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The team climate in residential care homes for adults with a learning disability who display challenging behaviour: A group level analysis.

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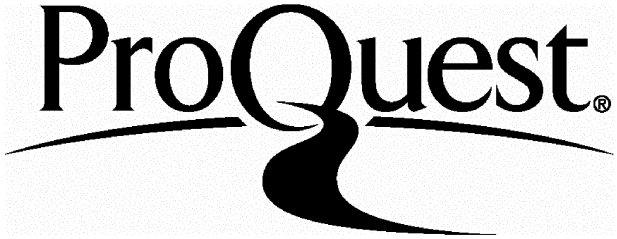

Acknowledgements

Long rain of May,
The whole world is
A single sheet of paper
Under the clouds
Nishiyama Soin (1605-1682)

For Tony and Georgina

This project was completed with the help and support of many people. Many organisations generously allowed access to their services and many busy staff gave their time to the completion of the questionnaires and for interviews, without which there could have been no project. Access to services was frequently facilitated by Clinical Psychologists, and in this the support of Victor Levenson (West Herts), John Newland (Camden and Islington), and Harry Davies and Roman Raczka (Kensington and Chelsea/Hammersmith and Fulham) was invaluable, as was that of Consultant Psychiatrist Dr Jack Piachaud (St Charles' Hospital).

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ABSTRACT

This cross-sectional survey in residential care homes for people with learning disabilities who display challenging behaviour used a group level analysis of the extent of challenging behaviours and of the organisational features of the homes. Measures of team climate were used as an assessment of team functioning and, particularly, of a team's capacity to innovate. New interventions with challenging behaviours, by the team and by external agents such as psychologists and other clinicians, are characterised as innovations, in the specific sense that they represent a novel application of ways of working in that context.

Staff working in 44 residential care homes completed Team Climate Inventories, an assessment of their level of functioning as a team, and Checklists of Challenging Behaviour, as an assessment of the levels of challenging behaviour in the homes overall.

It was hypothesised that there would be lower levels of team functioning in homes where there were higher levels of challenging behaviour. The results of this study tentatively confirm that hypothesis.

Managers of the homes were interviewed about the way in which they and their team managed challenging behaviour. A content analytic procedure was used to categorise their responses. Six superordinate categories, in three pairs, were generated, which corresponded to the ways in which the behaviours were managed or contained, the ways in which there were benefits or deficits in the processes of the team working together, and the ways in which the interventions by external clinicians were conceptualised.

It is suggested that such a group level analysis offers an additional dimension in which ecobehavioural assessment and interventions with challenging behaviour by psychologists can be set, so that the functions of the whole team and the overall levels of challenging behaviour in homes can be taken into account, rather than a purely functional analytic approach which considers behaviour at an individualised level. Implications for further research are suggested.

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CHAPTER FOUR: DISCUSSION

BACKGROUND AND OVERVIEW OF THE PROJECT

Over the last two decades there have been large increases in the number of adults with a learning disability living in supported residential care homes in England. Residential care homes are not merely peoples' homes; they are also the workplaces of large numbers of staff, who work alongside residents to support what is generally known as "an ordinary life" in the community (e.g. Blunden and Allen, 1987). This work requires that staff assume many different roles, and will frequently require staff to support such an ordinary life for people who behave in ways which may be difficult to manage and which may present a risk to themselves or to others.

For people with learning disabilities who live in community homes, the issue of how to manage these behaviours is an important one for staff, who must support residents, both inside their homes and when they are using ordinary community facilities, in ways which minimise the risks to the person, including that of drawing unwelcome attention, and to others.

The way in which staff work with problematic, or challenging, behaviours is often supported by interventions by psychologists, or other clinicians working in community teams for people with learning disabilities. Much of the research and theoretical literature relating to such interventions is largely focused on the individual behaviours of the residents and the individual responses of staff members to those behaviours. However, staff members work together in teams, and residents do not generally live alone, but with others, who may also display challenging behaviours.

This study considers the organisational and structural features of a surveyed sample of residential care homes for people with learning disabilities who display challenging behaviours. In particular, an account of some of the inputs to, and processes of, the work of staff in managing challenging behaviours are considered. The framework for this is a group-level analysis, which differs from analyses in which an individualised account of resident behaviours and staff responses is the main focus. This group-level approach uses aggregate measures of team functioning and of levels of challenging behaviour, to enable comparisons between homes, rather than between individuals, to be made.

The study considers the levels of challenging behaviours in the homes and the internal and external organisational features, including the way staff teams work together. Manager descriptions of their team's approach to the management of challenging behaviour are also considered. Specific hypotheses about the relationships between team functioning and levels of challenging behaviour are tested.

OVERVIEW OF CHAPTER ONE: INTRODUCTION

In this introduction, the setting for the research project is described. An outline of the constituency is given, and the definition and nature of challenging behaviour in adults with a learning disability is described. The research relating to staff issues, including staff responses to challenging behaviour and staff stress, is reviewed. An ecobehavioural approach to challenging behaviour is described.

A rationale for group level analysis of residential homes is offered. The aims of the study are described. Finally, the research questions are stated.

PEOPLE WITH LEARNING DISABILITIES AND CHALLENGING BEHAVIOURS

The constituency

Department of Health Statistics show that, at 31st March, 1998, there were approximately 50,000 bed spaces for people with learning disabilities in residential care homes and the number of places for adults (aged 18 – 64) had increased by 44% from 1994 levels, to 25,400. There were 7,700 residential care homes for people with learning disabilities, an increase of 6% on 1997 figures and a 58% increase on 1994 figures. 93% of these care homes were in the independent sector (Department of Health, 1998). This represents a large constituency of service users, both in terms of the number of supported clients and the staff members working in the homes. The terms used by different service providers and others to describe these entities are diverse. In this study, the term "resident" will be used to describe people who live in supported homes with 24-hour staffing; "staff" will be used to describe those whose work is directly to support the people living in the homes; "manager" will describe the person with front-line responsibility for the staff and the establishments, and "residential care home" will be used to describe the establishments in which residents and staff live and work.

Learning disability: Definition and Prevalence

Definition

While the terms most frequently used in the UK are "learning disability" or "intellectual disability", the most comprehensive and widely accepted definition (Hatton, 1998) is that devised by the American Association on Mental Retardation (AAMR). However, the term "learning disability" will be used throughout this report as it reflects the nomenclature used generally in statistical information and also for health service teams serving this population.

The AAMR definition (Luckasson, Coulter, Polloway, Reiss, Schalock, Snell, Spitalnik and Stark, 1992) is given below.

AAMR 1992 DEFINITION OF MENTAL RETARDATION

Mental retardation refers to substantial limitations in present functioning.

It is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following adaptive skill areas:

- Communication
- Self-care
- Home living
- Social skills
- Community use
- Self-direction
- Health and safety
- Functional academics
- Leisure
- Work

Mental retardation manifests before age 18.

Prevalence

Attempts to determine the prevalence of people with learning disabilities show a range of results, because of differences in sampling methods (whether whole

populations are studied, or administratively defined populations, such as those known to local services), differences in classification criteria used over time and across geographical areas, and assessment methods – for example, using IQ scores alone tends to produce higher prevalence rates than those studies which use additional adaptive behaviour assessments. Hatton (1998) summarises the European and North American findings as follows:

MILD LEARNING DISABILITY

General prevalence rates for mild learning disabilities (IQ 50-70) are between 3.7 to 5.9 per 1000, with the male:female ratio approximately 1.6:1. There is an increase in prevalence figures for mild learning disability throughout the years of schooling, with a drop around school leaving age. People with mild learning disabilities are disproportionately represented in those with disadvantaged socio-economic backgrounds.

SEVERE LEARNING DISABILITY

The general prevalence rates for severe learning disabilities (IQ<50) is between 3 and 4 per 1000. Some studies report higher prevalence in males, while others report little difference in prevalence. There is an increase in prevalence throughout the years of schooling, with little reduction in the figures around school leaving age. People with severe learning disabilities are represented in a range of socio-economic backgrounds.

Conditions associated with learning disability

There are varied estimates of prevalence for other conditions which people with a learning disability may also have. These conditions include:

a) *Epilepsy* - between 15% and 30% (McLaren and Bryson, 1987).

b) *Cerebral palsy* and/or other motor impairments - reported in 20-30% of people (McLaren and Bryson, 1987).

c) *Sensory impairments* -10-33% of people, with much higher rates reported in studies using clinical, rather than functional, criteria for diagnosis (Hatton and Emerson, 1995; McLaren and Bryson, 1987).

d) *Psychiatric disorders* – a very wide range of estimates of prevalence for psychiatric disorders in this population reflects the difficulties in accurate diagnosis, particularly for people with severe learning disabilities and/or those who do not use formal communication methods. Studies using more stringent psychiatric criteria tend to report figures of 15-20%, which is similar to the general population. However, a survey of people with learning disabilities living in the community found that, of those with expressive language who could be interviewed, 41% fulfilled DSM-III criteria for psychiatric diagnosis. Approximately 12% of these diagnoses were for schizophrenic or paranoid disorders (Bouras and Drummond, 1992). An ICD-10 diagnostic field trial, with a smaller sample of community-based people with learning disabilities, found that there were problems with the diagnostic criteria for schizophrenia and related disorders (Clarke, Cumella, Corbett, Baxter, Langton, Prasher, Roy, Roy and Thinn, 1994). Comorbidity of learning disabilities and psychiatric disorders appears

to become more prevalent and presents more client management issues as people move into the community. (Fuller and Sabatino, 1998).

It is clear that diagnosis of mental health problems in this population is problematic, particularly since behavioural problems may be conflated with psychiatric symptoms.

e) *Challenging behaviour* – there are widely differing criteria for determining and measuring challenging behaviour, and this will be considered in more detail.

Challenging Behaviour

The Mansell Report (1993), which focused on the tasks facing commissioners of services for people with a learning disability who presented behaviours that were difficult to manage, adopted as a working definition that given by Emerson (1987):

> "Severely challenging behaviour refers to 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 or delay access to and use of ordinary community facilities"
>
> cited in: Mansell,1993 p2

The report sets out a charter for services for people with learning disabilities who have challenging behaviour and/or mental health needs. The charter enshrines the principles of individually tailored services, with access and rights to community facilities such as those enjoyed by the general community, ensuring that each service user is treated with full respect and is in receipt of services provided in the least restrictive manner that can respond to their needs, by

appropriately trained and qualified staff, in a climate of evidence-based service development.

Behavioural difficulties of people with learning disabilities present a challenge not only to their own service – in terms, for example, of access to facilities in the community – but also to those who live and work with them, for example, in residential care homes. Criteria for defining problem behaviours in this context can be seen as reflecting a continuum model, with the definition of severe behaviours (Emerson et al, 1987) at one end of the continuum. A "working definition" may include behaviour that reflects some of the following criteria:

a) Behaviour and/or its severity that is inappropriate given the person's age and level of development.
b) Behaviour that presents a danger to the person or to others.
c) Behaviour that impedes the acquisition and development of new skills, or which results in the exclusion of the person from learning opportunities (such as access to facilities).
d) Behaviour causing significant stress and/or which impairs the quality of life of those living and working with the person to an unreasonable degree.
e) Behaviour that is contrary to social norms.

(Zarkowska and Clements, 1994)

Kiernan and Qureshi (1993) adopted an operational definition of challenging behaviour, in which people were identified through the consequences of their behaviour – injury to themselves, or others, or damage to their environment, or

severe social disruption to the lives of others. Qureshi (1994) identified people as showing challenging behaviour if they had at some time caused more than minor injuries to themselves or others, or destroyed their immediate living and/or working environment, *or* if they showed, at least weekly, behaviour which required intervention by more than one member of staff for control, or placed them in physical danger, or caused damage which could not be rectified by immediate care staff, or caused at least one hour's disruption, *or* if they caused more than a few minutes disruption, at least daily. McGill, Clare and Murphy (1997), however, argue that the term "challenging behaviour" should be reserved for behaviour which is dangerous or which interferes significantly with the individual's or others' lifestyles; they emphasise that the labelling process is open to functional use – for example, by carers to access external support in the management of behaviours – but also to use in a discriminatory way – to sanction or to deny access to services and facilities.

A definition advanced by Toogood (1993) states that challenging behaviour is an enduring pattern of behaviour which, at a given point in time, causes the ordinary range of services to be ineffective, either because of the nature, intensity and frequency of the behaviour or because of the negative consequences for the lifestyle of all concerned.

It can be seen that, just as learning disability itself is described by some commentators as socially constructed (e.g. Fryers, 1993), so also operational definitions of challenging behaviour are based on criteria which reflect the social impact of the behaviours on others and on the person's capacity to access and

engage with the social environment. This is particularly relevant in the context of "ordinary living", and the aims of services to support the access of people with learning disabilities to valued opportunities and community facilities. Just as then, there is an element of social definition of difficult or challenging behaviours, so too the decision to intervene, or not to intervene, may also be seen as socially determined. This social determination may lie in the interests of those applying the label and may also reflect the experience that carers have in working with individuals. "Causing an element of disruption, at least daily" may be much more likely to be identified in service users living in small, ordinary homes than in large institutions, and is a much broader definition than that cited in the Mansell report (1993). Such behaviour may, over time, serve to limit the access of people to services in the community and perhaps jeopardise their residential placement, but, from day to day, such behaviour is likely to impact on the staff working to support them and also on the lives of those living alongside them. It is also more likely to result in referral to services for intervention.

In a study of seven UK health districts (Qureshi, 1994; Qureshi and Alborz, 1992), approximately 7% of the people with learning disabilities surveyed showed behaviours meeting a composite definition, including injury to self or others, frequency of behaviour problems, behaviour likely physically to endanger self, disruptive behaviour, and level of control required. In this study, just over half of those identified (51%) were living in hospital. Given the rapid increase in the number of places in the community, and the decrease in places available in hospital, the actual prevalence of challenging behaviours in the community is likely to be higher. Those aged between 15 and 34 were over represented

amongst those showing challenging behaviour, and two-thirds of those displaying challenging behaviour were men. Men were more likely to be living in hospital than women and less likely to be living in their family home.

The hypothesised function of behaviours has also been found to be consistent across settings (Emerson, Thompson, Reeves, Henderson and Robertson, 1995). The structure of maladaptive behaviour may also be influenced by age and level of learning disability (McGrew, Ittennbach, Bruininks and Hill, 1991). In a longitudinal, large scale survey of the types of incidents in US urban residential care homes, behavioural incidents accounted for approximately 30% of all recorded incidents, with the majority of these incidents represented by aggression towards others. 18% of the incidents were self-injurious behaviour, 9% property destruction and 5% other maladaptive behaviours (Spangler, Gilman and La Borde, 1990).

It can be seen that there are problems in defining and measuring concepts of challenging behaviour, and these concepts may be conflated with degree of severity of learning disability and other behaviours. Staff may, for example, be more likely to rate behaviours as severe if they occur frequently and more behaviours are likely to be cited as causing severe management problems by carers working in community homes than in hospital settings (Lowe and Felce, 1995). Staff may also have inaccurate perceptions of the skills of people with learning disabilities whom they support – for example, they may over-estimate receptive language skills and under-estimate hearing difficulties (Purcell, Morris and McConkey, 1999). Such inaccuracies reflect the need for caution in the use

of informant data in assessments, both in terms of behaviours and in terms of skills of service users.

The use of the term "challenging behaviour" reflects the concept that such behaviours represent challenges to services, rather than underlying psychopathological processes (Felce and Emerson, 1996). Epidemiological data are based on samples likely to be biased towards social challenging behaviours, because actions which impact on others are more likely to be labelled as challenging and to be considered as a greater management problem than those impacting on the person alone. Challenging behaviour is likely to be enduring, and therefore the issues for services are the provision and support of access to a decent quality of life, the promotion and support of the development of "adaptive" behaviours and the reduction of the occurrence of behaviour that damages the person or those around them, despite these potentially enduring behavioural difficulties.

Behavioural topographies

A survey of the topography and behavioural function underlying the challenging behaviours of a sample of 70 people living in a defined geographical area found that more severe challenging behaviours were found in people with more severe disabilities; 44% of the sample showed more than one form of challenging behaviour and, for those with more severe behaviours, this figure was 79%. There also appeared to be specific clusters of problematic, aggressive and self-injurious behaviour. Assessment using the Motivation Assessment Scale suggested that the most common function of these behaviours was self-

stimulation, and gaining the attention of carers (for aggressive behaviours), although the only consistent relationship between form and function of particular behaviours was for self-injurious behaviour, which was associated with self-stimulation (Emerson and Bromley, 1995). Co-occurrence of several forms of frequent severe problem behaviour was the norm in one surveyed sample of people in a single geographical area identified as having the most severe challenging behaviour and severe learning disability and this was markedly associated with social impairment (Lowe, Felce, Perry, Baxter and Jones, 1998).

In a recent survey of adults known to services because of their listing on a UK learning disabilities register, 17.4% of this population were described by carers as having some forms of self-injurious behaviour. It was found that other maladaptive behaviours were highly associated with self-injurious behaviour, and that it was more prevalent in younger adults and those with a lower developmental quotient. (Collacott, Cooper, Branford and McGrother, 1998). Emerson (1992) suggests that self-injurious behaviour is shown by between 4% and 10% of people with learning disabilities, and summarises the range of such behaviours – most typically, repeated self-biting, self-hitting, particularly of head or face, hitting the head against walls or furniture, pica, skin picking or scratching and placing fingers in body cavities. Multiple topographies were found in 50%-75% of those who self-injure and approximately 50% of those who self-injured were also found to exhibit other forms of challenging behaviours (Griffin, Williams, Stark, Altmeyer and Mason, 1986). Self-injurious behaviour is also associated with some genetic syndromes, although the association is not clear cut (e.g. Deb, 1998). The existence of a clinical syndrome of violence and

self-injury in the severely learning disabled population has also been postulated (Read, 1998). Self-injurious behaviour may be seen as controlling important psychological aspects of the sensory environment and/or the social environment. It has been described as an attempt by the person to manage, cognitively and emotionally, the anger and distress arising from disability and trauma (Sinason, 1992; Stenfert Kroese, Dagnan and Loumidis, 1997; Halliday and Mackrell, 1998).

SUMMARY: People with learning disabilities and challenging behaviour

In summary, individuals with a learning disability may display a wide range of behaviours which are likely to challenge services in their continuing provision of support for living in the community in the context of the impact of these behaviours on the lives of the people displaying them, those living alongside and working with them, and, potentially, on the wider community. These behaviours will frequently occur in the context of other physical and mental health problems.

The staffing element of residential care homes is a key factor in the group level analysis and this will be considered next.

STAFF IN RESIDENTIAL CARE HOMES

Staffing issues are central to the consideration of what constitutes quality services for people with learning disabilities; they are the interface through which policy, both local to the provider organisation, and wider policy, which may be "funnelled" through those organisations, are implemented. They

constitute the largest cost factor in services and certain forms of staff activity may have key effects in determining quality of life for service users, particularly for those with severe learning disabilities and with challenging behaviours (Hatton and Emerson, 1995b). Community services are of widely varying quality, and research into the factors relating to staff performance, and its interaction with service outcomes for residents in residential care homes, is essential to the development of practical service models and models of interventions provided by services.

There are, broadly, two frameworks of research concerning staff in services for people with learning disabilities. The first research framework generally involves direct observations of staff activities and interactions with residents, characteristics of service users and their relationships to staff interactions, and research that investigates the relationship between staff behaviours and the direct contingent effects on many aspects of challenging behaviour. The second concerns the relationships between staff stress and well-being, which is frequently examined in terms of self-report measures and in the context of an assumption that high levels of staff stress and low levels of well being will be associated with poorer staff performance and higher turnover. Staff stress is therefore viewed as a factor that has the potential to impact not only on the mental health of the staff, but also on outcomes for residents.

Care staff responses to challenging behaviour

Staff beliefs about challenging behaviours and their working environment may affect their definitions of who represents a challenge to services and also their

responses to challenging behaviour. Staff training may emphasise the management, rather than the understanding, of challenging behaviours, which in turn supports the construct of challenging behaviour as something to be controlled (particularly problematic in light of the fact that such behaviours are likely to be enduring). The behaviours themselves are also likely to be aversive (Hastings, 1995a). Despite an increase in the knowledge about the provision of effective interventions, there may be shortcomings in staff implementation of practice, and a lack of congruence between knowledge derived from research and its professional application (Jahr, 1998). Staff beliefs about appropriate short-term interventions suggest that their responses are likely to maintain and/or develop challenging behaviours, although there may be a distinction in beliefs about short- and long-term interventions, with beliefs about longer term interventions more likely to be matched to contemporary psychological models of the development of challenging behaviours and their treatment (Hastings, 1997).

Beliefs and responses of care staff

Individuals showing the most seriously challenging behaviours are likely to receive the most attention from staff (Emerson, Thompson, Reeves, Henderson and Robertson, 1995), although Felce, Lowe and Blackman (1995) found that staff in their study gave least attention to challenging behaviours (see below). Staff beliefs and responses are likely to affect the nature and the amount of their interactions with residents displaying challenging behaviours. Staff may experience sadness, anger, disgust, and other similar emotions; they may attribute the causes of behaviour to diverse factors, related to inter- and intra-personal events, and to social and environmental factors; and significant stressors

may be those associated with the relentlessness of daily caring for someone with challenging behaviours, and the difficulties in understanding, predicting, and intervening successfully with such behaviours (Bromley and Emerson, 1995). This relates to the point made earlier about the potentially enduring nature of challenging behaviours; despite these difficulties, staff are expected to provide a service of quality which generates a dynamic range of opportunities for the service users. It is also to be expected that their beliefs and emotional responses will affect their practice in implementing and seeking interventions with challenging behaviours, particularly from outside sources, such as clinical team members.

Staff perceptions of emotional states of people with learning disabilities may vary widely (e.g.. Clark, Reed and Sturmey, 1991). After experiencing violence from a resident, staff may have heightened levels of general anxiety for several weeks; expressed emotion about the incident may be raised and remain high for some weeks, and staff tend to make attributions about the incident which are external to themselves, internal and/or personal to the client, and beyond the control of staff (Cottle, Kuipers, Murphy and Oakes, 1995).

Staff responses may also be counter-habilitative; they may behave towards incidents of challenging behaviour in ways which act as reinforcers for that behaviour. They may describe long-term interventions based on prevailing psychological models of intervention with behaviours, but in practice they may be observed to adopt counter-habilitative strategies (Hastings, 1996) and/or to attribute such behaviour solely to internal causes (Oliver, Hall, Hales and Head,

1996). This exemplifies the gap between what is known and what is implemented, and this gap may not be bridged by training in behavioural management alone, although behaviourally-trained staff are much more likely to respond in more habilitative ways. Pyramidal staff training, in which front-line managers receive training in assessment, data collection and interpretation and interventions with behaviours, and then train the staff group, may result in improved staff responses and reductions in the target challenging behaviours (Shore, Iwata, Vollmer, Lerman and Zarcone, 1995).

Staff may distinguish between behavioural topographies in terms of their causes (Hastings, Reed and Watts, 1997); this is important in the context of treatment interventions as related to hypotheses about causes, and also in the context of staff training based in this intervention model. There may be differences between experienced and inexperienced staff, in terms of their beliefs about challenging behaviour, and inexperienced staff may adopt a "needs-based" rather than a functional approach to interventions (Hastings, Remington and Hopper, 1995). Clearly, multiple variables will impact on the success or otherwise of intervention programs.

Hastings, Remington and Hatton (1995) attempt to define a framework which unifies the behavioural research and staff stress traditions. They suggest that there are two main kinds of influence on staff performance: the characteristics, formal and informal, of the organisation in which staff work, and the characteristics of staff themselves. They postulate an absence in the research: that is, the failure to acknowledge that the processes impacting on staff

performance are dynamic and multi-factorial, and subject to frequent change. Organisations change and adapt, and require front line care staff to do so, in response to wider philosophical and national policy changes (for example, the requirements of registration departments and, indeed, the requirement that homes should be registered). They point out that individual characteristics of staff may serve to generate an informal culture in services which is not equivalent to that of the formal organisational culture in which the service resides. The performance of staff is itself a recursive process, which may impact on the local informal cultural aspects of services and on the wider organisational culture.

Hastings, Remington and Hatton (1995) argue for the utilisation of models drawn from occupational and organisational psychology in understanding formal and informal service culture.

Two important findings emerged from Felce, Lowe and Blackman's research (1995). The amount and the quality of interaction between staff and residents was found to be variable. However, the quality of staff interaction, in terms of the way assistance was provided, the use of restraint and other contact was similar, on average, across different types of settings.

Staff, in that study, gave least attention to challenging behaviours. They did not appear to discriminate about the timing and content of their actions in response to challenging behaviours. It was found that, in general, there was generally too little staff and resident engagement, too little assistance to residents was given, and that staff attention was rarely sustained sufficiently to allow for protracted

engagement. The authors conclude that such research cannot untangle relationships between rates and durations of staff/resident interactions, staff attention and resident behaviour, and resident activity.

The quality of life for service users with severely challenging behaviour was assessed as generally inferior to that achieved for people with equally severe intellectual disabilities, in terms of the extent of assistance and attention from staff and of the participation of service users in purposeful activity. It is argued that this is consistent with literature indicating that people with severely challenging behaviour experience relative deprivation. • Felce, Lowe and Blackman (1995) consider that their research implies that staff need to develop greater discrimination over the purpose, quality and timing of their interaction with residents, and that carefully constructed approaches are needed to support service users in typical activities and in the reduction of challenging behaviours.

In summary, care staff beliefs and attributions about challenging behaviours may or may not be based on psychological models that are likely to support effective interventions; even in the context of an understanding of, and training in, the issues of behaviour (and its management), staff may still display responses which are counter-habilitative and the levels of engagement with residents may also be variable.

Care staff stress and its effects on services

It has been shown that perceived work stress can have a high impact on work performance, particularly when associated with uncertainty concerning job tasks,

and that perceived work stress is related to the emotional impact of the work, particularly violent service user behaviour, and the use by staff of what is described as a "wishful thinking" strategy, which does not deal realistically either with the problem, or the constraints on its management (Hatton, Brown, Caine and Emerson, 1995).

Rose (1995) asserts that staff will not be able to perform at optimum level if under stress. Most studies of staff stress use measures of staff perceptions of stress and their attributions for its sources, which are not always objective and depend on social influence. This social influence will, inevitably, include the nature of the team in which staff work. Staff may report considerable job satisfaction as well as job stress, and these may be interlinked, for example, supporting service users outside of the group home may be both stressful and a source of job satisfaction (Stenfert Kroese and Fleming, 1992).

Generally, organisational variables are cited as the most important stressors. These include: lack of control over factors affecting work, work load, specific organisational features – like the requirement to move between units – and role conflicts. Role conflicts in these settings may be represented by, for example, the requirement – and the beliefs of staff - that staff should support the access of residents to the use of community facilities, but also that the element of risk taking involved is appropriate. In the context of challenging behaviours, this may represent a significant role conflict, in that these behaviours may expose either the client, or those around them, to levels of risk. These risks may be actual physical risks, or they may be "social" risks – the risk of unwelcome

attention to behaviours inappropriate in a setting outside the privacy of the resident's home. Resident characteristics are rarely cited as sources of stress. Rose (1995) states that care staff may find it more acceptable to cite organisational issues, rather than service user characteristics, as sources of stress. The interrelationship between these variables is complex and studies are methodologically and demographically diverse, so that it is difficult to draw conclusions from them. While it is suggested that social support may act as a buffer against stress, for front-line managers, the presence of staff team members may actually constitute an additional form of stress, in the form of supervisory responsibility (Elliott and Rose, 1997). Supervision of staff by front-line managers may be seen as a way of transmitting knowledge about skills, administering the process of the work and for maintaining accountability. One aspect of this supervision process is the provision of support – for anxiety in dealing with the work and for a climate of innovation (Levy, Levy, Freeman, Feiman and Samowitz, 1988). The tensions experienced by the direct care worker will also be experienced by the front-line manager and this may be particularly acute if they themselves do not have access to supportive supervision.

Staff stress has been implicated in high turnover rates, although there are a large number of variables impacting on this and there are also variable rates of staff turnover. It is important to distance turnover from stress, which may contribute to turnover but is only one of a number of factors. Other factors predictive of higher turnover may be age (younger staff tending to be more likely to move on); education (higher stability associated with less formal education); length of

service (with longer-serving employees tending to be more stable) and age at initial employment (with older people more likely to stay). Geographical location, reasons for accepting the position initially and job satisfaction are also important. The organisational variables most predictive of turnover, however, are likely to be those connected with remuneration, opportunities for advancement, and opportunities for alternative employment (Lakin, 1988).

It is clear that staff stress may impact on the outcomes for service users in diverse ways, such as the emotional responses to challenging behaviour by staff, which may inform attributions and actual responses; it may also influence staff turnover, which will represent change for service users and, for organisations, costs in terms of replacing and training staff members. There will also be hidden effects of staff turnover; the lost knowledge of, and relationships with, service users cannot be replaced by the provision of replacement staff members alone, because of the extent of experience required to build up that knowledge and those relationships. The provision of temporary staff members to bridge gaps in staffing will also impact on service users and team members, in terms of lack of continuity. The effects of staff stress are also likely to impact on teams as a whole.

Outcomes for service users in residential care homes

Conneally, Boyle and Smyth (1992) evaluated the use of small residential care homes for adults with a severe and profound mental handicap. They found that there was a combination of factors affecting the outcome, in terms of quality of life, for residents. They found that the key issue was the "orientation, positive

attitudes and commitment" of staff members (p165). If this is not fostered and supported, small community homes have the potential to become mini-institutions. The model of service in which staff work was also found to be a significant contributor to a positive culture. This study does not address the issue of who is to offer the support for the development of a positive ethos, centred on the service users, although it is implicitly the task of the provider organisation. However, given the place of staff at the interface of service users, organisations and wider policy, it can also be argued that this is the role of clinicians working in community learning disability teams or in specialist behavioural support teams, because interventions for challenging behaviour will need to support the development of ways of responding which are truly service-user centred, by influencing the orientation of care staff. As such, clinical psychologists have a significant role to play in this task.

Hewson and Walker (1992), in their evaluation of staffed residential service development, emphasised the importance of an impact on service delivery, in the context of concern that the interests of researchers and policy makers are dichotomised, and are therefore less likely to have a positive impact on service delivery.

Felce, de Kock and Repp (1986) evaluated services in terms of the levels of constructive engagement of residents and of staff interactions with them, the extent to which residents showed disturbed behaviour and the organisational structures and processes which supported the development of appropriate staff performance. They suggested that there were some key organisational structures

and processes which are significantly associated with positive outcomes. These include clear, written statements of service aims, with written individual service plans for each resident, and a nominated key worker to co-ordinate, rather than implement, these plans; and weekly staff meetings, the primary purpose of which is the discussion of issues for individual residents. They also suggest that a regular staff appraisal system is vital to these processes.

Felce, de Kock and Repp comment that

> "...it is perhaps ironic that those who work with people with mental handicap [sic] have themselves been slow to understand that substantive learning difficulties lie in the organisations themselves. If the analogy is apt, then it suggests that change agents will have to work at a level acceptable to the organisation and help set clear but attainable goals. Gains will be hard-won and it is likely that there will be problems of maintenance and generalisation"
>
> p200

Over ten years later, the issues for change agents are still crucial. In the context of challenging behaviours, it is therefore vital that interventions and support are tailored to the organisation – or the individual residential care home – if they are to be effective. For psychologists working with care staff teams, this implies that interventions aimed at supporting an understanding of challenging behaviours and the factors that maintain or reduce these, and interventions to address them, must go beyond a functional analysis of the behaviours and staff training issues.

Despite all of these areas of difficulty, studies have shown that people with even severe or profound learning disability and very serious challenging behaviour may, over time and following relocation to community residences with high staffing ratios, show significant improvement in meaningful activity without

overall increase in problematic behaviours (Hastings, 1995b); behaviours may be enduring, but managed in ways which support the wider development of the resident's quality of life.

SUMMARY: Staff in residential care homes

It has been argued that staff represent a central feature of residential care homes. Their beliefs about, and responses to, challenging behaviour may be counter-habilitative, and challenging behaviours may engender staff stress. Staff stress may also impact on organisational features of the homes, such as turnover, as well as staff performance. The role of staff in interventions with challenging behaviour will be considered in the next section.

INTERVENTIONS WITH CHALLENGING BEHAVIOURS

An ecobehavioural approach to interventions

Halliday and Mackrell (1998) set out an ecological framework for intervening with self-injurious behaviour (and this may be extended to the consideration of challenging behaviours in general). Because of the multi-factorial nature of the behaviours, this emphasises the environmental, interpersonal and intrapersonal dynamics. Such a framework builds on the models of functional analysis, in which intervention is based on an analysis of the effects of events taking place before and after the target behaviours, and functionally equivalent behaviours are taught to take the place of these less adaptive behaviours. In an ecological framework, a wider range of environmental and social influences are taken into account, including intrapersonal factors, such as the person's state of arousal,

thoughts and feelings, experiences of pain or illness, their cognitive abilities and deficits. The wider social environment will include such things as multiple attachments and losses, including patterns of relocation and staff turnover within a home – Halliday and Mackrell describe five dimensions for the functional analysis of behaviour: biological, physical, social, interpersonal and intrapersonal. These dimensions will include past as well as present states.

This concept may be extended to other behaviours that challenge services. It can be seen that it is akin to the two-category model of intervention proposed by McGill (1993). In this framework, two categories of cause are postulated for challenging behaviours: challenging needs, which are the features of the individual person associated with a greater likelihood of challenging behaviour – such as particular genetic syndromes, communication limitations, sensory impairments; and challenging environments, which are the features of the social and physical environment associated with greater likelihood of challenging behaviour, such as lack of purposeful activity, abuse, overcrowding etc. These needs and environments are, argues McGill, likely to be interdependent and he argues for the need for investigation of the variable responses of individuals in varied environments to underpin an understanding of the mechanisms interacting between environments, individual needs and challenging behaviours.

A conceptual analysis of staff behaviours takes into account the concepts of attitudes and beliefs as self-generated rules; it is argued that rules in services for people with learning disabilities fall into two categories – those which shape the work of staff and direct their responses to challenging behaviour, and those

which hypothesise about causes of challenging behaviours. Externally supplied, performance-related rules will be represented by the service policies and guidelines, programs for managing challenging behaviour, and also the informal staff culture. Externally supplied, hypothesis-based rules will be represented by professional analyses of challenging behaviours (such as clinicians) and those derived from staff culture. The self-generated rules will be represented by individual beliefs about the management and the causes of challenging behaviours (Hastings and Remington, 1994). Much of the research relates to the self-generated rules, both performance and hypothesis related. The role of the informal staff culture, which will interact with the individual self-generated rules, is less researched. Staff team culture operates at a level which is different from that of the individual, and, as part of the wider ecological environment in which staff and service user behaviour occurs, is a significant contributor to the internal and external rules which may inform staff responses to challenging behaviour. It may also represent a point of incongruence – between individual, and group level, performance and hypothesis rules, and between the informal and the formal aspects of organisational culture (the staff group, working independently, and the provider organisation). Understanding of ways in which service user behaviours and the informal culture may interact would prove a vital adjunct to this model.

Three defining features of residential care models for people with learning disabilities are the orientation – the objectives to which a program aspires, structure – the relatively permanent features of the environment set up in the initial planning, and procedures – the operational and training systems guiding

staff performance (Felce, 1988). The informal culture of a staff team may be seen as impacting on the orientation of a particular service and also the implementation of the procedural elements, and as such forms an important part of the ecological environment.

External support for interventions

The problems arising as greater numbers of people with challenging behaviour have been accommodated in the community have led to the formation of specialist peripatetic teams. Their remit is give advice and support to carers with aim of reducing behavioural difficulties, promoting lifestyle quality and securing continued placement in the community (Felce, Lowe and Blackman, 1995). It can be argued that this is also a function of ordinary community learning disability teams. Different service models prevail in different areas (e.g. Simpson, 1997) and, for the purposes of the current study, these models will be conceptualised in the same way – as sources of external clinical support to the residents of homes and to the staff teams working within them, and as such, a point of interface between health and social care.

A definition of challenging behaviour adopted by an intensive behavioural support team (Toogood, Bell, Jaques, Lewis, Sinclair and Wright, 1994a) considers challenging behavior from a dual perspective: that of the individual, whose behaviour is described as challenging, and those close to the person and that of the service and/or the local community in which the person lives. In this context, "challenging" describes behaviours which place an unacceptable strain on the service – and its staff. They argue that such a dual perspective benefits

services because it can inform the developments of service design which prevent strain to the point of dysfunctional performance. Toogood, Bell, Jaques, Lewis, Sinclair and Wright (1994b) define two groups of consumers of their services: the client, and the services providing support. They report findings suggesting that the satisfaction with the service expressed by this second group was significantly linked to involvement in the assessment and intervention process and to the quality of the explanation provided by the assessment for the continuing occurrence of the challenging behaviour. A major source of dissatisfaction was the length of time to complete assessments and to support the implementation of intervention strategies. Toogood et al (1994b) emphasise the multi-factorial nature of this issue, including the additional constraints of joint working in teams and the complexity and chronicity of challenging behaviour generally. One survey of the level of satisfaction with a specialist team expressed by service users themselves found that service users were generally in agreement with referrers (Grey and Jenkins, 1994).

The effectiveness of such teams may be limited by the overall quality of the service in which the intervention takes place, and may not affect staff morale even if positive outcomes are noted for service users (Lowe, Felce and Blackman, 1996). The nature and severity of aberrant behaviour displayed by people referred to such teams may also vary from service to service, although there may be no differences in terms of social impairment, levels of dependence and ability, and mental health (Lowe, Felce and Blackman, 1995). Externalising behaviours may represent the most frequent reason for referral to psychological services generally for adults with learning disabilities and these behaviours may

reflect the disproportionate attention paid to such behaviours relative to internalising symptoms of an underlying mental health problem (Edelstein and Glenwick, 1997).

It is argued (McGill, Clare and Murphy, 1997) that successful intervention is more likely to result from a clear basis in the outcomes of assessment and that it is likely to involve a range of significant changes to the way in which an individual is supported. Such wholesale changes require the commitment of service providers and care staff to invest in those changes in practice and this should include early intervention and prevention measures. In view of the fact that carers frequently show distress and reactions which may help to maintain behaviour over time, this may require cultural changes in teams which are difficult to engender. "Camouflage" and "containment" of challenging behaviours (Felce and Emerson, 1996) – such as the use of antipsychotic medication (e.g. Read, 1998) - may serve to meet immediate and obvious service needs, but militate against the development of more socially valid outcomes for service users. However, community staff may be more likely than institution staff to describe interventions with challenging behaviour which emphasise the building of relationships with service users and identification of underlying causes and maintenance factors of the behaviours (Watts, Reed and Hastings, 1997). These are, arguably, more likely to support socially valid outcomes for service users and also to support more habilitative staff responses to behaviours.

There may be resistance to behavioural interventions from direct care staff. It has been argued that there are several roots of such resistance. Resistance is seen

as lying in the reluctance to change the informal traditions (and, perhaps, the reluctance of organisations to change the more formalised elements of organisational culture which this may entail), and the associated reluctance to the change in norms that may be required. It is also rooted in the inference, and perhaps the implication, that such interventions from outside may involve the surrender of control over at least some elements of the work, the perception that such external programs are presumptuous (because it is the team who "know what things are really like", and, associated with this, staff beliefs and attributions about clients (Thaw and Wolfe, 1986).

Group level analysis

It is apparent that traditional staff training and management models emphasise individual characteristics of personality and style of staff (Cullen, 1992). Both staff training and staff management interact with issues of optimum performance in terms of service outcomes for residents. Cullen describes the difficulties, engendered by the organizational ecosystem of which staff behaviour is a part, in maintaining optimum staff behaviour.

It is of note that, despite the recognised need for consistency of approach over time and settings and individuals, and despite the recognition that staff in residential care homes work as teams, in conditions which are frequently stressful, little or no research using a group level approach to the investigation of the association of staff and resident factors has been done. An intervention devised by a clinician to effect change in a resident's challenging behaviour will need to be carried out systematically by all team members. However carefully

designed the residential program, and however architecturally constructed the residence, it is in the hands of the direct care workers that outcomes lie (Rice and Rosen, 1991).

It can be argued that analysis of the way in which the team conceptualises its work together is a helpful starting point for clinicians considering the wider interpersonal and socioenvironmental factors in which an intervention will be set – and that such a level of analysis sits within the two-category framework for intervention postulated by McGill (1993, above) and the ecological model proposed by Halliday and Mackrell (1998, above). Given that it has been shown that staff may behave in counter-habilitative and inconsistent ways, and that they may be resistant for a number of reasons to the carrying out of a program of interventions, it seems logical to consider how it is that a particular team functions so that the potential difficulties for teams in implementing programs can be considered at the outset. Team-level measurement is likely to become increasingly important because teams are expected to work semi-independently and there are increasing demands for staff generally in all kinds of organisations to be innovative in their ways of working.

Furthermore, a referral for intervention with challenging behaviours is likely to be made for an individual resident, whether this is to a clinical psychologist working in a specialist behavioural support team or in a community learning disability team. The behaviours precipitating the referral, however, are likely to impact on the whole team over time and also to be set in the context of the general levels of challenging behaviour in houses. This will also affect the extent

to which interventions will be perceived as practical and potentially effective by staff. An ecological approach to intervention with challenging behaviour will also need to take into account the wider context of resident behaviours.

Intervention as innovation

The task for clinicians is to design appropriately targeted interventions and to recognise the constraints and limitations under which teams work. There is little point in recommending and designing interventions which require that the team undertake what may be significant changes in their thinking and activity if the team itself is not able to work in innovative ways. Any intervention constitutes innovation, in the technical sense of the word. Teams which have low levels of support for innovation are likely to have difficulty in implementing programs, whatever the accuracy of their perceptions of, and attributions about, challenging behaviours.

It has been argued that a review of research shows the most important contextual determinant of innovation by teams to be group climate (Agrell and Gustafson, 1996). Innovation, in this sense, is defined as the introduction and application, within a group, organisation or wider society, of processes, products or procedures that are new to that setting and which are intended to bring about benefits (West and Farr, 1990). This broad perspective, of innovation as an intentional process of relative novelty, is the one in which clinical psychologists work in the design and implementation of interventions with challenging behaviours. A key factor impacting on the ability of teams to implement interventions will be their ability to innovate. West and Farr (1990) describe a

model of innovation which takes into account the inputs to that innovation – the skills, knowledge and abilities of the group, the composition of the team and the organisational contexts; the process – the interactions in the group, the information exchange within it, the participation of the group in decision making and the social support and sanctions for group-related behaviour, and the outputs – the products of the group performance and the more intangible elements, such as the viability and wellbeing of the group and the growth and satisfaction of team members.

In this model, it can be argued that the role of psychologists interfaces with the skills, knowledge and abilities of the group – interventions both require information and knowledge of the team and also, crucially, are aimed to impart new knowledge and understanding and, perhaps, skills in behavioural management. It seems useful, in considering how teams implement interventions, to consider the process element. It is therefore important to consider how the way in which a team works may be explored, and whether this is associated with other factors, such as the organisational features of their work, and levels of challenging behaviour displayed by service users whom they support.

Team Climate

Group processes are related to the nature of relationships between the members of a work group, such as a team working in a residential care home (Kacen and Rozovski, 1998). These processes underlie the climate in which the group acts and can be seen as the driving force behind the group (Yalom, 1985). Group, or

team, climate is an aggregate assessment which takes into account the perceptions of all members of a team – the "shared perception of the way things are round here", including shared perceptions of policies, practice and procedures (Reichers and Schneider, 1990, p22). Anderson and West (1997) describe three necessary, but not sufficient, facets of work teams which determine the existence of shared perceptions of climate: interaction at work, at least on an infrequent basis; a common goal which predisposes collective action; and task interdependence, so that individuals within the team require a shared understanding and expected patterns of behaviour. West (1990) proposes four major factors of team climate which are predictive of innovativeness.

These factors are, firstly, vision, which represents higher order goals and motivation towards them. Participative safety refers to the extent to which the team makes decisions on a participative basis, and how "safe" team members feel to propose and support new ways of working. Support for innovation relates to the extent to which teams have access to support for new ways of working, both enacted (available in practice) and articulated (for example, stated in terms of policy and procedure). The fourth of these factors is task orientation, the extent to which the team is committed to achieving the highest possible standards of work performance, and the monitoring of that performance. It is argued that this measure is not only applicable to the assessment of group climates in organisations, in a variety of contexts, but that it may be useful for teambuilding and the development of organisational interventions.

AIMS OF THIS STUDY

The previous discussion has considered the many factors affecting staff performance in small residential homes where support is offered to people with a range of needs and challenging behaviours. It has been argued that, despite the growing body of knowledge and understanding about the factors bringing about and maintaining challenging behaviours, and the existence of practical interventions designed by psychologists and others working in specialist behavioural support teams or community learning disability teams, staff may continue to perform in ways that are counter-habilitative. The issue of staff stress and its links to challenging behaviours has also been considered in the context of the ways in which this may impact on the work of teams. An ecobehavioural model for intervention has been considered, in which attention is given to the wider social and interpersonal factors beyond a functional analytic perspective of challenging behaviours themselves, particularly in the context of the difficulties teams face in implementing interventions and the resistance that they may offer to such interventions. Such a perspective would take into account factors related to the way in which teams work. A key factor is the team climate, or the shared perception held by the team of the way it works.

One such approach, which would begin to integrate the concepts of the team culture, and the potential association of this with the work with service users, is to consider the capacity of teams to make innovations in the way in which they work, such as those required for changes in the management of challenging behaviours. The Team Climate Inventory (Anderson and West, 1994) is a

measure of team climate that focuses on the factors that are considered to be predictive of innovation (West and Anderson, 1996; Anderson and West, 1996).

It has also been argued that an individual for whose challenging behaviours intervention is sought will also, generally, be living alongside others who may also display behaviours that challenge services and that an ecobehavioural model of intervention will need to take into account this wider social context.

There has been little research which considers these wider factors at group level, for staff or for service users in residential care homes in the community. Patterns of association between the formal and informal aspects of a service culture and the levels of challenging behaviour represent an area of clinical significance for psychologists working with such teams.

The aim of this study was to attempt a group level analysis of these factors, including organisational features of the homes (inputs, both external and internal), and involving aggregate levels of challenging behaviour for each home, and assessment of team functioning. It was also intended that, in order to provide a richer source of information about how teams managed challenging behaviour, the managers of these surveyed homes would be asked to describe the processes as it operated within each home.

THE RESEARCH QUESTIONS

This study considers four research questions. The three preliminary questions are:

1) What are the levels of challenging behaviour in the residential care homes?

2) What are the organisational features of these homes?

3) How do managers describe the process of managing challenging behaviour in these homes?

The main research question is:

4) What are the relationships between the level of team functioning, as assessed by the Team Climate Inventory, and the levels of challenging behaviour, in the homes?

Two specific hypotheses about the relationships between these two features of the homes were tested.

Team functioning, as assessed by the TCI, is both a measure of the way teams work together and a factor predictive of innovativeness in teams. Teams with lower levels of functioning are likely to have greater difficulty using innovative ways of working and therefore to have greater difficulty in the flexible development and implementation of guidelines for managing challenging behaviours, including utilising the external support of clinicians, such as psychologists, in this process. The Team Climate Inventory includes a scale which measures the enacted and articulated support for innovation available to a team. Teams with lower levels of support for innovation are likely to have greater difficulty in implementing strategies for managing challenging behaviours.

a) It was hypothesised that there would be an inverse relationship between the level of team functioning and the level of challenging behaviour in homes.

b) It was hypothesised that there would be an inverse relationship between the level of support for innovation and the level of challenging behaviour in the homes.

In the following section, the methodology of the project will be described.

CHAPTER TWO: METHOD

OVERVIEW

This study used a cross-sectional survey design. The aim of the study was to apply a group-level analysis of the organisational features of residential care homes, including levels of challenging behaviour, assessment of team climate, and information about the process of challenging behaviour management in the homes. Literature reviews did not reveal any similar studies with which to compare such a group-level analysis and a survey method was selected to provide a larger sample than would have been possible with an observational method. Survey methods are appropriate for the collection of information where the intention is to generalise from a sample to a population (Babbie, 1990). A survey method offers simple, economical design with the possibility of fast return of data, which are important factors in the collection of multiple types of information from a relatively large sample in a short space of time. In this survey, data was collected over a four month period.

RECRUITMENT

Ethical Approval

Overall ethical approval was obtained from the North Thames Multiple Research Ethics Committee. Additional local ethical approval was obtained from West Herts Ethics Committee because some of the participants were recruited by contact with the Community Learning Disabilities psychology team in this NHS Trust. (Documents granting ethical approval are given in Appendix 1.)

Routes to recruitment

Recruitment of participating homes took place during March-August 1998. The multi-stage selection of the sample aimed to provide as wide a range of homes and provider organisations as possible. The main criterion for inclusion of a residential care home in this study was that there should be staff perception that challenging behaviour was displayed by at least some of the residents within the home. It is likely that there were other provider organisations operating within the area covered by the study who were not contacted because they were not known to the researcher. As no information was available about those homes which chose not to participate, either at the stage of recruitment or because they did not subsequently provide data, the effects of response bias cannot be estimated in this study.

There were two routes to recruitment:

(1) 26 homes were recruited by direct contact with provider organisations. Organisations with which the researcher had had prior involvement were contacted as well as organisations with which there had been no prior contact. Following initial contact, a letter outlining the project (Appendix 2) was sent to senior managers. Those organisations which agreed to take part then provided the contact details for possible participating teams. Managers of these potentially participating teams were then contacted by telephone. Letters outlining the project were sent to the managers, and follow-up telephone calls were made to determine whether or not teams would participate.

18 organisations were contacted. Of these 18 organisations, six declined to take part in the study, citing other commitments and/or shortage of staff. The 12 organisations which agreed to participate provided contact details for the residential care homes and the managers of these teams were contacted directly by telephone and follow-up letter. 14 managers (in five organisations) declined to participate at that stage, citing staff shortages, or that there was no challenging behaviour in the home. A further 10 agreed to participate but the teams were not included in the data analysis because they failed to return the questionnaires. 28 teams agreed to participate and returned completed data.

(2) 14 homes were recruited by contacting clinical psychologists working in community learning disabilities teams. A further two were recruited by prior contact with a psychiatrist. The initial point of contact with the teams was the clinician, and after the teams had agreed in principle to take part, further contact with the home manager was made directly by the researcher. A further six teams were suggested by these clinicians but the managers declined to take part, citing shortage of staff and/or pressure of work.

The 44 residential care homes which took part in this study were drawn from 21 different provider organisations. 37 of these were operating in the voluntary sector, six in the private sector and one was operated by social services. All the homes were in London and the South-East of England.

MEASURES

Three measures were used: a measure of team climate (The Team Climate Inventory), a measure of the levels of challenging behaviour displayed by each resident of the group homes (The Checklist of Challenging Behaviour) and a semi-structured questionnaire with open ended questions.

Team Climate Inventory (TCI) (Anderson & West, 1994)

The Team Climate Inventory is "a multi-dimensional measure of work group climate" (Anderson and West, 1994 p1). The measure was developed as a diagnostic tool for facilitating team development interventions in workgroups across diverse settings. The team profiles produced by the computerised scoring process are normed on samples of health care teams and the norms are built into the scoring software.

The TCI is a 44-item questionnaire with items relating to four climate scales, each of which is divided into subscales, and a social desirability scale (see Appendix 3). These 44 items load onto 15 sub-factors, which load onto four second order factors of climate and one social desirability response factor. Each member of a team completes, anonymously, one pencil and paper questionnaire. The individual responses are amalgamated to produce a team profile. The measure was selected for practical reasons as well as for its psychometric properties. It was possible to administer the questionnaire by mailing it to participants, and the team profiles produced by the computerised scoring process could be sent to teams for their use, together with the list of suggested team development exercises in the TCI manual. This provided a potential benefit to

teams from their participation in the research process and the completed profiles were made available to them generally within four to six weeks after they had returned the data.

Psychometric properties of the TCI (Anderson and West, 1994)

Exploratory factor analysis of a sample of 27 hospital management teams revealed a simple five-factor structure, but subsequent analysis revealed only four factors. The TCI is presented as a four climate dimension measure, with an additional social desirability scale.

In a sample of 121 teams from diverse organisational settings, Cronbach's alpha coefficients for levels of reliability (internal consistency) for scales range from 0.84 to 0.94 and for Subscales from 0.64 to 0.91 The test therefore has an acceptable level of reliability; that is, the scales and subscales measure with consistency across different teams.

Construct validity of the TCI was examined by examining correspondence between climate, as assessed by team members using the TCI, and content analysis of recorded team meetings . The initial sample included nine teams. Some categories were found to display weak or non-significant correlations between self-reported scales of climate and the analyses of team meeting content, but overall the findings suggest considerable congruence between elements of the subscales of the TCI and team behaviour in meetings. The TCI does provide an accurate and valid depiction of the particular facets of climate as measured on this self-report scale. The TCI was also found to have acceptable levels of

discrimination between groups on examination of the aggregate variables. Inter-rater reliability (groups) coefficients (IRRg) for groups in five samples were calculated. The average IRRg within each of the five samples across the five scales ranged from 0.67 to 0.98. This is held to suggest that the TCI elicits shared climate perceptions, rather than aggregating diverse individual perceptions

The Checklist of Challenging Behaviour

The Checklist of Challenging Behaviour – CCB (Harris, Humphreys and Thomson, 1994) was developed as an instrument for the survey of problematic behaviours amongst people with learning disabilities. There are three scales. Two scales (Aggressive Behaviour, with 13 items, and Self-injurious Behaviour, with 5 items) are rated on three subscales for frequency, management difficulty and severity. The third scale contains eighteen items relating to other challenging behaviours and these are rated for frequency and management difficulty only (see Appendix 4 for the measure and its scoring procedure). The CCB is designed to be completed by care staff who work with the persons concerned. It was selected for its ease of administration, and its design for use as a survey instrument.

Psychometric properties of the CCB (Harris, Humphreys and Thomson, 1994)

Spearman's rank-order correlation coefficient across 18 repeat interviews showed acceptable levels of agreement for inter-rater, test-retest and between-interviewer reliability – critical values of Spearman's rank-order correlation coefficient were significant at the p,0.05 level for the frequency, severity and

management difficulty scales for both aggressive behaviours and other challenging behaviours.

Two independent content analyses of 168 checklists suggested high content validity and the developers of the CCB emphasise the steps taken throughout its development to ensure content validity. The original 27 items used in the development of the measure were obtained from information given by service providers, reviewing available checklists of challenging behaviour and by examining hospital records of violent incidents. Service provider responses to the survey were also involved in its development.

The Interview Questionnaire

This questionnaire was designed to be administered face to face with managers of the participating residential care homes. It contained questions about structural elements of the home, such as the length of time for which it had been established, the numbers of staff and residents, and about the processes operating within it, such as team meetings and supervision. Managers were also asked to rate items such as the relationships between the team and other stakeholders, and their experience of supervision. The questionnaire also contained six questions about the way in which challenging behaviour was managed in the home. (Sample items are given in Appendix 5, together with the six questions about challenging behaviour management).

PROCEDURE

When teams had agreed to participate, a questionnaire pack was sent to each team leader. It contained:

- A covering letter, outlining the contents and instructions for their completion (Appendix 6).
- A copy of the Team Climate Inventory questionnaire for each member of the team.
- A copy of the Checklist of Challenging Behaviour questionnaire for each person living in the home.
- Consent forms for each team member (Appendix 7).
- Information sheet (Appendix 8).

Arrangements were made by telephone for each participating team leader to take part in a face to face interview. Interviews took place either at the home or in the administrative offices of the provider organisations. The participants were assured of confidentiality and that the home which they managed would not be identifiable.

Manager responses to the interview questions were recorded in writing at the time of the interview. The completed Team Climate Inventories and Checklists of Challenging Behaviour were collected at the interview. Following the interview, the team climate profiles derived from the computer-driven scoring process for the TCI were sent to each team leader, together with a covering letter and a list of suggested team development exercises to accompany the profiles (Appendix 9).

The teams were also asked to provide written information, including policies and procedures, and copies of incident records for the three month period immediately prior to the interview. This was intended to provide documentary evidence with which to compare manager responses to the questions about management of challenging behaviours. In practice, few teams provided this information, citing the difficulties of compiling this information and the problems associated with removing identifying information from so much documentation. Written information was therefore not analysed in this study.

DATA ANALYSIS

Quantitative analysis

Descriptive and hypothesis-testing quantitative data analytic procedures, related to the specific research questions described above, were used to analyse the information provided in the completed Team Climate Inventory and the Checklists of Challenging Behaviour (using SPSS 7.5, 1997).

The interview questionnaires were used to provide both quantitative and qualitative data. Detailed analysis of the general information given by managers in response to the questions was not carried out. The information was encoded numerically and the resulting data were included in the quantitative data analysis.

Qualitative data

The manager responses to the general information questions were used to amplify the quantitative findings, and direct, non-attributable quotes by managers are cited in the results section.

The manager responses to specific questions about the management of challenging behaviours within the homes were examined using content analytic procedures (e.g. Dey, 1993).

Content analysis is a technique used to provide systematic and objective descriptions of phenomena (Downe-Wamboldt, 1992). The process involves selection of appropriate text units from transcribed data, the grouping together of responses in related themes, assignment of text units to subordinate categories derived from these themes and the assignment of these categories to superordinate categories. The content analysis yielded both quantitative information (in terms of the frequency of response and respondents) and qualitative information (about the nature of the responses).

Three forms of validity assessment are generally used (Cavanagh, 1997). Content validity of categories refers to the degree to which they are a measure of that which they purport to measure. Hypothesis validity refers to the extent to which the analysis produces results in keeping with the theoretical constructs which have informed it. Predictive validity refers to the extent to which what is predicted can be shown to have occurred. In this study, no numerical assessment of content and hypothesis validity is made, but the extent to which the categories emerging from data analysis reflect theoretical constructs derived from the

review of the literature is considered; particularly, for the inputs to, and processes of, intervention with the management of challenging behaviours. Predictive validity measures were not built into the research design of this study as generalisation of the findings to other studies was not possible.

Reliability of the data coding procedure was assessed by measuring the percentage of inter-rater agreement about the assigning of text units to categories.

The content analysis procedure was assisted by the use of qualitative analytic software (QSR NUD.IST 4, 1997).

CHAPTER THREE: RESULTS

This study aimed to address four main research questions. The preliminary questions were: 'What is the extent of challenging behaviours?', 'What are the organisational characteristics of these residential care homes?', and 'How do managers describe the process of managing challenging behaviours in these homes?'. The main research question was 'What are the relationships between a team's scores on the Team Climate Inventory, and the levels of challenging behaviour displayed in the residential care home where they work?'

This chapter begins by summarising the information derived from the Checklists of Challenging Behaviour (Harris, Humphreys and Thomson, 1994). The extent of challenging behaviour is described in terms of the respondents' assessments of the frequency, management difficulty and severity of aggressive and self-injurious behaviours of the residents. For other challenging behaviours, no rating for severity is given but assessments of frequency and management difficulty are made.

Secondly, the results of the questionnaire relating to organisational features are presented, in terms of the external features of the homes and the internal features. In addition to the quantitative data from the questionnaire, managers' comments illustrating their views about these issues are also presented. These questions were designed to elicit information about some of the inputs to the work of the teams and, by extension, to innovation (the composition of the team and the organisational contexts) and the processes (interaction within the group, information exchange within it and the mechanisms impacting on group

behaviour), drawn from West and Farr's (1990) model of innovation. Managers' comments on these issues were used to illustrate some of their perceptions of the work of their team.

Next, the managers' answers to the question 'How would you describe the process of managing challenging behaviours in this house' are presented in the form of a content analysis of the participants' responses to this question and its subsidiary questions about the helpful and unhelpful aspects of this process and the ways in which managers felt it could be improved. These questions were designed to elicit more detailed information about the particular processes inherent in the management of challenging behaviours in the homes and may be seen as the foundation point for examination at a group level of the point at which intervention may take place.

Finally, the relationships between the Team Climate Inventory and the Checklist of Challenging behaviour data are described.

CHALLENGING BEHAVIOUR

A Checklist of Challenging Behaviour was provided for each resident in all of the 44 participating residential care homes. A careworker completed a checklist for each resident, and the scores derived from these individual checklists were aggregated to form total scores for each house. 212 checklists were completed.

The Checklist of Challenging Behaviour has three scales – for aggressive, self-injurious, and other challenging behaviours. Each scale has sub-scales for the

rating of management difficulty and frequency of the behaviour, and the scales for aggressive and self-injurious behaviours also have a sub-scale for the recording of the severity of each behaviour. The original scoring key (see Appendix 4) allocated scores of 1 = never in the frequency subscales (Harris, Humphreys and Thomson, 1994). In the current study, where careworkers gave responses coded as 1 (never) in the frequency sub-scale, they tended to leave the other sub-scale code(s) blank for that item, signifying an absence of that particular behaviour, or they tended to write "0", or "not applicable" in the frequency scale, signifying an absence of that particular behaviour. The coding scale was therefore amended at the scoring stage to include a code for 0 = never in the frequency sub-scales, with corresponding codes of 0 in the other sub-scale(s) for an item where 0 was scored for frequency and thus, logically, there could be no rating for management difficulty or severity. The possible minimum score on any sub-scale for any item therefore became zero.

Aggregate scores for the homes and comparisons with individual mean scores from a previous study

Table 1 shows the aggregate mean Checklist of Challenging Behaviour scores on each scale and subscale of the checklists for the homes.

Table 2 shows a comparison between the mean scores for individual residents on the aggressive and other challenging behaviour scales and subscales of the Checklist of Challenging Behaviour in this study and those obtained in a previous study (Jenkins, Rose and Jones, 1997). For the purposes of comparison, Table 2 shows the mean individual scores adjusted to reflect the original scoring

procedure which was used in the Jenkins et al study (1997). All scores of 0 for the checklists in the current study were re-assigned scores of 1.

Table 1. Summary of aggregate challenging behaviour scores

Scale/subscale	Mean	S.D.	Range
TOTAL - *all challenging behaviour*	222.89	135.57	471
TOTAL - *aggressive behaviour*	69.95	52.84	222
TOTAL - *other challenging behaviour*	133.06	75.69	265
TOTAL – *self-injurious behaviour*	19.88	20.56	77
AGGRESSIVE BEHAVIOUR			
- *frequency*	29.06	21.15	97
- *management difficulty*	22.53	18.39	70
- *severity*	18.36	14.72	55
SELF-INJURIOUS BEHAVIOUR			
- *frequency*	9.08	9.38	31
- *management difficulty*	5.15	5.82	25
- *severity*	5.67	5.99	25
OTHER CHALLENGING BEHAVIOUR			
- *frequency*	82.65	44.73	177
- *management difficulty*	50.40	32.42	120

Table 2. Comparison of the mean individual CCB scores in this survey with those in the Jenkins, Rose and Jones study (1997)

Scale/subscale	Current Study Mean	S.D.	Jenkins et al Study Mean	S.D.
TOTAL – *aggressive and other challenging behaviour*	98.23	24.60	107.95	23.62
TOTAL – *all aggressive behaviour*	47.22	12.24	55.66	15.09
TOTAL – *other challenging behaviour*	53.80	15.50	52.27	11.59
(Scores for self- injurious behaviour not shown in the Jenkins et al study)				
AGGRESSIVE BEHAVIOUR				
- *frequency*	16.91	5.39	19.95	6.08
- *severity*	14.73	3.32	7.43	4.20
- *management difficulty*	15.58	4.45	18.27	5.61
OTHER CHALLENGING BEHAVIOUR				
- *frequency*	30.18	9.74	28.93	7.11
- *management difficulty*	23.61	6.87	23.35	5.54
	Current study: N = 212		Jenkins et al study: N = 63	

Table 1 shows that there was, in this study, an extremely wide range of challenging behaviour scores within the surveyed houses. The minimum possible aggregate score on the challenging behaviour scales and subscales was zero. No houses scored zero for other behaviours, although some houses scored zero for aggressive and for self-injurious behaviours. There were, however, no significant differences between the means of the standardised scale totals.

Table 2 shows that the mean total challenging behaviour scores (with self-injurious behaviour scores omitted) in the current study were lower than those in the Jenkins et al (1997) study. In the current study, the mean score for the severity of aggressive behaviour was higher than that for the previous study, whereas the scores for the frequency and management difficulty of such behaviour were higher in the previous study. In both studies, the mean scores for aggressive behaviour were higher for frequency than for severity or management

difficulty, and higher for management difficulty than for severity. In both studies, mean scores for other challenging behaviours were higher for frequency than for management difficulty.

The subscale comparisons for the current study are shown in Table 3, below.

Resident age, degree of learning disability and Challenging Behaviour scores

Previous studies have found that challenging behaviour was more likely in younger populations (e.g. Qureshi and Alborz, 1992) and those with more severe learning disabilities, (e.g. McGrew et al, 1991). Additionally, given the previous findings that those with more severe challenging behaviours were more likely to be living in hospital than in the community, almost a decade later and in the context of decreasing numbers of hospital places, it can be inferred that those residents newly settled in the community are more likely to be those with more severe challenging behaviours.

In this study, no significant differences were found between the mean standardised checklist total scores when homes where residents were aged under 30 were compared with those aged 30-50 ($t = .226$, df 16, n.s.). Because of the small size of the group of newly-established homes (i.e. those established for 18 months or less - N=3), it was not possible to compare the scores of these homes with those established over a longer period. There was also no significant difference between the standardised checklist total scores when homes where residents had severe or profound learning disabilities were compared with homes where residents had mild or moderate learning disabilities ($t = -.751$, df 22, n.s.).

The assumptions of normality of distribution of scores within these groups necessary for the performance of independent samples t tests were met and no data transformation was necessary. It should be noted that these comparisons were of aggregate, rather than individual, challenging behaviour scores. The possible reasons for these findings are considered below.

Aggregate challenging behaviour scores and selection of participating homes

Table 3 shows the comparison of the standardised means of the total Checklist of Challenging Behaviour score, the total scale scores and the subscale scores when those homes selected by prior contact with psychologists are compared with those selected by direct contact with organisations. No data transformation was necessary as the basic assumptions of the normality of distribution of scores within the groups was met.

Table 3. Comparison of CCB scores by selection of participating homes

		Selection Method:			
		OTHER		DIRECT	
CCB scale/subscale	**t**	**Mean**	**SD**	**Mean**	**SD**
TOTAL – *all challenging behaviour*	1.64	196.57	110.18	237.93	147.93
TOTAL – *aggressive behaviour*	1.88	55.45	42.09	78.25	57.16
TOTAL – *self injurious behaviour*	.85	18.11	15.00	20.89	23.36
TOTAL – *other challenging behaviour*	1.66	123.01	66.73	138.80	80.97
AGGRESSIVE BEHAVIOUR					
- *frequency*	1.96	23.07	16.32	32.49	23.05
- *management difficulty*	2.04*	17.15	15.43	25.61	19.47
- *severity*	1.57	15.23	12.64	20.15	15.72
SELF-INJURIOUS BEHAVIOUR					
- *frequency*	.49	8.77	7.66	9.25	10.37
- *management difficulty*	1.00	4.33	3.98	5.62	6.67
- *severity*	.82	5.01	4.20	6.05	6.85
OTHER CHALLENGING BEHAVIOUR					
- *frequency*	1.28	77.61	38.64	85.54	48.30
- *management difficulty*	1.55	45.40	28.80	53.27	34.50

*$p<.05$ df=42

There were no significant differences between the standardised mean scores, with the exception of that for the management difficulty of aggressive behaviours, where the mean aggregate scores in homes where direct contact was made with organisations were significantly larger. The possible sources and implications of this finding will be considered below.

Comparison between aggregate subscale scores

The scores on the self-injurious behaviour subscales for management difficulty and severity were negatively skewed and square root transformation of the data was carried out before further analysis. It can be seen in Table 4 that, for all of the sub-scales, the mean scores for frequency of the behaviours were larger than those for severity or management difficulty. Mean scores for management difficulty were also larger than those for severity, although this difference was not significant for the self injurious behaviour scale.

Table 4. Comparisons of mean sub-scale scores in homes

Paired subscales	t	Mean	SD
AGGRESSIVE BEHAVIOUR			
Frequency		29.06	21.15
Management difficulty		22.53	18.39
Severity		18.36	14.72
Frequency/management difficulty	5.97***		
Frequency/severity	7.23***		
Management difficulty/severity	3.44***		
SELF-INJURIOUS BEHAVIOUR			
Frequency		9.08	9.38
Management difficulty		5.15	5.82
Severity		5.67	5.99
Frequency/management difficulty	6.27***		
Frequency/severity	5.34***		
Management difficulty/severity	1.75		
OTHER CHALLENGING BEHAVIOUR			
Frequency		82.65	44.73
Management difficulty		50.40	32.42
Frequency/management difficulty	11.05***		

***p<.001 df=43

SUMMARY – THE EXTENT OF CHALLENGING BEHAVIOURS

In this survey, there was a wide range in the frequency, management difficulty and severity of the challenging behaviours assessed by the checklist. Aggressive and self injurious behaviours were rated as significantly more frequent than they were difficult to manage or severe, and aggressive challenging behaviours were significantly more difficult to manage than they were severe. Other challenging behaviours were significantly more frequent than they were severe.

Comparisons with a previous study (Jenkins et al, 1997) using the Checklist of Challenging Behaviour were of limited utility due to the differences in the

scoring systems adopted by the two studies. The total mean individual challenging behaviour scores, not including scores for self-injurious behaviour, were lower in the current study than those of the previous study.

There was no association between challenging behaviour scores and the age or degree of learning disability of the residents, or the length of time for which homes had been established. The management difficulty of aggressive behaviours was significantly higher in homes which were selected by direct contact with organisations, but there were no other significant differences between the aggregate scores for challenging behaviour in homes in this group when compared with those homes selected by prior contact with psychologists.

THE ENVIRONMENTAL CONTEXT

The participants

Residences

Eighteen (41%) of these 44 participating homes were in inner-city locations. 26 (59%) were in suburban locations. The length of time over which the homes had been established ranged from less than one year (one home) to twenty years (one home). The mean length of time for which the homes had been established was just over six and a half years. Approximately 80% (33) of the homes had been established for more than two years. Twenty-five of the homes (57%) were in houses which formed part of the existing housing stock in their street or road, and 19 (43%) were in purpose-built housing. Some of this housing was part of wider building projects, for example, as part of a housing association development of a variety of types of housing in their area. The vast majority of these residential care homes were in "ordinary" houses in "ordinary" streets,

although a few were part of a complex of housing for a variety of people with special needs.

Provider organisations

Twenty-one different provider organisations took part in this study, of which only one was a social services establishment. 37 of the homes (84%) were part of voluntary sector organisations, and 6 (13%) were from the private sector.

Residents

Two hundred and twelve Checklists of Challenging Behaviour were included in this survey. Checklists were not completed for five residents in two different houses, because they had not consented to the disclosure of information about them. The number of residents in each group home ranged from one (1 home) to 12 (1 home). One third of the homes catered for four or fewer residents, and the greatest majority of homes (39, or 88%) catered for six or fewer residents. The mean number of residents in each home was five.

The majority (37, or 84%) of the homes catered for both men and women, although a few housed only women (three houses) or only men (four houses). The residents were from a mixture of ethnic origins in 18 (49%) of the homes. The range of ages of the residents varied widely. Managers were asked to give the range of ages of the residents in the home which they managed and the age ranges were banded according to whether residents were aged under 30, between 30 and 50 yeas of age, over 50 years of age, or across more than one of these bands. In 18 homes (41%), the age range of residents spanned more than one of

these bands. In 13 homes (30%), the residents were aged between 30 and 50. In three homes, all the residents were aged over 50 and in 5 homes the residents were aged under 30. The figures were not available for 5 of the homes.

The people living in these homes had lived in a variety of different types of services and other locations before they moved to their current residence. 140 (65%) had come from long-stay hospitals. 43 (19%) had come from other locations in the community, including the family home. The remaining 34 (16%) had come from locations which were not known, or from other types of service provision. (This figure includes the five residents for whom checklists were not completed). The mean length of time for which people had lived in their home was approximately 5 years and 8 months.

The degree of learning disability of the people living in the residential care homes was assessed by manager report. 12 of the home managers reported that the residents in the home that they managed were severely learning disabled, and a further 12 reported that there was a mixed degree of learning disability. Three respondents reported that the residents in the home which they managed were profoundly learning disabled, while a further five reported that the people living in the home which they managed had a mild learning disability. Two managers were not interviewed and a further four felt that they could not ascribe a degree of learning disability to the residents in the home which they managed. The information was not available for the remaining six homes.

Managers were asked to describe whether the degree of independence of the residents in the homes was low, moderate, high or mixed. This also showed a great deal of variation, as might be predicted from the manager reports of degree of learning disability. Only one manager reported that the residents in the home were highly independent, and a further two reported a moderate degree of independence. 13 managers reported low levels of independence and a further 17 reported mixed levels of independence amongst the residents in the group homes that they managed. Data were not collected for 11 of the homes as this question was included after the first 11 managers had been interviewed. The question was included to give an alternative dimension on which to consider resident support needs, besides manager assessment of learning disability amongst the residents in each home.

Residents' activities

Residents took part in a range of daytime activities outside the home. All managers reported that residents took part, to some extent, in domestic activities, and this information is not considered further. The majority of the residents (in 30, or 77% of the homes) did not take part in full-time structured activities. However, the majority of houses reported that all of their residents had access to some structured activities. 31 managers (80%) reported that all residents had access to some activities, and, of those who reported that there were no structured activities for some of their residents, in two homes this was because residents organised their own daytime activities and in two of the others this reflected the fact that the homes were newly established and it was in these cases planned that residents would in the future have access to structured activities. In

two houses, one to one support was provided to residents by external staff to facilitate access to structured activities outside the home. Most of the residents (in 41 of the homes) took part in structured activities outside the home which were part-time. These activities included attending day centres on a sessional basis, and for some residents the centres facilitated access to further education colleges for specialist programs. Some residents took part in employment schemes, although these were in the minority. The access of residents to part-time activities was in some cases by choice, because this was felt to offer the person a wider range of opportunities in the community at large, facilitated by the staff working in the home. For others, this reflected the lack of available facilities in the area, particularly for people who challenge services.

One manager commented:

> *"For a lot of people, we're increasing classes and trying to get away from the day centre. Two people do have placements in the day centre with independent activities in the community like dancing and gym – this gives flexibility for the tenants but it's a bit of a fix for staff* [to facilitate and support access to so many different activities]".

Other manager comments reflected the choice of service users <u>not</u> to use day centres; one manager commented that:

> *"Everyone has* [the opportunity for] *full time structured activities but they choose not to use them... "*

<u>Care staff</u>

The number of staff in teams varied from three staff, including the manager, to 19 staff. The mean number of staff in a team was approximately 11. Team members also ranged in age, with 71% of managers reporting that the team age range was across more than one band, in the same way as the resident ages were banded. The majority of teams (52%) included staff from a mixture of ethnic

origins. Managers reported sickness rates to be low in 55% of the homes, and average in 37% of the homes, with only two managers reporting high sickness rates. No numerical corroboration of these manager descriptions was sought.

A number of managers commented that their sickness rates were very good – one manager described the rate in that team as "incredibly low", given the intense and sometimes stressful nature of the work, and several commented that the rate had improved recently; one manager commented that sickness rates in that team were:

> *"... intermittent – there have been quite a few major illnesses, but minor illnesses have reduced since monitoring* [of sickness rates] *was introduced. The sickness policy has been revised, it was subject to abuse in the past. The new policy is structured and looks for patterns of sickness etc."*

It seems that, in this study, staff sickness levels are not indicated as a function of the levels of stress in the workplace, although no statistical comparisons can be made.

In all but one of the houses, managers reported that at least one of the staff team had prior experience. The overall percentage of staff with experience was 69%. 17% of the staff were reported to have relevant qualifications (in nursing, social work or social care) and this figure included the 45% of managers who reported their own relevant qualifications. The actual number of managers with qualifications is likely to be greater than this as the data were not recorded separately for 43% of the homes. 88% of the managers had been in post for at least one year, 35% of them for over three years.

The ratio of staff to residents varied across the homes. 66% of managers reported staff to resident ratios of 2:1 or greater, including 9.5% of homes reporting ratios of greater than 3:1. Of the remainder, 19% reported ratios that were greater than 1:2 but less than 2:1. In almost all cases it was impossible for managers to give an accurate figure because of the complicated arrangements of part-time and overlapping shifts, so that the number of staff in the teams was seldom fixed. This was further complicated by the number of staff vacancies, or by the knowledge that posts were about to become vacant and would not be replaced. Only 13 managers (31%) reported no staff vacancies, with 10 managers (24%) reporting one vacancy, eight managers (19%) reporting two vacancies and the remainder reporting three or more. One manager of a large team reported 6 vacancies. However, none of the managers were able to give a clear description of whether these vacancies represented full or part-time posts, or what percentage of the staff hours complement was presently uncovered. All managers had access to a variety of means to cover vacant posts and staff sickness, including the use of extra shifts from within the team, a bank of care staff maintained by the organisation providing the home, and external agency shifts. All managers reported that they preferred wherever possible to use staff known to the residents and the team to cover shifts.

When asked to describe the home which they managed, the majority of managers spoke in terms of the people for whom the service was provided and of the type of service which was intended. A typical comment was that

> *"It's a project that's been set up for people with challenging behaviour – the client group referred mostly seem to share other behaviours and autism... .....the main objective is to resettle six people from institutional care to a community setting with the aim of giving a much better quality*

of life – these are long term institutionalised people. That's it, in a nutshell."

Organisational features of the homes

Training

Managers were asked about the extent to which the available training matched what they considered to be the needs of the house and the team. 23 managers (55%) considered that the training available was a good, or quite good, match to the needs as they perceived them. By far the majority of managers (33 – 79%) reported that training was provided from a mixture of sources, generally by the organisation with additional, locally-defined training needs met by the purchase of places on external courses or by the provision of external trainers. Some managers reported that they held separate budgets to facilitate this. 33 of the managers were asked whether training on challenging behaviour was provided, and 27 of them stated that it was.

Relationships with the organisation

Managers were asked about a number of aspects of their relationships with the provider organisation which was their employer. 37 managers (84%) reported that the policies and procedures which they were expected to implement were clear and available to them. 35 managers (79%) stated that there were specific opportunities to provide input to the wider work of the organisation for which they worked, typically as members of working parties developing specific policies or areas of work. One organisation was developing an in-house

challenging behaviour support team, designed to provide support to care staff independently of and alongside the input available from clinical specialists and one of the interviewed house managers was also managing this team. Some managers commented that there were plenty of opportunities but little time available to support the extra work that active participation in such working parties entailed and that, although there were opportunities, they did not always take them up. One manager commented:

> *"I don't want to move into that field – like marketing and stuff – I don't want to do that. It's other areas where I feel I perhaps need to develop in.*

Several managers reported that they felt unwelcome pressure from their line managers to be involved in such working parties and that there was little recognition for the work that was done in this way.

Managers were asked to rate their relationships with the provider organisation on a scale of neutral/positive/negative. 32 managers (76%) said that their working relationship with the organisation which employed them was neutral or positive. Of those who stated that it was negative, some cited specific reasons why this was so, such as changes in the organisation's work, a change of line manager, or specific incidents which had left them feeling unsupported. Others cited a feeling that they had reached a point where it was time to move on in their careers. Of those who felt generally positive about their relationship with the organisation, several commented that they had had the opportunity for career and personal growth as a result of their work.

Approximately half of the managers felt that they could not develop their careers further within the provider organisation. This frequently reflected length of service, and a number of the issues impacting on managers' perceptions of the quality of their working relationships with provider organisations. Managers who had served for one and a half years or less were more likely to state that there was the potential to develop their careers (value of Pearson $\chi^2 = 6.617$, asymptotic significance p=.01; Fisher's exact test p=.013 - one-sided).

Supervision of managers

30 managers (71%) stated that their experience of receiving supervision was neutral or positive. A typical positive comment was that supervision is

> *"...long – there's usually loads to talk about – supervisions with staff, events in the home, things going on in* [the organisation]. *It's the only chance I get to talk to* [supervisor] *for an hour – otherwise it's half an hour here and there. It's a really positive time – I get feedback on what I've been doing."*

Of those who stated that their experience of their own supervision was negative, this reflected a number of features of their supervision, such as feeling that it amounted to no more than a list of tasks to be assigned, or a checking exercise on the part of the line manager. It also reflected some uncertainty in the face of changing organisational structures.

One manager commented:

> *"I haven't been supervised by my new supervisor yet – the old supervisor left two months ago. It's a real issue – I keep asking. The old supervisor was brilliant, really positive. I don't expect the new one to be like that from things I've picked up – I may be wrong, I'll have to wait and see."*

Another manager commented:

> *"I tend to find it a time for communicating information about the home and the organisation, rather than for me as an individual. I need time to develop myself and I don't get it. The new supervisor now has a lot more homes to cover."*

Managers' supervision was most likely to be monthly (50%) or fortnightly (21%) and to last for more than two hours on each occasion. Some reported that a whole day was set aside for supervision with their line managers.

Supervision of staff

82% of managers reported that supervision was provided to staff monthly or fortnightly. 50% of managers reported supervising all of their teams, while 43% shared supervision with their deputies or other senior staff. Two managers reported that they only supervised their deputies, who then supervised the remainder of the team. 90% of managers reported that their experience of supervising staff was positive or neutral, frequently citing the learning experience that they themselves gained from this process as source of their satisfaction. Some managers reported difficulties in communicating with staff.

A typical comment on positive experience of supervising the team was that

> *"... it's useful – more than that, it's essential....people understand what it's about, why they have it. Some people are not used to bringing their own agenda so I'm doing all I can to increase that and encourage the use of supervision."*

One manager commented, on a negative experience of supervising within the team:

> *"... it varies – sometimes I feel inadequate – that I'm "no good at this" – and sometimes it's quite difficult because people bring it back to tasks because they're safe to talk about, rather than issues – I find out more about people outside of supervision, like when I'm working on shift with them. One person is stressful to supervise because they're so angry..."*

Relationships between the team and other groups

All managers reported some that form of individual care plan or service plan was in place and implemented for each resident within the homes. By far the majority of managers reported positive or neutral relationships between the team that they managed and other stakeholder groups. Table 5 summarises this information.

Table 5. Relationships between staff teams and other groups

	Manager description		
OTHER GROUP	Positive	Neutral	Negative
Care Managers	26	11	1 missing data N=6
CTLD	30	8	2 missing data N=4
Primary health care providers	27	8	6 missing data N=3
Service providers	21	12	4 missing data N=6
Residents	32	9	1 missing data N=2
Inspection unit	33	4	3 missing data N=4
Residents' significant others (where applicable)	28	11	2 missing data N=3

The Team Climate

Social desirability

The Team Climate Inventory has four scales, together with a social desirability scale. Social desirability is a measure of the extent to which respondents may have given responses which they felt were desirable, rather than those which reflected their actual assessments of the items within the questionnaire. The

maximum possible social desirability score across the two sub-scales which make up the scale is 30. In this survey, the mean score on this scale was 18.299 (S.D. 3.521). A score of between 10 and 19 is considered to show some evidence of social desirability, whereas a score of 20 or above is considered to show definite evidence of social desirability responding. Only one team's social desirability score was below 10. 50% of the teams had social desirability scores of between 10 and 19 (range: 12.8 to 18.6) and the remaining 47.7% of the teams had scores of 19 or above (range: 19.2 to 24.7). Such high levels of social desirability responses suggest the need for caution in the interpretation of other scores, but, given the consistency of this level of responding, some interpretation within this survey is possible, although this may be of limited generalisability to other samples.

TCI Scale scores

324 TCI scales were completed by staff in the 44 participating homes. Table 6 shows the mean scale scores and the maximum possible scores for each of the TCI scales. There were no significant differences between the standardised mean scale scores. When homes selected by prior contact with psychologists were compared with those selected by direct contact with provider organisations, there was no significant difference between the standardised mean total TCI scores ($t = .090$, df 43, n.s.), or between the standardised mean scale scores. These mean scores lie within the average range for the scales.

Table 6. Mean scale scores

TCI Scale	Maximum possible score	Mean	S.D.
Support for innovation	40	29.75	3.03
Task orientation	35	25.75	2.91
Participative safety	60	45.46	4.70
Vision	55	42.45	4.10

There was no significant difference between the mean total TCI scores when houses established for longer than the mean duration of establishment were compared with those established for less than the mean duration (t=.375, df=40, n.s). By far the majority of teams (31 teams) were comprised of team members ranging in age from below 30 to over 50 years of age (across more than two age group bands) and no statistical comparisons of TCI scores between different age groups of team members were possible. There was no significant difference between the mean total TCI scores when teams with the median number of team members (eight) or below were compared with teams with membership above the median number (t=.615, df=40, n.s.).

SUMMARY – THE INTERNAL AND EXTERNAL ORGANISATIONAL FEATURES OF THE HOMES

All of the houses in this survey were community-based and all but one of these homes were run by private or voluntary sector organisations. The length of time for which the homes had been established ranged from less than one year to twenty years. The homes were generally small and all were staffed 24 hours. The ages, degree of learning disability and independence of the residents varied

and was in many cases mixed within homes. The residents had generally moved from hospital settings, although some had come from community settings. Almost all of the residents had access to part- or full-time structured activities outside the home.

Within the homes, all managers reported that team meetings were held regularly and that they and their staff had formalised supervision systems in place. Managers reported generally gave positive or neutral ratings of their experience of meetings, and of offering and receiving supervision. All homes had access to training programs and the majority of the homes had access to challenging behaviour training. Managers reported a generally reasonable match between the training that was available and that which they felt the team and the house required. All the homes implemented some form of individual service plans for residents. Managers' ratings of the relationships between the team and other services were generally positive or neutral. Their ratings of their own relationships with the organisations which employed and the extent to which they felt that they could develop their careers within the organisations were varied.

Most homes had one or more vacancies in the staff team, and the staff generally had prior experience. Less than a fifth of staff had relevant qualifications, and this figure included almost half of the managers.

Measures of team climate, using the TCI, found that the majority of homes had scale scores falling within the average range, when compared to standardised norms for the scale. All but one of the teams produced high social desirability

scores in the TCIs, suggesting that caution will be needed in the generalisation of these findings to other samples.

HOW DO MANAGERS DESCRIBE THE PROCESS OF MANAGING CHALLENGING BEHAVIOUR IN THESE HOMES?

The questionnaire included a group of questions designed to elicit managers' descriptions of the way in which challenging behaviour was managed in that particular home. 42 of the managers of the 44 participating homes were interviewed. The remaining two homes returned completed questionnaires, but the managers were not interviewed. The responses to these questions were fully transcribed and subjected to a content analysis procedure, as described by Dey (1993).

In this procedure, the data is first divided into manageable parts, and then related responses are grouped together. Categories are then created to describe these similar responses, and finally categories are combined or split where this provides a more appropriate rearrangement of the data. A sample of the data was then encoded by an independent rater in order to provide a measure of reliability.

Inter-rater reliability

Each text unit in a randomly-selected sample of six transcripts was then coded, according to the system of categorisation described above, by an independent rater who was given information about the structure of the category system and the criteria by which data units were assigned to a particular category. The overall percentage agreement was 73%, suggesting that these codings are

reasonably reliable across raters and that they would therefore have some generalisability.

Construct and hypothetical validity

No numerical assessment of construct and hypothetical validity was used in this study. However, the category system clearly describes the key elements of challenging behaviour management, in terms of its planning, the actions of staff, and resident issues. It can therefore be said to have a degree of construct validity, in that the system measures what it purports to. The categories also reflect the input/process model of intervention and the analysis can therefore be said to have a degree of hypothetical validity, since these are the theoretical constructs of the model of intervention as innovation which was investigated in this study. The limitations to this assessment of validity are the possibility that analysis of the data within a particular theoretical framework may lead to the omission of other possible constructs which might arise from the data.

Dividing the data into manageable parts

The interview questions provided the initial starting point for the division of data into manageable parts. Managers were asked the following questions:

1. 'Describe the way difficult behaviours are identified and managed in this house.'
2. 'Who gets involved [in this process]?'
3. 'What are the helpful things about this process?'
4. 'What are the unhelpful things about this process?'

5. 'What, if anything, do you think could improve this process?'

Additionally, 17 of the managers, who were interviewed later in the project, were asked a question designed to elicit information about the most difficult aspects of meeting the needs of clients who display challenging behaviour, as the other five questions did not seem to bring out this information, which is separate from the identification of the aspects that could be improved:

6. 'What is the most difficult aspect of meeting these needs?'

The basic unit of data for analysis was each separate idea in a sentence.

Grouping together related responses

Using the input/process/output model for interventions, described above, the initial stage of analysis of the data was the grouping together of responses under these themes. At this stage, the managers' responses to the questions were considered as a whole, rather than individual text units, and the number of different ideas occurring under these themes was recorded, rather than the number of text units grouped in each theme. This is akin to Dey's (1993) description of the use of a middle-order of initial categorisation as a starting point, where specific themes of interest are already identified in advance of the analysis.

At this stage it could be seen that issues of process, rather than input, accounted for the largest number of groups of manager responses in these questions. The point of intervention by clinicians will be largely concerned with process, rather than input, particularly in terms of devising and amending strategies and

guidelines which may already exist, and this also seems to have been a key focus for the managers interviewed in this study.

Assigning categories

The next step was to use these groupings as a starting point from which to assign each text unit in all of the transcripts to a subordinate category. This process generated 108 subordinate categories for input and process issues combined, and 15 stakeholder categories. These stakeholder categories were generated from the answers to question 2, which elicited responses largely in the form of a list. The stakeholder categories, and the percentage of managers who listed them, are shown separately in Summary Table 1, below.

Summary Table 1.

The percentage of managers listing different stakeholders.

Stakeholder	Percentage of managers
Team	100%
Manager (of team) – explicitly stated	81%
Line manager	36%
The person displaying challenging behaviour	71%
Other residents	40%
Significant others of person displaying the behaviour (if applicable)	62%
Clinicians:	
CTLD (cited as such, clinicians not specified, or in addition)	43%
Intensive support team (or other similar specialist service)	10%
Psychiatrist	14%
Psychologist	38%
Community nurse	19%
Speech and language therapists	7%
Care managers/social workers	21%
Inspection unit	7%
Other services (e.g. day services)	7%

The question specifically concerned the stakeholders in the process of managing challenging behaviour; although these stakeholders may have been mentioned elsewhere in response to other questions, these percentages relate solely to managers' descriptions of the people or bodies concerned as stakeholders in the process, rather than their involvement with the residents and the home itself. Managers' comments about the nature of their involvement appeared in response to the other questions and they are therefore subsumed within the other 108 subordinate categories.

Combining categories

The next step was the generation of a group of superordinate categories, formed by combining the 108 subordinate categories. This generated 6 categories, to which the manager responses to all of the set of questions, except the question concerned with stakeholders, were assigned.

Summary Table 2 (below) shows the numbers of subordinate categories contained within each superordinate category, the percentage of managers who gave responses which were assigned to each superordinate category, and the percentage of text units (of all the text units altogether) which were assigned to the categories. These superordinate categories included both input and process responses, and exemplars of each are shown for each category.

Definitions and elaborations of these 6 categories are given below, together with some illustrative comments where these provide richer information than the exemplars in Summary Table 2.

Summary Table 2. Statistical information and exemplars of superordinate categories.

Category	# subordinate categories	% managers	% text units	Exemplar: INPUT	Exemplar: PROCESS
1a Behaviours and other factors described as issues for management/solution.	31	100%	39%	*We make decisions to act as a team.*	*It's reassuring that we can try hopeful solutions ... if it doesn't work, we go back without beating ourselves up about it.*
1b Behaviours and other factors described as problems for containment.	25	83%	6.9%	*Having more staff around - that would reduce the frustrations of people who can't get out of the house and who don't get on with the other tenants... the opportunities are not there*	*[CB] is dealt with as it arises... we might have an event and staff deal with it then. There's not much in terms of posthoc planning for next time.*
2a Team work – positive aspects.	11	76%	6.6%	*It's nice that the whole team gets involved – it's very useful, and to know that there's the support of the team, even if someone's dealing with it one to one.*	*It's a shared process - we collectively own it. It's a team response with a single voice.*

Category	# subordinate categories	% managers	% text units	Exemplar: INPUT	Exemplar: PROCESS
2b Team work – negative aspects	18	57%	6.0%	*Certain skills are lacking in some of the team. We're trying to address this; one staff member has been transferred because they were experiencing difficulties.*	*Certain staff don't agree on the guidelines. Depends on their background. It can be difficult to overcome. Just one person not following the guidelines can ruin the whole process – it's back to square one.*
3a External services intervention described in terms of "rescue"	7	71%	7.4%	*We get professional input – we'd request it. We wouldn't move, other than in a dire emergency, without professional input.*	*Sometimes it's* [trigger for CB] *so blatantly obvious that we can't see it and the outside team can.*
3b External services intervention described in terms of "intrusion"	10	29%	2.6%	*I'd prefer permanent psychology input. I really don't feel that trainees should be dealing with residents on a short-term basis.*	*There can be difficulties in the process when people come in and see themselves as more of an expert, and try and pull rank*

Superordinate category definition and elaboration

1a *"Manageable solutions" - Behavioural and other factors as issues for which there are manageable solutions.*

Definition: Acts of discussion, forming of attributions, planning, prioritising and monitoring in the devising and/or implementation of strategies and management guidelines for dealing with challenging behaviours; recognition of sub-optimal levels of these activities and/or attempts to improve them (PROCESS). The utilisation of team and other resources (including pre-existing guidelines) to carry out these activities (INPUT).

Elaboration: Planning and monitoring, looking for triggers and setting events for challenging behaviours, and forming attributions about the behaviours, all supported the development and the implementation of guidelines and strategies for managing challenging behaviours. These processes were also involved in the decisions to dispense with previous guidelines, including those provided by others, and to work towards identifying the most appropriate strategies. Several managers (e.g. see Summary Table 2) spoke of the positive nature of the process of being able to try out strategies, and of having the confidence to work together as a team to reformulate their ideas if things did not work according to plan. These activities were also cited in the context of aiming to prevent situations where challenging behaviours might occur, and in

identifying and addressing areas of inconsistency within the team's approach. For example, one manager commented:

If there's a major incident, we discuss the ABC model and think about what to do differently, and how to prevent it, etc.

Responses related to input were largely concerned with the team working collectively to manage behaviours. One manager contrasted this arrangement with that which prevailed in the home in the past:

"Before, the manager laid down plans for the staff to implement and they didn't understand them. The focus now is on them understanding – well, not them, but us as a team – working together and achieving consistency for clients."

1b *"Problems for containment" - Behavioural and other factors as issues which are problems to be contained.*

Definition: Acts involving dealing with challenging behaviours as they arise, with little or no planning, monitoring or discussion, without reference to guidelines and with few or no attributions made about sources or triggers for behaviours (PROCESS); description of shortcomings or difficulties with resources or the environment, without the implication that these are situations which can be managed by the team (INPUT).

Elaboration: The majority of managers made some responses which reflected that, even if the overall stance of the team was that of the use of strategies and organised management of challenging behaviours, there were issues or situations which required containment, or

were dealt with in that way. This was in part due to the fact that almost all of the managers who made some responses which were coded in this category were describing the process of dealing with challenging behaviours as they arose, particularly for sudden, severe, or novel forms of behaviour. Some of these responses occurred in response to the question about what were the most difficult aspects, and reflected a number of relatively immutable features, such as the nature of the environment, the enduring and/or daunting nature of challenging behaviours themselves, and the wish for more resources (e.g. Summary Table 2).

One manager commented:

"It's one of the grungiest projects in terms of urine and faeces and regurgitated food – it's quite awesome and you really have to keep a strong stomach."

Other issues which were raised were the problems with differing viewpoints held by other services used by residents – e.g. day services – and when the views of residents' significant others ran counter to the strategies which the team were using to manage behaviours.

2a *"Teamwork benefits" - Positive aspects of team work.*

Definition: Positive aspects of the way in which the team works together, including in terms of communication, support and avoiding a culture of blame amongst staff (PROCESS); collective working practices, such as the use of team meetings for discussion (INPUT).

Elaboration: Many managers cited the importance of teamwork practices which supported the team members and in which individual strengths and abilities were recognised and encouraged. One manager commented:

> *"We look to use the skills, knowledge and resources within the house – to maximise it and take responsibility for some of the issues involved – owning that, rather than looking at the negative and passing it on to someone else. People are more receptive to issues we've discussed and planned – there's very good work in the house and it's about sharing that, in meetings and separately."*

Other manager responses reflected the view that it was important to work in this way to reduce staff stress and/or to build staff confidence.

2b *"Team work deficits" - Negative aspects of team work.*

Definition: Problems arising because of difficulties in working together as a team, such as inconsistency and/or lack of agreement within the team about the way in which challenging behaviours should be managed, and stressful issues for staff resulting from team work itself, such as feeling blamed or unsupported (PROCESS); problems arising because of the nature of the team itself (e.g. Summary Table 2), or because of issues such as the time that the process of managing challenging behaviours actually takes (INPUT).

Elaboration: A major issue highlighted here is that of the problems of inconsistency in team work, resulting either from faulty implementation of guidelines, or lack of understanding of them, or

by design, because of the lack of agreement amongst staff about what is the most appropriate strategy to adopt in the management of challenging behaviour (e.g. Summary Table 2).

Inconsistencies within the team were also seen to arise from external features, such as discontinuity in staffing, due to the turnover of staff and the deployment of temporary staff to cover shifts. One manager commented:

"Sometimes there are inconsistencies, and you can see the behaviours creeping back again. There's inconsistencies with the faces [when temporary staff cover shifts] *and so on – you feel somewhat that if that person is not inducted thoroughly, things can slip – it's not always that consistent."*

3a *"Intervention as cavalry" - The involvement of interventions from external sources, particularly clinicians, as rescuers of the team.*

Definition: Response to challenging behaviour includes accessing external support as one of the features of the team approach, including in the context of "when all else fails", and seeking and/or using ideas and support from clinicians (PROCESS); the implication that more input from external sources, or improvement in the logistics of referrals, would improve the team's ability to manage challenging behaviours (INPUT).

(Note: these responses did not include those categorised as "stakeholders" in the process, as elicited by question 2 – see summary table 2, above).

Elaboration: Several managers complained that one of the problems was the time that elapsed between making a referral, and its uptake. Accessing external support was frequently described as something which took place when the team themselves had already made some attempts to manage behaviours. One manager commented:

"Depending on the need, we would bring in an outside service, or if we couldn't devise a strategy to work with a person we'd ask for help outside. We could ask the community team, the psychologist, the community nurse or the speech and language therapist, depending what the need was."

Managers also described the usefulness of external support and interventions in ensuring a more objective view of the situation. One manager described a policy of calling the police to deal with the particularly difficult behaviours in that home.

3b *"Intervention as intrusion" - The involvement of interventions from external sources, particularly clinicians, in ways that are experienced as intrusions in the team.*

Definition: Problems arising because of the feeling that clinicians do not understand the home as a whole, or the residents as well as the team do; problems with the recommended interventions themselves, or because of conflicts of ethos between the team and the clinician's approach (PROCESS); problems arising because of the short-term nature of the involvement of clinicians, including short-term involvement due to the turnover, especially of trainee psychologists (INPUT).

Elaboration: Several managers cited difficulties arising from the turnover of clinicians (e.g. Summary Table 2). One manager commented:

"It was very annoying when we had too many people and too many things, but unrealistic measures."

Difficulties with the interventions themselves were largely seen as connected to the different, external, viewpoint of clinicians. One manager commented:

"Possibly some of the ideas are impractical... psychiatrists need to have residential experience, because then you see people as individuals – and outside services don't look at everyone in the home as a whole, which we have to do. They need more information about what we actually have to do".

Team work - negative aspects and team climate

The standardised TCI scores of those teams whose managers described negative aspects of team working (57% of managers) were compared with the TCI scores of those teams whose managers did not describe negative aspects of team working, according to the categories described above. There was no significant difference between the mean scores for the two groups ($t = .152$, df 25, n.s.).

There were no significant differences between the mean standardised total or scale scores for the TCI when the group of homes where managers' responses included descriptions of intervention as intrusion were compared with the group of homes where managers did not make such responses. However, this comparison is of limited validity since the numbers of homes in the two groups

were very uneven and the sample size was small. No other meaningful comparisons of the TCI or CCB scores could be made within the category groups, given the unequal distribution of percentages of manager responses in each of the paired category groups.

SUMMARY – CONTENT ANALYSIS

The results obtained from the content analysis of the manager responses to questions about how challenging behaviour is managed in that particular home do not support meaningful comparison with the results of the TCI analysis. However, a number of themes emerged from the data which suggest that the input/process model of innovation may have some utility in the examination of interventions with challenging behaviour in residential care homes. Manager comments illustrate some of the key theoretical issues related to resistance to interventions and to the problems and benefits of working in teams. Most managers cited positive aspects of working together in teams and were also able to identify the difficulties which this entails.

Another dimension of manager responses suggests that managers generally believed that they, and the teams which they managed, were attempting to find solutions to the management of challenging behaviours which involved monitoring, looking for triggers, minimising inconsistency and devising, implementing and testing strategies and guidelines, which may reflect the increasing familiarity of care staff with such procedures.

THE MAIN RESEARCH QUESTION

The main research question which this study aimed to address was: 'What, if any, are the relationships between a team's scores on the Team Climate Inventory, and the levels of challenging behaviour displayed in the residential care homes where they work?'

Correlations between the standardised total scores on the TCI (omitting the social desirability scale) and the CCB yielded coefficients displayed in table 7.

Table 7. Correlation coefficients – TCI and CCB

Scales compared	Pearson's r	Significance
Total scores: TCI and CCB	-.254	.048* (one-tailed)
TCI total and aggressive behaviour	.127	.081 (two-tailed)
TCI total and other CB	-.266	.081 (two-tailed)
TCI total and self-injurious behaviour	-.204	.234 (two-tailed)
Total CB and support for innovation scale	-.212	.083 (one-tailed)
Total CB and task orientation scale	-.172	.264 (two-tailed)
Total CB and vision scale	-.358	.017* (two-tailed)
Total CB and participative safety scale	-.186	.227 (two-tailed)

* $p<.05$ Note: one-tailed tests are quoted where a specific hypothesis was made about the direction of correlation.

Table 7 shows that the total score on the TCI is inversely correlated with the total score on the CCB, which is the hypothesised direction of correlation and therefore tentatively supports the hypothesis that higher levels of challenging behaviours within residential care homes will be associated with lower levels of team function in terms of its climate. No significant correlation was found for support

for innovation and total challenging behaviour scores, which does not support the initial hypothesis. The scale score for vision was significantly negatively correlated with the total challenging behaviour score, but no other two-tailed significant correlations were found for the other TCI scales. There was no significant correlation between the TCI social desirability scale and the total challenging behaviour scores.

A subsidiary question concerning the team scores on the TCI concerns whether there are demonstrable relationships between the TCI and organisational features of the residential care homes, both internal to the house and external.

The team scores on the TCI did not correlate significantly with the length of time for which the residential care home had been established, with the manager descriptions of their working relationship with the organisation, or with the degree of learning disability of the residents of the home.

There was a significant correlation between the frequency of team meetings and the vision scale scores on the TCI (Pearson's $r = .326$, $p=.035$), but no other significant correlations between scale scores and organisational features were found. These results do not support the hypothesis that organisational features will be an important factor in team climate, in this survey. The possible sources and implications of these findings will be discussed below.

SUMMARY – THE MAIN RESEARCH QUESTION

The hypothesis that team climate would be inversely associated with levels of challenging behaviour in residential care homes was offered some tentative support from the findings in this survey. Causal effects are not established by this study, although possible implications are discussed below. A subsidiary question, concerning the relationships between the team climate and organisational features of the homes, produced findings that did not support the hypothesis that organisational features would be associated with team climate.

CHAPTER FOUR: DISCUSSION

This study used a group level analysis of the extent of challenging behaviours in residential care homes for people with learning disabilities, and of the organisational features of the homes Measures of team climate were used as an assessment of team functioning and, particularly, of a team's capacity to innovate. New interventions with challenging behaviours, by teams and by external agents such as clinicians, are characterised here as innovations, in the specific sense of the application of a way of working that is novel in that context.

RESEARCH QUESTIONS

1. What is the extent of challenging behaviour?

The first question which this study considered was the extent of challenging behaviours shown by the residents of the participating homes. No cut-off point of levels of challenging behaviour was used as a criterion for inclusion, as it was intended that aggregate scores for challenging behaviour in homes, rather than scores for individuals, should be compared. The key aim was to investigate whether overall levels of challenging behaviour in the homes were associated with levels of team functioning. Aggregate levels of challenging behaviour were also compared for homes where residents were described as having different levels of learning disability, for homes where residents were of different age ranges, and for homes selected via the two different routes to recruitment.

This survey used the Checklist of Challenging behaviour to assess aggregate levels of challenging behaviour in the homes. The findings related to reliability and validity of the Checklist (Harris, Humphreys and Thomson, 1994) tend to

support its use as a survey instrument and, although in this fairly large sample a large number of individual raters will have provided the information, the checklist is likely to have provided a reasonably accurate summary of the range and level of behaviours displayed by each resident. Only one batch of checklists returned by one home was excluded from the study because they were incorrectly completed. The alterations made to the scoring in this study, in which scores of zero were given where a behaviour was recorded as not occurring, were made because forms were consistently returned with indications that items did not ever occur for that person and therefore had not been scored. This amendment therefore reflects the way in which the instrument was used by the care staff and, given the consistency with which this occurred throughout the sample, this is likely to be valid. Overall, given the limitations of any questionnaire method, the Checklist of Challenging Behaviour is likely to have provided a reasonably reliable estimate in this study.

The extent of challenging behaviours

A wide range of total aggregate scores derived from the whole Checklist of Challenging Behaviour, and of aggregate scale scores, for aggressive, self-injurious, and other challenging behaviours was found in the current study. When the sub-scale scores were compared, there were statistically significant differences between the ratings for frequency of behaviours, on all scales, and for management difficulty and severity, with scores for frequency being higher than the scores on the other sub-scales.

Previous studies (e.g. Lowe and Felce, 1995) have found that staff were more likely to rate frequently occurring behaviours as more severe. In terms of the aggregate subscale scores for aggressive and self-injurious behaviours, frequency scores were significantly greater than severity or management difficulty scores, and for other challenging behaviours the frequency scores were significantly greater than the management difficulty scores. This suggests that staff did not, in this study, rate more frequently occurring behaviours as more severe, but that they were able to distinguish between these features of the behaviours. There have been a social desirability element to their responses, particularly about management difficulty. Staff filling in the checklist may have felt that their assessment of management difficulty could be seen by other team members or the home manager as a reflection on their competence. The finding that there was no significant difference between the mean standardised scale scores (i.e. between the standardised totals of aggressive, self-injurious and other challenging behaviour scores) suggests that there may be aggregate constellations of behaviours displayed by residents within these homes, as found in previous studies, where people who displayed one type of challenging behaviour were also likely to display others (e.g. Emerson and Bromley, 1995).

Staff perceptions of challenging behaviours may be subjective, and their perceptions of the severity and management difficulty of challenging behaviours may be less reliable than their assessment of its frequency (e.g. Lowe and Felce, 1995). This is also consistent with the findings of Harris, Humphreys and Thomson (1994) in the development of the Checklist of Challenging Behaviour. All of the participating homes included residents where there was either an "expert" acknowledgement of the existence of challenging behaviours (by

psychologists who worked with the teams and residents) or a staff acknowledgement that challenging behaviours were displayed by residents (in homes where direct contact was made with organisations).

The socially constructed, varying operational definitions of challenging behaviour have already been considered; in this study, the selection process is likely to have resulted in the inclusion of homes where challenging behaviours are more likely to fulfil the criteria cited by Zarkowska and Clements (1994), which include behaviour contrary to social norms, than those given by Emerson (1997), which include only behaviours involving more severe levels of risk to the person or to others and more serious levels of disruption. Care staff working in small community homes are likely to perceive behaviour contrary to social norms as challenging in the context of their work to support residents' access to, and participation in, community facilities and wider opportunities outside the home. This is likely to be so even when the actual element of physical risk to the person, or to others, is low. Lowe and Felce (1995) found that staff working in small community homes were more likely than those working in hospital settings to state that behaviours caused severe management problems. In the current study, staff perception that residents displayed challenging behaviour was a basic criterion for inclusion of that home in the survey.

These inclusion criteria are likely to have contributed to the finding that there was a slightly wider range of other challenging behaviour scores for individuals in this study than those cited in a previous study (Jenkins, Rose and Jones, 1997), although these results must be interpreted with caution. No comparisons

between the studies of individual mean scores on self-injurious behaviour scale can be made as these figures are not cited in Jenkins et al's (1997) study. That study only included residents whose challenging behaviour scores were above a cut-off point on each of the checklist scales, reflecting frequencies of one to four times in the previous month, and management difficulty recorded as being "very difficult to manage alone". The participants in that study were drawn from institutionalised hospital settings and community settings and included both those known to have histories of challenging behaviour and those with no known history. In the current study, participants were all drawn from community settings (which may also influence the reduced scores, given that the previous study found higher scores in the hospitalised group) and were selected on the basis of an acknowledgement by staff teams (and/or psychologists offering input to the homes) that there was some challenging behaviour amongst residents in the home.

Comparison between the two selection groups

When participating homes in the two selection groups were compared, there were no significant differences between the standardised scale scores, which suggests that there was no significant difference between the overall levels of aggressive, self-injurious or other challenging behaviours in the homes in the two groups. The finding that there was a significant difference between the management difficulty subscale scores (with higher scores for the directly-selected homes) may reflect lower levels of clinician involvement with these homes. Although all managers reported that psychologists and/or other clinicians were involved with, or available to be involved with the management

of challenging behaviours within the homes, psychologists may have been more likely to suggest the inclusion of homes where they were currently more actively involved. Involvement and support from clinicians may result in staff feeling that the behaviours are less difficult to manage, or that the level of management difficulty had actually reduced. This cannot, however, be substantiated from the findings in this study because no information about the amount and type of psychologist involvement was collected.

Comparison by age group of residents

The findings that there were no significant differences between standardised aggregate challenging behaviour total scores when homes where all residents were aged 30 or under were compared with those where all residents were aged between 30-50 appears to conflict with previous research (e.g. Qureshi and Alborz, 1992) and must be interpreted with caution, given the small size of the sub-samples and the range of total challenging behaviour scores involved. Only one manager in the current study had worked with a group of younger residents long enough to be able to comment that there seemed to have been a reduction in challenging behaviours as residents progressed from their early to their mid-twenties. Younger residents in community-based homes may be more likely to have access to a wider range of activities outside the home, which may reduce levels of challenging behaviour compared to their peers living in institutionalised settings. The small sub-sample size of homes established for less than 18 months also requires highly cautious interpretation of the finding that the challenging behaviour total scores for such homes did not differ significantly from homes established for more than 18 months. There was a significant correlation

between the length of time over which a home had been established and the number of residents who had come from the community. Care workers in the newer homes may have more experience in other settings, or the homes may be set up with the expectation that managing difficult behaviours will be an important part of this work. This may in turn influence staff perceptions of the non-normative nature of challenging behaviour, and thus their ratings of it, at least in terms of management difficulty. More detailed subscale comparisons were not performed because of the small size of the subsample.

Comparison by degree of learning disability

Manager assessments of the degree of learning disability of the residents of homes were used in this study as it was not feasible to provide a more objective measure for over 200 participants. This is, inevitably, a subjective assessment, although it is also likely that many residents will never have received any formalised assessment of the extent of their learning disability. One manager commented that the team perception of the learning disability of residents in the home was of people with a mild to moderate learning disability, in contrast to the "labels" with which they had been discharged from hospital, when they had been described as severely learning disabled. Given the subjective nature of the assessment of learning disability and the small sub-sample sizes, the finding that there was no significant difference between the groups in this study requires cautious interpretation. However, Lowe Felce and Blackman (1995) found that there were no differences in the nature and severity of challenging behaviours of people referred to specialist support teams in terms of their dependence, social

impairment and mental health. The relationship between levels of challenging behaviour and degree of dependence and impairment seems to be equivocal.

Summary

In the current study, a wide range in the aggregate levels of challenging behaviour in the homes was found. There were no significant differences between the aggregate scores when these were compared according to the age range of residents, or their degree of learning disability, but these scores must be interpreted with caution because of the small sub-sample sizes. When residents in the two different selection groups were compared, the only significant difference between the groups was that for management difficulty, when directly-recruited homes had higher recorded levels of management difficulty. This may reflect different perceptions of staff in homes where there may have been lower levels of clinician involvement, but this cannot be substantiated in the current study.

2. What are the organisational characteristics of these residential care homes?

The literature on the organisational features of homes relates to the way in which these features impact on staff behaviour and also to the informal culture in teams. The information about organisational features of the homes in this survey was collected in order to provide a picture of the way in which staff activities were managed, the activities of residents, and of the range of other agencies involved with the homes.

Felce (1988) described three defining features of residential care models; the orientation, or objectives of the program, the structural aspects, such as the features of the environment and the procedures which guide staff performance.

The questionnaire was designed to elicit information about these three defining features of the homes, particularly structural and procedural factors, and thus to provide information about the social dimension in which any behavioural analysis within these homes would be set.

All of homes had formalised structures for meetings, staff and manager supervision and for developing and implementing care plans for the residents. The residents themselves had a wide range of abilities and support needs and varied programmes of activities, within the homes and outside them.

Structural features

The model of conceptual analysis of staff behaviour postulated by Hastings and Remington (1994) has two categories of self-generated rules which govern staff behaviour; those which shape and direct their responses to challenging behaviour, and those which hypothesise about causes. These rules are both externally and internally supplied. External performance-related rules are represented by service policies and guidelines, programs for managing behaviour, and also the informal staff culture; hypothesis-related rules, by professional analyses of challenging behaviour supplied by clinicians, and also those derived from staff culture. Self-generated, internally-supplied rules will

derive from individual beliefs about challenging behaviours. The external, performance-related rules can also be conceptualised as the structural and procedural factors described by Felce (1988).

All of the homes in this survey were small and set in community residences, with relatively high staffing ratios compared with those which would prevail in institutionalised settings. These are features which have been found to be associated with improvements for residents in terms of meaningful activity without an overall increase in problematic behaviour (Hastings, 1995b). Almost all of the residents in this survey had access to structured activities outside the home, including attending day centres, regularly scheduled use of community facilities, and, in some cases, using further education courses and supported work programs. The extent to which these activities can be described as meaningful was not investigated, but the overall finding was that staff activities focused on facilitating such access, rather than custodial care. This posed logistical problems for staff, in terms of the multiplicity of settings and the part-time nature of much of these activities, which were often facilitated by the staff themselves, in addition to facilitating resident involvement in the domestic life of their home. In the context of the management of challenging behaviours, manager comments suggested that the different attitudes of day services, or the different levels of behaviour which residents were perceived to display in these different settings, sometimes posed problems, particularly in ensuring consistency of response to behaviours, and also in terms of the logistics of involving staff from these services in planning meetings. Such complex arrangements are likely to represent additional structural stressors for staff teams.

Staff turnover was not assessed in this survey, although many managers reported that there was at least one vacancy in the team, and several commented on the additional problems posed for the team and for residents when temporary staff were used to cover vacancies, and by the time it takes to recruit and induct new staff. Some managers also commented that at least some of the team had worked in the home for some time, so it is likely that there are elements of both change and stability for many teams. An over-emphasis on stability may militate against innovation in the form of changes in management of challenging behaviour, and, inevitably, frequent changes in teams may lead to problems with consistency of approach. This is further complicated by part-time staffing arrangements in many homes, which manager comments suggested provided more flexibility, but greater logistical problems in arranging meetings and other staff work as a team.

Although the majority of staff were not reported to have formal qualifications in care work or in related academic subjects, the prevailing expectation was that training and experience are necessary to support high quality work by staff. All homes had access to a range of training for the team provided by the organisation and/or by external courses.

Almost all managers reported that organisational policies and procedures were clear and available to them. These policies were often evolving, and some managers were involved in working parties to develop and amend specific policies and procedures. These external guidelines may both support clarity about how to handle specific situations arising in homes, and constrain the ways

in which staff work and generate additional amounts of administrative work not directly connected to the day-to-day work of resident support. In the context of complex provision of access to activities for residents by staff, this is likely to represent additional stressors for teams. Jenkins, Rose and Lovell (1998) suggest that the major stressors for staff were the immediate environmental factors, including the organisation of work. In the current study, a more detailed examination of the different aspects of these organisational features of the homes through analysis of organisational policies, procedures and mission statements was not possible.

Another element of the environment of residential care homes which forms part of the structure is the characteristics of the residents themselves. In many homes in this study, residents had a wide range of abilities and support needs and a variety of features related to their different ages and to their cultures of origin. There was also a wide range of physical and mental health support needs. Such diversity of needs and abilities in a resident group requires staff to balance the needs of individuals with those of the group as a whole, and is likely to present additional task burdens and, possibly, difficulties in striking that balance.

Procedural features

All managers reported that individual planning systems were in place for residents, and these were implemented and developed over time, with regular meetings and resident reviews. Such procedures are likely to support staff in taking a wide view of resident support needs, including biological/medical, environmental, social and interpersonal aspects, and to facilitate the development

of a higher quality of life for residents. The nature and quality of these planning systems was not assessed in this study.

In all the homes, regular supervision of staff and managers took place. Staff may work alone, but do not work in isolation, in the sense that supervision should provide both support and development of their work. Managers generally reported that their experience of receiving and offering supervision was positive or neutral. Problems with supervision reflected the logistics of arranging it; for receiving supervision, the problems were generally related to the infrequency of supervision and to the sense that it was more related to the needs of the organisation than to the managers themselves. Problems experienced in supervising staff reflected the different attitudes of staff to supervision, including the development of staff as active participants in the process and also dealing with their expectations that supervision implied that there was a problem with their performance, rather than its use an ongoing mechanism for the development of the work in the homes. A previous study found that, while social support systems may act as a buffer against stress, the supervisory responsibility of front-line managers may constitute an additional form of stress in their role (Elliott and Rose, 1997).

All homes reported regular team meetings. Overall there was an emphasis on the need for teams to meet and exchange information and ideas, for team members to share the administration of these meetings and the implementation of decisions made in them, and use of these times to discuss the management of challenging

behaviours, both in terms of acknowledging and monitoring the behaviours, and planning and reviewing the implementation of guidelines.

Informal culture of the team

In addition to the more formalised ways of working, described above, a measure of the informal culture of the team was provided by the manager assessments of working relationships between the team and other stakeholders in the service, including residents, their significant others where applicable, and organisational stakeholders such as primary care health service providers, clinical teams for people with learning disabilities, care managers or social workers, and inspection units. These stakeholders represent both internal and external features of the team, in that ways of dealing with them will impact on the way the team works together and the way in which the team interfaces with these stakeholders. Managers generally reported these relationships to be positive or neutral, and spoke particularly warmly of team relationships with residents. Relationships with residents are likely to be of major importance in the staff team's ability to maintain positive input to the lives of people who may present them with behaviours which are sometimes difficult and even threatening to their safety, and to require a variety of forms of intimate support and personal care.

The informal culture of teams will be considered more fully in the context of challenging behaviour management in the following section.

Summary

In general, the organisational features of homes, both structural and procedural, were likely to be those which are supportive of flexible work, in which the team as a whole are involved, with systems in place to monitor that work, in terms of meetings, supervisions, and external features such as maintaining adherence to organisational policy and procedure and fulfilling the requirements of the inspection units. Such features are also likely to pose additional difficulties for staff, in terms of balancing the needs of all the stakeholders in the service and setting priorities for work. This study did not examine documentary or other more objective evidence for the managers' descriptions of these features, and the problems with the use of such self-report data must be borne in mind. However, the consistency with which the same issues were raised by managers suggests that these reports are reliable. They may also be seen to be socially valid, in the sense that they represent the perceptions of the people with a key role in managing the internal and external work of teams, as providers of services to people with learning disabilities and as employees of organisations which are themselves providing services in the context of accountability to purchasers, external monitors of the services, and in the wider context of current prevailing policy and procedure. Just as teams operate at the point of interface between residents and the community, so too the managers can be seen to operate at the point of interface between the rest of the team and the organisation which employs them, and between the team and other external stakeholders in the service.

3. How do managers describe the process of managing challenging behaviour in these homes?

The content analysis of managers' responses to this group of interview questions generated six superordinate categories, together with the separate group of 15 stakeholder categories. The content analysis was framed by the constructs of inputs to, and processes of, intervention, derived from West and Farr's (1990) model of innovation. Manager responses did reflect both inputs and processes involved in the existing approaches to the management of challenging behaviours and also in the use of clinician support for this work. Intervention by clinicians is, in this study, framed as a form of innovation, in which new approaches to the problems are applied; both clinicians and teams are involved in this process.

Functional analytic approaches to interventions with challenging behaviour have been set in an ecobehavioural framework by Halliday and Mackrell (1998). In this model, successful intervention requires consideration of the wider framework of environmental, interpersonal and intrapersonal dynamics, as well as the behaviours and their antecedents and consequences.

Manager responses suggested that, in almost all teams, the process of acknowledging and monitoring behaviours, and considering them in their wider contexts, such as the social settings in which behaviours occur, the physical and mental health of residents, and the relationships between residents and between the team members and residents, was a central feature of their work in supporting people with challenging behaviours. In many teams, this framework was already in place and had informed the development and review of guidelines and

strategies to be used by the team in managing behaviour; such guidelines, already in existence, were considered as elements of the input to this work. The development of new guidelines for novel or escalating behaviours were considered to be elements of the process. Furthermore, manager responses overwhelmingly reflected recognition of the need for consistent approaches by the team, particularly so that the effects of guidelines could be monitored. They also highlighted the problems when individual staff attitudes problematised behaviours, or when individuals were resistant to particular strategies. That such work was seen as jointly shared by teams was reflected in responses made by all managers, and many also described the need for teams to work together and the need for support for staff, particularly those who were newly appointed and those who had been on the receiving end of difficult behaviours. The need for confidence-building within the team was also described by many managers, and some spoke of the need for a flexible approach to reviewing strategies for behavioural management, and a separation between identifying where staff behaviours, attitudes and responses might be exacerbating the effects of behaviour, and avoiding a culture of blaming staff for behaviours. This is akin to the role of supervision in providing support described by Levy et al (1988). The enduring nature of many behaviours was recognised, and this was seen as both a source of frustration and something that had to be acknowledged.

Managers generally described responses to behaviours as both solution-seeking – devising guidelines – and problem-containing – seeing behaviours either as problems to be contained, rather than problems which could be solved, or distinguishing between the need for immediate responses to certain behaviours,

particularly in the context of risk, and ongoing planning to devise strategies for the management of these behaviours. Prevention and diffusion of episodes of behaviour were also described by many managers.

Manager responses suggested that staff attributions about behaviours were based in a consideration of wider social, biological and environmental factors, although this may reflect their general level of experience and understanding of the sources and triggers for challenging behaviours, which may be greater than that of the staff in their team. No information about individual staff team member beliefs and attributions were obtained in this study. Previous studies (e.g. Hastings, Remington and Hopper, 1995) have suggested that staff members are more likely to seek explanations for behaviour in terms of their causes, or in terms of resident needs, rather than the functions that such behaviours may have for residents. In this study, there were few manager responses which emphasised directly the functions that challenging behaviour might have, although much of this was implicit in manager emphasis on knowing and understanding residents, and on communication with and by residents. This suggests that managers and teams in this study do make attributions about challenging behaviours in terms of their functions and that they perceive an element of communication in behaviours, rather than attributing the behaviours solely to internal causes.

Managers also frequently described the effects that some behaviours had on staff and recognised their need for support and, in some cases, formalised debriefing and time out for staff was available when they had been in receipt of violence.

The majority of managers spoke about external input into the process of managing challenging behaviours in terms which were categorised as "rescuing" the team. A significant minority also described such input in terms which were categorised as "intrusion". There were no significant differences between the total TCI scores or the scale scores of the TCI when those two groups were compared. Team climate does not appear to be associated with the experience of clinician intervention as intrusion. Manager comments describing clinician intervention as intrusive generally reflected either that they perceived the suggested interventions to be impractical and, in some cases, inappropriate to the needs or ages of residents, or that the clinicians did not see the home as a whole, or understand the residents as well. This suggests that teams are attempting to adopt an ecobehavioural approach to their management of challenging behaviours, in the sense that they consider the wide range of factors involved. Clinician turnover, especially of trainee psychologists, was also experienced as intrusive. This seemed to heighten the sense that clinicians did not really know the residents or the situations. Despite this, the managers frequently recognised the value of objectivity and perceived this as something that was more likely to come from an external viewpoint. There was considerable overlap of the two kinds of response about clinician interventions.

Summary

Overall, in this survey, manager responses suggest that teams generally take an approach to challenging behaviours which involves teams working together to identify and monitor behaviours, devise and implement guidelines and strategies, use and access the support and ideas of clinicians, and review the strategies in

use. Attributions were made about the triggers and sources of behaviour which reflected the wider ecobehavioural model and, to a lesser extent, manager responses implied that the functions of behaviours were also considered. Consistency was emphasised, and the importance of staff support and a flexible approach were also described. Camouflage and containment of challenging behaviour did not appear to be the overall aims of teams. Such approaches to the management of challenging behaviours are those which are, in current theoretical and applied literature, seen as more likely to support the maintenance of habilitative staff responses to challenging behaviours. They may be seen as lying within a broadly functional analytic model, in its widest sense. This may reflect the continuing involvement of clinicians, especially psychologists, in providing input to homes and also in setting up newer homes, especially those designed to provide specialist services to residents displaying challenging behaviours. The majority of staff and managers were reported to have prior experience and training was provided in all homes, including challenging behaviour training in the majority of the homes, which may serve to reduce the gap between what is known about effective responses to challenging behaviour management and what is implemented.

4. What are the relationships between a team's scores on the Team Climate Inventory, and the levels of challenging behaviour displayed in the residential home where they work?

This study set out to test two specific hypotheses about the relationships between levels of challenging behaviour and measures of team functioning.

The first of these relates to the literature on staff stress. This has mostly considered staff stress at the individual level, in terms of the impact of challenging behaviours on staff stress, and the effects of staff stress on performance (e.g. Rose, 1995). It was hypothesised that similar relationships would operate in teams as a whole and that this would be reflected in a negative correlation between measures of team climate and levels of challenging behaviour.

There was a significant negative correlation between total team scores on the Team Climate Inventory and the total challenging behaviour scores in the homes. As this is, however, a cross-sectional study, no conclusions about the causal direction of this correlation can be made. Higher levels of challenging behaviour may impact on team functioning, in the way that it has been suggested that challenging behaviour impacts on individuals. Alternatively, teams functioning at lower levels, as assessed by the TCI, may be less able to deal with challenging behaviours and/or to be more likely to work in ways which are inconsistent. Team climate is seen as a major contributor to a team's innovative ability (West, 1990). It may be that teams with lower TCI scores are less able to work flexibly in the devising and implementation of new strategies and guidelines for managing behaviours and they may find it harder to incorporate external interventions in supporting residents who display challenging behaviour. They may actually be resistant to innovative ways of working. There was no significant difference between TCI scores in the teams where managers described the experience of intrusive features of clinician involvement with teams and TCI scores where no such features were described and there is therefore no

demonstrable relationship between team climate, as assessed by the TCI, and the manager perception of clinician involvement. This may reflect the overlap of the two kinds of response; managers who described intrusive features also frequently made responses which were categorised as "rescuing" features of clinician intervention.

The second hypothesis which this study set out to test was that concerning the support for innovation scale on the TCI. Support for innovation, both articulated by organisations in terms of policies and procedures, and enacted, in the provision of resources for innovation, is assessed by the support for innovation scale. It was hypothesised that there would be a negative correlation between a team's score on the support for innovation scale, and the levels of challenging behaviour within the home. No significant negative correlation was found. It may be that, because teams work to support so many different aspects of residents' lives besides the challenging behaviours that they may display, support for innovation reflects the wider aims of services and that this construct does not apply solely to the management of challenging behaviours. Levels of support for innovation may be high, but the particular support for innovation which teams require in the management of challenging behaviour may be in place as part of the wider support for innovation. Deficits in support for innovation may impact on other aspects of team work, for example, in the provision of resources to support residents' access to community participation.

The only other significant correlation between TCI scale scores and challenging behaviour scores was a negative correlation between scores on the Vision scale

of the TCI and total challenging behaviour scores. The Vision scale on the TCI represents higher order goals of the team and motivation towards them. No causal relationship between these findings can be described, but it may be that higher levels of challenging behaviour in residential care homes make it more difficult for teams to identify and work towards the higher-order goals of their work as a team if there are frequent episodes of difficult to manage behaviours, requiring immediate containing responses and subsequent monitoring and planning to devise strategies for management. Such work may deflect teams from the focus on wider service aims. Alternatively, it may be that lower levels of focus and motivation towards higher order goals impact on the ability of teams to address the task of managing challenging behaviours.

A subsidiary question related to team climate was that of relationships between internal and external organisational features within the homes and scores on the TCI. Individually-focused research has found that organisational variables are cited as the most important stressors for staff (e.g. Rose 1995). These stressors include role conflicts, lack of control over factors affecting work, work load and specific organisational features. It was hypothesised that organisational features would be related to team scores on the TCI. The only significant correlation between TCI scale scores and organisational features found in this study was that between the frequency of team meetings and the Vision scale. It is likely that teams which have fewer meetings have a reduced ability to identify higher order goals and reduced motivation towards them as a team.

The findings that there were no other significant correlations between TCI scores and internal organisational features such as supervision frequency and quality, relationships between teams and other stakeholders, manager descriptions of their working relationships with the provider organisation, or external features, such as the degree of learning disability of residents in the home, does not support the hypothesis that organisational features will be related to measures of team climate. It may be that the measures of organisational features used in this study do not focus sufficiently on specific working practices to enable rigorous testing of this hypothesis. In particular, while the diversity of team functions in their work to support the ordinary life of residents has been discussed here, no objective measure of these different functions, and the amount staff of time they occupy, was obtained. It has been suggested that role conflict for staff may result from these diverse functions, but the relationships between this and team climate cannot be investigated in this study. No significant relationships between team climate scores and length of establishment of the homes, and between team climate scores and numbers of team members in the homes were demonstrated, although these findings must be interpreted with caution.

The group level analysis of residential care homes described here has implications for clinicians working with teams and also for further research, and these will be discussed below.

LIMITATIONS OF THE CURRENT STUDY

Organisational and demographic features of the homes

It was not, in this study, possible rigorously to investigate the relationships between the structural features of the residential care homes and the team climate. The provision of individual demographic data related to staff tenure, age, prior experience and qualifications, and individual demographic data related to resident age, degree of learning disability and dependence, previous residence, and other health problems would have enabled this to be carried out. Such information was not collected in this study for two reasons. The first of these was logistical; in order to obtain as large a sample as possible, only the measures of team climate and challenging behaviour were mailed to the teams to reduce the amount of time that participants would need to spend on completing the measures. The second reason for the omission of this kind of data collection is concerned with confidentiality and with consent to participation in the study. Provision of detailed and potentially identifying demographic information by staff about themselves was also likely to have raised difficulties in terms of their consent to participation.

Resident consent was not required for this study, as individual information about each resident was not collected. Obtaining informed consent from people with learning disabilities to participation in research is a problematic issue, particularly for a relatively large sample in many settings, in which consent would in effect have to be secured by third parties (the staff working in the homes). A way to overcome this, in the current study, was to omit the collection

of identifying information about residents alongside the checklists of challenging behaviour.

The manager interviews were intended to provide information about the numbers of staff in teams, their qualifications and experience, the age range of staff and the length of time for which the home had been established. In practice, such an aggregate approach did not yield sufficient information to support the investigation of relationships between these variables and the team climate. There are a number of ways in which these variables might contribute to team climate in residential care homes. Younger, less experienced staff may be more optimistic about the way in which the team functions, or they may be more likely to experience difficulties working under stressful conditions. Their presence in a team may also impact on the supervisory load borne by home managers, which may in turn contribute to their perceptions of the way in which the team works together to manage challenging behaviours.

It was apparent that, in almost all cases, managers were not able to state exactly how many staff were on their team without consulting current team rota documents. This seemed to reflect the complex patterns of part-time employment in such work, often designed to provide maximum flexibility in the support offered to residents. Again, the presence of larger numbers of part-time staff in a team may affect both the team climate and the way in which teams work together to manage challenging behaviour; for example, the problem of consistency of approach was mentioned by many managers and this is likely to be exacerbated with larger numbers of part-time staff.

The issue of the length of time for which the team has been established is problematic; individual demographic information including team members' length of service would have provided the opportunity to examine whether this factor is associated with team climate. However, this is likely to be an apparent, rather than an actual, measure, because there may be differences in teams where the manager's tenure is longstanding, even if many of the staff are relatively new in post, when compared with teams who have a longer mean tenure but a new manager. This is likely to be compounded further by the issue of the length of time for which the residents have lived together, and the length of time for which homes have been established. Residents may have lived together in institutional settings prior to moving to a community-based home, where they may subsequently have been joined by additional residents not previously known to them. In practice, distinguishing between homes in terms of the length of their establishment appears objective, but this is likely to mask the relationship between other features of the teams and their climate.

Overall, only the most superficial analysis of the relationship between team climate and team demographic variables was possible in this study because of the data collection procedure.

Features of the organisations and impact on team climate

It was intended that content analysis of such documents as organisation mission statements would provide the opportunity for comparison of the team climate scores in homes according to features of the provider organisations. In practice,

the limited return of documents made such comparisons impossible. Relationships between teams and provider organisations are likely to represent a contributing variable in terms of team climate, and manager descriptions of their perceptions of the relationships between the team and the organisation are not sufficiently objective to provide a point of comparison between teams.

No objective measure of the quality of training or prior experience was possible in this study; again, these variables are likely to contribute to the organisational features of the homes and their internal culture. Individual team member information about the length and nature of prior experience, and the level of their training and qualifications, would have provided a useful measure on which team climate scores could be compared.

Objective measures of challenging behaviour management

As described above, the original research design included triangulation of the manager responses about challenging behaviour management by teams with documentary data about organisational policy and procedure and incident records, risk taking policies and individual challenging behaviour management guidelines. In practice, this was not possible because of the limited amount of such information which was returned. The limitations of manager response, in terms of its representativeness of team views and actual activity of teams, have been discussed. Such written data would have provided an additional, more objective dimension, on which to compare the homes. This study did not include information about which residents were in receipt of psychological intervention,

or for what purpose, which would also have provided an important dimension on which to compare homes.

To have included such objective data would have overcome some of the difficulties associated with the social desirability element, demonstrated in all but one of the team profiles derived from the Team Climate Inventory; it is likely that there was also an element of social desirability responding by managers during the interviews. However, as has already been stated, the consistency of social desirability responding in this sample makes it possible to make comparisons within it, although it is likely to limit the generalisability to other samples.

Researcher bias and qualitative analysis

Prior experience in managing residential care homes for people with learning disabilities who display challenging behaviours, and more recent experience of working as a trainee clinical psychologist with staff teams in such homes, informed the original concept for this study. However, the basis for the qualitative analysis in existing theoretical literature, together with the reasonable inter-rater reliability for the categorisation of the data, suggest that researcher bias is unlikely to have limited the generalisability of this study to other settings. It can also be argued that experience of what may be termed both sides of the intervention equation may actually have served to reduce researcher bias.

One potential limitation in this study concerns the method of interview data collection. Because of the issues of confidentiality, and the logistical difficulties

of transporting recording equipment by public transport around a wide geographical area, the interviews were not audio-taped. Interview data recording was by verbatim note-taking at the time of the interview, with transcriptions being made as soon as possible after the interview had taken place. However, this procedure is more likely to result in inaccuracies, such as omission of responses, and the potential introduction of interviewer bias in the mis-representation of what was said. In practice, these limitations were minimised to some extent by checking with interviewees at any point where their statements were unclear, and by prompt transcription of interviews. The transcribed interviews frequently contained colloquialisms, indications of repetitions and hesitations and particular use of terminology, suggesting that the verbatim notes did record the interviewees' responses rather than the interviewer's impressions of them. Nevertheless, it would have been preferable to have used audio-taping to ensure consistency, particularly as large numbers of interviews were conducted over a period of time, so that inaccuracies potentially inherent in both the process (the possible introduction of researcher bias) and the practice (such as lapses of concentration during interviews) could be eliminated as far as possible.

IMPLICATIONS OF FINDINGS: CLINICAL INTERVENTIONS

The implications for clinical interventions from this group level analysis of residential homes can be considered within two frameworks: theoretical approaches to interventions with challenging behaviours, and practical approaches to working with teams. These will be considered in turn.

Theoretical approaches

Group level approach

It has been argued that models drawn from occupational and organisational psychology should be used in understanding the formal and informal culture of services (Hastings, Remington and Hatton, 1995). The group level approach used in this study was predicated on the idea that individual challenging behaviours, and individual staff responses to them and beliefs about them, can be considered in the context of the group setting in which they occur. At this group level, it was argued that both the staff team as a whole and the overall levels of challenging behaviour in homes should be taken into account. Staff work in teams and residents live with others, who may also display challenging behaviours. The multiple roles of staff mean that the management of challenging behaviours will not be the only focus for staff work, although it is likely to be the main reason for referral of residents for psychological intervention.

This represents a move from individualised focus on behaviours and staff responses, towards an analysis of the wider culture of services. It was argued that clinician-led interventions need to be based not only in functional analytic models of behavioural intervention, but also in an understanding of the wider ecobehavioural factors impacting on challenging behaviours and staff responses. This study attempted to investigate some of those formal and informal aspects of staff culture in a framework of analysis of the team climate, a concept derived from occupational psychology. Team climate is a measure of "staff perceptions of the way things are round here" (Reichers and Schneider, 1990) and it is cited as the most important contextual determinant of innovation by teams (Agrell and Gustafson, 1996. The Team Climate Inventory used in this study purports to

measure the four factors that are predictive of innovativeness in teams (West and Farr, 1990). This concept of innovativeness has a specific meaning; that is, the ability of teams to apply constructs and approaches in ways which are novel in that particular setting. In residential care homes, the work of teams in devising new strategies for managing challenging behaviours, and in utilising external interventions provided by clinicians for that process, can be characterised as innovations. The inverse relationship demonstrated here between measures of overall team climate and aggregate levels of challenging behaviour suggests that there may be some theoretical and clinical utility in the application of such a group level analysis to the development of understanding not only how teams manage challenging behaviours, but also the process of that management and the way in which teams work together.

Analysis of team climate can be conceptualised as a way of investigating the interaction of individual self-generated rules for the management of challenging behaviours, performance and hypothesis-related, with the externally-supplied, performance related rules and the externally-supplied hypothesis related rules represented by informal staff culture as well as organisational policies and procedures and clinician intervention (Hastings and Remington, 1994).

Interventions with challenging behaviours

The content analysis of manager descriptions of the processes and inputs to the management of challenging behaviour revealed a number of features of this work which add weight to the social validity of a group level analysis. All managers described the team as the agents for the work of challenging behaviour

management. Managers typically described the teams working in ways which reflect current psychological approaches to the management of challenging behaviours, and in which consistency of approach by all members of a team, and the need to be able to review and devise new strategies for challenging behaviour management were emphasised. The potential discrepancy between what is known by staff about management of challenging behaviour and what they actually do must be borne in mind. In the context of services which set out to "meet the needs of residents", it is perhaps not surprising that staff may adopt a needs-led, rather than a more functional, approach to challenging behaviours (Hastings, Remington and Hopper, 1995). However, in general it seems that managers do conceptualise the work of teams as taking into account both the challenging needs of residents, and the challenging environments, as factors which are likely to be implicated in the development and maintenance of challenging behaviours and as factors which should shape staff responses to such behaviour (McGill, 1993). That staff teams may be working in this way suggests the need for a conceptualisation of staff perceptions of challenging needs and challenging environments which also takes into account the effects of these needs and environments on staff stress and staff responses to challenging behaviour, if ways to prevent counter-habilitative staff responses are to be developed. The research implications of this will be considered below.

Clinical approach

The finding in this study that there was a significant negative correlation between levels of team climate and levels of challenging behaviour in the homes has several implications for psychological input to teams.

While no causal relationships between these measures can be defined in this cross-sectional study, measures of team climate are, as has been described, considered to be the most important contextual determinant of innovativeness in teams. In a framework of intervention as innovation, it is likely that teams with below average measures of team climate will be less able to apply innovative methods in their management of challenging behaviour. A group level approach, in which psychologists consider the way the team functions as a whole as part of the assessment process, could highlight areas of potential difficulty for the team prior to the devising and implementation of strategies and guidelines for managing challenging behaviours. Measures such as the Team Climate Inventory can be used to inform interventions with teams to enable them to identify and address any specific areas of difficulty.

Associated with this group level approach is the clinical implication of the association of aggregate levels of challenging behaviour with team climate. An ecobehavioural model of intervention with challenging behaviour suggests that the whole range of challenging behaviours in a residential care home will form part of the challenging environment in which the behaviours of an individual resident will be set. The overall level of challenging behaviour will also impact on the way in which a staff team is able to implement guidelines drawn up as a result of the assessment process and this may be masked by a purely functional analytic perspective which includes only the individual resident who has been referred because of challenging behaviour.

An additional factor which is likely to impact on the way in which staff implement challenging behaviour management strategies is the whole range of functions which they are required to perform within the home. These are likely to influence what staff teams consider to be manageable and practical forms of intervention. Manager comments, cited above, about their perceptions that clinicians do not see the home as a whole, or know the residents in the way that the team does, suggest that such factors could also be considered as part of the assessment process.

Manager comments which about clinician intervention which were categorised as the experience of "intruder clinicians" suggest that a further clinical implication of this study is of the need for clinical teams to consider ways in which the turnover of psychologists who work with a staff team can be reduced, or ways in which care staff teams can experience some continuity even if there is a rapid turnover of individuals, such as by the provision of a named clinician who is a continuing link between a home and the clinical team.

RESEARCH IMPLICATIONS

The findings in this study suggest a number of further research implications to develop the understanding of ways in which a group level analysis can be used to inform psychological interventions with the management of challenging behaviours.

It has been suggested that interventions at the level of the team, such as those which result from the profiles derived from team climate measures, may be

clinically important. A longitudinal study which investigated the outcome of such interventions in terms of changes in team climate and in levels of challenging behaviour would form an appropriate starting point for this work.

Observational studies of staff responses to challenging behaviours, as an adjunct to the assessment of aggregate levels of such behaviour in homes and of the team climate, would provide more objective data about whether team climate is associated with the ways in which staff actually respond to specific incidents and types of challenging behaviour.

The relationships between role conflict and staff stress and between challenging behaviour and staff stress have been the subject of research in the context of residential care homes. A development of this area of research would be an investigation of relationships between role conflict, staff stress and team climate.

Staff support and resident support

It has already been argued that a group level analysis takes into account the wider ecobehavioural factors for staff and residents. In this study, the different needs of staff and of residents in the context of requests for support with challenging behaviour management were not separated. Content analysis of manager responses suggests that both are taken into account by teams and that psychological intervention is requested both to access support and, perhaps, to problematise behaviour, which may serve both to legitimise staff needs for

support, including in the eyes of the external stakeholders, and to show that "something is being done". Research which investigated the perceptions of staff about why interventions with challenging behaviour are needed for the team and for the residents would further enable the development of a group-level application of assessment and intervention. While some needs of residents, and of staff, may be met by reduction in the levels of challenging behaviour *per se*, an ecobehavioural approach must also take into account the possible functions of the interventions themselves.

CONCLUSION

In this study, it was demonstrated that there is a significant inverse relationship between the level of team climate prevailing in the residential care home, and the levels of challenging behaviour displayed by the residents. No causal relationship can be described in this cross-sectional study, but suggestions for further research have been made.

This study was not able to demonstrate relationships between organisational features in the homes and the team climate, although the particular organisational data which were collected may have lacked sufficient specificity to allow for the rigorous examination of this relationships between these features and team climate.

Content analysis of manager descriptions of the process of managing challenging behaviours resulted in the categorisation of data in three areas; the benefits and deficits of team working, the perception of challenging behaviour as problems requiring solutions or as problems to be contained, and the experience of intervention by clinicians as rescuing or as intruding. There was some degree of overlap of manager responses in these pairs of categories. Managers generally described both the inputs and the processes involved in intervention with challenging behaviours, and they described the involvement of whole teams in the monitoring, discussion, devising and implementation of challenging behaviour management strategies. Many of the features of staff responses which are seen as counter-habilitative, such as inconsistency, and attributions stressing internal causes and sources of challenging behaviour, were clearly described by managers as issues which the team worked to overcome, and generally teams were described as working in ways which are consistent with an ecobehavioural approach to the assessment and management of challenging behaviours.

It has been suggested that a group level analysis has clinical utility for interventions with challenging behaviour and that, in particular, the whole team perspective, and the aspects of the team's work which may militate against successful intervention or increase resistance to strategies and guidelines devised by psychologists, should be considered as part of an assessment process which goes beyond functional analytic assessment of individual challenging behaviours and takes into account the wider context of team functioning and challenging behaviour which may be displayed by others living in the home.

Felce, de Kock and Repp (1986) assert that change agents (such as clinical psychologists) need to work at a level acceptable to the organisation and "to help set clear but attainable goals" (p200). This is likely to be particularly important in the context of the provision of services for a group of people for whom the distinction between health and social care is not easily made (Holt and Joyce, 1999) and where so many stakeholders are involved. In this study, a way in which psychologists can develop assessment and intervention with challenging behaviours to enhance the setting of clear but attainable goals has been described, and it has been argued that such an approach may benefit not only the people who live in residential care homes but also those who work in them to support residents' lives in the community, often despite enduring and complex patterns of challenging behaviour.

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The haiku quoted in the Acknowledgements section is sourced from:

Bicknell, J. (1994).
Hiroshige in Tokyo: The Floating World of Edo.
San Francisco: Pomegranate Art Books.

APPENDIX 1

th Thames
ti-centre Research Ethics Committee

man: Dr Hugh Davies Administrator: Mr John Richardson

1 April 1998

Ms Anne Sheeran
2nd year DclinPsy Trainee
Sub-Department of Clinical Health Psychology
University College London
Gower Street
London WC1E 7NS

Dear Ms Sheeran

Application reference number ***MREC/98/2/64*** *(please use in all correspondence)*
Protocol title ***Residential care for people with learning difficulties who display challenging behaviour: what is the nature of an effective staff team***

Thank you for submitting the above application, and for your response of 8 March to comments made by the Chairman of the North Thames Multi-centre Research Ethics Committee. The full Committee considered the application at its meeting on 25 March 1998.

The members of the Committee agreed that there is no objection on ethical grounds to the proposed study whose title is given at the head of this letter. I am therefore happy to give you the Committee's approval on the understanding that you will follow the protocol as agreed. The documents approved by the Committee are referenced in the enclosed Response Form, which also contains the Committee's comments, if any.

Conditions of approval

Please read the notes regarding notification of changes and completion of progress reports at the end of the Response Form, as the MREC requires that they be followed.

You will no doubt realise that whilst the MREC has given approval for your project on ethical grounds, it is still necessary for you to obtain management approval from the relevant Clinical Directors and/or Chief Executive of the Trust(s) or Health Authority (ies)/Board(s) in which the work will be done.

Local submissions

It is also your responsibility to ensure that any local researcher seeks the approval of the relevant Local Research Ethics Committee before starting their research. To do this, you should submit the appropriate number of copies of the following to the relevant LRECs:

- this letter
- the MREC application form and supporting documents
- the enclosed response form
- Annexe D of the MREC application form
- one copy of the protocol

st Office Central Middlesex Hospital Acton Lane London NW10 7NS
Tel 0181 453 2336 Fax 0181 961 0012

APPENDIX 1

It is important to check with the respective LRECs on the precise numbers of copies required as this will vary and failure to supply sufficient could lead to a delay.

MREC evaluation

During the first year after its establishment, the MREC would like to hear your views and experiences while using the new system. Could you please help us by completing the Principal Researcher Evaluation Form enclosed with this letter and returning it to **Jo Duggan, Centre of Medical Law and Ethics, King's College, London, Strand, London WC2R 2LS.** Your help is also appreciated in ensuring that local researchers are sent a Local Researcher Evaluation Form also enclosed with this letter. Your views and comments are vital to ensure the process evolves and responds to the needs of multi-centre researchers and we look forward to receiving your comments.

Local sites

While the MREC would like as much information as possible about local sites at the time you apply for approval, it is understood that this is not always possible. You are asked however to send a completed copy of Annexe C for each local site as soon as a researcher has been recruited. This is essential to enable the MREC to monitor the research it approves and for the smooth running of the evaluation.

ICH GCP compliance

North Thames MREC is fully compliant with the International Committee on Harmonisation (ICH) Guidelines for Good Clinical Practice as they relate to the responsibilities, composition, function, operations and records of an Independent Ethics Committee/Independent Review Board. To this end it undertakes to adhere as far as is consistent with its constitution to the relevant clauses of the ICH Harmonised Tripartite Guideline for Good Clinical Practice adopted by the Commission of the European Union on 17 January 1997. The Standing Orders and a Statement of Compliance were included on the disk containing the guidance and application form and are available on request or on the Internet at http://dspace.dial.pipex.com/mrec

Yours sincerely

John Richardson
Administrator, North Thames Multi-centre Research Ethics Committee

APPENDIX 1

NORTH THAMES MULTI-CENTRE RESEARCH ETHICS COMMITTEE
Trust Office, Central Middlesex Hospital, Acton Lane, London NW10 7NS
Tel: 0181 453 2336 Fax: 0181 961 0012 E-mail: ntmrec@aol.com

MREC RESPONSE FORM

Application reference number ***MREC/98/2/64*** *(please use in all correspondence)*
Protocol title ***Residential care for people with learning difficulties who display challenging behaviour: what is the nature of an effective staff team***
Principal researcher ***Ms Anne Sheeran, Sub-Department of Clinical Health Psychology, University College, London***
Sponsor ***NHS Executive***

Items reviewed

Protocol	(✓)
Subject information sheets	(✓)
Subject consent forms	(✓)
Methods of initial recruitment to study	(✓)
Compensation for investigators participation	(✓)
Provision for compensation/treatment of subjects	(✓)

Comments

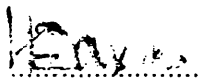
The Committee received assurances that:

1) *Consent to the administration of a team climate inventory and checklist of challenging behaviour would be sought from managers in each residential home.*
2) *The completed checklists of challenging behaviours would not be traceable to the individuals concerned.*

Decision

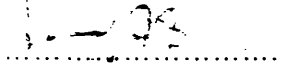
Approved

Signed:



Dr Hugh Davies. Chairman North Thames Multi-centre Research Ethics Committee

Date:



APPENDIX 1

NOTES

1 Once MREC approval has been obtained, local research ethics committees in every locality involved will have the opportunity to accept or reject the protocol for local reasons but will not be allowed to amend it. LRECs may occasionally need to seek locally applicable amendments, which do not affect the integrity of the protocol, for example information sheets and consent forms in minority languages. They should do so only when essential. LRECs will be asked to notify their decisions to the designated MREC within a specified timescale and in particular to give reasons if they refuse a protocol.

2 No research subject is to be admitted to this trial until approval has been obtained from the appropriate research ethics committee.

3 No significant changes to the research proposal should be made without the appropriate research ethics committee's/chairman's approval

4 You must promptly inform the MREC and appropriate LRECs of:

- deviations from or changes to the protocol which are made to eliminate immediate hazards to the research subject;
- any changes that increase the risk to subjects and/or affect significantly the conduct of the research;
- all adverse drug reactions that are both serious and unexpected;
- new information that may adversely affect the safety of the subjects or the conduct of the trial.

5 You must complete and send to the MREC the enclosed Progress Report Form once a year, and the enclosed Final Report Data Collection Form when your research is completed.

6 You must start the project within three years of the date approval is given; extensions can be applied for.

APPENDIX 1

RESS FOR CORRESPONDENCE
AVERLEY ROAD, ST. ALBANS
FORDSHIRE, AL3 5TL

one: 01727 811888
Line: 01727 897811
727 897788

West Hertfordshire
Health Authority
LOCAL RESEARCH
ETHICS COMMITTEE
(incorporating West Herts Community Health NHS Trust and Horizon NHS Trust)

23 March 1998

Our ref: WH07/98

Ms Anne Sheeran
Clinical Psychology Trainee
Sub-Dept of Clinical Health Psychology
University College London
Gower Street
LONDON WC1E 6BT

Dear Ms Sheeran

Residential care for people with learning disabilities who display challenging behaviour: Does team climate affect the way teams work?

Thank you for attending the meeting of the LREC last week. I write to confirm approval of the above study subject to the following:

(i) It is the responsibility of the investigator to notify the LREC immediately of any information received or of which you become aware which would cast doubt upon, or alter, any information contained in the original application, or a later amendment application, submitted to the LREC and/or which would raise questions about the safety and/or continued conduct of the research.

(ii) The need to comply with the Data Protection Act 1984.

(iii) The need to comply, throughout the conduct of the study, with good clinical research practice standards.

(iv) The need to refer proposed amendments to the protocol to the LREC for further review and to obtain LREC approval thereto prior to implementation (except only in cases of emergency where the welfare of the subject is paramount).

(v) The requirement to inform the LREC should the research be discontinued or any subject withdrawn.

Committee members considered it essential to contact each Care Organisation involved in order to obtain permission to access staff working in residential homes. I enclose a list of Committee members who reviewed the study.

Yours sincerely

Pauline Southworth

Pauline Southworth (Mrs)
Chairman
West Hertfordshire Health Authority
Local Research Ethics Committee

APPENDIX 2

Dear

Re: Research Project for Doctorate in Clinical Psychology

I am writing to ask whether you would consider the participation of care homes run under the auspices of your organisation in the research project which I am undertaking as part of my training in Clinical Psychology.

I am carrying out research with staff teams working in houses where adults with a learning disability also display some challenging behaviour, formally or informally designated as such. The focus of the investigation is the Team Climate, a measure of the way staff teams work.

Participation requires the completion of a Checklist of Challenging Behaviour for each person living in the house, and a Team Climate Inventory for each team member. The Team Climate is completed anonymously by each team member and these measures are amalgamated to produce a team profile. Teams will be able to receive feedback on their profiles. The questionnaires can be sent out by post.

I would also like to have copies of policies/procedures and any records or reports relating to the management of challenging behaviours in the house. The final element of participation is a semi-structured interview with house managers.

All details will remain anonymous. I do not need to meet or to know the names of service users and the interviews can take place away from the houses. The project has received ethical approval from West Herts Local Research Ethics Committee and from North Thames Multiple Research Ethics Committee.

The research will be presented as a thesis, forming part of the requirements of the training course, and it is anticipated that an article will be submitted to a relevant journal. Teams will have two forms of direct feedback – on their individual team

profiles, and, following the completion of the thesis, a synopsis of the findings and implications will be circulated to all participating teams and organisations.

I should be most grateful if you would discuss this with managers, and contact me to let me know whether or not any teams would like to take part. If teams do want to participate, the next step is for me to contact managers directly to arrange dates for sending the questionnaires and for the interviews.

Please do not hesitate to contact me if you have any other queries. I am also happy for team managers to contact me directly to discuss any queries that they may have. I can be contacted on (telephone number). I look forward to hearing from you.

Yours sincerely

Anne Sheeran
DClinPsy Trainee

APPENDIX 3

TEAM CLIMATE INVENTORY

QUESTIONNAIRE

Neil Anderson and Michael West

DATE: _____

TEAM: _____

INSTRUCTIONS

This questionnaire asks about the climate or atmosphere in your work group or team. It asks about how people tend to work together in your team, how frequently you interact, the team's aims and objectives, and how much practical support and assistance is given towards the implementation of new and improved ways of doing things. There are no 'right' or 'wrong' answers to any of the questions – it is more important that you give an accurate and honest response to each question. Do not spend too long on any one question. First reactions are usually best. For each question consider how your team *is in general* or *how you feel in general* about the climate within your team. Please circle your chosen answers using a ball point pen.

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APPENDIX 3

PART I COMMUNICATION AND INNOVATION

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1 We share information generally in the team rather than keeping it to ourselves.	1	2	3	4	5
2 Assistance in developing new ideas is readily available.	1	2	3	4	5
3 We all influence each other.	1	2	3	4	5
4 The team always functions to the best of its capability.	1	2	3	4	5
5 We keep in regular contact with each other.	1	2	3	4	5
6 In this team we take the time needed to develop new ideas.	1	2	3	4	5
7 People feel understood and accepted by each other.	1	2	3	4	5
8 Everyone's view is listened to, even if it is in a minority.	1	2	3	4	5
9 People in the team never feel tense with one another.	1	2	3	4	5
10 The team is open and responsive to change.	1	2	3	4	5
11 People in the team co-operate in order to help develop and apply new ideas.	1	2	3	4	5
12 Being part of this team is the most important thing at work for team members.	1	2	3	4	5
13 We have a 'we are in it together' attitude.	1	2	3	4	5
14 We interact frequently.	1	2	3	4	5
15 The team is significantly better than any other in its field.	1	2	3	4	5
16 People keep each other informed about work-related issues in the team.	1	2	3	4	5
17 Members of the team provide and share resources to help in the application of new ideas.	1	2	3	4	5
18 There are consistently harmonious relationships between members of the team.	1	2	3	4	5
19 There is a lot of give and take.	1	2	3	4	5
20 We keep in touch with each other as a team.	1	2	3	4	5

APPENDIX 3

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
21 People in this team are always searching for fresh, new ways of looking at problems.	1	2	3	4	5
22 The team consistently achieves the highest targets with ease.	1	2	3	4	5
23 There are real attempts to share information throughout the team.	1	2	3	4	5
24 This team is always moving towards the development of new answers.	1	2	3	4	5
25 Team members provide practical support for new ideas and their application.	1	2	3	4	5
26 Members of the team meet frequently to talk both formally and informally.	1	2	3	4	5

PART II OBJECTIVES

	Not at all		Somewhat		Completely
27 How clear are you about what your team objectives are?	1	2	3	4	5
28 To what extent do you think they are useful and appropriate objectives?	1	2	3	4	5
29 How far are you in agreement about these objectives?	1	2	3	4	5
30 To what extent do you think other team members agree with these objectives?	1	2	3	4	5
31 To what extent do you think your team's objectives are clearly understood by other members of the team?	1	2	3	4	5
32 To what extent do you think your team's objectives can actually be achieved?	1	2	3	4	5
33 How worthwhile do you think these objectives are to you?	1	2	3	4	5
34 How worthwhile do you think these objectives are to the organization?	1	2	3	4	5
35 How worthwhile do you think these objectives are to the wider society?	1	2	3	4	5
36 To what extent do you think these objectives are realistic and can be attained?	1	2	3	4	5
37 To what extent do you think members of your team are committed to these objectives?	1	2	3	4	5

APPENDIX 3

PART III TASK STYLE

	To a very little extent		To some extent		To a very great extent
38 Do your team colleagues provide useful ideas and practical help to enable you to do the job to the best of your ability?	1	2	3	4	5
39 Do you and your colleagues monitor each other so as to maintain a higher standard of work?	1	2	3	4	5
40 Are team members prepared to question the basis of what the team is doing?	1	2	3	4	5
41 Does the team critically appraise potential weaknesses in what it is doing in order to achieve the best possible outcome?	1	2	3	4	5
42 Do members of the team build on each other's ideas in order to achieve the best possible outcome?	1	2	3	4	5
43 Is there a real concern among team members that the team should achieve the highest standards of performance?	1	2	3	4	5
44 Does the team have clear criteria which members try to meet in order to achieve excellence as a team?	1	2	3	4	5

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For further copies of this Questionnaire see the *Team Climate Inventory* Administration Pack (code 4703 02 6). Copies are also included in the *Team Climate Inventory* Starter Set (code 4703 01 6). Please telephone ASE on 01753-850333 for further details.

APPENDIX 4
CHECKLIST OF CHALLENGING BEHAVIOUR AND RATING SCALES

HOUSE.....PERSON.....

Has the person exhibited any of the following behaviours *during the past three months?*

Please see attached key for scoring **(page 4)** and enter the appropriate numbers.
KEY: **S** = SEVERITY **MD** = MANAGEMENT DIFFICULTY **F** = FREQUENCY

AGGRESSIVE BEHAVIOUR	S	MD	F
1. Pinching people?	.....	.....	.....
2. Biting people?	.....	.....	.....
3. Scratching people?	.....	.....	.....
4. Hitting out at people? (Punching or slapping)	.....	.....	.....
5. Grabbing, squeezing, pushing or pulling people?	.....	.....	.....
6. Kicking people?	.....	.....	.....
7. Headbutting people?	.....	.....	.....
8. Pulling people's hair?	.....	.....	.....
9. Choking or throttling people?	.....	.....	.....
10. Using objects as weapons against people?	.....	.....	.....
11. Throwing things at people?	.....	.....	.....
12. Tearing other people's clothes?	.....	.....	.....
13. Making unwanted sexual contact?	.....	.....	.....

DOES THIS PERSON EXHIBIT ANY OTHER TYPE OF *AGGRESSIVE BEHAVIOUR*?

YES = 1 **NO = 0**

If **YES**, please describe it here:

HOUSE.....PERSON.....

SELF-INJURIOUS BEHAVIOUR	**S**	**MD**	**F**
1. Head-banging?	.....	.....	.....
2. Eye poking/gouging?	.....	.....	.....
3. Biting?	.....	.....	.....
4. Scratching?	.....	.....	.....
5. Behaviour using objects (eg cutting self)	.....	.....	.....

DOES THIS PERSON EXHIBIT ANY OTHER TYPE OF *SELF-INJURIOUS BEHAVIOUR*?

YES = 1 NO = 0

If **YES**, please describe it here:

OTHER CHALLENGING BEHAVIOURS (Note: These are NOT rated for severity)

	MD	**F**
1. Damaging clothes, furniture or other objects?	.....	.....
2. Smashing windows?	.....	.....
3. Slamming doors?	.....	.....
4. Shouting and swearing at people?	.....	.....
5. Making loud noises (eg banging, screeching, screaming)?	.....	.....
6. Threatening to hurt others (verbally or nonverbally)?	.....	.....

HOUSE.....PERSON.....

	MD	F
7. Taking food and drink from others?	.....	.....
8. Eating inappropriate things? (eg rubbish, faeces, dangerous objects)	.....	.....
9. Displaying ritualistic or repetitive behaviours? (eg closing/opening doors, rearranging furniture, hoarding rubbish, etc)	.....	.....
10. Engaging in stereotyped behaviours? (eg body-rocking, finger tapping, hand waving, etc)	.....	.....
11. Showing withdrawn behaviour? (ie difficult to reach or contact)	.....	.....
12. Spitting at people?	.....	.....
13. Deliberately soiling, wetting or vomiting?	.....	.....
14. Smearing or flicking faeces, and/or anal probing?	.....	.....
15. Exposing his/her body inappropriately? (eg stripping or masturbating in public)	.....	.....
16. Refusing to do things? (eg to eat, to move, to wash self, etc)	.....	.....
17. Absconding/disappearing from the house? (or attempting to do so)	.....	.....
18. Causing night-time disturbance?	.....	.....

DOES THIS PERSON EXHIBIT ANY OTHER TYPE OF *CHALLENGING BEHAVIOUR*?

YES = 1 **NO = 0**

If **YES**, please describe it here:

KEY TO RATING SCALES

SEVERITY

1 = No injury:	Did not appear to cause pain or tissue damage to other person
2 = minor injury:	Caused superficial scratching or reddening of the other person's skin (eg light slaps or hits, gentle pushes, hair pulling without force). First aid or medical attention was not needed
3 = moderate injury: bites/	Caused moderate tissue damage to other person (eg hits/kicks breaking the skin or resulting in bruising). First aid, but not medical attention, was needed.
4 = serious injury:	Caused serious tissue damage (eg cuts/wounds requiring stitching). Medical attention essential.
5 = very serious injury:	Caused very serious tissue damage (eg bones broken, deep lacerations/wounds). Hospitalisation and/or certified absence from work necessary.

MANAGEMENT DIFFICULTY

1 = no problem	I can usually manage this situation without any difficulty at all.
2 = slight problem	I can manage this situation quite easily although it does cause me some difficulty
3 = moderate problem	I find this situation quite difficult to manage, but I feel confident that I can
4 = considerable problem	I find it very difficult to manage this situation on my own
5 = extreme problem	I simply cannot manage this situation without help

FREQUENCY

1 = never	This behaviour has not occurred during the past three months
2 = rarely	Has occurred during the past three months but not in the past month
3 = occasionally	Has occurred 1-4 times in the past month
4 = often	Has occurred more than 4 times in the past month
5 = very often	Has occurred daily or more often

APPENDIX 5

SAMPLE ITEMS AND NUMERICAL CODING FROM STRUCTURED INTERVIEW QUESTIONNAIRE

DEMOGRAPHIC DATA

1. What type of organisation runs this home?
   .....
   Score: 1=Private, 2=Voluntary/Not for profit sector, 3=Social Services
2. How many residents live here?
   M...F.....
   Score: Give numbers of men and women
3. Where did the residents move from when they came here?
   Score: Give numbers: Longstay hospital Community Other
4. Number of staff with prior experience:
   .....
5. Ratio of staff:clients
   .....

MANAGEMENT DATA

1. How often do team meetings take place?
   .....
   Score: 1= weekly, 2=fortnightly, 3=monthly, 4= other

2. What happens in team meetings? Record manager response below

3. Would you rate the overall quality of team meetings as
   (1) Neutral (2) Positive (3) Negative ?

SPECIFIC QUESTIONS ABOUT CHALLENGING BEHAVIOURS

Record all manager responses below:

1. Describe the way difficult behaviours are identified and managed in this house.
2. Who gets involved in this process?
3. What are the helpful things about the process?
4. What are the unhelpful things about the process?
5. What, if anything, do you think could improve this process?
6. What is the most difficult aspect of meeting these needs?

APPENDIX 6

Dear

Re: Research Project

Thank you for agreeing in principle to take part in the research project. Here are the questionnaires and other relevant information. Once you have received these, the meeting for the interview can be arranged.

1. **Checklist of Challenging Behaviour**
One copy should be completed for **each** person living in the house. You will see that I have numbered each set; I do not need to know any names of service users. The checklist should be completed by a **keyworker or other person who knows the service user well.** The responses should be completed according to the **general degree of management difficulty experienced by all members of the team**, rather than for any particular difficulty experienced by the person completing the form.

2. **Team Climate Inventory**
One questionnaire should be completed by **each member of the team**, including night, part-time and agency or bank staff who work regularly in the house.

3. **Written information**
I would like to have copies of the following documents or any equivalents to them (all names can be tippexed out):

- Operational policies and procedures for risk-taking for the house and/or individual service users
- Operational policies relating to behaviour, restraint guidelines, etc
- House rules
- Copies of logs and/or incident records for the past three months regarding difficult behaviours relating to each individual service user
- A list of any consultations or appointments with psychologists, psychiatrists or other mental health workers which have taken place or have been made over the last three months. Again, this should be for each individual service user.

Please attach the records relating to each service user to the Checklist of Challenging Behaviours which have been completed for the person, so that I can be sure that I collate the data correctly.

Any photocopying costs can be reimbursed when we meet.

APPENDIX 6

You will also find the following enclosures:

1. **Consent forms**
Each team member taking part should complete one of these and they should be returned to me with the other documents. No team member's name will be disclosed in any way. The consent forms are part of the requirements of ethics committees.

2. **Information sheets**
These are for you and the team and they provide an overview of the project.

Please bring the completed documents when we meet.

Thank you, and the team working in the house, very much indeed for your participation.

If there are any queries, please do not hesitate to contact me on:

(telephone number)

Yours sincerely

Anne Sheeran
DClinPsy Trainee

APPENDIX 7

AGREEMENT TO PARTICIPATE IN A RESEARCH PROJECT

TITLE OF PROJECT
The Team Climate in Residential Care Homes for People with Learning Disabilities who display Challenging Behaviour: A group level analysis.

I (name) .....
Of (address).....
.....

voluntarily consent to take part in this research project.

I confirm that I have read and understood the information describing this project and all my questions have been answered to my satisfaction. I also understand that I may withdraw from the project at any time if I find that I am unable to continue for any reason and that, if I do so, this will not affect my employment.

I understand that I am entitled to receive a signed copy of this form.

Signed.....Date.....

Investigator's statement
Through the information sheet provided, I have explained the nature, demands and foreseeable risks of the above research to the participant.

Signature.....Date.....

APPENDIX 8

Information Sheet

This sheet provides information for members of staff teams who have been invited to participate in the following project, which is being carried out by a Clinical Psychology Trainee as part of the training course.

TITLE

Team Climate in Residential Care Homes for People with Learning Disabilities who display Challenging Behaviour: A group level analysis.

WHAT IS INVOLVED

Members of staff teams who work in residential care homes for adults with learning disabilities will be asked to complete 2 questionnaires:

(1) The Team Climate Inventory. (TCI) This will be completed anonymously by each team member and then the information from each form will be amalgamated to produce a measure of Team Climate. The house and staff members will not be named.

(2) The Checklist of Challenging Behaviours. (CCB) This will be completed by keyworkers or other appropriate team members for each person living in the house where they work. All data will be anonymous. Residents will not be interviewed or otherwise contacted for this project.

These questionnaires will be sent and returned by mail.

(3) Additionally, the manager or team leader in each house will be asked to take part in a semi-structured interview. This will be for the purposes of obtaining some basic information about training, policies and procedures and related matters. No information given will subsequently be attributed to individuals or organisations and complete confidentiality will be maintained.

TOTAL TIME COMMITMENT:
ABOUT 20-30 MINUTES PER PERSON TO COMPLETE THE TCI.
ABOUT 20-30 MINUTES FOR EACH RESIDENT'S CCB.
INTERVIEW WITH MANAGER/TEAM LEADER: APPROXIMATELY 1 HOUR.

Access to written information concerning policies, procedures and incident records for each resident will also be requested. This information can also be completely anonymous; it will not be necessary to know the names of any of the residents.

WHAT ARE THE AIMS OF THE PROJECT?

It is hoped that this project will help in the development of an understanding of how teams work together effectively in what are frequently intense and challenging working environments. Such knowledge can be applied to working practices with the aim of improving the quality of life for those who live in residential care homes, as well as those who work in them.

WHAT ARE THE BENEFITS OF TAKING PART?

It is intended that feedback will be offered to teams at the end of the project. This may be a general outline of the way in which teams work effectively and the nature of team climates in such work. It may also be possible for teams who wish it to receive some individual feedback concerning their particular Team Climate Inventory amalgamated scores and what these suggest.

You do not have to take part in this study if you do not want to. If you decide to take part you may withdraw at any time without having to give a reason.

All proposals for research using human subjects are reviewed by an ethics committee before they can proceed. This proposal was reviewed by the Joint UCL/UCLH Committees on the Ethics of Human Research.

Anne Sheeran 0171-380 7897
C/O UCL Sub-department of Clinical Health Psychology, 1-19 Torrington Place, London WC1

APPENDIX 9

TEAM DEVELOPMENT INTERVENTIONS

THESE REPRESENT A SELECTION OF THE POSSIBLE TEAM-BUILDING TECHNIQUES WHERE THE TEAM SCORES ARE LOW FOR PARTICULAR SUBSCALES. THEY ARE SUMMARISED FROM THE TCI SCORING MANUAL (Anderson and West, 1994).

If the team score is low in the area of:	*Consider trying:*
INFORMATION SHARING	***COMMUNICATION AUDIT – examine the ways in which the team communicates and uses information***
SAFETY	***INTERPERSONAL PROCESS REVIEW – Consider the ways in which people deal with each other's ideas and how different opinions are dealt with within the team***
INFLUENCE	***REVIEW OF DECISION-MAKING PROCEDURES – Examine the ways decisions are made and enacted, and by whom***
INTERACTION FREQUENCY	***INTERACTION AUDIT AND REVIEW OF FORMAL TEAM MEETINGS – Examine the amount of interaction between team members, and the content of interactions, particularly with respect to team meetings***
ARTICULATED SUPPORT	***USE OF CREATIVITY TECHNIQUES, SUCH AS BRAINSTORMING – consider the extent to which development and innovation within the team is encouraged and use "neutral" techniques, such as brainstorming, to encourage this***
ENACTED SUPPORT	***REVIEW PROVISION OF TIME, FINANCE AND COOPERATION FOR INNOVATION WITHIN THE TEAM – consider what can be done within the existing constraints, even if additional resources are not available.***
CLARITY	***CLARIFY TEAM OBJECTIVES – Consider setting aside time for the whole team to think about what its objectives are now, and whether and how they should be changed***
PERCEIVED VALUE	***DEVELOPING A MISSION STATEMENT – If one is already in place, consider whether the team works with this in mind, and if not, why not***
SHAREDNESS	***NEGOTIATING TEAM GOALS – Consider examining what these are, and how they have been derived***

TEAM DEVELOPMENT INTERVENTIONS CONTINUED

If the team score is low in the area of:	Consider trying:
ATTAINABILITY	***NEGATIVE BRAINSTORMING ON TEAM GOALS – Brainstorm all the problems with team goals.***
EXCELLENCE	***"CONSTRUCTIVE CONTROVERSY TRAINING" – Consider using an outside facilitator for this***
APPRAISAL	***TIME OUT FOR TEAM REVIEWS –Consider using team meeting time, or team building days, for reviewing the way the team is working, including thinking about how the team would explain to those outside of it why it works the way it does, and why this is the best method***
IDEATION	***BRAINSTORMING TECHNIQUES – Consider ways in which the team generate ideas on which work is built, and look for opportunities to increase this. Brainstorming techniques are one way in which ideas can be generated***

(FOR HIGH SOCIAL DESIRABILITY SCORES – SOCIAL AND TASK PROCESSES – INTERVENTIONS FROM OUTSIDE THE TEAM ARE SUGGESTED)