“Who’s Challenging Who?” empathy training for staff: The results

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WCW programme theory

- **Hypothesis 1** - staff attitudes are an important factor determining how staff behave towards those whose behaviour challenges.
- **Hypothesis 2** - staff attitudes are several steps removed from policy and guidance and so must be tackled directly.
- Values/attitudes-based training is a strong feature of induction, and also core to current best practice (e.g., PBS).
- No existing research reporting outcomes from attitude change interventions for staff supporting individuals whose behaviour challenges - how do we change attitudes and does it work?

Contact hypothesis

MH stigma reduction/attitude change more effective if contact with people with MH problems (meta-analysis) [Mehta et al., 2015; BJP]
Mechanisms of change

- Through multiple, positive, valued, opportunities for contact with an individual labelled as “challenging” and with a focus on “putting oneself in the shoes” of individuals whose behaviour challenges:
  - Increase empathy
  - Change attitudes
  - Increase self-efficacy (confidence)
WCW training v1.0
- ½ day training session (3 hours, 20 minutes)
- Designed to be delivered to 6-10 staff
- Delivered by a person with a disability supported by a person without learning disability
- Content directly informed by trainer experience and syntheses of existing research
- Interactive training experience
- Training activities designed to increase empathy and improve attitudes
- Various multi-media used to enhance learning
- Training ended with drafting an Action Plan to take back into the work setting

WCW content
- Communication and how staff listening can prevent escalation of CB
- How the living environment contributes to frustration and CB
- The experience of being physically restrained
- What it is like to be on medication “for” CB
- Experiences of feeling excluded because of CB
- Unhelpful attitudes and behaviour of support staff, and a discussion of positive staff qualities that contribute to good support/care

Pilot evaluation
- 76 staff attended one of 10 WCW training sessions
- 36 male, 40 female, mean age 39 years (range 19-64)
- Working in health/social care for an average of just over 10 years
- 47 support workers; 29 in managerial, technical or specialist roles
- Regularly supporting on average of 13 individuals (6 of whose behaviour challenged)
- Outcome measures before training and immediately post-training
Pilot results

WCW training v2.0

- Practical (replacement staff costs) and evidence-informed choice (managers influential in implementation e.g., Totsika et al., 2008):
  - One residential home manager/leader + one other support staff member to attend training
- Meta-analysis showed classroom + coaching more effective than classroom learning alone in staff training (van Oorsouw et al., 2009):
  - 30min Telephone coaching session 1: sharing WCW Action Plan with remainder of staff team, and revising actions
  - 30min Telephone coaching session 2: how to implement the WCW Action Plan and to monitor outcomes

Inclusion criteria

<table>
<thead>
<tr>
<th>Residential settings</th>
<th>Staff</th>
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<tbody>
<tr>
<td>In the community</td>
<td>Either a manager (or lead staff member) or direct support worker</td>
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<tr>
<td>Provided services via publicly-funded contracts</td>
<td>Worked at least 0.7 WTE</td>
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<tr>
<td>Supported between 1 and 10 people with LD</td>
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</tr>
<tr>
<td>Employed staff who provided at least some 24-hour support for residents</td>
<td></td>
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<tr>
<td>Provided care for at least one person with LD who displayed aggressive/challenging behaviour</td>
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<tr>
<td>Could identify one manager and one support staff who could attend WCW training together</td>
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</table>
Trial design

• A cluster randomised controlled trial
  – Residential settings allocated to WCW or waiting list control
  – WCW training as described previously
  – Control group offered WCW training at the end of the trial
    follow-up period
• Sample size of 118 settings (236 staff) based on:
  – Effect size of 0.5
  – 0.05 alpha and 90% power
  – Two staff per residential setting and an ICC of 0.1
  – 20% loss to follow-up
• Randomisation balanced for phase, region, and number of
  residents in the setting

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>WCW</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential</td>
<td></td>
<td></td>
<td>118</td>
</tr>
<tr>
<td>Phase 1</td>
<td>29</td>
<td>29</td>
<td>58</td>
</tr>
<tr>
<td>Phase 2</td>
<td>30</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Midlands</td>
<td>44</td>
<td>47</td>
<td>91</td>
</tr>
<tr>
<td>NW England</td>
<td>15</td>
<td>12</td>
<td>27</td>
</tr>
<tr>
<td>Total number of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>people living in</td>
<td>5 (3 to 6)</td>
<td>4 (2 to 7)</td>
<td>4.5 (2 to 7)</td>
</tr>
<tr>
<td>the setting</td>
<td>118</td>
<td>118</td>
<td>236</td>
</tr>
<tr>
<td>Number of recruited staff members</td>
<td>118</td>
<td>118</td>
<td>236</td>
</tr>
</tbody>
</table>
Intervention receipt

- Face-to-face training was delivered to staff
- Follow-up coaching calls were delivered to one staff member within a residential home

<table>
<thead>
<tr>
<th>Intervention element</th>
<th>Residential settings</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocated to WCW</td>
<td>59 (100%)</td>
<td>118 (100%)</td>
</tr>
<tr>
<td>Training</td>
<td>47 (80%)</td>
<td>91 (77%)</td>
</tr>
<tr>
<td>Coaching call 1</td>
<td>26 (44%)</td>
<td>N/A</td>
</tr>
<tr>
<td>Coaching call 2</td>
<td>13 (22%)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

- Training less well attended during Phase 2 (63% of staff) than Phase 1 (91%)

Intervention fidelity

- Assessed using
  - checklist capturing fidelity to the manual (max score 100)
  - global rating of the session (max score = 16)
- 13 sessions delivered in total
  - IRR for first 8 sessions was 0.97 (95% CI: 0.88 to 1) for fidelity to manual and 0.98 (95% CI: 0.92 to 1) for global
  - Group sizes ranged from 4-10 staff members (median = 7)
- Fidelity to the manual: Median = 98 [IQR: 97 to 99]
- Global rating of the session: Median = 15 [IQR: 14 to 16]
- No major differences across regions or phases

Outcome measures

- Staff empathy (6 and 20-weeks)
  - Staff Empathy towards those whose Behaviour Challenges Questionnaire
- Self-efficacy when managing CB (6 and 20-weeks)
  - Challenging behaviour self-efficacy scale
- Attitudes towards people with ID and CB (6 and 20-weeks)
  - Similarities and empowerment subscales of the Community Living Attitudes Scale
- Staff burnout (20-weeks only)
  - Emotional exhaustion, depersonalisation, and personal accomplishment subscales of the Maslach Burnout Inventory
- Staff positive perceptions (6 and 20-weeks)
  - General positive contributions and positive work motivation subscales of the Staff Positive Perceptions Questionnaire
- Recorded incidents of CB and use of restrictive practices (20-weeks)
Empathy measure

1. I can relate to the everyday problems faced by people with ID and challenging behaviour
2. I can apply the things from the point of view of people with ID and challenging behaviour
3. I can imagine what it might be like to have an ID and challenging behaviour
4. I can understand why a person with ID might present with behaviour(s) that can challenge
5. If I was faced with some of the life circumstances of people with ID, I might resort to challenging behaviour

Staff and setting retention

- 118 homes randomised (236 staff)
  - 59 WCW homes (118 staff)
  - 59 Control homes (118 staff)
  - Up to 71 homes included in 6-week analysis (107 staff)
  - 33 WCW homes (50 staff)
  - 38 Control homes (56 staff)
- 33 WCW homes (52 staff)
- 43 Control homes (69 staff)

Presentation of results

- Focus on standardised effect sizes
  - Between-group difference in means / Standard deviation (Control Group)
  - Small: 0.2; Medium: 0.5; Large: 0.8
- Positive values – potential benefit from WCW training
- Negative values – potential harm from WCW training
Primary outcome

- Staff empathy at 20-weeks post-randomisation
  - Baseline and outcome cubed to fulfil regression assumptions

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Adjusted mean difference</th>
<th>Lower 95% CI</th>
<th>Upper 95% CI</th>
<th>p-value</th>
<th>Standardised effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>SECBQ at 20-weeks</td>
<td>1073</td>
<td>-938</td>
<td>3085</td>
<td>0.296</td>
<td>0.19</td>
</tr>
</tbody>
</table>

- Small effect size
- Point estimate in direction of benefit from WCW
- ICC = 0.16

Sub-group analysis

Differential intervention effect according to proportion of residents with behaviour described as challenging in the residential setting

Secondary outcomes 20wks

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Standardised effect size</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenging behaviour self-efficacy</td>
<td>0.15</td>
<td>0.079</td>
</tr>
<tr>
<td>Similarities (CLAS)</td>
<td>0.09</td>
<td>0.640</td>
</tr>
<tr>
<td>Empowerment (CLAS)</td>
<td>0.42</td>
<td>0.032</td>
</tr>
<tr>
<td>Emotional exhaustion (MBI)</td>
<td>0.30</td>
<td>0.120</td>
</tr>
<tr>
<td>De-personalisation (MBI)</td>
<td>0.37</td>
<td>0.053</td>
</tr>
<tr>
<td>Personal accomplishment (MBI)</td>
<td>0.38</td>
<td>0.048</td>
</tr>
<tr>
<td>General positive contributions (SPPQ)</td>
<td>0.15</td>
<td>0.390</td>
</tr>
<tr>
<td>Positive work motivations (SPPQ)</td>
<td>0.26</td>
<td>0.160</td>
</tr>
</tbody>
</table>

No differences for CB incidents (p=.95)/restrictive practices use (p=.41)
Qualitative data

• All participants provided fully informed consent – Easy Read information was provided to the trainers with LD.
• Participants were managers (n=7), social care staff (n=6), trainers with LD (n=3), and the trainer without LD (n=1).
• Interviews were conducted over the telephone or face-to-face.
• Interview data were transcribed verbatim and analysed using Thematic Analysis (Braun & Clarke, 2006).

Theme 1: Valued roles

Benefits to trainers
• Became more confident with time
• Valued being able to help other people
• Appreciated the pay
• Equal partners in training and felt respected
• Sharing their experiences was cathartic

Benefits to trainees
• Valued hearing the perspective of people with LD
• Not always clear that the person with LD was the lead trainer
• Helped trainees think about the feelings of people they support
### Future trainees
- WCW could be especially useful for new staff
- Managers were using ideas in induction training
- Shared learning with other staff in the service

### Key outcomes
- Reflection about their own practice (not nec. recognised as tangible outcome)
- More aware of how they might affect people they support
- Reductions in CBs
- Needed support to implement the Action Plan
- Positive results when Action Plans implemented

### General conclusions
- Methods of staff training for challenging behaviour are needed that support strong values
- Just talking about values is not enough - we need ways to change support staff attitudes directly
- Research and theory has highlighted this for over 20 years. Unless we act now, care scandals will continue to plague challenging behaviour services
- People with learning disability have a core role to play in staff training: co-designing and delivering training
WCW key learning points

• Co-production can be theoretically strong and evidence-informed as well as a “good thing”
• People with learning disability can deliver high quality (well-received) training with high fidelity, and they benefit enormously doing this work
• To do WCW properly took dedication, time, hard work on accessibility, good support and positive relationships – from everyone involved
• Delivering work of high quality people with learning disability need to be paid properly, and there are still barriers that make this difficult
• It is possible to recruit to and run high quality RCTs outside of healthcare settings, but retention was a problem
• We have some evidence that WCW “works” (and is valued and not harmful), but more development and testing is needed especially to understand if behaviour change can be achieved

WCW potential next steps

• Examine longer term outcomes, and potential impact on the day-to-day lives of people with learning disabilities
• WCW as a framework from which various training interventions could be developed (different settings, focus on individuals…)
• People with learning disabilities leading the training of new trainers
• “Market” research
• Employment models to allow “scaling up”

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