

TRAINING CARE STAFF TO MANAGE CHALLENGING BEHAVIOUR: AN EVALUATION OF A THREE DAY TRAINING COURSE

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Introduction

Challenging behaviour among people with learning difficulties is an area of increasing interest of applied behaviour analysis (Emerson, 1993). Such behaviour can lead to the breakdown of family placements (Ronsey *et al.*, 1990) and re-admission of people with learning disabilities to hospital settings. The physical management of challenging behaviour can also lead to care staff injuries (Hill and Spreat, 1987). Recent research has suggested that challenging behaviour is not simply a product of institutional environments and easily changed by transfer to community housing (Felce *et al.*, 1994). Training staff in methods of managing challenging behaviour has been acknowledged as important (Kiernan and Qureshi, 1993; Emerson *et al.*, 1994). Despite this there has been little emphasis on training carers in the management of such behaviour (McDonnell and Sturmev, 1993). This article will attempt to describe such training in more detail.

Staff training is a relatively common activity in services for people with

learning disabilities. This form of service delivery has become known as the triadic or pyramidal method of service delivery (for reviews see Bernstein, 1982, 1984). Two rationales are usually offered for this approach. First, there is an efficiency argument. This advocates the dissemination of skills to all care staff. This has been implicitly acknowledged by the DHSS circulars and documents which require widespread staff training, not only training for staff working with high risk groups (DHSS, 1976, HMSO, 1988). Second, the behaviour of carers may inadvertently contribute to the maintenance of challenging behaviour. This raises the possibility that staff behaviour could be altered to reduce incidents of challenging behaviour. The effects of staff training are complicated by organisational issues (Cullen, 1987). Research has been conducted into the training of care staff in management of aggressive behaviour in psychiatric settings. A survey of 67 psychiatric nurses found that 75% had received no training in the prevention and management of disturbed behaviour (Basque and Merhige, 1980). Very few

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studies have reported evaluations of such training. In a comparison of trained versus untrained staff in a State Psychiatric Hospital it was found that there were fewer reports of assault on staff who had received training (Infantino and Musingo, 1983). Gertz (1980) described the effects of a two day workshop taught to 317 staff members in a mental health centre. They found a reduction in patient related incidents from 174 incidents to 117.

Staff training in the management of challenging behaviour is a comparative rarity. In a series of articles McDonnell *et al.* (1991, abc) made a number of recommendations about the nature and content of training care staff in the management of challenging behaviour. They described a non-aversive approach to behaviour management strategies. This article will attempt to describe a pilot evaluation of a three day training course based on these principles.

Course Aims

There were four overall aims to the training course. First, to create a better understanding of the causes of challenging behaviour. Second, to teach verbal and physical skills to aid in the defusing of incidents. Third, to teach non violent methods of physical restraint (McDonnell *et al.*, 1993; McDonnell *et al.*, 1991) which care staff could use within homes in the Health Authority. Finally, it was hoped to increase the confidence of staff in the management of challenging behaviour. A major focus of the course was in training staff in how to manage such behaviour when it occurred rather than changing behaviours.

Course Content

The three days of the training course had three separate themes, these will be described in more detail.

Day 1

Understanding the law as it relates to violence and aggression in the caring services; group exercise in understanding qualitative differences in violence and aggression; causes of challenging behaviour; group discussions of participants' experiences of challenging behaviour (conducted by two facilitators); defusing incidents involving course participants examining their own interpersonal skills and strategies for managing difficult behaviours.

Day 2

Non violent methods of managing challenging behaviour including: hair pulling from the front and rear, biting and scratching, grabbing wrists with one or both hands, the grabbing and tearing of clothing, airway protection. Physical advice was also provided in how to assist a member of staff who had been bitten or had their hair entangled with a client. All of these physical techniques did not require the abnormal rotation of joints. They also had to score high on the indices of social acceptability. These physical strategies were integrated with the interpersonal skills taught on the first day. A role play test was conducted to help staff practice these skills. The role play involved a facilitator mimicking a situation which would require both verbal and

physical defusion methods. Feedback was then given to care staff.

Day 3

A non violent physical restraint method was taught to care staff (McDonnell *et al.*, 1991; McDonnell *et al.*, 1993). A final role play test was administered to all participants. A facilitator would describe a situation where they as a client would need to be physically restrained and then act out the behaviour.

Method

Participants

Twenty one care staff (7 males, 15 females, mean age = 32.5, SD = 11.1) were selected to participate in the training course. They were drawn from a broad background (12 nursing assistants, 4 qualified nursing staff, 2 care assistants, 2 psychology assistants, 2 student nurses).

Measures Used

Three measures were used to evaluate the training course. A 20 item multiple choice Violent Incident Knowledge Test (VIKT) was administered to all course participants before and after the training course. The questions related to the general material taught on the training course including; incidence of violence in different care settings, physical management strategies and behavioural recording. The answers were scores correct if they adhered to the course philosophy (judged by the two course tutors). The

questionnaire produced a reliability coefficient of 0.50 (Cronbachs Alpha, $n = 280$) and several factors using factor analysis.

A 15 item Managing Challenging Behaviour Confidence Scale (MCBCS) was administered before and after the training course, consisting of a hierarchy of items pertaining to the management of violent incidents. The participants were asked to rate how confident they would be to carry out these behaviours 'right now' on a ten point scale with anchor labels being either 'certain' or 'uncertain'. The items ranged from 'I would be able to talk to a potentially violent person' to 'I would be able to restrain a violent person on my own'. The questionnaire produced a reliability co-efficient of 0.92 (Cronbachs Alpha, $n = 57$) and a three factor solution, containing one large factor, pertaining to the physical management of challenging behaviour (Eigenvalue = 6.53), a second factor related to the prevention of challenging behaviour (Eigenvalue = 1.54) and a third factor which related to people feeling confident about making demands or requests of a person who presents with challenges.

The last measure consisted of a Restraint Role Play test (RRPT). The physical restraint method was task analysed into 9 steps, and the performance of the participants was rated in the final role play test. Two independent raters separately scored the videos and an inter rater reliability coefficient was calculated by dividing the number of agreements by the number of agreements + the number of disagreements and multiplying by 100. This produced an inter rater reliability coefficient of 94%.

Results

There was a significant difference between the self confidence scores before and after the training course ($t = 6.43$, $p < .01$, two tailed test). There was a difference between the knowledge scores of the participants before and after training which approached significance ($t = 1.88$, $p < .10$, two tailed test). All participants passed the role play test, the agreed passing score being 8 out of 9 steps completed. Of the 22 participants 8 achieved a perfect score, 14 achieved a score of 8.

To test whether the age of the participants had an effect on the three main measures, product moment correlations were computed between age and both the VIKT and the MCBCS before and after training. These were all non significant [Age vs VIKT = 0.017 (before), Age vs VIKT = 0.156 (after), Age vs MCBCS = 0.342 (before), Age vs MCBCS = 0.197 (after)]. However, there was a significant inverse correlation between age and the RRPT ($r = -0.438$, $p < .05$). Therefore, the older the participants, the more likely it was that their role play performance would be rated as poorer.

Discussion

The participants did demonstrate the acquisition of some skills on the training course. Knowledge scores did improve and all subjects demonstrated that they could carry out the physical restraint procedure. However, the most significant result is the improvement of self confidence scores. It has been suggested that training in the management of violence and aggression should increase the belief of care staff in their own coping

responses (McDonnell *et al.*, 1991c). This study appears to provide some evidence for this assertion. The participants reported more confidence in managing challenging behaviour.

Post course discussion with participants suggested that the role play test was a realistic test, because of the uncertainty created by trying to manage the behaviour of a person who will be unknown to the individual. A large number of the care staff attributed their increases in confidence to the physical restraint role play. It is interesting that older participants performed less well on the role play test. Physical fitness may well be a factor although further research would be required to test this assumption.

The course content combined both physical skills and verbal and non-verbal defusion strategies. Whether there were differential effects of these components is a debatable point. There are significant improvements in knowledge and reported self confidence. However, there are no data to suggest whether attitudinal changes may have taken place. It has been acknowledged that training staff to manage challenging behaviour may have beneficial effects, especially if the training fits with the values of the service (Emerson *et al.*, 1994). There is evidence that attitude change should be a goal of staff training (Harper, 1994). Further research is needed to investigate the effects this type of training has on staff attitudes.

There are a number of problems with this study. For example there are no measures to show if the skills taught and the confidence engendered on the training course generalised to the work settings of the participants. The main effect of the course may have been due in part

to the individual characteristics of the tutors rather than the content of the course. Although hard evidence cannot be provided to refute these claims, it has been the experience of the author that these skills do have dramatic effects on the behaviour of care staff. Furthermore, follow up data and the addition of a control group would be useful for future research.

A Model

A great deal of research has focused on intervention methods which aim to change challenging behaviour in a non-aversive manner (LaVigna and Donnellan, 1986; Guess *et al.*, 1987; Berkman and Meyer, 1988; Jones *et al.*, 1991; Jones, 1991; McGee *et al.*, 1987; Whitaker, 1993). These positive approaches have a central theme of building a positive relationship between the carer and client by increasing activities for individuals and aiding the development of life skills. These goals of behaviour change may take a considerable time to achieve. Reactive strategies are often recommended to manage these behaviours in the short term (Willis and LaVigna, 1985; McDonnell and Sturmev, 1993).

Training courses in the management of challenging behaviour may help to provide carers with the belief that a person can cope with violent and aggressive behaviours. This increase in confidence can increase the likelihood that a person with learning difficulties will have the opportunity to have access to ordinary community services (Blunden and Allen, 1987). This is because the reputations that people with challenging behaviour

acquire can affect their relationship with their carers. Many approaches to challenging behaviour share a common theme of developing positive relationships with clients (McGee *et al.*, 1987; LaVigna and Donnellan, 1986; Lovett, 1985; Donnellan *et al.*, 1988). Literally you cannot have a positive relationship with a client who frightens you. Training can help to build a relationship of trust between the client and the carer. While training in the management of challenging behaviour is no substitute for long term intervention work with clients, it does provide a useful adjunct to these strategies.

Abstract

Challenging behaviour among people with learning disabilities is an area of increasing concern to service providers. Despite this concern there is little information available about how these behaviours should be managed. This paper presents pilot data on a three day training course which aimed to train staff to manage challenging behaviour. It was found that course participants acquired physical management skills such as physical restraint, and there were significant improvements in measures of knowledge and self confidence after training. The implications of these findings were discussed.

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