift 'Oh thanks for that, you've been good today, you've had a good shift' or I'll say 'You're marvellous with the women'. It all helps doesn't it?"*.

As a resolution to previous problems, Paula (SC) felt that two meetings with SBT that that involved the whole staff team in the discussion of a new PBS plan were effective and gave staff the chance to comment and be included in decisions regarding the plan.

As a nursing assistant, Nadine (SRS) felt that she should be more involved in meetings about service users and the PBS plan: *"It would be nice to be more involved. Sometimes you feel that all the decisions are made up here and then we are not involved and we're the ones taking service users out and implementing the plan"*.

Sandra (SRS) felt that new staff should undertake their PBS qualification before being expected to write a PBS plan: *"I definitely think for anybody coming into the service now, I don't think they should be involved in developing PBS plans until they've done the BTEC⁷ because they will find it easier"*.

Paula (SC) felt that the PBS plan reviews could be more regular: *"I think it could be more regular because service users change all the time. They become more relaxed, unsettled... I think the reviews need to be more regular"*.

⁷

BTEC is the qualification that staff in SRS are expected to undertake

A3.7 SUMMARY OF INTERVIEW DATA

Following analysis of the interviews, four core concepts emerged. These were **EXTERNAL SUPPORT**, **INTERNAL SUPPORT**, **MEDIATORS** and **DELIVERING PBS IN PRACTICE**. Within these core concepts, key factors for the successful implementation of Positive Behavioural Support emerged, with the converse of these being barriers. All participants reflected on what they found helpful, including training and support, and on how they overcame barriers encountered.

B3.8 PART B - RESULTS OF THE FOCUS GROUP ANALYSIS

B3.8.1 Categorisation of data

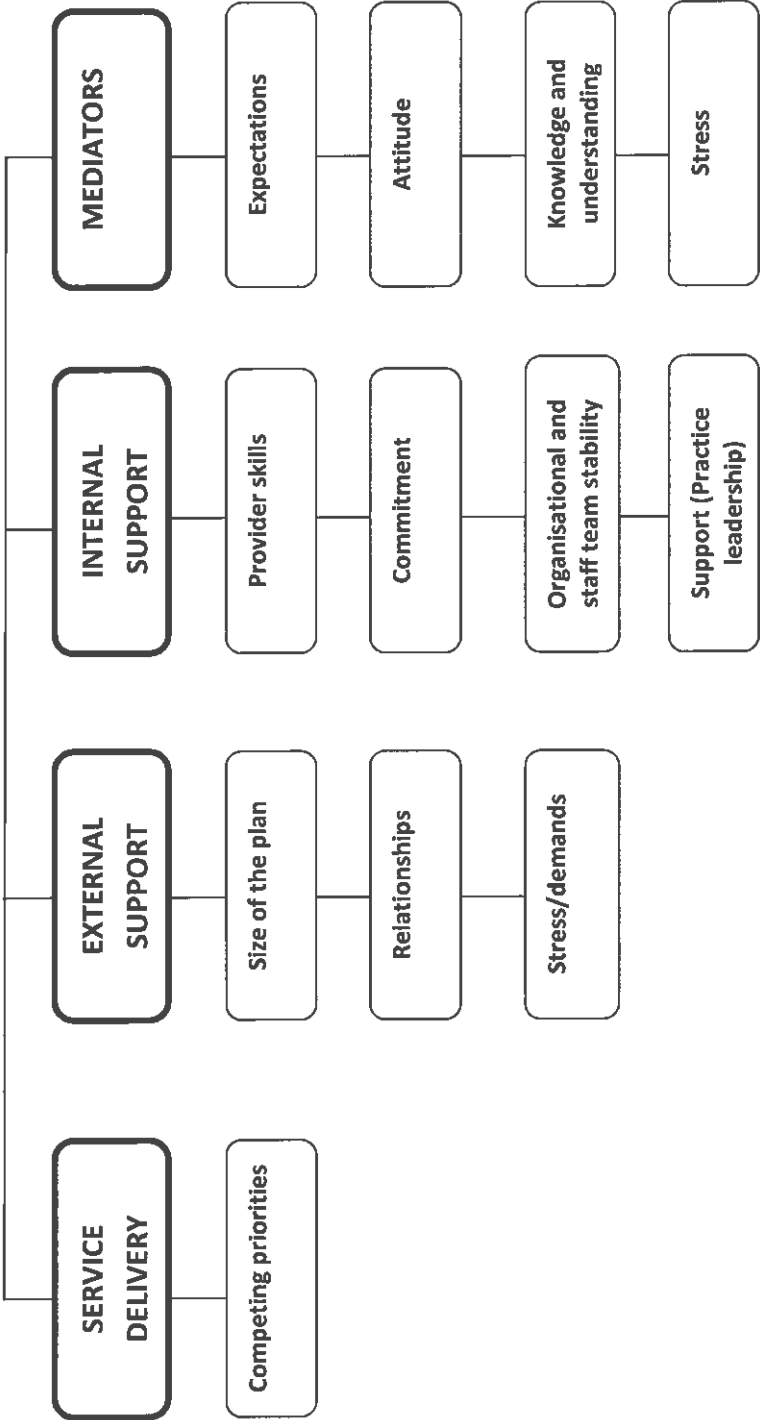
The focus group data was analysed and organised into **CORE CONCEPTS**, **Categories**, and **Sub-categories**.

B3.8.2 Overview of focus group results

The figure below shows the four **CORE CONCEPTS** and their component **Categories** representing the themes that emerged from the focus group with Specialist Behavioural Team clinicians about their perceptions of the factors that affect the successful implementation of Positive Behavioural Support. In comparison with the **CORE CONCEPTS** identified from the interview data, an additional **CORE CONCEPT** was identified (**SERVICE DELIVERY**). It is also of note that focus group participants did not discuss topics associated with **DELIVERING PBS IN PRACTICE** identified from the interview data. **EXTERNAL SUPPORT**, **INTERNAL SUPPORT** and **MEDIATORS** were **CORE CONCEPTS** identified from both the interview and focus group data.

This diagrammatic representation is not intended to be a flow diagram and any links between concepts will be given in Figure 3.11 (Page 109). **Sub-categories** are not shown on this diagram.

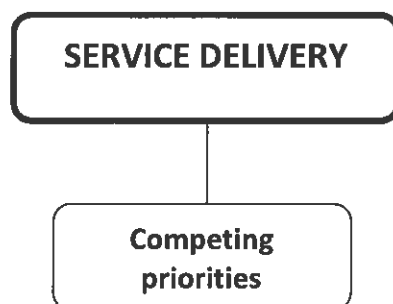
Figure 3.6 Diagrammatic representation of the emerging themes (key factors identified for the successful implementation of PBS plans) from the focus group



B3.9 CORE CONCEPT: SERVICE DELIVERY

Definition: This concept relates to aspects of service delivery that were discussed in the focus group.

Figure 3.7 Diagrammatic representation of the core concept **SERVICE DELIVERY**



B3.9.1 Category: Competing Priorities

This category refers to the influence of competing priorities of different services upon the SBT's ability to support staff in the successful implementation of PBS plans, and was not a factor identified by the direct-care staff interviews. This category covers a number of factors. It was discussed that barriers to implementing a PBS plan could be other systems not being in place, or a lack of multi-disciplinary professionals working collaboratively with clinicians in the SBT. Competing priorities also refers to the emphasis placed by multi-disciplinary professionals upon different aspects of an individual's care, for example financial implications. Teresa noted that *"The care management side is financially driven so priorities are different"*. There also appear to be issues with a mix of opinions amongst professionals involved with individuals with challenging behaviour about where the 'problem' lies. All participants in the focus group identified these factors as barriers, and which Teresa described as, *"a lack of joined-upness"*.

Teresa talked about SBT service values being difficult to uphold when other teams/professionals and the organisation do not adopt them: *"There's a real conflict where you feel you need to cover everything and that's a service value of our own I suppose about having comprehensive plans"*.

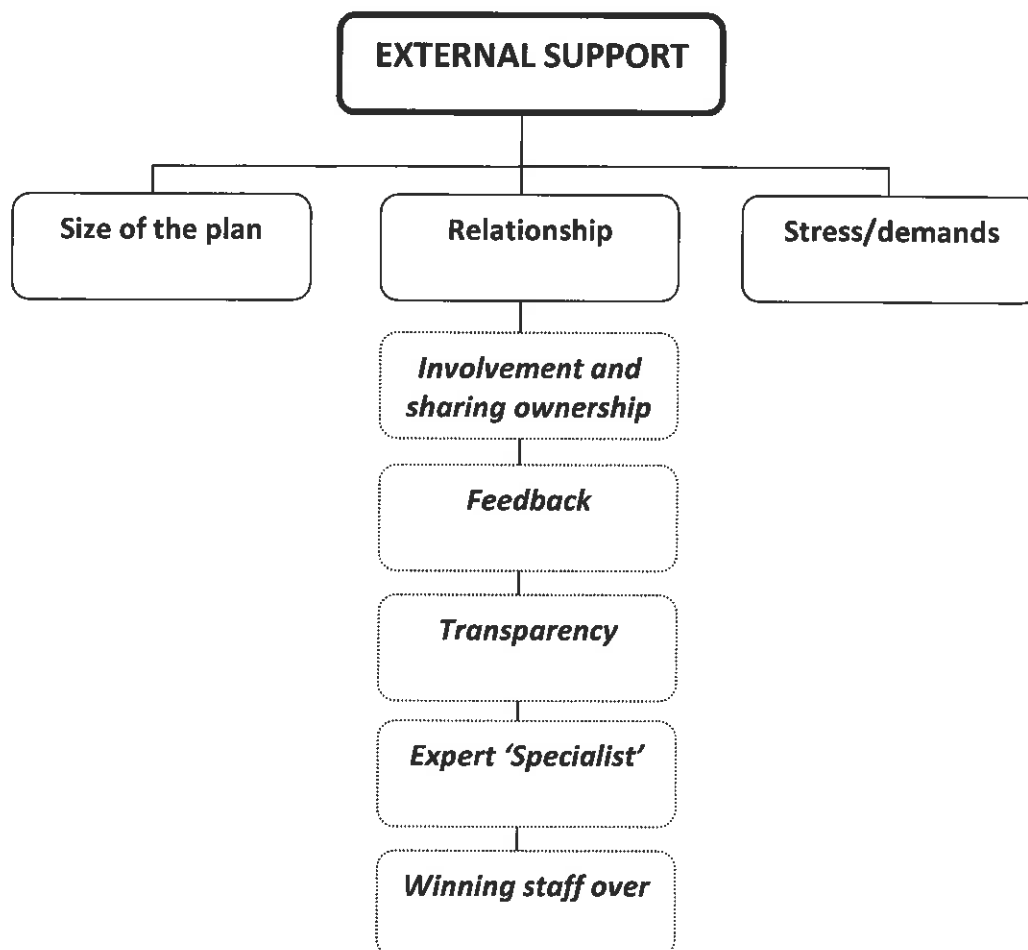
Karen felt that competing priorities was a major influence on the success of PBS plans: *“That’s a biggy for me, it’s the conflicting priorities. It’s our priorities, it’s the priorities of the people doing the hands-on care, the priorities of the managers, the priorities of the service the priorities of the care manager and everyone is pulling in slightly different directions”.*

Sally spoke about competing priorities when working with multi-disciplinary teams, the importance of offering direct-care staff a consistent message and the importance of ongoing support when the SBT withdraw: *“It’s about the MDT as well because if you haven’t got the MDT on board saying ‘Follow that plan’ and giving them the same message as us. Thinking about some of the care managers we work with they just disappear as soon as we come along and get involved. But it’s them that need to carry it on as soon as we discharge, it’s them that’s meant to be reviewing the plans, how reliable is that?”*

B3.10 CORE CONCEPT: EXTERNAL SUPPORT

Definition: This concept encompasses factors that relate to the approach of SBT and the impact of this.

Figure 3.8 Diagrammatic representation of the core concept **EXTERNAL SUPPORT** from the focus group



B3.10.1 Category: Size of the plan

This category covers a topic that was discussed during the interviews described in Part A that came under the category of **Training**. Here the focus group participants felt it a more significant factor contributing to the likelihood of a PBS plan being successfully implemented. There was consensus around the necessity for the plans to be readable and understood by direct-care staff. It was also agreed that the plans needed to be remembered by direct-care staff.

David felt that the PBS plans were currently *“too wordy, too complex”*. Helen described the SMOG ratings⁸ that they had completed on plans: *“You’ve got to have the goodness of fit and that means the plans are readable. We did recent SMOG ratings on plans...We’re expecting a bit too much for staff here...I think we need to take stock about how we structure plans, how we write them. Because a 40 page plan, and they’ve got six people in the house, it’s just not do-able”*.

As a solution, and as discussed as part of the interview data described in Part A, the SBT have already begun changing how they write plans, however these changes had only been made in SRS services.

B3.10.2 Category: Relationships

This category covers the relationship that SBT have with staff members that they are working with to develop and implement PBS plans. Sub-categories include ***Involvement and sharing ownership, Feedback, Transparency, Expert ‘Specialist’ and Winning staff over.***

B3.10.2.1 Sub-category: Involvement and sharing ownership

This category was also identified as a factor in the interviews with participants. Within the focus group this category was discussed as a key factor and specifically referred to the importance of all direct-care staff feeling involved and that they share ownership of the PBS plan with clinicians in the SBT.

David felt that it was important that direct-care staff felt that they had contributed towards the PBS plan, rather than it being solely developed by the clinician: *“Including staff in that*

⁸ SMOG stands for Simple Measure of Gobbledygook (Harry, 1969) and is a readability formula that estimates the years of education needed to completely understand a piece of writing

process so they feel ownership of the plans and they feel included in the design stage of the plan so they feel it's their plan rather than something I've given them. That definitely helps".

Helen emphasised that all staff needed to feel included and that it was important that SBT did what they could to meet this need: *"Big thing for me is that you've got to get all the staff. You've got to get round every person in a team so very often that's a stumbling block because you can't get all the staff out even if you do it three times. So we're quite prepared in our service to do it more than once, sometimes 3 or 4 times, we will train them on the same plan".*

For Teresa, the involvement process needs to begin from the outset, identifying and involving key staff members through the recognition that it may be unrealistic and unnecessary to include all staff during the early phases of SBT involvement: *"The key there is getting that key person involved in the assessment process, making sure the right people are involved with the assessment at the beginning because you're not going to get around the whole staff team...if you get to speak to the right people and get that first assessment correct and manage to feed that back to people and they agree with it at least what you're writing the plan on is going to be based on the right information and you've got a good starting point. That's a definite thing that helps".*

B3.10.2.2 Sub-category: Feedback

This was also a factor identified by direct-care staff who were interviewed. The focus group participants highlighted the methods they use for offering feedback to direct-care staff and also difficulties in how the feedback is handled by the organisation, for example passing on selected (negative) information, as Vera had found: *"There were lots of incidents of that where we're picking up on areas of bad practice that we needed to feedback. They were being addressed but all the positive stuff wasn't going back at all. It was a shame but it made me think we certainly need to look at how, when we first get involved with a case, how*

do we do that, how we set those rules with the manager or service manager whoever right at the start?". Practical suggestions for improving feedback channels included working more alongside staff, agreeing with managers how feedback is communicated to staff and writing to staff members when direct verbal contact was difficult.

David suggested that it was perhaps difficult for people to receive 'negative' feedback and reflected upon the difficulty this poses for clinicians in SBT: *"In social care or any staff group people don't want negative feedback even though you try and be positive about it. When you give feedback on whatever issue we identify, they don't like that...we try and give feedback in a nice way but even though we're trying to be nice about it, staff don't want to hear that. It's really hard"*.

It was also recognised that the process of interaction, that is the relationship built with direct-care staff, managers, and the organisation, was important. Helen referred to the more subtle uses of communication that help when offering feedback: *"It's how, it's process, it's interaction, it's communication. You'd choose the right moment, it's those softer skills we talk about how we would feed this back, to who, what words you use, how are we going to address this issue"*.

When discussing problems or issues with direct-care staff, Helen felt it useful to share ownership of the problem or issue: *"I think the way you address it, you share the ownership of it even though it wasn't our issue, and it was clearly case management, we always say I don't think we are going to get to where we want to be if these things don't get done now, how can we make sure...using all those shared words so the person doesn't feel you're saying what she is going to do"*.

B3.10.2.3 Sub-category: Transparency

This sub-category reflects discussions in the focus group regarding the importance of open and honest communication. This includes the importance of having others know what the SBT does, but also requiring that direct-care staff be honest with SBT clinicians.

Teresa reflected that perhaps SBT clinicians needed to be more transparent about the processes they use with direct-care staff and not just managers: *"Maybe it's not always properly put across what our roles are and how people work together with staff teams. It might be in the beginning with the manager but maybe the message might not filter down about how we do things. Because I doubt many people would know about case lead meetings for example where we bring all our information together. Everyone who is doing every bit of an assessment would come together, which would probably give people a bit more confidence if they knew that the person they saw all the time was meeting with people and sharing everything regularly and doing emails and contacts"*.

Helen felt it important to be transparent about how people felt about SBT clinicians working with them: *"What we've found useful in those times where we feel we're not wanted in a particular setting is just about being transparent about what things we're picking up on and meet with the senior managers about it, lay cards on the table, 'Are we wanted here? If not what can we do? What do you not want us to do?' It's just about transparency rather than fudging about the issues and then just walking away and no-one's been helped so I'm getting to be much more of a fan of just saying it"*.

David felt that the transparency needed to come from direct-care staff, as well as SBT clinicians: *"It's down to the relationship and honesty. If you can get that honesty back...staff are saying to you what they think you want to hear, you don't know, you assume you're doing ok but you can never assume in this job and then you wonder why things don't get implemented and staff don't agree with it"*. He described how he tries to foster an honest

relationship: *"We acknowledge it's difficult 'This is what we can do to address it. Do you agree?' Have some honest discussions really and being realistic".*

Sally believed that an indicator of honesty was if direct-care staff were approaching SBT clinicians about difficulties with the PBS plan: *"They don't want to show you that that's not working there because then you'll know they're not implementing your plans so that communication is them coming to you for stuff, not always having to go in and constantly interview them and try and drag things out".*

B3.10.2.4 Sub-category: Expert 'Specialist'

This sub-category was discussed during the focus group with reference to how clinicians in the SBT are perceived by direct-care staff and other services. It was felt that having a perception that SBT clinicians are 'experts' may act as a barrier to engaging and building a relationship with staff. Good practice for SBT clinicians was discussed as the need to build trust with staff that they wish to work collaboratively with, rather than tell staff what to do.

David felt that developing a good relationship with the staff team was a priority and described how he went about building this relationship to work collaboratively: *"I think a relationship with the staff team is so important ...Ok let's work together. I've got some knowledge and some experience, you know the service user, how can I help you?' It's attitudes and relationships, it's so important and it's not always easy".*

Karen felt that the expectation of 'expert' was a barrier to the development of a collaborative relationship despite people asking SBT for their support and input: *"People refer to us because they're having difficulties so that's why we get a referral in the first place. So it's almost like 'Oh the experts are going to come in now and tell us where we're*

going wrong' and that's the attitude I've had when I've worked with some staff teams when I've first gone in. So it's a barrier before you even start".

Teresa felt there could be somewhat of a contradiction between being seen to be 'like' direct-care staff, i.e. having an understanding of the issues because of a background in similar work, and needing to be an 'expert' who has the solutions for staff: *"There's a tension there then isn't there between the staff teams valuing experience and knowledge in the SBT and not taking up that expert position. I think that's a tension".*

B3.10.2.5 Sub-category: Winning staff over

As identified from the interviews, direct-care staff can have negativity towards clinicians coming to support them with service users with challenging behaviour. This was also recognised by participants in the focus group as a factor that affects the success of PBS plans. Therefore focus group participants discussed 'winning staff over' as an important factor that affects the success of PBS plans. Some of the discussion concerned clinician credibility from direct-care staff's perspective. It appeared that clinician's revealing a background in hands-on roles and working alongside direct-care staff, or at least being present, increased a clinician's credibility from a staff perspective, as Karen found: *"One of the first things I do when I introduce myself to a staff team is I give them a little bit about my background so they understand I come from a long history of working with people with challenging behaviour from the ground floor upwards. Yes so I've not only got the theoretical side of it but I've got the hands-on. And yes I've had the throw-away comments 'Oh so you're going to come in and you're going to change her pad for her are you when she's being challenging and aggressive?' And I say 'Yes, that's what I'll do', and I did it for 4 weeks every morning. I was there on the dot and the whole staff attitude changed".*

It was also felt that this work was an additional layer that would be necessary to the ultimate success of working with staff to develop an effective PBS plan for service users with

challenging behaviour, as Helen found: *“Working with challenging behaviour is difficult, PBS is difficult but I think we start at the bottom, constantly facing an uphill battle with those things that are already difficult”*.

Karen emphasised the importance of changing the negative attitudes of direct-care staff: *“I spend more of my time and effort working with the team members who are very anti you coming in. They’re the ones you get involved from the word go to get on board because others will come on board with them as well”*.

Sally reflected upon the effect of this need to ‘win staff over’ on SBT clinicians, especially when feeling that direct-care staff are resistant to their involvement: *“We’ve pushed it and gone in there, changed things around a bit and the staff team have been really good with us. But it’s us battling with those feelings ‘I’m not working with this. It’s not going anywhere”*.

B3.10.3 Category: Stress/demands

While ‘Stress’ was identified as a factor during the interviews described in Part A, the stress was related to the stress of direct-care staff. Here, the stress relates to the clinicians working in SBT. Focus group participants discussed the demands on them, such as high expectations that the team and service sets itself, as Sally points out: *“That expectation to be at the top”*, and having to fit into other services, as well as being an extremely busy service with an expanding role. This also involved some of the discussion described above in ‘Competing Priorities’.

It was found that the stress and demands of the role can affect how well clinicians can deliver best practice, or things that would be ‘ideal’. Vera and Sally both commented that they were not able to be present in the settings as much as they would like or needed to be,

and David reflected this was due to a lack of time. Helen felt that she would like to be present in the settings a lot more.

David considered that an effective method of coping with the stressors of the job was to recognise constraints, and work as well as possible within them. He also felt that having more time might allow him to pre-empt barriers: *"We'll go in there and do the best we can with what we've got and what constraints we're working with...I think sometimes, in the course of my career, if I've got more time and I'm more aware then I can try to prevent problems but sometimes if I've got two or three new referrals or a number of deadlines I haven't got the luxury of time"*.

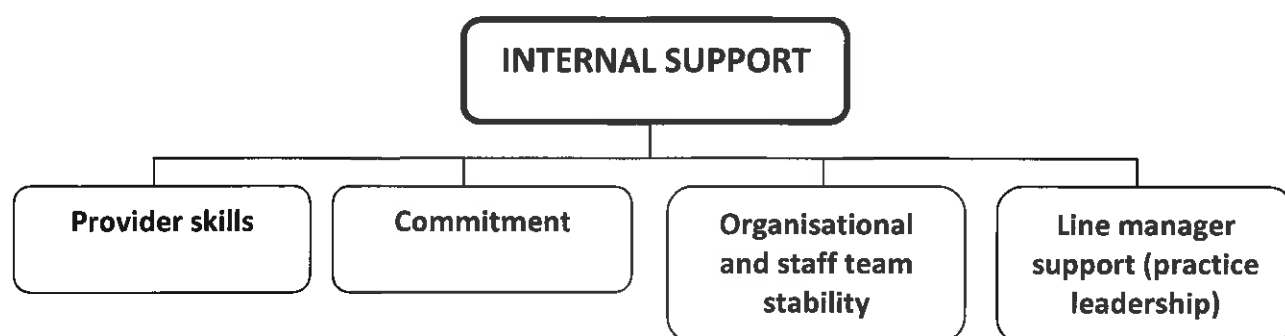
The SBT support structures that helped staff cope with the stress and demands of the role were described. Helen felt that working in the same model, and in small teams, helped to bond the team and reduce stress: *"I think what makes us quite different is we're working to the same model. We're all doing the same kind of things. We all believe in it...Even though we're fast-paced and competing demands service, it's less stressful in some ways because we're in the same boat and we can sound off...We do work in small teams and I think that makes us more resilient"*.

Teresa commented that the support structures in SBT were essential for clinicians to be able to work effectively: *"Everyone does have separate management and clinical supervision and that is unheard of. Other people might say that's a luxury and what we would feel is that it's our structure that hopefully means the rest of it works more effectively because if you didn't have that you would be struggling with things and not having anywhere to take things"*.

B3.11 CORE CONCEPT: INTERNAL SUPPORT

This core concept refers to all aspects of the organisation within which the direct-care staff are working.

Figure 3.9 Diagrammatic representation of the core concept **INTERNAL SUPPORT** from the focus group



B3.11.1 Category: Provider skills

This category refers to the focus group identifying the need to train providers in the skills needed to eventually implement PBS with minimal support from the Specialist Behavioural Team. This was identified as a potential solution to some of the issues identified with working with staff teams and organisations by participants during interviews and the focus group. These issues were identified at the organisational level and included organisation stability, organisation commitment and line manager support, with also some reference to the competing priorities identified by the focus group and discussed above.

Sally commented that increasing the PBS skills in provider organisations would mean clinicians in SBT would be able to spend less time training new staff in the basics of PBS in organisations where turnover of staff is high. This would give SBT clinicians more time to spend in individual settings, which was a factor identified by interview participants as an important factor in the success of PBS plans: *“It’s almost like doing that stuff will give us*

more time to develop stuff that will mean we're more with the complex cases that we're meant to be with rather than dipping in and doing more of the stuff that we want to be doing like being in the setting more often".

Having discussed the barriers faced by clinicians in SBT in supporting staff to successfully implement PBS plans, Helen felt that the best way of tackling difficulties was to work at the level of influencing organisations to embrace PBS: *"I think it's what we're doing in the SPT⁹, which is more developmental and strategic work with the health and local authority and the voluntary sector. It's the providers which we're actually working with at the strategic level on how to work with challenging behaviour so there's that wider and broader work that is happening now and I think that will start to shift things because what we're doing is getting providers and all health people on board so we're all working to the same model".*

B3.11.2 Category: Commitment

This category was also identified as a factor during the interviews as described in Part A. During the focus group, the commitment of an organisation was judged by how much they engaged with processes and interventions implemented by SBT. This category seemed to be crucial to the success of any SBT intervention and therefore had direct implications for the successful implementation of PBS plans. Focus group participants appeared to express frustration towards the clash of priorities between SBT and organisations to which they provide input.

Helen had previously discussed the delivery of training several times on the same PBS plan to ensure that all direct-care staff felt involved. However, this relied on the commitment of the organisation to release staff: *"You've got to have the agreement of the provider.*

⁹ SPT, or Special Projects Team, is a service development team. Some clinicians from SBT are involved in service development projects with the Team.

Obviously in our SRS services, we've got a bit more control over that but getting around all the staff is a problem and having the manager present for all of them".

Teresa commented on priorities of the organisation within which direct-care staff and the managers need to work. These priorities may compete with what is required for the successful implementation of a PBS plan: *"If the organisation is putting more responsibility on paperwork and systems and not allowing hands on hours for the manager for example, then no matter what the manager thinks they're not going to have that face-to-face time with staff to get across the importance of the plan".* Helen followed this with the comment that the *"whole infrastructure has to be right".*

Helen also felt that being accepted by the provider was crucial to any input SBT clinicians could offer direct-care staff: *"It feels that sometimes we just can't get in there. We can't get absorbed into that provider. Once we can, it's brilliant".*

B3.11.3 Category: Organisational and staff team stability

This category was also identified during the interviews described in Part A. This was described in the focus group as important for maintaining the implementation and consistency of a PBS plan. This also included discussion around the turnover of staff, but also the 'right staff' being employed in organisations.

David said that his *"biggest gripe"* was staff turnover. David described a situation that led to a PBS plan no longer being implemented: *"I worked with somebody and this person was doing ok. I discharged them and I think a manager left and nearly all the staff. I was asked to go back in and have a consultation...When I met with the new staff team, the new manager, and asked all these questions, I mentioned the old plan and 'Oh yeah I think I've heard of the*

old plan, it's been filed away'. When I left it appeared to be working quite well, when the manager and staff left it had been filed away and forgotten, which is a real danger".

Karen commented that organisations will sometimes “take anybody” when recruiting and empathised with direct-care staff who may leave the job or not be committed to maintaining the PBS plan: *“It's so difficult when you're paying them basic minimum wage and expecting them to put up with real significant challenges, work 24 hour shifts, sleep-ins, wake-ins. So when you work with that day in day out, which we all know because we've all worked in the hands- on end of things, some days you just want what's easiest”.*

David specified the commitment of direct-care staff towards their job as a factor that affected the successful implementation of PBS plans: *“If you get a staff member who is very committed, they're going to follow that plan, if they're not committed they'll do their own thing”.*

Karen felt that the resilience of direct-care staff was an area that was often over-looked: *“I think it's very important to build up staff resilience in that staff team...for their resilience to be able to cope so you don't get the staff turnovers, the burnout”.*

B3.11.4 Category: Line manager support (practice leadership)

This category was identified as a factor in the interview data described in Part A. However the focus group also discussed the qualities of leadership needed by managers, as well as the support they offer to work in a PBS model as a crucial factor in the successful implementation of a PBS plan by direct-care staff. Practice leadership was felt by Teresa to be *“the linchpin for everything else”*. It was also felt that the manager needed not only to be supportive of a PBS model, but also to embrace working with SBT clinicians and to support the direct-care staff to also work collaboratively with SBT.

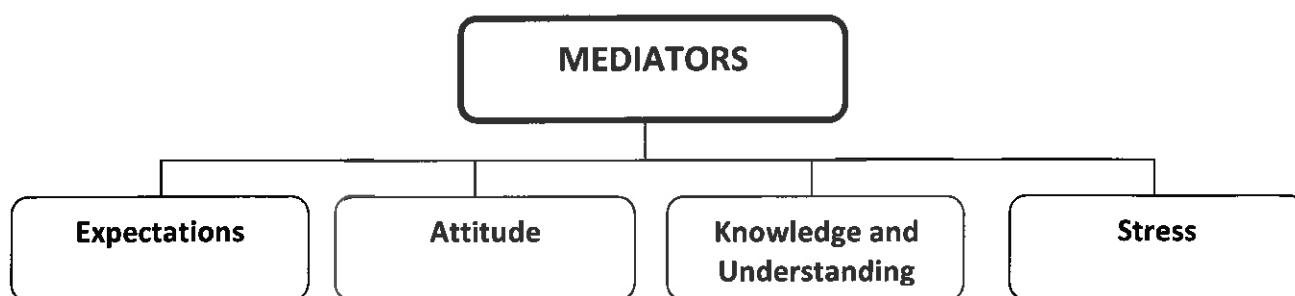
Helen highlighted practice leadership as a key factor in the successful implementation of PBS plans: *“The key process for me, what helps, is having the manager managing that staff team and leading that staff team, monitoring that PBS plan, the practice leadership. The main thing to work with is the managerial layer and when that’s not working as it should no matter how much of the other variables that you try to impact on I think you’ll still have a problem”*.

David felt it crucially important to have a manager who was a *“motivator to push this change to follow PBS plans”*. David had found it difficult working with managers who did not address issues that he had raised, which impacted upon the successful implementation of the PBS plan: *“I did a plan review recently and they were very committed staff and I had positive feedback from them, but there were some colleagues working with them who don’t follow the plan and they agree with the plan, they were happy with the plans and it’s in the service user’s best interests, but you brought it to the attention of the manager and the manager is not addressing that”*.

B3.12 CORE CONCEPT: MEDIATORS

This core concept encapsulates the key intra-personal factors of staff members that affect the effectiveness of PBS plans and how they work with them.

Figure 3.10 Diagrammatic representation of the core concept **MEDIATORS** from the focus group



B3.12.1 Category: Expectations

This category was also identified as a factor in the interview data described in Part A. The focus group discussed how direct-care staff expectations of PBS may not be met, and this can have different outcomes dependent upon the expectation. Where the expectation is negative, staff may find that this is not met, and where the expectation is that PBS will be an all round solution, this also may not be met. Where expectations are overly positive as to what PBS will be able to achieve, this may impact negatively upon direct-care staff attitude. The unique input of SBT was also discussed and how this may be misunderstood from the outset of involvement.

Sally considered there to be a difference between SRS and social care settings where it had been identified from the interviews that direct-care staff in SRS had some apprehension about getting involved in PBS: *"I think the apprehension is them getting involved in writing it, rather than it being delivered at them. So they're happier doing it, happy in the theory, it was just 'Oh god I've got to write it'".*

David described having worked with families who had high expectations of what PBS could achieve, which can also be relevant to working with direct-care staff: *"I think sometimes PBS is seen as a magic answer that will solve all their problems and when we get involved they could have false expectations. I worked with two families recently and on both occasions the families thought it would be the answer to everything when really I can design the plan, make it simple for them and help them to implement the plan but it is down to them really".*

Helen reflected on the possibility that people referring to SBT may not understand the nature of intervention and input to be expected: *"I sometimes wonder when people are referred to us, the service doesn't know exactly what they're going to be getting. It is quite unique what we offer, we have the resources to invest a lot more, the model is different. I think maybe people aren't quite ready for it".*

B3.12.2 Category: Attitude

This category was also discussed as a factor described in the interview data in Part A. The focus group identified that the attitude of direct-care staff was an important factor, and specifically the degree to which they felt positive about PBS. A more positive attitude towards PBS was felt to increase the likelihood that PBS plans would be implemented successfully, as demonstrated by the comment from David: *"If you can get staff on board with their attitude, you're half way there. If you don't then there are lots of problems"*. David considered some of the factors that may be useful in fostering a positive attitude towards PBS: *"I suppose if staff actually feel it's going to help them as well, then they're more likely to be on board and follow the plans"*.

While it was felt that a certain amount of training could be used to increase direct-care staff skills and knowledge in PBS, the focus group participants felt it more difficult to change negative attitudes believing that they were due to an individual's value base. This linked with the discussion regarding 'the right staff' discussed above, and therefore there was a feeling that this was a barrier that was very difficult to overcome, as Helen comments: *"Trying to get the staff on board sometimes we're not responsible. Some of the things that are required for staff to be different aren't down to us. We could try and help but the responsibility lies with the organisation or the provider and it just wouldn't be our role because we wouldn't be credible in that role"*.

Teresa considered which factors about PBS may be contributing to the difficulties of increasing positive attitudes towards PBS: *"The carers have got to recognise the plan is about them doing something different, changing what they do and not changing the person. I think that bit is really difficult for people. It comes into attitude and understanding again"*.

B3.12.3 Category: Knowledge and understanding

This was also a category identified during the interviews described in Part A. The focus group discussed the importance of direct-care staff knowledge and understanding, and their role as SBT clinicians to work to increase knowledge and understanding of PBS in direct-care staff. In particular, direct-care staff understanding of challenging behaviour and its' causes was felt to be crucial to the ability to develop an understanding of PBS principles, as Vera commented: *"It's this thing that people want service users to have consequences to their behaviour and PBS isn't about that and it's that that's the biggest...They think they're being manipulative, or they know what they're doing. I think it goes back to attribution theory¹⁰, feeling the person has control and don't take any responsibility for the impact they can have".* Helen felt that *"PBS is a really difficult concept for staff to understand"*.

It was also discussed that there were likely to be differences between staff in SRS services and social care services in their knowledge and understanding due to the widespread and intensive training that had been offered and undertaken within SRS services. Teresa wondered whether direct-care staff fully understood all the processes involved with PBS: *"If you asked a member of staff in SRS and social care that we've been involved with for a while what PBS is, I'm not sure how much you would get back on that. I think they'd know what a PBS plan was but perhaps not that the positive monitoring, periodic service reviews¹¹ and things like that all fitted under the PBS heading. It's quite complex really to understand from beginning to end"*.

¹⁰ Vera is referring to attribution theory, which in this context refers to people believing that the causes of an individual's behaviour is internal to that person and therefore other people have no control over it. This is described further in Chapter 1, page 22.

¹¹ Periodic service reviews are regular reviews to check the PBS plan is being implemented appropriately and that systems are in place to support this.

B3.12.4 Category: Stress

Again, this category was identified as a factor during the interviews described in Part A. The focus group felt that this was important, however stress was also felt to have multiple influences and therefore had multiple solutions. This was discussed to a lesser extent than direct-care staff attitude.

Teresa highlighted staff stress as a factor for the focus group to consider: *"We haven't talked at all about stress and emotions. We keep saying about attitudes and values. Just something to put on the table really that ok you can raise and provide some general support around stress but it's affected by workload, job satisfaction, job clarity, pay all sorts of things that people are faced with but I do think emotional reactions to the work and to the service users is important because support is quite key"*.

Teresa felt that it was the responsibility of the management to deal with factors contributing to stress, however she also felt that some of the processes that are implemented as part of PBS should reduce stress levels: *"All the things that we put in place to try to help get plans implemented effectively include systems for reducing stress and increasing confidence and the competency. All those things are there to try and make lives easier"*.

Vera commented that, with regard to emotional reactions to challenging behaviour, SBT do provide the opportunity for direct-care staff to seek support, but this is often not taken up: *"Post-incident is on our PBS plans, but if you asked staff 'Do you get post-incident support?' they very rarely do. Also when you offer organisations post-incident support they say 'No we've already done that'"*. David felt this to be a *"fear of the blame culture"* and Helen believed that *"if the culture has already been set it's very hard to shift it"*.

B3.13 SUMMARY OF FOCUS GROUP DATA

Following analysis of the focus group, four core concepts emerged. These were **SERVICE DELIVERY**, **EXTERNAL SUPPORT**, **INTERNAL SUPPORT** and **MEDIATORS**. Likewise with the interview data, within these core concepts, key factors for the successful implementation of Positive Behavioural Support emerged, with the converse of these being barriers. All focus group participants reflected upon what they found helpful, (including the focusing of energy at a strategic level), what they found difficult, (including working with staff and organisations that appeared resistant to their input), and also how they overcame barriers encountered. This involved the development of good support structures within the Specialist Behavioural Team and working to develop good relationships with staff teams and organisations.

3.14 GROUNDED THEORY

The Grounded Theory is presented in Figure 3.11 on page 109. The **EXTERNAL SUPPORT** (SBT) and **INTERNAL SUPPORT** (Organisation) need to be optimum to have a positive influence over the **MEDIATORS**. The **INTERNAL SUPPORT** influences the **MEDIATORS** because the **MEDIATORS** operate within it. However the **EXTERNAL SUPPORT** influences by working *with* the **MEDIATORS** but *via* the **INTERNAL SUPPORT**. These influences are all within the wider context of **SERVICE DELIVERY**, which affects the **EXTERNAL SUPPORT**, and in turn the **EXTERNAL SUPPORT** attempts to influence **SERVICE DELIVERY** to optimise the context for PBS implementation. If any of the **EXTERNAL SUPPORT** factors or **INTERNAL SUPPORT** factors are lacking, then these can act as barriers and the positive influence over **MEDIATORS** is weakened. There is then a cyclical relationship between **MEDIATORS** and **DELIVERY OF PBS IN PRACTICE**, as the more that **MEDIATORS** deliver and implement PBS, the more that their attitude is positive towards PBS through seeing its effectiveness. Thus their knowledge and understanding is increased, their negative expectations are seen to be unfounded and potentially their stress levels are reduced. The cyclical relationship between **MEDIATORS** and **DELIVERY OF PBS** can also be a negative one, so that where PBS plans are ineffective, the more negative the attitude towards PBS, their knowledge and understanding

is not increased and their negative expectations are confirmed. When **MEDIATOR** factors are optimum, the **DELIVERY OF PBS** is more likely to be successful. When all these factors come together, the Goodness of Fit is high and it is more probable that good outcomes will be achieved for service users. The influences can be seen to be so diverse however, that it might be expected that the probability of achieving such Goodness of Fit is low.

Direct relationships are also apparent:

- 1) The **SERVICE DELIVERY Competing Demands** has an influence over **EXTERNAL SUPPORT Stress/Demands** (1a), which has a knock-on effect of affecting **EXTERNAL SUPPORT Knowing the Service User** (1b).
- 2) The **EXTERNAL SUPPORT Relationship** factors (i.e. *Transparency, Expert 'specialist', Winning Staff Over, Support, Involvement and Sharing Ownership and Feedback*) and **INTERNAL SUPPORT** factors (i.e. *Line Manager and Peer*) appear to have a direct relationship upon staff **Knowledge and Understanding** (2a). A tentative relationship is put forward by the researcher between the same factors and staff **Attitude** (2b).
- 3) A further influence on direct-care staff attitude is that of **INTERNAL SUPPORT Commitment**.
- 4) A direct relationship is also apparent when **INTERNAL SUPPORT Stability** affects **MEDIATORS Stress**. Both these factors affect **DELIVERY OF PBS Maintaining Consistency**.
- 5) **INTERNAL SUPPORT Communication** also affects **DELIVERY OF PBS Maintaining Consistency**.

The diagram in Figure 3.11 (page 109) represents the proposed relationships between the factors influencing the successful implementation of Positive Behavioural Support.

Green text shows the agreement between the focus group and interview participants.

Pink text shows the core concepts and categories identified by the interview participants only.

Blue text shows the core concepts and categories identified by the focus group only.

Chapter 4

DISCUSSION

4.1 OVERVIEW

This final chapter will summarise the study's findings and review the key issues identified within the context of the existing literature. Implications for clinical practice and service provision will also be discussed. Methodological strengths and limitations will be outlined. Finally recommendations for future research are proposed and overall conclusions are drawn from the study.

4.2 REVIEW OF RESULTS IN RELATION TO EXISTING LITERATURE

The study aimed to develop an understanding of the views and experiences of direct-care staff and Specialist Behavioural Team clinicians working to implement Positive Behavioural Support with people with learning disabilities and challenging behaviour. From this information key elements needed for the successful implementation of PBS could then be explored. Following the data analysis of eight interview transcripts and a focus group of six participants, five core concepts emerged. These core concepts were 'Service Delivery', 'External Support', 'Internal Support', 'Mediators', 'Delivery of PBS'. The resulting grounded theory represents the influences that emerged through analysis upon the goodness of fit of PBS interventions. This section will summarise the main themes from the results in relation to existing literature.

4.2.1 Necessity and sufficiency of influences on goodness of fit

The grounded theory outlined the key factors that influenced the goodness of fit of PBS interventions. The issue to be discussed here relates to the question of whether some key factors that emerged from the data are more 'key' than others, or whether all factors are necessary but none sufficient. On closer examination of the inter-dependency of factors in the grounded theory, a small number of crucial factors emerge as having wider-reaching influences both on other factors and the overall goodness of fit of PBS interventions. It is hypothesised that these are: relationships, attitude, and commitment of the organisation. The inter-dependent relationships between these factors are described below and represent the rationale for their increased power and influence over other factors.

The focus group paid particular attention to issues around relationships, of which one hypothesised reason is that they find direct-care staff attitude is a powerful influence on the successful implementation of PBS, and that the relationship between SBT and direct-care staff can be a way of facilitating a positive attitude towards PBS. Where direct-care staff attitude and values are congruent with those of PBS, the implementation of PBS is more likely to be successful, whereas if there is a clash of values then the implementation of PBS is less likely to be successful. This can then be seen as a process that involves the 'most key' factors. The hypothesised process suggests that the SBT clinician begins engagement with direct-care staff, which involves the commitment of the organisation. The success of PBS can be maintained by the direct-care staff seeing it work, which has the effect of increasing congruency of direct-care staff attitude and the values of PBS. Such an emphasis was placed upon the attitude of direct-care staff as a facilitator or a barrier by the focus group, that it is felt by SBT clinicians that they have little influence over attitude. This supports the suggestion by Allen (1999) that the influence of external clinicians may be relatively weak compared to the influence of the work culture. Similarly, organisational culture has been shown by organisational psychology to influence important aspects of staff behaviour (Hatton *et al.* 1999). This may lead clinicians to feel that there was little they could do to change the situation, and then go on to direct their attention to strategic level working.

The effect that attitude has upon direct-care staff behaviour, that is, whether they implement PBS effectively or not, can be linked to the theory of planned behaviour (Ajzen, 1985). This theory maintains that a person's attitude towards a certain behaviour, in this case implementing PBS, together with subjective norms and their perception of how much control they have over their own behaviour, has a strong influence over their intention and carrying out of that behaviour. Depending on the situation, behaviour and factors influencing motivation to carry out that behaviour, attitude can vary in its power over influencing intention. The results from this study suggest that attitude has far-reaching influences and the theory of planned behaviour can be used to explain the link between attitude and behaviour of direct-care staff (issues regarding behaviour change of direct-care staff are discussed further in sub-section 4.2.3.1).

Additionally, the presence of adequate training to increase knowledge and understanding is a powerful influence over the success of PBS interventions, but also over attitude. As knowledge and understanding of PBS increases, so does attitude shift more positively. This is in line with Campbell (2007) who suggested that appropriate values are essential for this work. So again, attitude of direct-care staff increases its power as a crucially influential factor.

While the grounded theory represents the ideal, it is felt that some factors are more influential than others, as described above, and can perhaps compensate when other less influential factors are lacking. So, for example, where stress levels are high amongst staff, this can be compensated by support from peers, managers and SBT clinicians, which relates to relationships. A further example is that of the competing priorities at the service delivery level, which can be compensated by the commitment of the organisation to PBS.

4.2.2 Agreement and differences between direct-care staff and SBT clinicians

One of the aims of the study was to explore any similarities or differences between direct-care staff and SBT clinician perspectives. There were more agreements than differences in the issues identified by both sets of participants, which is an encouraging finding. Given that the study questions were based around the implementation of PBS, and that this is done by direct-care staff, the amount of agreement would suggest that SBT clinicians have a good grasp on the relevant issues faced by those staff. Areas of agreement were factors related to the External Support (SBT), the Internal Support (the organisation) and all categories under the core concept of Mediators. However, despite these areas of agreement, there were themes that were expected to emerge from the focus group that had been seen to be important for direct-care staff during the interviews. The support of staff was not directly discussed by the focus group, which may suggest that despite an awareness of the issues faced by staff, that the focus is on winning staff over, rather than listening and supporting. It is of note also that one factor involved in winning staff over concerns the offering of support, which may not have directly been named during discussion in the focus group. Some elements of 'feedback' also could be interpreted as offering support for staff, although again were not named as such.

A possible reason for the lack of discussion pertaining to support for direct-care staff by SBT clinicians relates to a process described by McBrien and Candy (1998). They suggest that the psychologist, or any external clinician, can adopt a 'take it or leave it' attitude to his/her own advice, which can adversely affect the relationship by making it harder to gain commitment and co-operation from the setting. It is clear that SBT have a passion for PBS and spend much energy bringing others on board to show them the value of a PBS model. However, this focus may have the potential to lead direct-care staff to feel they have not been heard if their ideas are different. A possible response by SBT clinicians may be that any difference is due to direct-care staff attitude, rather than the way clinicians offer support and listen to staff.

McBrien and Candy (1998) suggest that when advice has not been followed by external clinicians, those clinicians can look to blame the setting, the staff or the management, rather than the quality of his/her own advice or the way it is delivered. Chapter 1 discussed attribution theory (Hastings *et al.* 1995), which suggests that staff attribute challenging behaviour to factors that they have little control over (such as internal factors and general environmental factors), rather than factors over which staff do have some control (such as communication) (Allen, 1999). There could be a parallel process here where direct-care staff may lay 'blame' within the service user, and SBT clinicians may lay 'blame' within the direct-care staff. This could have implications on the beliefs of SBT clinicians about, and emotions towards, direct-care staff. For example, Weiner (1980) suggested that internal, controllable attributions maximised negative affects amongst observers, (e.g. disgust or anger), and gave rise to behavioural avoidance, whereas external/uncontrollable attributions generated positive affects (e.g. sympathy) and gave rise to helping behaviour. The main barrier put forward by SBT clinicians was staff attitude; something which is internal to the person. Thus while SBT clinicians may work to enhance a positive attitude in direct-care staff towards PBS, there may be underlying negative feelings towards those staff which will affect the relationship. SBT clinicians may also feel less able to help the situation, or be in a state of 'learned helplessness' (Seligman, 1975) as mentioned in Chapter 1. Focus group participants discussed at length the need to win staff over, based on the need sometimes to change staff attitude, beliefs and values, which are internal to the individual. Where staff attitude could not be changed, then it could be perceived by SBT that there is little they can do.

Observation of the grounded theory shows that the 'outer layer' was only discussed by SBT and the 'inner layer' was only discussed by interview participants. This could be seen to be understandable based on the relevant issues for each set of participants, rather than a mismatch of perceptions.

The focus group emphasised the 'expert' or 'specialist' role and discussed the idea that these are the terms in which staff can perceive them, that is, as coming in and telling them

what to do. The data from the interviews would suggest that a minority of direct-care staff participants felt this way. This perception from the focus group has some support from the literature. For example Osborne-Davis (1996) in a small survey of attitudes to clinical psychologists found that clinical psychologists continue to be a virtually unknown group in the eyes of other healthcare staff. Psychologists were perceived as 'remote' and 'aloof' and playing a 'minimal or no role in providing a service'. They were seen as occupying well-paid, well-resourced and privileged positions. Given that the SBT is a specialist team, it may be the expectation that they are removed from more generic services, as participants in the focus group discussed. These concerns however were largely unfounded based upon the interviews with the eight direct-care staff included in this study as the majority attitude towards PBS and SBT clinicians was found to be a positive one.

Similarly, direct-care staff participants did not discuss issues around being won over. However, there was some evidence amongst the specialist residential services that initial expectations may have been negative, but these were more around the introduction of a new model of working, rather than PBS itself. Seeing PBS work was a factor that contributed towards any changes in attitude as well as any perceived support from SBT clinicians.

It struck the researcher that the focus group did not discuss knowing the service user. Some interview participants felt that SBT clinicians not knowing the service user was an issue that needed attention. They felt that SBT clinicians may know the service user "on paper" but it was felt that they needed to be in the setting and spending time with the service user to get to know them. The lack of discussion on this point in the focus group may represent a mismatch of the perception of relevant issues, and perhaps shows some support for the 'blaming' of organisation, manager or staff team by SBT clinicians, rather than reflecting on aspects of work carried out by the clinician as discussed above. However it could also be that focus group participants did not feel that issues around the service user were relevant to the success of PBS interventions, given that the responsibility of supporting individuals with learning disabilities and challenging behaviour falls to the system around them. The

focus group did however discuss being in the setting more, something they were prevented from doing due to the stress and demands of their role.

The issue of communication was also not discussed at the focus group, despite this being a theme that emerged from the participants who were interviewed and there was also an expectation that this would emerge held by the researcher. However there was some discussion regarding the handling of feedback from SBT clinicians to direct-care staff via the organisation that implied that this was not always handled effectively (this is discussed in Section 4.2.3.2 below).

4.2.3 Overcoming barriers - what is realistic?

Chapter 1 outlined a promising emerging evidence-base for the effectiveness of PBS, however one criticism of the evidence is that it often lacked real-world validity. The question then is about the realistic possibility of implementing PBS as a package in real-world settings. The grounded theory shows a diversity of factors that it is suggested need to come together to maximise the success of any PBS intervention. The findings from this study are discussed in relation to the barriers found in the literature and outlined in Chapter 1. The intention is to demonstrate barriers that can be overcome, as well as barriers that are perhaps more difficult to resolve.

4.2.3.1 Intra-personal factors and behaviour change

As has been described, direct-care staff are key to implementing PBS, which is an approach that highlights the need for direct-care staff to alter their behaviour when supporting service users, in a way that promotes consistency between direct-care staff. The theory of planned behaviour (Ajzen, 1985) has been used to explain the influence of attitude over behaviour, which may prove to be an insurmountable barrier as discussed at the focus group. However, the grounded theory in this study suggests a cyclical relationship between

attitude and behaviour (the category of Delivery of PBS), therefore shifting either attitude or behaviour can affect the other correspondingly. It is therefore worthwhile to consider theoretical explanations of influences over the behaviour change of direct-care staff.

There are a number of theories of behaviour change that describe change in stages (e.g. Prochaska & DiClemente, 1986; Sallis & Nader, 1988). Rogers (1983) developed a stage-based theory that explained how new ideas or innovations are disseminated and adopted at community and population levels. The five stages proposed were persuasion, decision, implementation and confirmation. Rogers (1983) argued that the diffusion of an innovation, for example PBS, is enhanced when the perceived superiority of an innovation is high compared with existing practice (the relative advantage), and when the compatibility of the innovation with the existing social system is perceived to be high (compatibility). In theory, PBS should be compatible with the values of services, and this again highlights the importance of the commitment of the organisation to PBS. However the relative advantage for direct-care staff of implementing PBS may be perceived to be low given the slow behaviour change of service users, and therefore a weak return on their efforts and investment. According to Rogers (1983), other influences on the diffusion process are the complexity of an intervention, the ability of an intervention to be adopted on a trial basis, and how easily it can be observed. Therefore, according to Rogers (1983), simple interventions that are able to be adopted on a trial basis and can be easily observed are more likely to be implemented. In contrast, PBS requires a greatly enhanced knowledge-base, outcomes are not necessarily easily observed and PBS needs to be implemented in the long-term.

Owen and Lee (1984) highlighted commonalities between stage-based theories of behaviour change (used here in relation to direct-care staff behaviour change) and noted that each stage is said to involve different cognitive processes and require different interventions at each stage. This implies that where there is resistance to changes in practice by direct-care staff, the methods for changing these practices are not straightforward.

Jensen (1996, cited in Wirth, 2002) highlighted a dialectic process when an individual decides to change, including questions of amount of effort and relative advantage. However Jensen (1996, cited in Wirth, 2002) also contextualises this process in organisational change, highlighting the need for clear practice leadership to follow through the change and remove barriers. This suggests that the individual behaviour change can be influenced by hierarchical figures within the organisation. Again, commitment within the organisation finds support as a central influence, which may weaken the influence of clinicians with a different message to the organisation.

4.2.3.2 Stress and emotional factors

Staff stress and emotional factors have been suggested as potential barriers to implementing behavioural interventions (Hatton *et al.* 1999; Mutkins *et al.* 2011). Indeed stress was an issue that emerged from the data in this study, however emotional factors featured little during interviews and the focus group. One reason for this could be that the settings included in the study were successfully implementing PBS. As one participant described, the implementation of PBS had reduced her stress levels. This is in line with literature that suggests a cause of stress in staff supporting individuals with challenging behaviour is a lack of effective intervention strategies (Bromley & Emerson, 1995). A further reason could be that direct-care staff included in this study appeared to have good support from peers and line managers, which can contribute to the reduction of stress for staff (Mutkins *et al.* 2011). It was interesting that there was little discussion around staff sickness, stress-related or otherwise, which has been found to be prevalent in learning disability services (Alexander & Hegarty, 2000). It is noted however that there seemed to be a lack of awareness of the emotional effects of working with challenging behaviour amongst the direct-care staff in this study, with examples of staff not seeking post-incident support or not noticing that they are 'stressed' until later. It is possible however that direct-care staff were aware, but felt that they had effective coping mechanisms in place. This area may require further attention given the findings that direct-care staff can use ineffective coping

strategies, particularly emotion-focused coping strategies such as wishful thinking (Hatton & Emerson, 1995; Thompson, 1987).

Work demands is also a contributory factor found in the literature (Power & Sharp, 1988; Razza, 1993; Rose, 1993), which finds support from this study, relating particularly to staff in the specialist residential services. Social support from peers and managers also contributes to the management of stress for direct-care staff (Dyer & Quine, 1998; Hatton & Emerson, 1993; Hatton *et al.* 1995; Razz, 1993; Rose, 1993, 1995; Rose & Schelewa-Davies, 1997). This is something which direct-care staff clearly found helpful in this study, not only with managing stress but in their learning and developing confidence with PBS. Feedback on job performance can also help with stress (Hatton & Emerson, 1993), which was discussed by all participants as being important. Direct-care staff appear to appreciate feedback on how they are doing, however an issue that was identified by the focus group referred to the way feedback is handled by the organisation. There was a concern that any positive feedback may not be reaching the intended recipients, which can possibly affect direct-care staff morale, motivation, and relationship with SBT clinicians. There are a number of factors that contribute to the development of stress and so it was not expected that all factors identified in the literature would emerge in this study. However stress as a general theme was found amongst the responses of direct-care staff included in this study. The stress/demands of the SBT clinicians that emerged in this study is felt by the researcher to be more related to how clinicians can manage their time effectively, to reach 'the ideal' as far as possible, which is more a service delivery issue.

This study did not support previous research that suggests that direct-care staff tend to attribute causation of challenging behaviour to factors over which they have little control, such as internal states of the individual (Allen, 1999). Indeed, the data from this study showed an awareness of the principles of PBS, which includes the need to adapt the environment and staff's own behaviour, and the effects of implementing PBS on challenging behaviour, including a reduction in challenging behaviour. This implies an understanding

that some factors that affect challenging behaviour are within the control of people around the service user. Such knowledge may be the result of having been trained to implement PBS. Direct-care staff in this study had all 'seen PBS work', which would suggest that it is being implemented successfully, something that would be more difficult if staff did not have an understanding of challenging behaviour. The implication is that they were not in a state of learned helplessness (Seligman, 1975). The focus group however did discuss a lack of understanding about challenging behaviour amongst some of the direct-care staff they had supported.

4.2.3.3 Staff training

The training of staff did not appear to consist of ineffective 'train and hope' strategies (Stokes & Baer, 1977). It appeared that SBT clinicians were willing to adapt their training to meet the needs of the organisation, for example in delivering training over a number of different days. This adaptation of training approach and putting in the time to meet with all staff is something that McBrien and Candy (1998) advocate. They suggest that front-line staff need interventions and their rationale explained at first-hand, which, while time-consuming, is time well spent because of the direct communication, rather than relying on 'Chinese whispers'. This initial training was followed up by the use of Positive Monitoring, carried out either by SBT clinicians or the organisation's in-house staff. McBrien and Candy (1998) suggest that the maintenance of interventions over time is affected by clinician commitment to monitoring, refining and providing summarised feedback on progress. The barriers that emerged in this study were related to the basic knowledge and skills of the staff employed by the organisation.

4.2.3.4 Aspects of services

As mentioned in Section 4.2.1, and also Section 4.2.3.4 organisational cultures and commitment to interventions can have a strong influence over staff behaviour (Jensen, 1996, cited in Wirth, 2002; Hatton *et al.* 1999). Corrigan *et al.* (1992) suggested that lack of

available resources could be an obvious barrier to implementing behavioural interventions. This study did not strongly support this; however some data showed that direct-care staff can struggle to implement activities in the community due to a lack of accessible or appropriate services. Staff shortages and high turnover has been found to contribute to a lack of success of behavioural interventions (Burdett & Milne, 1985; Emerson & Emerson, 1987; Repucci & Saunders, 1974) and this notion finds support from the data in this study. The stability of the staff team was discussed by direct-care staff and SBT clinicians and felt to be strongly influential over the success of PBS interventions. Indeed the focus group gave examples where time and resources had been invested into a staff team only for the staff team to leave and be replaced by new staff. The implication for SBT is the need to invest additional time and resources to increase the skills in PBS of the new staff. If this negative pattern continues, the success of the PBS intervention can be severely impacted upon. While SBT can address this to a certain extent with additional training and investment, the problem lies at the organisational level. As some participants suggested, organisations are struggling at the recruitment stage to recruit appropriate and committed staff. As also noted during the focus group, direct-care staff are poorly paid and the work is demanding. This barrier is multi-layered and would require a multi-layered approach. The question is then a matter of who would be responsible for stabilising turnover. Clinical and service implications are discussed in Section 4.3.

Participants did not discuss aspects of services such as high levels of bureaucracy or rules and regulations that clashed with PBS implementation. There did not seem to be a lack of person-centred approaches within the organisations, which can otherwise adversely affect the implementation of PBS (Woods & Cullen, 1983). This would suggest that these barriers were not relevant in this study.

Motivation for implementation of PBS is also a relevant factor found in the literature (e.g. as affected by staff attributions about challenging behaviour (Allen, 1999) or organisational culture (Hatton *et al.* 1999)). While this was not identified as its own category, motivation is

implicit throughout the core concept Mediators and Delivery of PBS. The factors contributing towards motivation, as found in the literature, did emerge in the data in this study. For example, the importance of feedback and support for their work has been found to affect the motivation of direct-care staff both in this study and in previous research (Burdett & Milne, 1985; Corrigan *et al.* 1992; Emerson & Emerson, 1987; Hall & Baker, 1973; Woods & Cullen, 1983). As discussed in relation to stress in Section 4.2.3.1 above, line managers, peers and SBT clinician feedback were all identified as helpful factors for direct-care staff. The literature suggests that having these factors in place increased the motivation of direct-care staff to implement interventions. Motivation can also relate to the organisation's motivation or culture, and again this is implicit throughout the Internal Support factors, and particularly the commitment aspect, as both factors are likely to influence the other. This study found that the commitment of the organisation affected the motivation of direct-care staff in the implementation of the PBS intervention. Differences were found here between specialist residential services and social care residential settings. SBT form part of the management of specialist residential services and therefore there is a strong commitment to working in a PBS model from the top-down, something which was not found to be as strong in the social care settings.

4.2.3.5 Nature of behavioural programmes

This study found that the size of the plan was a factor that direct-care staff felt was a difficulty and that SBT clinicians also acknowledged was an issue. Participants in the focus group also discussed the terminology used in the plans that may be confusing for the reader and the person responsible for implementing the plan. There does not appear to be previous research that discusses the size of an intervention as a barrier. Previous research in this area has referred to the difficulty of maintaining motivation in the face of small and slow changes seen when behavioural interventions are implemented (Hastings & Remington, 1993), and also being intrusive (Walker *et al.* 1985) and perceived as inflexible (Backer *et al.* 1986), none of which found support in this study.

4.2.3.6 Co-ordinating approach

The difficulties of co-ordinating care for service users were noted by McBrien and Candy (1998). This idea found some support from this study due to the discussion of competing demands of services around service users by the focus group. It appears to be a common issue across learning disability services (McBrien & Candy, 1998). Despite government policies which advocate a co-ordinated approach (Department of Health, 2001; Welsh Assembly Government, 2001), this study would suggest that this is difficult to achieve in practice.

4.2.3.7 Summary

This section has discussed previous literature on common barriers to behavioural interventions in relation to the findings in this study. The overall question and purpose of this leads to whether it is realistic to implement behavioural interventions in the face of these barriers. The settings included in this study all appeared to be successfully implementing PBS interventions, and the factors identified were factors that were helpful towards this outcome, with the lack of any factor acting as a barrier. Given that not all the barriers identified in the literature were found in this study suggests that settings in this study had a number of helpful factors in place already, such as a person-centred approach, low staff sickness and sufficient resources to implement PBS. As suggested in Section 4.2.1, some factors may be more influential than others, but also some factors, if barriers, would be more difficult to overcome than others, such as influencing the commitment of the organisation, recruitment of staff and co-ordinating the approach of all involved stakeholders. Section 4.3 discusses some of the clinical and service implications as a result of the findings of this study.

4.2.4 Reflections on outcomes of the study

The themes that emerged in this study were generally a reflection of what might have been expected at the outset of the study. However, the extent to which the experiences of direct-

care staff participants were positive ones was a pleasant surprise to the researcher, which shifted a problem-focused approach towards a solution-focused one. The discussions of the focus group however were more reflective of the frustrations expected. This difference may be due to the inclusion of settings and participants that were particularly effective at implementing PBS, and perhaps not representative of the wide range of settings with which SBT engage. It is also possible that the difference reflects difference in perception of what is a successful intervention.

It was always expected that naming the factors that can facilitate the successful implementation of a PBS intervention was not going to be straightforward. Indeed the findings indicate complex relationships between factors and inter-dependency, despite the grounded theory appearing quite linear.

A factor that was expected as a category was that of confidence, which did not emerge as a distinct category. On reflection, the researcher perceives confidence to be integral across a number of factors related to the mediators and delivery of PBS, and in particular 'becoming second nature' and 'support' from SBT clinicians. As noted above, motivation is also a factor that is considered integral.

A more general reflection on the process of the study is that the researcher set out to give staff a voice, since this was lacking in the literature, and yet this is the most crucial element in the implementation of behavioural interventions. Having come from a background in the clinician role (more about the researcher's background in Appendix E), the researcher aimed to be neutral and to be seen as a neutral researcher. The researcher feels that this original intention was achieved.

4.3 CLINICAL AND SERVICE IMPLICATIONS

Participants discussed what they found helpful as well as difficulties they encountered and how these can be overcome. As has been noted, the influential factors on the successful outcome of PBS interventions are diverse. The following section therefore outlines broad factors that can impact widely to maximise the potential for the success of PBS interventions with reference to the implications for learning disability services and clinicians working within a psychological approach in those services.

4.3.1 Commitment

The issue of commitment could be seen to be the common theme across the delivery of services and the organisation within which PBS is implemented. Commitment, or lack of it, at the organisational level strongly influences the success of clinicians and direct-care staff implementing PBS. A commitment from organisations should include the 'skilling up' of their service managers so that they can support their own staff who are implementing and maintaining PBS interventions, and provide line manager support, or practice leadership. The importance of practice leadership has been emphasised in the literature (Mansell *et al.* 1994; McGill & Bliss, 1993). An e-learning training has been developed by a local service development team (Allen *et al.* 2007) for the purpose of increasing the skills base of PBS in organisations. This should continue to be encouraged and taken up by provider organisations. The increase in skills base amongst those working in provider organisations would free up clinicians to focus their work on supporting organisations which are supporting the most complex of individuals.

A long-term influence on commitment of organisations might be the introduction of a mandatory element to PBS. Person-centred planning has become mandatory in England and several US states (Department of Health, 2001; Schwartz *et al.* 2000). Across the UK, person-centred planning is central to current governmental health and social care policy for people with learning disabilities (Department of Health, 2001; Scottish Executive, 2000) and more

recently has been established as a key component of the provision of social care to all adults (Department of Health, 2005; Welsh Assembly Government, 2007). It is the case that statutory services are required to introduce person-centred planning as a means of increasing the extent to which supports are tailored to the needs and aspirations of adults with learning disabilities. PBS has a strong element of person-centred planning and it may therefore not be unreasonable to extend policy to include PBS as mandatory for people with learning disabilities and challenging behaviour.

There are two anticipated criticisms that may be levied against PBS becoming mandatory. Firstly, it could be argued that the evidence-base is limited in real-world examples of the effectiveness of PBS as discussed in Chapter 1. This presents an argument for increased practice-based evidence in the form of routine data collection on outcomes such as quality of life and behaviour change within services. Secondly, having PBS as a mandatory approach may limit the use of other approaches. However, it is useful to perceive PBS as a framework within which other approaches and models can be used as appropriate and tailored to the individual (Allen, 2009).

4.3.2 Relationships

Participants placed a strong emphasis on relationships between clinicians and the organisation and direct-care staff. This seems justified given the role of consultants in working to influence the behaviour of direct-care staff, who in turn work to influence the behaviour of service users (Tharp & Wetzel, 1969). The implication therefore is to continue to prioritise relationships and the following paragraphs outline some suggestions for ensuring that the mechanisms are used to full effect.

It was suggested at the focus group that perhaps direct-care staff and organisations are unclear about the processes that SBT use, for example how assistant behaviour specialists are utilised and the use of a 'clinical team'. The data showed that direct-care staff make

assumptions about clinicians tasked with writing plans for PBS implementation including the assumption that they were unaware of the issues for service users and staff because they were not present enough. This issue could be addressed by negotiating a formal or informal contract with the organisation and with all or some direct-care staff members of a residential setting at the outset of involvement. This could outline the expectations and needs of both clinicians and direct-care staff. This could be used as an opportunity to be clear to direct-care staff about how clinicians gather information and to seek from direct-care staff what support they wish to be offered. This process could then be followed up once the PBS intervention is ready to be implemented. Whilst the data showed that agreement is sought from direct-care staff about the PBS intervention, it is less clear if this implies that the direct-care staff are clear about their role and that their expectations are similar. McBrien and Candy (1998) advocate the use of a contract at this stage which will clarify who will do what, when and for how long, what constitutes success or progress, when to seek further advice or a change and how the plan will be monitored and evaluated. Of course, this mechanism can also be translated to any clinician supporting direct-care staff in the implementation of any intervention that requires a change for staff.

Involving staff was also discussed as a key influential factor. It was clear however from the data that some direct-care staff, particularly those who worked 'lower' in the ranks, do not feel as involved as they could be. It is understood that clinicians often have to work within their constraints of competing demands, and any recommendations here need to be realistic. It is also assumed by the researcher that clinicians work to involve staff as far as possible. However, it is suggested here as a recommendation that clinicians working in this field consider the use of bringing all direct-care staff working with referred service users together and openly discussing what works and what doesn't when working with the referred service user. This could go some way towards ensuring that all staff feel they have a voice and have been heard. Some direct-care staff in this study felt that despite being involved in deciding PBS interventions, they may feel unheard if their strategies are not used. Bringing all staff together gives the opportunity for the rationale of some interventions over others to be discussed. There is an increasing use of the application of

systemic practice to working with the support networks around individuals with learning disabilities. Jenkins and Parry (2006) outlined a systemic approach which they termed 'network training', in which the support network surrounding an individual with learning disabilities is brought together in order to share information and address pertinent issues by reaching a consensus about how to move forward. This can be quite time consuming, however it may be an approach considered by clinicians where there are particular difficulties in reaching a consensus about how to move forward.

Feedback and support was also a key factor that can affect the relationship between clinicians and direct-care staff. Both were identified as important however there was less emphasis on feedback from direct-care staff to the clinician. The SBT has conducted a qualitative study that set up focus groups of direct-care staff to seek the views of SBT input (Smith, 2010). However, to enhance the feeling of support, it is recommended that clinicians actively seek feedback regularly from direct-care staff about how they feel about the process and whether they have any issues. The clinician then has an opportunity to emphasise the importance of openness and transparency for an effective working relationship.

4.3.3 Awareness of stress

The results showed that direct-care staff can feel that their job is stressful. Stressors included the failure of other staff to follow the PBS plan, feeling negative about management, demands of the job and competing demands and frustrations with the care system. The implications of stress can be far-reaching, including reduced productivity and individuals taking stress-related sickness (Health and Safety Executive, 2011). This in turn has the effect of increasing demands on the remaining staff team and, as the grounded theory in this study suggests, ultimately impacts on care for the service user due to the reduced capability to successfully implement PBS interventions. A commonality across the interview and focus group data was the issue about direct-care staff not seeking post-incident support, which may be a contributing factor to stress. The literature outlined in

Chapter 1, together with the findings in this study, strongly suggest that organisations that provide staffed residential services for people with learning disabilities and challenging behaviour need to have strategies in place to tackle stress in the workplace. Whilst there are many benefits for addressing stress in the workplace, there are also legal obligations (Health and Safety Executive, 2011). Strategies could include raising staff awareness about the impact of stress and the emotional demands of their work, and to encourage a culture whereby direct-care staff seek support when they feel they need it. It may be that direct-care staff have other coping strategies in place, for example “sounding off” with peers as described in the interview data, however this requires further investigation. There could be a role here for external clinicians given the recent evidence that suggests that mindfulness-based interventions designed to help direct-care staff to develop mechanisms for coping can have a variety of beneficial effects (Singh *et al.* 2006; Smith, 2010).

4.3.4 Service user involvement

The researcher was struck by the absence of any data that alluded to the involvement of service users. There may be several reasons for this, such as a lack of relevance to the questions asked. It could also be the case that the research topic regarded methods for supporting service users, and therefore what helps and what hinders lies with the individuals who support the service user.

Results showed that direct-care staff can be unclear about the processes that SBT use, and this is discussed further in Section 4.3.2. However, it is unclear about how the involvement of SBT is explained to the service user. Inclusive communication¹² tools can be utilised to ensure that service users are made aware of who clinicians are and why they are there wherever possible and appropriate. The results indicated that PBS plans can be bulky and contain lots of detail for direct-care staff to absorb and retain and there were plans under

¹² Inclusive communication is an approach that seeks to ‘create a supportive and effective communication environment, using every means available to understand and be understood (Royal College of Speech and Language Therapists, 2003).

way to make PBS plans simpler. However, it is recommended that, where appropriate, PBS plans are made accessible for the service user. This may require the support of speech and language therapists to assist in both visual and verbal communication.

The involvement of service users in their own care-planning was not discussed by any participants. Again, there may be several reasons for this, but the implication here is the need to ensure that, wherever possible, service users are involved in their own care. Addressing these implications for service user involvement would bring services in line with a number of policy documents that emphasise the need to include service users in planning and delivering services (Department of Health, 2001; Welsh Assembly Government, 2001).

4.3.5 Summary of recommendations

Commitment

- Collect data routinely on PBS interventions that include measures of quality of life and behaviour-change to develop practice-based evidence that can inform policy-makers
- Support organisations to ensure they have skilled leaders and managers in PBS.

Relationships

- Clinicians negotiate a formal or informal contract that outlines expectations from them and from direct-care staff
- Use of a contract at the stage prior to PBS implementation that clarifies who will do what, when and for how long; what constitutes success or progress; when to seek further advice or a change and how the plan will be monitored and evaluated

- Where possible bring all staff together to ensure all staff have a voice and are clear about the rationale for choosing some interventions over others
- Consider the use of Network Training where there are particular difficulties in reaching a consensus about how to move forward.
- Clinicians actively seek feedback from direct-care staff and managers about how the process feels for them in order to encourage honest and open communication

Awareness of stress

- Organisations to take responsibility for tackling stress such as raising staff awareness about the impact of stress and the emotional demands of their work, and to encourage a culture whereby direct-care staff seek support when they feel they need it.
- Clinicians to consider the use of mindfulness-based approaches to support direct-care staff to cope with stress

Service user involvement

- Clinicians ensure that service users are aware of who they are and why they are there wherever possible and appropriate
- Service users are involved in their own care wherever possible and appropriate
- PBS plans are accessible to the service user wherever possible and appropriate

4.4 METHODOLOGICAL STRENGTHS AND LIMITATIONS

This section gives consideration to the methodological strengths and limitations of the study, specifically with regard to design, participants and analysis. Suggestions for improvement are also put forward.

4.4.1 Design

The qualitative design of this study can be considered to be one of its main strengths given that the aim was to explore views and perspectives. Qualitative design is ideal for gaining rich and detailed information about how individuals experience their world and the meaning they attribute to their experiences (Willig, 2008). In this respect, the understanding of the factors that influence the successful implementation of PBS could be enriched, something that the literature described in Chapter 1 has not yet directly addressed. However there are a number of limitations in the use of qualitative methodology.

It is important to acknowledge the researcher's position and potential influence upon data collection and interpretation as it is understood that grounded theory requires a personal interpretation. The researcher had some experience of working as a clinician with direct-care staff to implement PBS interventions. This may have had an effect on assumptions prior to data collection about the perspectives and experiences of both direct-care staff and clinicians. It is of note that the processes involved with grounded theory methodology allow interviews to be adapted according to interpretation of the data and should therefore be participant-led. However it is likely that these interpretations and subsequent avenues for exploration will be influenced by the researcher's own interests. The researcher's position was further complicated by accepting a clinical psychology post with SBT during the data collection phase of the study. Furthermore, one of the supervisors of the study was the Head of Service for the Specialist Residential Services and the Specialist Behavioural Team. These factors combined could have influenced the responses from participants, some of whom may have affiliated the researcher with the SBT, and so possibly felt pressured to give

a positive account and/or were inhibited about sharing more controversial thoughts and feelings about their experiences. Future research may benefit from being conducted by researchers who are more removed from the services involved and the research issue itself.

Whilst the researcher made every attempt to ensure that the guidance to achieve validity as outlined in Section 2.2.3 was followed, there are some areas where this could have been improved. Firstly, it was not possible to check the validation of core concepts, categories and sub-categories with the participants due to time constraints. In addition to limited time available to complete the study, validation of data and interpretation with participants would have necessitated considerable additional time and commitment on the part of the participants. To meet the need for validation, the researcher checked the accuracy and credibility of the interpretations on an ongoing basis with the study supervisors and responded appropriately to feedback. Validation and triangulation of data is also achieved to some extent by the presentation of emerging themes from the interview data at the focus group. Furthermore, quotes are presented in Chapter 3 along with the core concepts, categories and sub-categories to maintain transparency for the reader.

4.4.2 Participants

A strength of the study lies in the nature of the participants who were interviewed and who took part in the focus group. All participants had a great deal of experience working with people with learning disabilities and challenging behaviour. This meant they could offer perspectives on PBS in comparison to other approaches. They could also provide rich and insightful views on implementing PBS and supporting people with learning disabilities and challenging behaviour. Whilst the richness of data was a strength, there were some limitations associated with the participants.

Firstly, the sample in this study was small, although diversity in the data was enhanced by recruiting participants with different types of posts and lengths of experience. Interview

participants were recruited from across four residential settings representing two different types of services, and therefore themes represent commonalities across these services. All participants were accessed with the permission of service managers and recruited on a voluntary basis. This could suggest that participants came from services that were more easily accessed, for example due to a positive attitude towards PBS and/or SBT. They may also have had some particular interest in sharing their views and experiences of supporting service users in a PBS model, which may have skewed the results in an atypical positive or negative direction.

The clinicians who took part in the study were all members of the Specialist Behavioural Team. The rationale for including SBT in the study arose from the team focus on the implementation of PBS, as opposed to clinicians in multi-disciplinary community teams who have a wider remit. The sample therefore cannot be considered to be representative of all direct-care staff or clinicians working to support direct-care staff in implementing PBS. The aim of qualitative research methodology is to capture the diverse aspects of individuals' experiences with the result being a meaningful account that enhances understanding of the subject being studied, rather than the production of universal principles. Any generalising of the results should be grounded in the context of the participants and their situations (Elliot *et al.* 1999). However, Willig (2001) suggested that accumulative studies can be carried out in order to gain a more general account. If this study was to be repeated across different contexts, then wider conclusions could be drawn.

It should be noted that the study lacks a service-user perspective. This contravenes increasing awareness of the importance of the service-user perspective and a number of government policies aimed at expanding the areas in which people with learning disabilities can make a valued contribution (Department of Health, 2001; Welsh Assembly Government, 2001). A comparison of views and experiences across people with learning disabilities, direct-care staff and clinicians could be further enlightening and enhance understanding of the relevant issues further. Also, families implementing PBS were not included in this study.

To do so would have broadened the remit of the study too widely so that important themes specific to either families or direct-care staff could be missed. Ideally, exploration of family perspectives on implementing PBS would be a study within itself.

4.5 SUGGESTIONS FOR FUTURE RESEARCH

As outlined in Chapter 1, the evidence base for PBS has many inconsistencies in methodology and measured outcomes. It has therefore been difficult to draw out from the literature the key elements that support the successful implementation of PBS. This study has focused on direct-care staff and specialist clinician perspectives to begin to define the key factors that influence the success of PBS. However, it would be useful to carry out further work in this area, including a replication study. In particular, it would be useful to include the perspectives of service users that can provide information on how involved they currently feel. Do they feel any ownership; how important is their relationship with staff delivering PBS and clinicians developing PBS interventions? How can staff and clinicians incorporate a service-user perspective and ownership of PBS intervention? How much awareness do they currently have about PBS and the use of inclusive communication in the literature about PBS? The responses to these questions by service users would provide insights into their experiences of PBS and inform both direct-care staff and clinicians of how to include and respond to service users.

It would be useful to hear from clinicians in community teams, who are in the position of supporting direct-care staff in the implementation of PBS, about what they find are the facilitative factors and barriers. Similarly, the perspective of senior managers in provider organisations could be explored, in particular to learn about their constraints and whether full and successful implementation of PBS is realistic, despite PBS interventions being designed to account for strengths and limitations of the organisation and direct-care staff team.

PBS is also used in family homes, and this is also an area where further exploration is needed about what helps and what hinders under those circumstances. This could be explored across all service user ages and again include the service user perspective.

4.6 CONCLUSION

The importance of staff as agents of change is well-recognised (Emerson *et al.* 1995; Reid *et al.* 1989; Rice & Rosen, 1991) and that importance has been demonstrated by this study. However, it is felt that while this study can go some way towards supporting the conclusion drawn by Woods and Cullen (1983), there is no simple explanation for the determinants of staff-behaviour change, it is felt that this study can go some way to uncovering and naming the relevant factors. As one of the first studies to include the perspectives of direct-care staff and SBT clinicians on what helps them to successfully implement PBS interventions, this study has made a valuable contribution to an under-researched area.

A number of interesting themes emerged in the data and three of these were felt to be of crucial importance and to have the most powerful influence over the success of PBS interventions. These were relationships, organisational commitment and direct-care staff attitude. The findings from the current study are generally supportive of previous research; however some new and rich insights were discovered.

The negative consequences for individuals as a result of challenging behaviour have been well-documented and there is clearly a need for effective support mechanisms for service users to be prioritised and supported by all levels of services. The findings from this study have a number of clinical and service implications that identify specific areas that can be worked towards for the achievement of effective support for people with learning disabilities and challenging behaviour.

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Appendices

A – Letter of approval from Cardiff and Vale R&D committee (host Trust)

B – Letter of approval from ABM R&D committee (Trust where the study was carried out)

C – Letter of ethical approval (minor changes)

D – Researcher's response to ethical committee

E – Researcher's position

F – Excerpts from reflective diary

G – Participant Information Sheets

H – Consent form

I – Semi-structured interview schedule

J – Example of transcript

Appendix A:

Letter of approval from Cardiff and Vale R&D committee (host Trust)



Eich cyf/Your ref
Ein cyf/Our ref
Welsh Health Telephone Network 1872
Direct line/Llinell uniongyrchol

Cardiff and Vale NHS Trust

Ymddiriedolaeth GIG
Caerdydd a'r Fro

University Hospital of Wales Ysbyty Athrofaol Cymru

Heath Park,
Cardiff CF14 4XW
Phone 029 2074 7747
Minicom 029 2074 3632

Parc Y Mynydd Bychan,
Caerdydd CF14 4XW
Ffôn 029 2074 7747
Minicom 029 2074 3632

Tel: 029 20743742
Fax: 029 20745311
Research.Development@cardiffandvale.wales.nhs.uk

From: Dr J Bisson
Acting Trust R&D Director
Radnor House
University Hospital of Wales
Cardiff
CF14 4XW

17 July 2009

Mrs Samantha Woolls
Trainee Clinical Psychologist
Cardiff And Vale Nhs Trust
Archway House
77 Ty Glas Ave
Cardiff
CF14 5DX

Dear Mrs Woolls

Project ID : 09/MEH/4574 : Challenging Behaviour In People With Learning Disabilities: The Goodness Of Fit Of Positive Behavioural Support Plans.

Thank you for your recent communication regarding the above project, which was reviewed on 17 July 2009 by the Chair of the Joint Trust/University Peer & Risk Review Committee.

I am pleased to inform you that the project has been approved and that Cardiff and Vale NHS Trust will act as research Sponsor under the Research Governance Framework for Health and Social Care. The Trust is therefore happy for the project to begin, subject to:

- 1) Approval from the appropriate NHS Research Ethics Committee
- 2) Honorary Contracts, where required, being in place before the research begins.

Please ensure that the appropriate Research Ethics Committee have a copy of this letter. Once you have gained ethical approval, please forward a copy of the approval letter to the Research and Development Office at the above address.

May I take this opportunity to wish you success with the project and remind you that as Principal Investigator you are required to:

- Inform the Trust R&D Office if any external or additional funding is awarded for this project in the future.
- Inform the Trust R&D Office of any amendments relating to the protocol, including personnel changes and amendments to the actual or anticipated start / end dates.
- Complete any documentation sent to you by the Trust R & D Office or University Research & Commercial Division regarding this project.
- Ensure that adverse event reporting is in accordance with Cardiff and Vale NHS Trust Policy and Procedure for Reporting Research-Related Adverse Events (Refs 164 & 174) and the Trust Incident Reporting and Investigation Procedure (Ref 108).
- Undertake the project in accordance with ICH-GCP.
- Adhere to the protocol as approved by the Research Ethics Committee.
- Ensure the research complies with the Data Protection Act 1998.

Yours sincerely,



Dr J Bisson

Acting Chair of the Joint Trust/University Peer & Risk Review Committee

CC R&D Lead Dr Jonathan Bisson

[ENCS] Obtaining a Sponsor Signature – Guidelines

S:\databases\study folders\4574\RD Letters\09-MEH-4574 Chairmans Decision Approval Letter 17-07-2009.doc

**Cardiff and Vale NHS Trust
Research and Development Office**

**Obtaining a Sponsor Signature – Guidelines
For use with IRAS version 2.3 Forms**

If applying to the Local Research Ethics Committee (LREC) for ethical approval, the NHS REC form will need to be signed by a designated authorised signatory on behalf of the sponsoring organisation, before the application can be validated.

For projects sponsored by Cardiff and Vale NHS Trust this signature is obtained from the Trust R&D Office.
For all other projects, advice regarding this matter should be taken from individual research sponsors.

The authorised signatories for Cardiff and Vale NHS Trust are as follows:

Dr J Bisson,	Acting Trust R&D Director
Dr J Jones,	Trust R&D Manager
Mrs L Hathaway,	Trust R&D Facilitator

In order to facilitate the process please note the following points:

1. The project must have been approved by the Joint Trust/University Peer and Risk Review Committee.
2. The hard copy signed by the Principal Investigator (*i.e.* the copy of the form that you intend to submit to LREC) must be submitted to the R&D Office.
3. The form will be processed as soon as possible; however, you are advised to allow 3 - 5 working days to give sufficient time for identification of any issues that will need to be resolved prior to signing. Once the form has been signed you will be advised that it is ready for collection.
4. The details that should be included are as follows:
 - A64-1. 'Sponsor', and A-68. 'Lead NHS R&D Contact for this research':

<i>Name of Organisation:</i>	Cardiff and Vale NHS Trust
<i>Given Name:</i>	Jonathan
<i>Family name:</i>	Bisson
<i>Address:</i>	Research and Development Office, Radnor House, Heath Park, Cardiff, CF14 4XW
<i>Telephone:</i>	029 2074 3742
<i>Fax:</i>	029 2074 5311
<i>E-mail:</i>	research.development@cardiffandvale.wales.nhs.uk

Appendix B:

Letter of approval from ABM R&D committee (Trust where the study was carried out)

Please reply to: Research & Development Support Office
Clinical Research Unit
Abertawe Bro Morgannwg University
NHS Trust
Morriston Hospital
SWANSEA
SA6 6NL

Telephone: 01792 704056

Fax:

E-mail: jemma.hughes@abm-tr.wales.nhs.uk

Mrs Samantha Woolls,
Trainee Clinical Psychologist
Cardiff & Vale NHS Trust
Doctoral Programme in Clinical Psychology
Archway House, 77 Ty Glas Avenue
CARDIFF
CF14 5DX

03 September 2009

Dear Mrs Woolls,

ID: 09Psync25

**Challenging behaviour in people with Learning Disabilities: The
goodness of fit of positive behavioural support plans**

The above project was recently registered with this office. At that time ethical approval had not been granted.

We have received a copy of a letter from South West Wales REC dated 24 August 2009 which is requesting minor adjustments to be made.

Should any changes be made to your protocol or supporting documents, please can updated copies also be sent to us at the R&D Office, in order that our records are kept up to date.

Thank you for your co-operation in this matter.

Yours sincerely



Jemma Hughes

**Research & Development Manager
Abertawe Bro Morgannwg University NHS Trust**

Appendix C:

Letter of ethical approval (minor changes)



**Canolfan Gwasanaethau Busnes
Business Services Centre
South West Wales REC**
Swansea
36 Orchard Street
SWANSEA
SA1 5AQ

Telephone: 01792 607416
Facsimile: 01792 607533

24 August 2009

Mrs Samantha Woolls
Trainee Clinical Psychologist
Cardiff and Vale NHS Trust
Doctoral Programme in Clinical Psyc
Archway House, 77 Ty Glas Avenue
Llanishen, Cardiff
CF14 5DX

Dear Mrs Woolls

Study Title: Challenging behaviour in people with learning disabilities: The goodness of fit of positive behavioural support plans.
REC reference number: 09/WMW02/48
Protocol number: 1

The Research Ethics Committee reviewed the above application at the meeting held on 19 August 2009.

Ethical opinion

The Committee agreed that this project had been very well put together and may produce some useful information.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below. The Committee would also like to see the following minor adjustments in due course. These are not however, a requirement for the favourable opinion.

- The Committee would like to see the information sheet and consent forms for the two different study aspects clearly identified.
- The Committee note that you have mentioned that this study is in part fulfilment of your Doctoral training in Clinical Psychology, however, agree that this should be mentioned towards the beginning of the information sheets.
- The Committee note that the venues for the research include participant's place of work and learning disability services. The Committee seek assurance that any reasonable travel/parking expenses would be reimbursed for any location outside usual place of work.
- The Committee agree that it would be more appropriate for someone who is removed from the research study to be named as an independent source of impartial advice to be offered to participants [15-1, p.8]
- The Committee would like clarification of recruitment.

Canolfan Gwasanaethau Busnes GIG Cymru,
Canolfan Henffordd, 36 Stryd y Berllan,
Abertawe. SA1 5AQ
Ffôn: 01792 458066
WHTN: 1780
Ffacs: 01792 607533
TNT QW5/QW3 52

NHS Wales Business Services Centre,
The Oldway Centre, 36 Orchard Street,
Swansea. SA1 5AQ
Telephone: 01792 458066
WHTN: 1780
Fax: 01792 607533
TNT QW5/QW3 52

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Protocol	1	
REC application	1	22 July 2009
Participant Information Sheet: SBT	1	
Participant Information Sheet: staff interviews	1	
Participant Consent Form: staff interviews	1	
Participant Consent Form: focus group	1	
Interview Schedules/Topic Guides	1	
Letter from Sponsor	1	17 July 2009
CV - David Allen	1	
CV - Rosemary Jenkins	1	
Investigator CV	1	

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating

South West Wales REC

Attendance at Committee meeting on 19 August 2009

Committee Members:

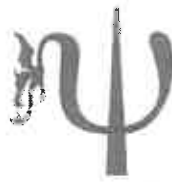
<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr Idris Baker	Consultant in Palliative Medicine	Yes	
Dr Ann Benton	Consultant Haematologist	Yes	
Dr Kate S Bullen	Senior Lecturer in Psychology - Vice Chair	Yes	
Dr Wai-Yee Cheung	Statistician	No	
Mrs Heather Darnell	Senior Nurse Advisor	Yes	
Dr John Doran	Consultant Chemical Pathologist	Yes	
Mr Roy L. Evans	Retired - Chairman	Yes	
Dr Hayley Hutchings	Senior Lecturer in Health Services Research	No	
Professor Jenny Levin	Retired	No	
Mr Andrew Matthews	Curriculum Manager	Yes	
Mr Paul Morcous	Consultant in Upper GI Surgery	Yes	
Mr Steve Newbury	Pharmacist	No	
Dr M Obaidullah	GP	Yes	
Dr Billie Shepperdson	Lay Member	Yes	
Dr Stefan Siebert	Consultant Rheumatologist	Yes	
Dr Mushtaq Wani	Consultant Geriatrician	No	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Ms Penny Beresford	Co-ordinator

Appendix D:

Researcher's response to ethical committee



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY
CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

13th October 2010

Ms Penny Beresford
Coordinator
South West Wales REC
Floor 12 NHS Wales Business Centre,
36 Orchard Street
Swansea
SA1 5AQ

Dear Ms Beresford

Study title: **Challenging behaviour in people with learning disabilities: The goodness of fit of positive behavioural support plans.**

REC reference number: **09/WMW02/48**

Thank you for your correspondence dated 11th October 2010 requesting an annual progress report for the above study. Please find enclosed a completed annual progress report dated 13th October 2010.

I also enclose updated versions of my participant information sheets and consent forms, with amendments as suggested by the Committee when reviewing my study on 21st August 2009. The amendments are as follows:

- Information sheets and consent forms for the two different aspects of the study clearly identified
- I have mentioned that the study is in part fulfilment of my Doctoral Training in Clinical Psychology towards the beginning of the information sheets.

Please do contact me should you have any queries about the enclosed.

Many thanks,

Samantha Woolls
Trainee Clinical Psychologist



1st Floor, Archway House 77 Ty Glas Avenue Llanishen Cardiff CF14 5DX
Ty Archway, 77 Ty Glas Avenue, Llanishen, Caerdydd CF14 5DX

Tel/Ffon 029 2020 6464 Fax/Ffacs 029 2019 0106



Appendix E:

Researcher's position

Researcher's position

I am a 34 year old white middle class female and I grew up, and continue to live, in South Wales. I am married with a son who is nearly two. I have been a trainee clinical psychologist since 2007. Prior to this my main work experience was in the field of learning disabilities in both a research and clinical capacity.

My experience working with people with learning disabilities and challenging behaviour comes from my 4 years as an assistant psychologist in a service development team in South Wales. I was initially involved in an epidemiological study and it was during this time that I became aware of Positive Behavioural Support. I felt it was an approach with great value for people with challenging behaviour. However it was my experience of working with nursing staff to implement PBS that really got me fascinated. Working with nursing staff coming from institutions, with many years of experience, challenged my simplistic expectation that you just 'did' PBS. I encountered various resistances, some obvious and some more subtle, which made me question what was it all about. My bias is clearly in support of PBS, and I initially took a stance against staff, questioning their 'duty of care' in not implementing PBS appropriately. While I felt I was respectful towards staff and their perspective, I was ultimately left thinking, 'Why won't they do it!?' I was frustrated, feeling that we had done, and were doing, all we could, and felt that this was a feeling shared with other clinicians. It was after leaving this post that I was able to take a step back and see a wider scope to the issues. In other work experience I was surprised, or maybe not, to find that these experiences are common. But I was also able to take a step back from the clinician role and I feel that at the time of implementing the study I was in as neutral position as possible.

During data analysis I became aware of a dilemma, which was the question of whether I was exploring issues associated with the Specialist Behavioural Team, or whether I was exploring issues associated with PBS. Supervision helped me to disentangle the issues and to focus on PBS. I was able to use themes associated with SBT and consider them under the category of relationships. Supervision also helped me maintain a neutral position, especially against the danger that I over-compensate and neglect the voices of clinicians. I also tried to be aware of my own biases based on my experiences outlined above, and made these known in supervision.

Appendix F:

Excerpts from reflective diary

Excerpts from reflective diary

09/10/10

Six interviews done with four analysed and analysing the 5th. I'm struggling with the being ruthless bit of getting rid or merging categories. Not because I'm particularly attached to them, but I guess I'm worried about losing something important. I've yet to find a way of organising the themes that I'm satisfied with and until then it all feels a bit unmanageable.

15/11/10

Trying to be ruthless with the coding and feeling nervous about missing stuff. I'm particularly worried after selling the study to the participants that this is their chance to be heard and I really want that to be the case. I don't want to become just another person who doesn't listen or who doesn't understand. STUCK.

16/11/10

Final two interviews today. Really tried to hone in and check out my emerging theory. But I felt myself worrying that I would miss something through doing this or that I would be too closed down. I think the interviews were still broad enough not to be the case though. The final interview really pleased me in a way as it talked directly about the sorts of issues I'd expected from through all the interviews. I was however mindful that if only one person says it, no matter how interesting, that it can't be included, which I was a bit gutted about. Although thinking back to the other interviews I think those issues are there, namely a 'them and us' so maybe just need to rethink the naming and sorting of categories. Need a good think and sort before the focus group and can check out my new ideas when I meet with supervisor this week.

29/11/10

I've been steadily more aware of the potential for a change in my stance from a neutral one to one that sides with SBT. Having secured a job with the team and conducting two more interviews and transcribing four, I notice I have gone from considering what might be relevant and useful for SBT to know to thinking about what I need to know and how I can make use of it. I also feel a bit uncomfortable about earlier interviews having sold it as confidential, neutral, external, when now there is the potential that I could be working with these very people – how uncomfortable might that be for them? Admittedly they were sensitive about naming people and did not appear concerned about information getting back to SBT, but still... Need to be aware in my analysis of the focus group. I am also struggling with my focus. Am I looking at attitudes and relationship with PBS or SBT because I find I'm focusing on SBT. I suppose the two are linked.

19/1/11

Feedback from supervisors today on my grounded theory. Reinforced to me that I'm not quite there, which I knew. I just can't seem to make that leap, to get it just right so it's an accurate reflection.

Appendix G:

Participant Information Sheets

First for interview participants

Second for the focus group participants



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

Challenging Behaviour in People with Learning Disabilities: The Goodness of Fit of Positive Behavioural Support Plans

INTERVIEW PARTICIPANT INFORMATION SHEET

Part 1

You are being invited to take part in a research study, which is being conducted as part fulfilment of my Doctoral Training in Clinical Psychology. Before you decide you need to understand why the research is being done and what it would mean to you. Please take time to read the following information carefully and discuss it with others if you wish. Please do ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

The purpose of the study is to identify what it is that helps and/or hinders the implementation of positive behavioural support (PBS) plans. It also hopes to uncover potential solutions to any factors that hinder the implementation.

Why have I been invited to participate?

As someone who works with people with learning disabilities and challenging behaviour within a PBS model, ***your thoughts and opinions are extremely important***. I am keen to hear from staff with any involvement with PBS, as these views will be very helpful to us.

Do I have to take part?

No, participation in this study is entirely voluntary and it is up to you to decide. Hopefully this information sheet will help you with your decision. If you decide to take part I will ask you to sign a consent form to show that you have agreed to take part. However, you will be free to withdraw at any time, and you do not need to give a reason for this decision. This would not affect you in any way.

What does the study involve?

I am asking direct care staff who work with people with learning disabilities and challenging behaviour to participate in this study. You will be asked to

take part in an interview. ***The interview will last for about one hour.*** I would like to hear your views and experiences of working within a PBS model and the need to implement PBS plans. I want it to feel as relaxed and informal as possible, so you can comfortably express your views. As far as possible, the date, time and location of the interview will be arranged at your convenience.

Will participation in this study be kept anonymous and confidential?

I will follow ethical and legal practice. All the information I receive from you will be kept ***strictly confidential and anonymous.*** This means that when the results are reported, you will not be identified by name. Confidentiality would however need to be broken if any disclosures of misconduct or malpractice are made during the interview, in which case I would be obliged to report these. You will also be requested to not disclose personal details of any service users you support.

Interviews will be audio taped and transcribed (written up) to assist with the analysis of data. The audiotapes and transcripts will be stored in a locked cupboard and erased/destroyed at the end of the study. Only myself as the researcher will have access to the information you provide. Any discussions with my supervisors regarding the data will be anonymous.

Are there any benefits to taking part?

By telling me your views about your experiences, thoughts and feelings of being involved in implementing PBS plans, I can begin to think about some important changes in how the process of developing and implementing plans is addressed. ***This will hopefully contribute to the support you receive when implementing PBS plans and thereby reduce any stress the process involves. In turn, this will improve the lives of the individuals you support.***

Are there any disadvantages to taking part?

It is understood that working with people with learning disabilities and challenging behaviour can be very stressful and talking about it may be distressing. Therefore if you would find this topic too difficult to talk about then I would ask you not to participate. If you became distressed during the interview, I would stop immediately and offer you sources of support.

What if there is a problem?

If you have a concern about any aspect of the study, you should speak to the researcher who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure.

What will happen to the results of the research study?

The results will be written up as part of my Doctoral Training. It may also be submitted for publication in learning disability journals. Participants and others who express an interest will be sent a summary of the results of the study and its recommendations. Please inform the researcher if you do not wish to take part, but would be interested in a summary of the results.

Who has reviewed this study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee. This is to protect your safety, rights, well-being and dignity. This study has been reviewed and given favourable opinion by the South West Wales Research Ethics Committee.

This study has also been granted approval from the research and development departments of the Abertawe Bro Morgannwg University NHS Trust and Cardiff and Vale NHS Trust.

How do I take part?

If you want to get involved, please return the attached reply slip in the stamped addressed envelope. Being involved in this study is entirely voluntary. You don't have to take part if you don't want to. If you do want to get involved, I just need to know your name and contact details. I will then contact you to discuss your involvement further. If you are chosen to participate in the study, then a date, time and location that are convenient to you will be arranged. Please could you return your consent form within one month of receiving this information sheet.

For further information...

If you would like further information before deciding whether to take part in this study, please contact the researcher, who will be happy to answer any questions you may have.

CONTACT:

Samantha Woolls, Trainee Clinical Psychologist (Tel: 029 20206464);

Dr Rosemary Jenkins, Consultant Clinical Psychologist and Senior Tutor for Learning Disabilities/Academic Supervisor (Tel: 029 20206464); or

Prof Dave Allen, Consultant Clinical Psychologist and Head of Specialist Services/Clinical Supervisor (Tel: 029 20569204).

Please keep this information sheet so that you can refer to it at any time during the course of the study.

Thank you for taking the time to read this information sheet.



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

Challenging Behaviour in People with Learning Disabilities: The Goodness of Fit of Positive Behavioural Support Plans

FOCUS GROUP PARTICIPANT INFORMATION SHEET

Part 1

You are being invited to take part in a research study, which is being conducted as part fulfilment of my Doctoral Training in Clinical Psychology. Before you decide you need to understand why the research is being done and what it would mean to you. Please take time to read the following information carefully and discuss it with others if you wish. Please do ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

The purpose of the study is to identify what it is that helps and/or hinders the implementation of positive behavioural support (PBS) plans. It also hopes to uncover potential solutions to any factors that hinder the implementation.

Why have I been invited to participate?

As someone who works to develop, and support staff to implement, PBS plans for people with learning disabilities and challenging behaviour, ***your thoughts and opinions are extremely important***. I am keen to hear from staff with any involvement with PBS, as these views will be very helpful to us.

Do I have to take part?

No, participation in this study is entirely voluntary and it is up to you to decide. Hopefully this information sheet will help you with your decision. If you decide to take part I will ask you to sign a consent form to show that you have agreed to take part. However, you will be free to withdraw at any time, and you do not need to give a reason for this decision. This would not affect you in any way.

What does the study involve?

I am planning to interview direct care staff who work with people with learning disabilities and challenging behaviour. This will then be followed by a focus

group that you are invited to. ***The focus group will last for about one hour.*** I would like to hear your views and experiences of working within a PBS model and supporting staff to implement PBS plans. I want it to feel as relaxed and informal as possible, so you can comfortably express your views. As far as possible, the date, time and location of the focus group will be arranged at participant's convenience.

Will participation in this study be kept anonymous and confidential?

I will follow ethical and legal practice. All the information I receive from you will be kept ***strictly confidential and anonymous***. This means that when the results are reported, you will not be identified by name. Confidentiality would however need to be broken if any disclosures of misconduct or malpractice are made during the focus group, in which case I would be obliged to report these. You will also be requested to not disclose personal details of any service users or staff members you support.

The focus group will be audio taped and transcribed (written up) to assist with the analysis of data. The audiotapes and transcripts will be stored in a locked cupboard and erased/destroyed at the end of the study. Only myself as the researcher will have access to the information you provide. Any discussions with my supervisors regarding the data will be anonymous.

Are there any benefits to taking part?

By telling me your views about your experiences, thoughts and feelings of being involved in supporting the implementation of PBS plans, we can begin to think about some important changes in how the process of developing and implementing plans is addressed. ***This discussion will hopefully identify solutions for overcoming barriers to the implementation of PBS plans. In turn, the successful implementation of PBS plans will improve the quality of life for service users.***

Are there any disadvantages to taking part?

It is understood that working with people with learning disabilities and challenging behaviour can be very stressful and talking about it may be distressing. Therefore if you would find this topic too difficult to talk about then I would ask you not to participate. If you became distressed during the focus group, I would stop immediately and offer you sources of support.

What if there is a problem?

If you have a concern about any aspect of the study, you should speak to the researcher who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure.

What will happen to the results of the research study?

The results will be written up as part of my Doctoral Training. It may also be submitted for publication in learning disability journals. Participants and others who express an interest will be sent a summary of the results of the study and its recommendations. Please inform the researcher if you do not wish to take part, but would be interested in a summary of the results.

Who has reviewed this study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee. This is to protect your safety, rights, well-being and dignity. This study has been reviewed and given favourable opinion by the South West Wales Research Ethics Committee.

This study has also been granted approval from the research and development departments of the Abertawe Bro Morgannwg University NHS Trust and Cardiff and Vale NHS Trust.

How do I take part?

If you want to get involved, please return the attached reply slip in the stamped addressed envelope. Being involved in this study is entirely voluntary. You don't have to take part if you don't want to. If you do want to get involved, I just need to know your name and contact details. I will then contact you to discuss your involvement further. If you are chosen to participate in the study, then a date, time and location that are convenient to you and other participants will be arranged. Please could you return your consent form within one month of receiving this information sheet.

For further information...

If you would like further information before deciding whether to take part in this study, please contact the researcher, who will be happy to answer any questions you may have.

CONTACT:

Samantha Woolls, Trainee Clinical Psychologist (Tel: 029 20206464);

Dr Rosemary Jenkins, Consultant Clinical Psychologist and Senior Tutor for Learning Disabilities/Academic Supervisor (Tel: 029 20206464); or

Prof Dave Allen, Consultant Clinical Psychologist and Head of Specialist Services/Clinical Supervisor (Tel: 029 20569204).

Please keep this information sheet so that you can refer to it at any time during the course of the study.

Thank you for taking the time to read this information sheet.

Appendix H:

Consent forms

First for interview participants

Second for focus group participants



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY **CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL**

Interview consent form

Challenging Behaviour in People with Learning Disabilities: The Goodness of Fit of Positive Behavioural Support Plans

Researcher: Samantha Woolls

South Wales Doctoral Programme in Clinical Psychology
Archway House, 77 Ty Glas Avenue
Llanishen, Cardiff, CF 14 5DX

		Please initial the box
1.	I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	
3.	I understand that the interview I participate in will be audio taped and transcribed. The audio tapes and transcripts will be erased / destroyed at the completion of the study.	
4.	I understand that the research findings will be presented and discussed in a written format. I also understand that the research will be submitted in part fulfilment of the researcher's doctoral training in Clinical Psychology.	
5.	I understand that direct quotations from my interview may be used in the write up of the research findings to illustrate themes. All quotes that are used in the final write up will be anonymised.	
6.	I agree to take part in the above study.	

Name of Participant:	Date:	Signature:
Name of Person taking consent:	Date:	Signature:



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

Focus group participation consent form

Challenging Behaviour in People with Learning Disabilities: The Goodness of Fit of Positive Behavioural Support Plans

Researcher: Samantha Woolls

South Wales Doctoral Programme in Clinical Psychology
Archway House, 77 Ty Glas Avenue
Llanishen, Cardiff, CF 14 5DX

		Please initial the box
1.	I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	
3.	I understand that the interview I participate in will be audio taped and transcribed. The audio tapes and transcripts will be erased / destroyed at the completion of the study.	
4.	I understand that the research findings will be presented and discussed in a written format. I also understand that the research will be submitted in part fulfilment of the researcher's doctoral training in Clinical Psychology.	
5.	I understand that direct quotations from my interview may be used in the write up of the research findings to illustrate themes. All quotes that are used in the final write up will be anonymised.	
6.	I agree to take part in the above study.	

Name of Participant:	Date:	Signature:
Name of Person taking consent:	Date:	Signature:



1st Floor, Archway House 77 Ty Glas Avenue Llanishen Cardiff CF14 5DX
Ty Archway, 77 Ty Glas Avenue, Llanishen, Caerdydd CF14 5DX

Tel/Ffon 029 2020 6464 Fax/Ffacs 029 2019 0106
Email/Ebost kate.furlong@cardiffandvale.nhs.uk



Appendix I:

Semi-structured interview schedule



SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY **CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL**

Challenging Behaviour in People with Learning Disabilities: The Goodness of Fit of Positive Behavioural Support Plans

Semi Structured Interview Schedule

Introduction:

My name is Samantha Woolls and I am training to become a Clinical Psychologist on the South Wales Doctoral Programme in Clinical Psychology. For my research project I am interested in looking at the use of the Positive Behavioural Support (PBS) model when working with people with learning disabilities and challenging behaviour. In particular I want to find out about the views of staff around their experiences and feelings about working within this model, and what helps and what hinders being able to implement a PBS plan. The interview should not take longer than one hour, but please tell me if you want a break at any time or wish to stop.

Demographic Details:

- Job Title
- Time in post
- Experience of working with PWLD
- Experience of working with PWLD who challenge

Theme 1: Understanding of PBS

Stem Question:

- What is your understanding of PBS?

Prompts:

- What are some of the reasons for working within this model?
- What are your thoughts about PBS?
- What do you think the benefits of working in this model are?

Theme 2: Impact of PBS model of working

Stem Question:

- What are your experiences of implementing a PBS plan?

Prompts:

- Have you worked within other models previously?
- What else has been tried?
- How has your working practice changed?

Theme 3: Skills/training/support required

Stem question:

- Have you felt adequately supported to implement PBS plans?

Prompts:

- Do you feel you have the skills/training to implement PBS plans?
- Did you receive PBS teaching as part of your qualification?
- How well does the support you receive match your needs?
- Do you feel listened to?
- What do you feel you need to successfully implement a PBS plan?

Theme 4: Challenges to working in a PBS model

Stem Question:

- What are the biggest challenges to working within this model?

Prompts:

- Do you find working in this model stressful?
- What can be done to overcome the challenges?
- How else would you work with the service users you support?
- How can you improve your working practices?
- What can be done to help with these challenges?

Challenging behaviour in people with learning disabilities
Staff interview version 1 (May 2009)

Thank you very much for your time. Your views have been really useful.

I can send you a summary of the outcomes of this research if you are interested in it. (Collect name and correspondence address)

Appendix J:

Example of transcript

Attitude reviews

S. Yes so they're a bit more person centred, almost as if the person is writing it rather than us because I think nursing jargon comes in and I think the new ones are going to be better again and no doubt 5 years time they'll have moved on again.

I. Yes I heard that they are being written from the service user's perspective?

Attitude

S. Yes, I think that's probably easier to understand, like if you've got student nurses coming in or anything. The service user I work with, I actually did a PCP on him, he's the only one here that had a PCP. I just did it in my own time because I thought it would be a nice thing to do. I know from students that we've had here they've picked up a lot more from that than the old PBS plans. They got to know service user a little bit more through that than the actual plan itself. I'm not saying it replaces the PBS plan, absolutely not, but I think they're taking little bits of PCPs and putting them into the PBS plans and I think that's a good idea.

I. Yes, ok so it's a bit more personalised and it helps people coming in to know that person

challenge to staff? amount of detail attitude? challenge to staff

S. And I think the old ones were very very detailed and lengthy and again what's good with the new ones is they've got that core plan for the bungalow, which is across the board for every service user, more environmental stuff and that kind of thing and slow triggers, and I think that's good as well because very often if you've got a thick thick plan it's putting people off from the getgo and a lot of it is repetitive in all of the other plans, so I think that's a good idea to have one core plan and then their individual plans offsetting that.

Plan

I. SO how it's being changed is an improvement?

challenge to staff

S. I think so definitely.

I. You've said already a bit about the benefits, which was one of my questions. Are there anymore to add?

Attitude to react PBS

S. I definitely think, where we've had incidents and issues here, I much prefer, and I don't know anybody who would rather react to a behaviour than prevent it. It can be stressful trying to prevent a behaviour but much more stressful having to deal with behaviours. I'd rather deal with someone at baseline and try and prevent the behaviour rather than at crisis point.

I. SO either way it's quite stressful, but more stressful to react.

effects of PBS? it's more Attitude Knowledge of staff

S. Yes, much more stressful. I do think they're effective. I don't think they're just a paper exercise. I don't think there's anything in there that isn't worthwhile. I think we know our service users really well. Even the old ones, as lengthy as they were, everything was in there for a reason.