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Emotional Welfare of Staff working in services for people with intellectual disabilities who present challenging behaviour

Dr Peter Baker (BCBA-D)

Senior Lecturer in Intellectual Disability

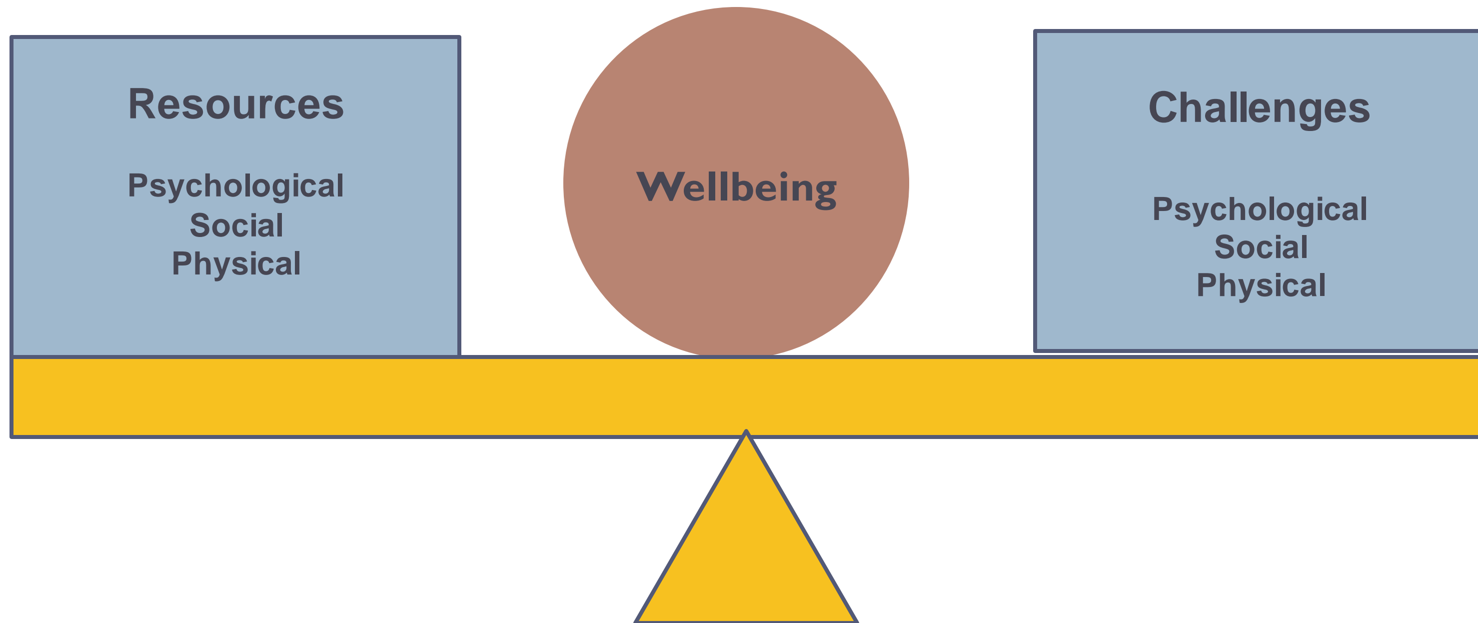
Agenda

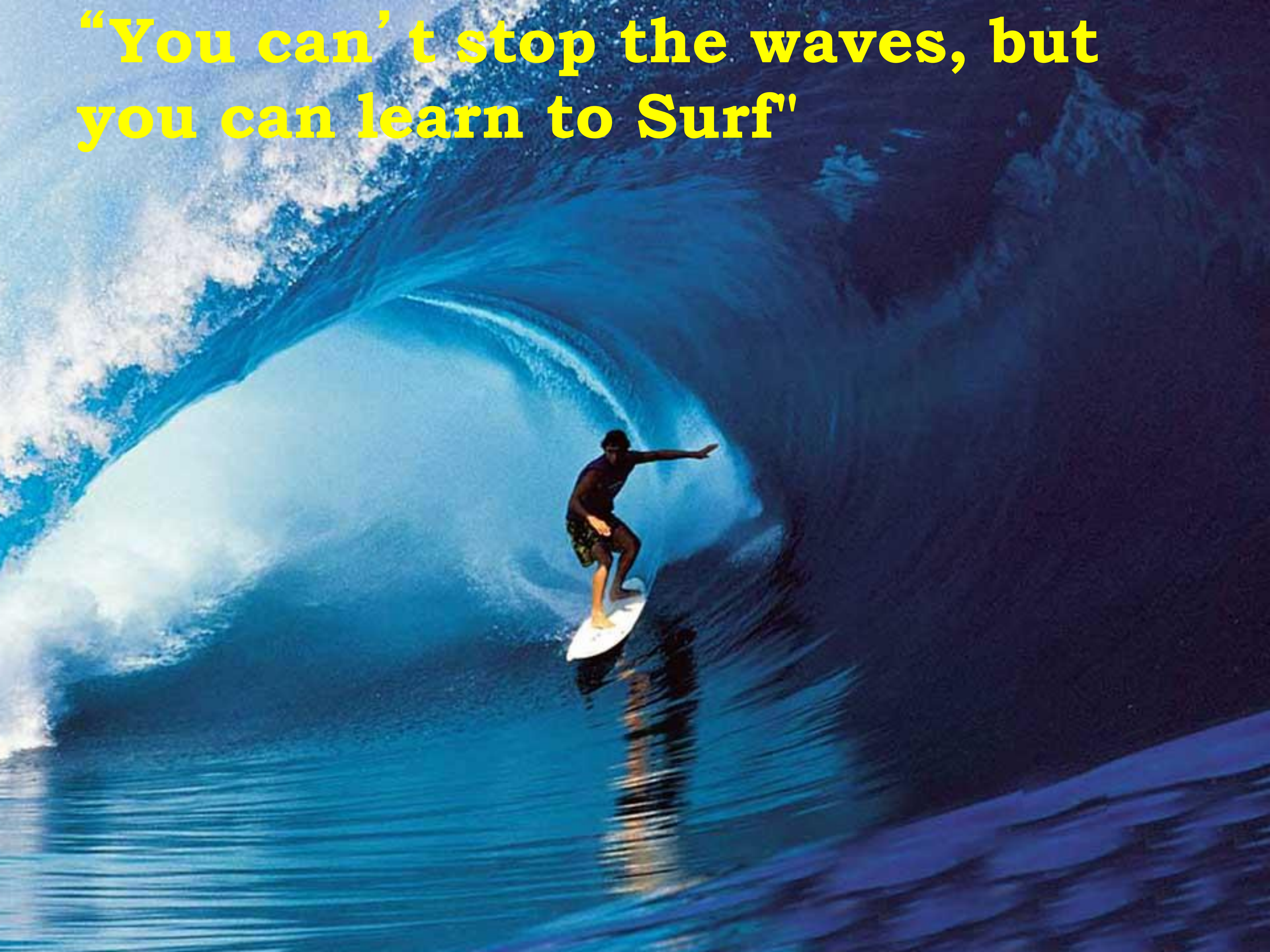
- Definition of wellbeing
- Why is wellbeing important?
- Evidence about staff wellbeing
- What supports and challenges staff wellbeing?
- Trauma experienced by staff
- Promotion of staff wellbeing

What is Wellbeing?

- Dodge et al (2012) "*the balance point between an individual's resource pool and the challenges faced*…In essence, stable wellbeing is when individuals have the psychological, social and physical resources they need to meet a particular psychological, social and/or physical challenge. When individuals have more challenges than resources, the see-saw dips, along with their wellbeing, and vice-versa"

Wellbeing




“You can’t stop the waves, but
you can learn to Surf"

Why is staff wellbeing important?

- Important in its own right (moral and legal responsibility for welfare of employees).
- Reduction in sickness rates and staff turnover.
- Important within the framework of PBS as staff are the mediators of interventions (and decreased well-being may impact on their ability to do this).

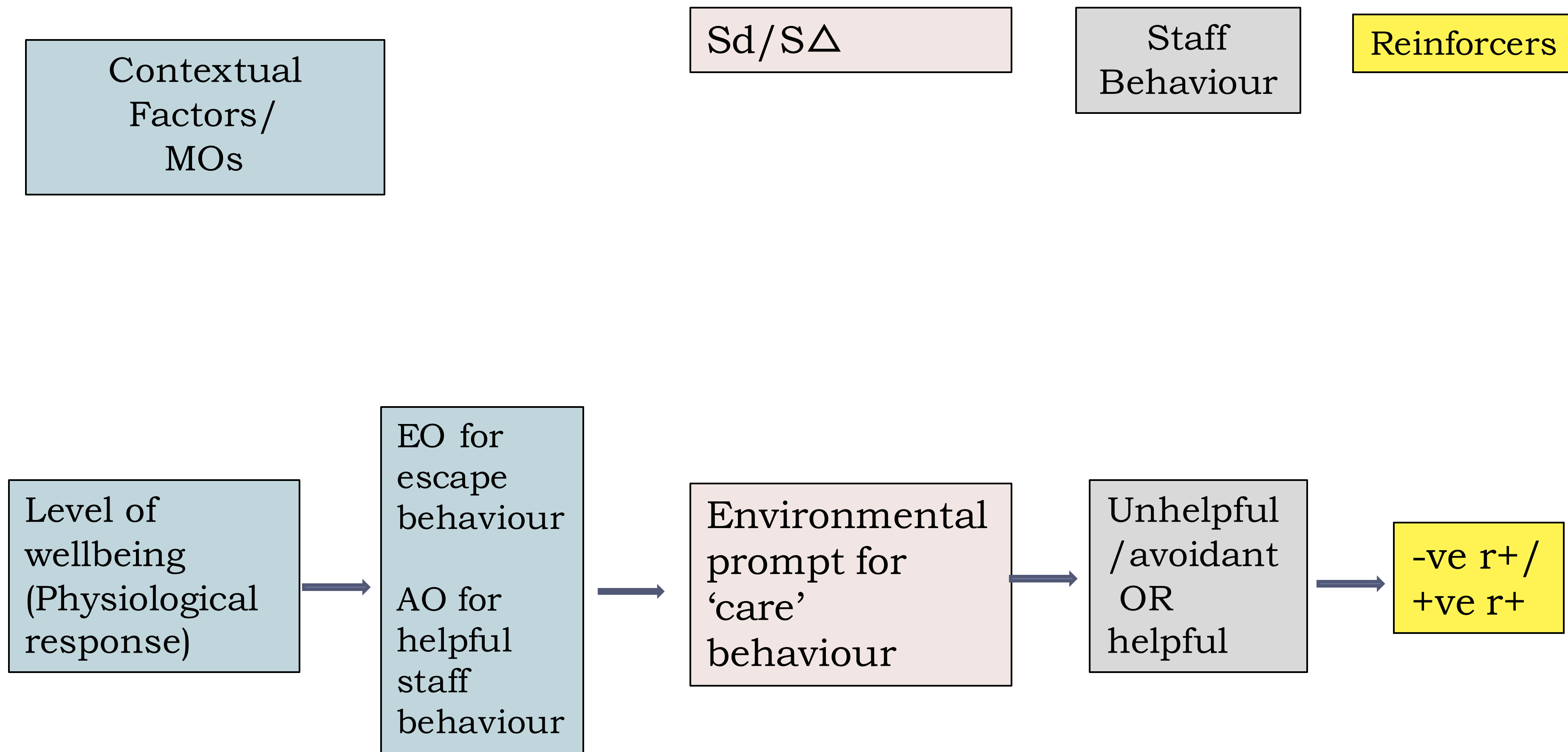
Put behaviourally……..

- Challenging behaviours can be aversive for staff.
- If staff behaviour makes the CB stop, their behaviour will be negatively reinforced.
- The challenging behaviour of the individual will be reinforced and maintained.
- Adopting positive strategies is likely, in the initial periods, to take more effort and more 'resource'.
- Staff who have reasonable levels of wellbeing are more likely to have the necessary resources to be able to make these efforts and follow PBS plans.

Hatton & Emerson 1993, Razza 1993, Hastings et al 2004

Put behaviourally……..

- Wellbeing is a Motivational operation and sets the occasion for staff behaviour



Adapted from Gore & Baker (2017) International Journal of Positive Behavioural Support

Challenges and Resources for Support Staff

- Dodge et al.'s definition points to both Resources and Challenges.
- What challenges are there to wellbeing?
- What resource issues might there be?

Challenges to wellbeing: service factors

- The assumption that challenging behaviour generates stress for carers is regarded by some as one of its defining features (Zarkowska & Clements 1996)

- BUT.........there is not a obvious simple direct relationship between CB and Wellbeing.

Challenges to wellbeing: service factors

Burnout –

Defined as a state of physical, emotional and mental exhaustion that occurs when workers feel overburdened by the demands of long-term involvement in emotionally demanding situations.

Characterised by emotional exhaustion, a reduced sense of personal accomplishment, and depersonalisation.

Maslach & Jackson 1993

Challenges to wellbeing: service factors

- As studies became more recent burnout scores decreased
- Levels were less than that which would be expected in the general population
- Not specifically associated with challenging behaviour
- Burnout might impact negatively on staff responses to challenging behaviour
- May be higher in workers with less direct contact with people with intellectual disabilities
- Personal variables were predictive
  - Negative view of the organisation
  - In need of greater support from managers
  - Give more than they get back

Skirrow and Hatton (2006)

Challenges to wellbeing: challenging behaviour

- Highlighted as a general potential stressor
- Association between challenging behaviour & burnout is weak
- Responses may differ to aggression than to other challenging behaviour
- In particular the use of restraint produces intense negative emotional reactions for services users and staff

Elford, Beal & Clarke et al (2010); Hawkins, Allen & Jenkins (2005); Ravoux, Baker & Brown (2012); Howard, Rose & Levinson (2009)

Challenges to wellbeing: challenging behaviour

- Relationships with the organisation & colleagues were more highly correlated with burnout than service user factors
- Characteristics of organisations rather than service users are more important influences on staff wellbeing

Thomas & Rose (2010) Hatton et al (1999)

Trauma

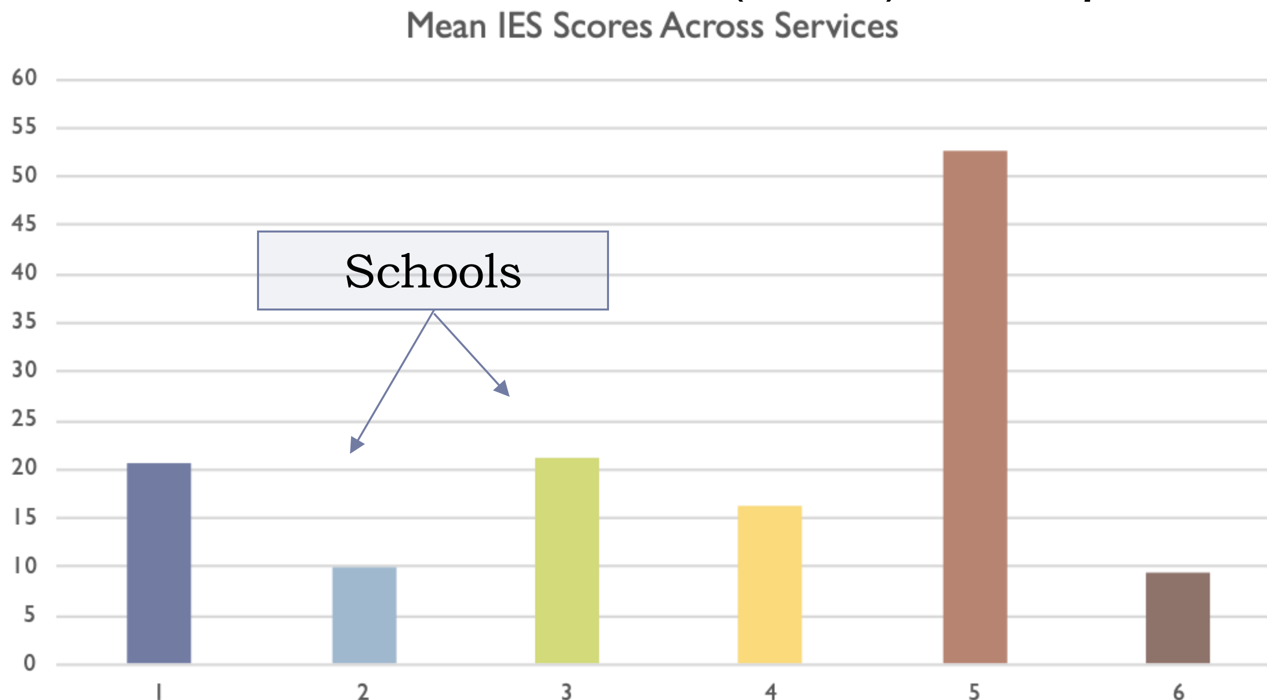
- 126 members of staff from nine different services including special schools and adult residential with the highest reported incidence of challenging behaviour
  - Impact of Events Scale- Revised (IES-R. Weiss, 2007: a self-report measure that assesses subjective distress caused by traumatic events), Participants were asked to complete in relation to an impactful incident that had occurred within the previous three months and report symptoms that experienced during the past seven days.
  - Challenging Behaviour Exposure Measure (Hastings & Brown, 2002)
  - Questionnaire designed to assess perceived levels of support in the workplace.

Trauma

- **Percentage of staff displaying trauma-related symptomatology.**
- Full IES-R datasets were available for 113 staff working in social care & education.
- 69% (78) below the clinical-cut off on the IES
- 10.6% (12) clinical concern
- 20.4% (23) very significant clinical concern for PTSD.

Trauma

- There was no significant difference between the mean total IES score for adult social care (M=19.78, SD=19.466) and educational services (M=15.42, SD=16.285); t(111)=1.109, p=.270.
- There was a significant difference in IES scores across individual service environments $F(5,107) = 5.7, p < .01$



Trauma

Reactions typically do not last long. Within days/weeks most people feel as if they were back to the way they were and getting on with their lives.

Trauma

Psychological Responses

- Anxiety
- Hypervigilance
- Sleep disturbance
- Intrusive memories
- Guilt
- Shame/embarrassment
- Sadness
- Irritability and anger
- Emotional dumbness or blunting
- Withdrawal
- Disappointment
- Mental avoidance
- Behavioural avoidance
- Increased startle response

Regal & Joseph (2017)

Trauma

Physical Responses

- Shakiness and trembling
- Tension & aches (neck)
- Insomnia, tiredness, fatigue
- Poor concentration and forgetfulness
- Palpitations, shallow breathing and dizziness
- Gastrointestinal symptoms such as nausea vomiting and diarrhoea
- Disturbance of menstrual cycle

Regal & Joseph (2017)

Trauma

Relationships between SSQ (1-8) total scores & IES scores

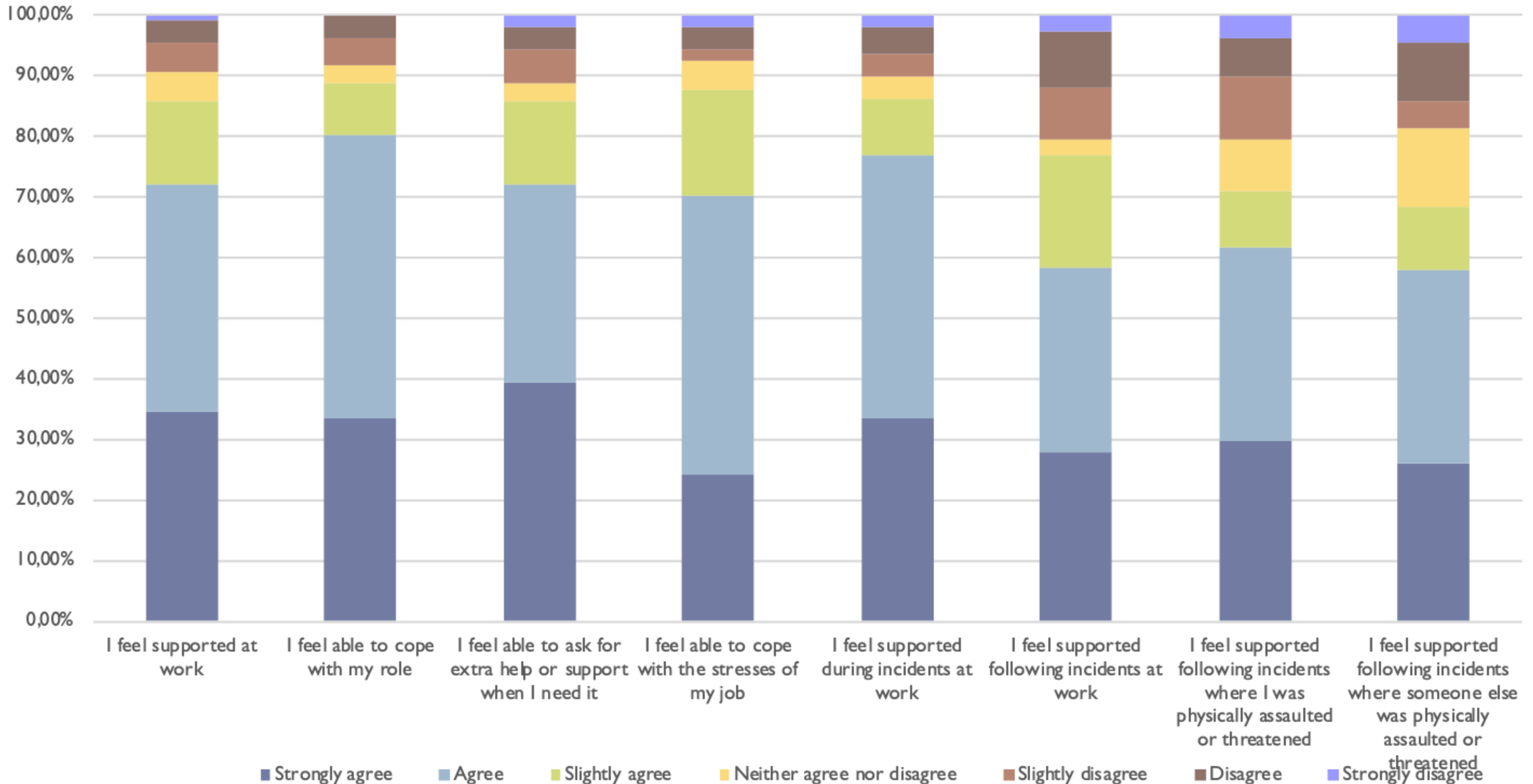
Full data sets were available for 106 participants. (NB lower SSQ score indicates higher support.)

- IES total subscale - significant: $r_p(105)=.420, p<.01$ $(p<.001)$
- Avoidance Subscale - significant: $r_p(105)=.319, p<.01$ $(p=.001)$
- Intrusion subscale - significant: $r_p(105)=.401, p<.01$ $(p<.001)$
- Hyperarousal subscale - significant: $r_p(105)=.448, p<.01$ $(p<.001)$

Trauma

- There was a significant difference between the mean total SSQ score for adult social care (M=20.77, SD=10.752) and educational services (M=16.03, SD=6.306); t(91.725)=2.821, $p<.05$ ($p=.006$)
- Adult social care staff had overall poorer perceptions of organisational support than education staff.
- Staff in educational services perceived they were better able to cope with their role, more able to ask for extra help when required, and better supported during and following incidents at work, compared with staff in adult social care settings.

Trauma



Trauma

- **Exposure to challenging behaviour**
- Significant relationships were found between the intrusion sections of the IES-R and exposure to SIB resulting in injury ($r = 0.21, n = 99, p = 0.037$).

Trauma

'I was supporting X with two other members of staff. We had a good walk but as we got nearer the house he became anxious. There was a gentleman out walking his dog. 2 members of staff had X in a 2 person hold due to his behaviour/ running off and there was a member of the public nearby. X had dropped to the ground and was sat cross legged. The two members of staff were knelt beside him and had him in a hold (holding his arms). The gentleman walked past with his dog and X was let out of hold. X got up and started to hit toward myself and the two other members of staff put X in a hold again. I didn't move out the way fast enough due to helping the other two staff members which resulted in a kick to my groin area.'

Baker & Hardiman (2016)

Trauma

'Not knowing I was pregnant, I took a test and it showed positive but then my monthly cycle started the day after the incident. I went to the doctors as had cramps and very heavy bleeding= very high chance of miscarriage.'

Baker & Hardiman (2016)

Trauma

'I was required to do essential training and therefore not physically in attendance when the incident happened. Due the increase in challenging behaviour, one young man we support had his support hours increased to 3:1 in the community. As I was on training that day I had to attend I asked my supervisor to cover the 3:1 if required. She had been trying for a baby for several months, but had informed me that she thought she wasn't pregnant. On this day, a young man became anxious whilst out on a walk and needed to be escorted back as was a risk to the public.'

Baker & Hardiman (2016)

Trauma

‘Whilst using a 2 person escort, my colleague managed to kick [name] in the stomach/groin area. The next morning she went to her GP with stomach cramps and heavy bleeding and diagnosed as having a miscarriage. This was a highly emotional time for myself as well as her, as I also felt guilty for asking her to cover this shift but there was no one else due to chronic and on-going staff shortages which had been raised with senior management on multiple occasions.’

Baker & Hardiman (2016)

Question

- What would be the implications if a significant proportion of a staff group were traumatised?

Wellbeing Resources: Before incidents

- Hastings (2002) - Role ambiguity, role conflict, managerial support, coping strategies, and low feelings of self-efficacy may explain link between CB and reduced wellbeing. Addressing these factors increases staff resources.

- Vassos et al (2013) – Recommended improved job descriptions, on-the-job feedback, & specialist support (of staff) workers

Wellbeing Resources: Before incidents

- Training
  - Wills, Shephard & Baker (2013) PBS training increased knowledge, influenced more positive attributions, more likely to engage in proactive strategies, less likely to engage in unhelpful behaviour, and reported higher levels of optimism in supporting a service user with challenging behaviour. Similar findings reported by Lowe et al 2007 & McGill et al 2007.

Wellbeing Resources: Before incidents

- Training
  - Hutchinson et al. (2014) – Who's challenging Who (WCW) training package. Small to moderate effects including increase in staff empathy and self-efficacy

Wellbeing Resources: Before incidents

- Acceptance & mindfulness based support
- An emerging evidence base of the effectiveness of acceptance & mindfulness based interventions on psychological distress and well-being of support staff. With some more limited evidence of a reduction in service user challenging behaviour and the use of restrictive practices. (McConachie et al 2014; Smith & Gore, 2012; Noone & Hastings 2090, 2010, 2011; Singh et al 2006a, 2006b, 2009)

Question

- What is the current practice in your organisations in regard to post-incident support?

What Supports Wellbeing?
After incidents

Debrief and post incident reviews

De-briefing is essential and can be a way of offering support and developing learning. It might identify a learning need for an individual worker or team, an amendment to a care plan or inform organisational actions through incident review, data collection and analysis.

A positive & proactive workforce (DoH 2014)

What Supports Wellbeing?
After incidents

De-briefing following an incident or a ‘near miss’ should:

- be led by the needs of the worker
- be undertaken by a skilled practitioner with a ‘no blame’ attitude, emphasising any learning and considering the psychological impact on the people involved
- identify any further or on-going support and learning that is needed.

All of the above forms of support should feed back into individual and team learning and development plans and into organisational development plans. These include restrictive practice reductions plans, stress management and reduction plans and reviews of policies and procedures.

What Supports Wellbeing?
After incidents
Post incident reviews

Appropriate lessons learned

- evaluate physical and emotional impact on those involved
- identify need for counselling/support for any trauma
- identify what led to the incident and what could have been done differently
- what alternatives, service barriers or constraints
- recommend change to policy/procedure

What Supports Wellbeing?
After incidents

1.2.1 Organisations policy framework includes ….a commitment to post incident management, debriefing and support systems for individuals who use the service and staff.

2.5.14 Training should include information about……….the importance of an appropriate evidence based system of debrief that provides emotional and psychological support for individuals and staff following any incidents and/or the physical interventions

- BILD Code of Practice (2014)

What Supports Wellbeing?
After incidents

Quality statement 5: Immediate post-incident debrief

Restrictive interventions are most likely to be used in inpatient psychiatric settings. Conducting a

post-incident debrief helps the organisation to identify and address any physical harm to service users or staff, ongoing risks, and the emotional impact on service users and staff

- NICE Guidance: Violent and aggressive behaviours in people with mental health problems (2017)

80. As soon as possible after the use of restraint the member of staff involved should be de- briefed by an appropriate manager to allow for reflection and the manager to deal with the emotions raised by the incident. This improves staff learning and contributes to professional development.

Reducing the Need for Restraint and Restrictive Intervention – Children and Young People with Learning Disabilities, Autistic Spectrum Disorder and Mental Health Difficulties DoH DoE (2017)

Debriefing

Evidence-Based ?

NICE Guidelines & Cochrane Review
do not appear to recommend debriefing:

"For individuals who have experienced a traumatic event the systematic provision to that individual alone of brief, single-session interventions (often referred to as debriefing) that focus on the traumatic incident should **not** be routine practice when delivering services." *(NICE Guidelines for PTSD 26, 2005)*

- BUT: this is for *single-session individual* debriefing to *treat* trauma
- AND: based on poor studies. Eg too short, too soon, untrained debriefers, wrong purpose

Unpacking the Research

- Surveys consistently report group debriefing to be subjectively helpful if done properly (eg, Everly, Flannery & Mitchell 2000)
- Cochrane & NICE ignore surveys, all qualitative studies & anything that is not an RCT
- Of the 11 RCTs in Cochrane (Rose, **Bisson** & Wessely, 2003) & 4 in 2006 update, ALL involved 1-off sessions for individuals
- 4 indicated positive outcome, 9 no effect, 2 negative. Conclusion was: no effect. No attempt to break this down.
- NICE comments based on same studies
- Dept of Health (2001) evidence-based practice guidelines: concerns about quality of these studies. 'Many of the published studies showing negative results for critical incident debriefing do not assure the quality of the intervention' (p.24).
- Cochrane authors: quality of studies 'was generally poor'

Research on Group Debriefing

- “There is now emerging evidence that prompt delivery of brief, acute phase services in the first weeks after an event can lead to sustained reduction in morbidity years later, reducing the burden of secondary functional impairment, presumed daily average life years lost, and costs to both the individual and the public”

Schreiber, M. (2005). PsySTART rapid mental health triage and incident command system. The Dialogue: A Quarterly Technical Assistance Bulletin on Disaster Behavioral Health, 14-15

Critical Incident Stress Management (CISM)

- Package of staff care following traumatic incidents
- eg, serious assault, restraint, anything that has significant emotional impact on team
- Reduces potential for post-traumatic stress reactions, helps well-being & team cohesion, improves retention
- Not just 'debriefing' - includes immediate support meeting ('defusing'), follow up, & preventative measures
- Not a magic solution! Part of a 'culture' of support within the organisation

Critical Incident Stress Management (CISM)

Four Elements

1. Immediate support meeting ('defusing')
2. Debriefing
3. Follow up care
4. Preventative measures - the 'culture of support' within the organisation

Critical Incident Stress Management (CISM)

Immediate Staff Support: What is a 'Defusing' Meeting?

- Comes from recognised good practice in 'standing down' of emergency service teams
- Opening strategy of support for staff after incident
- 15-30 mins, occasionally longer
- On day of event, before any staff go home (unless severe shock)
- Taken by team leader
- Significant trauma may be dealt with directly eg. phone personal contacts, take home / GP / A&E
- Symptom leaflets/training will assist this decision
- Managers can request own support meeting
- Service users may also have own meeting

Critical Incident Stress Management (CISM)

What are the Aims of 'Defusing' ?

- Reduce immediate potential for psychological harm
- Prevent misinterpretation of what has happened
- Prevent rumours from spreading
- Explain what response will follow - eg investigation
- Affirm value of staff involved
- Evaluate immediate reactions & normalize if appropriate
- Begin to assess whether debriefing is necessary
- Encourage mutual support from this point on
- Re-establish social network of staff group & prevent feelings of isolation

Critical Incident Stress Management (CISM)

What is Debriefing ?

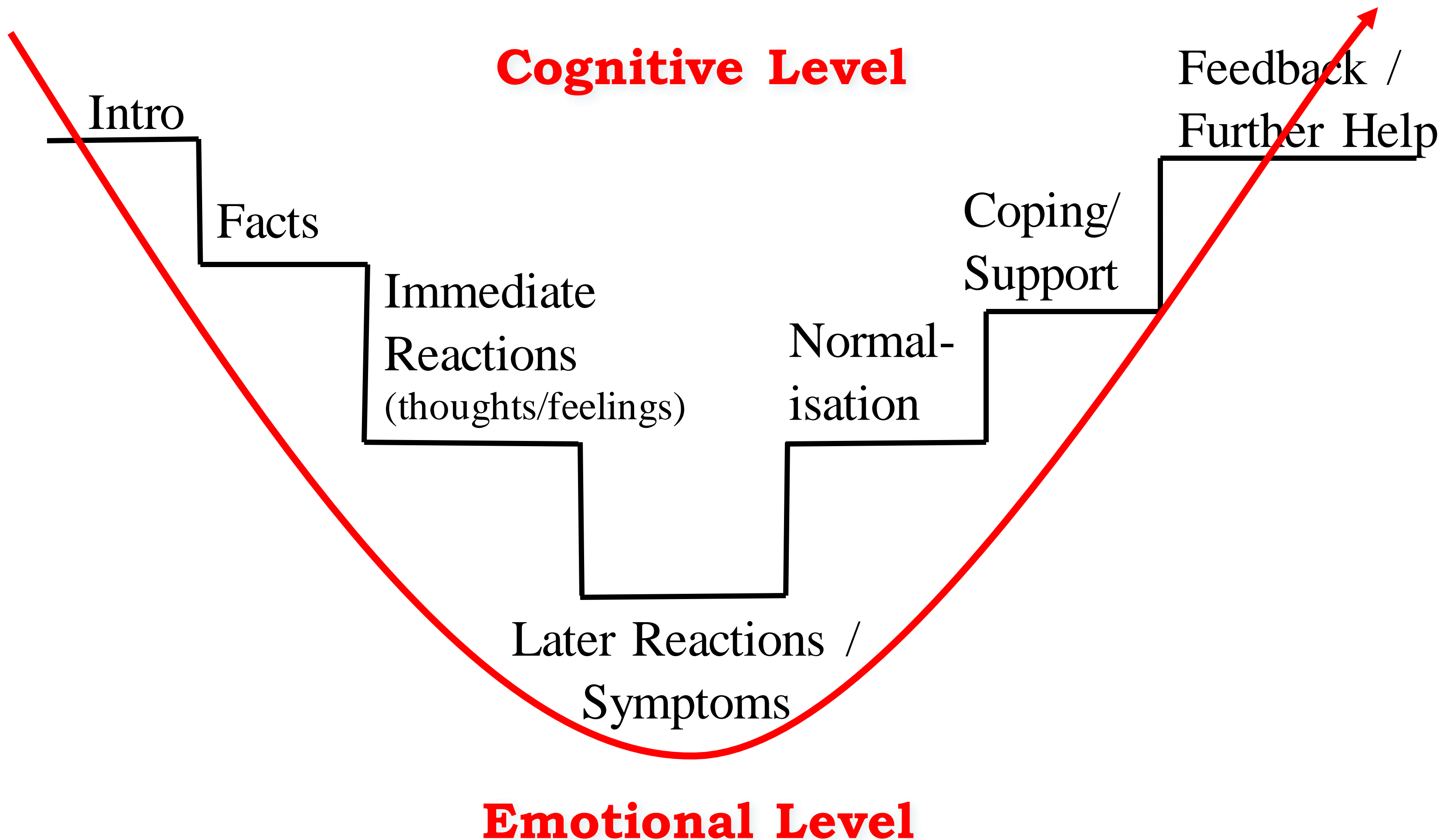
- Different to Procedural / Operational debriefing
- Reflective group meeting to assist personal adjustment & team cohesion after critical incident
- 2-4 weeks after serious event.
- Takes on average 2 hrs. Follow-up usually offered
- Conducted by two clinicians with experience of working with teams, ideally trained in debriefing
- Sensitivity needed & some knowledge of research (eg not everyone benefits from retelling events)

Critical Incident Stress Management (CISM)

What Are The Aims of Debriefing ?

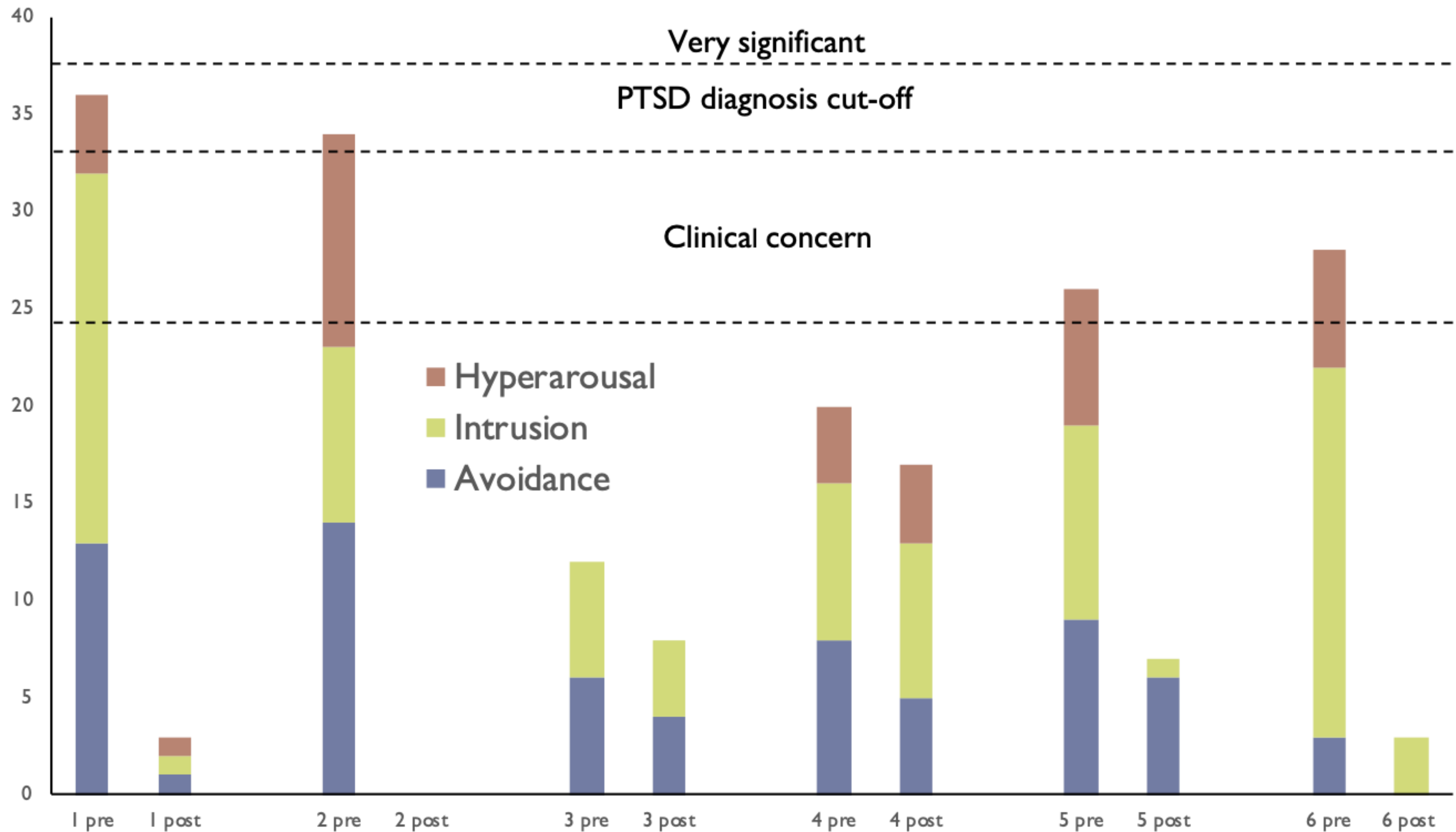
- Draw people together – sense of safety & containment
- Establish shared picture of what happened
- Assist expression of thoughts & feelings
- Limit feelings of self-blame / isolation
- Normalise stress reactions
- Share coping mechanisms
- Give opportunity for further support
- Pick up on more serious difficulties

The Steps of a Debrief



Based on Mitchell (1988) & Dyregrov (1989)

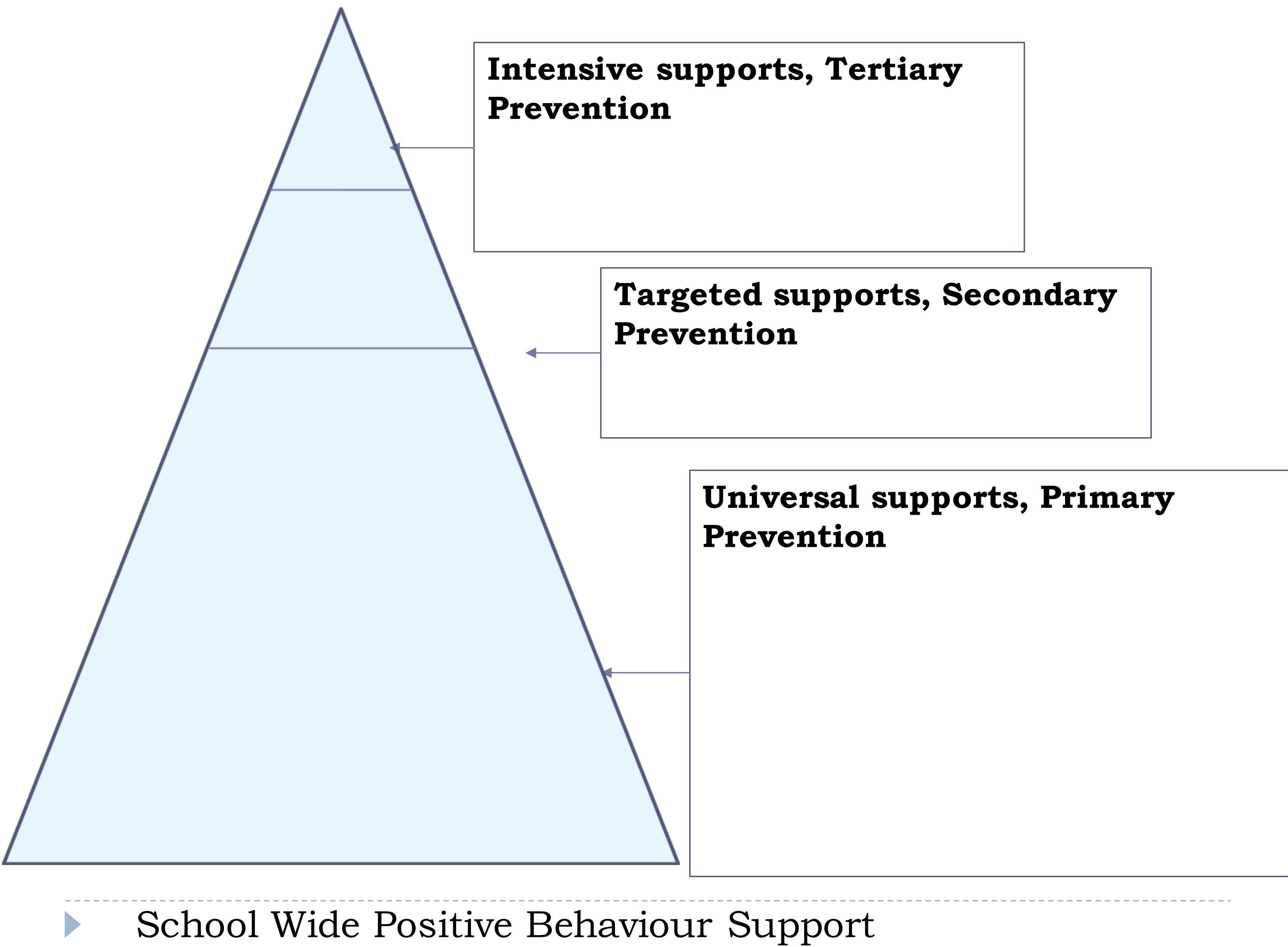
Baker (2017) Attending to debriefing as post-incident support of care staff in intellectual disability challenging behaviour services: An exploratory study. International Journal of Positive Behavioural Support, 7,1 38-43

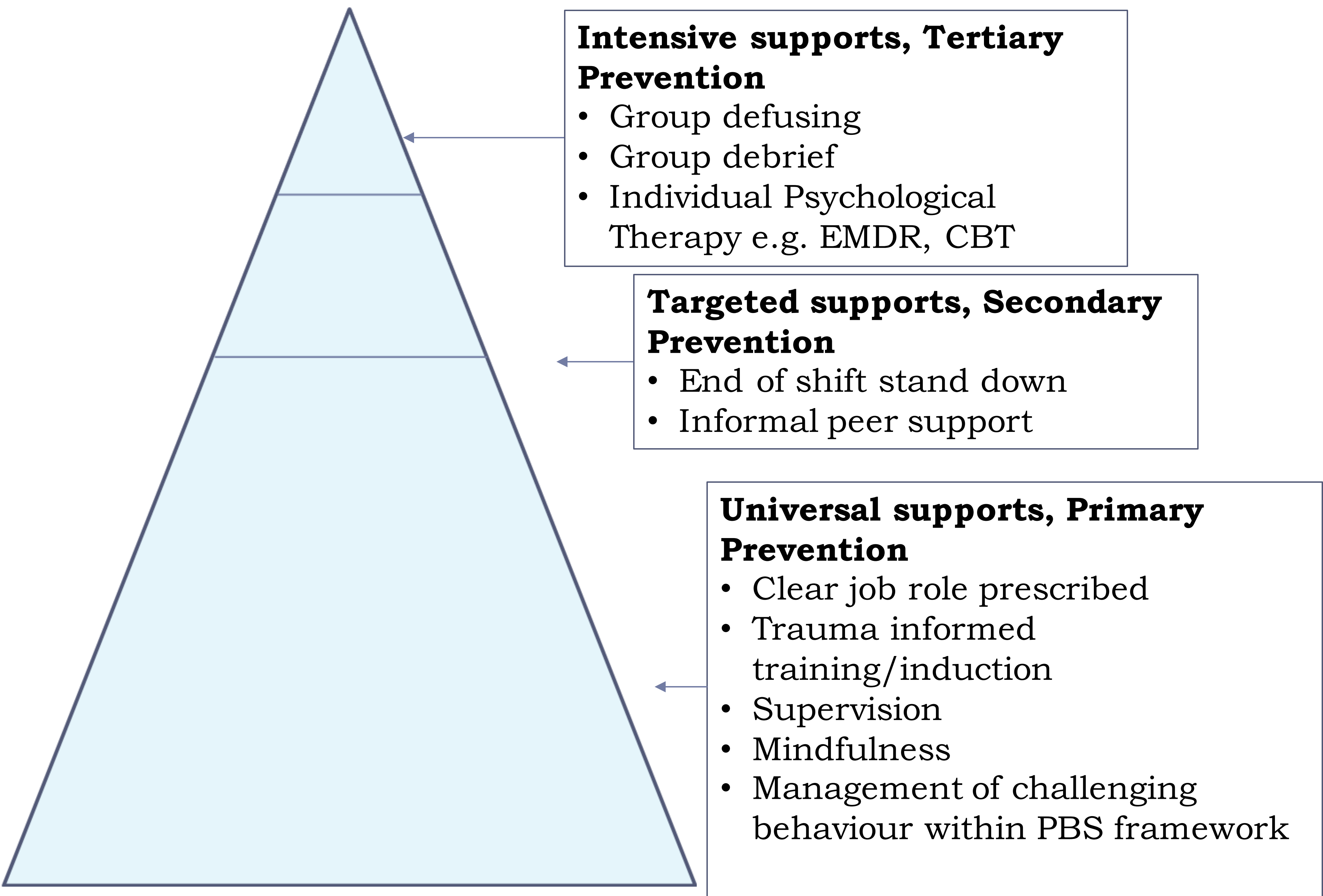


Impact of Events Scale – Revised (Weiss & Marmar 1995)

Question

- What would good practice in regard to staff support look like in your services?


Intensive supports, Tertiary Prevention
Targeted supports, Secondary Prevention
Universal supports, Primary Prevention
School Wide Positive Behaviour Support



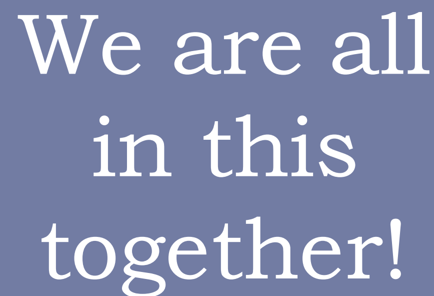
Organisation Wide Positive Staff Support

Concluding thoughts on debriefing

- Needs to be part of a comprehensive organisational response to promotion of staff psychological wellbeing
- Needs to be offered as a range of options
- Cause of the trauma needs to have finished – exceptional rather than routine incidents
- Need to be separated from organisational learning need
- Group debrief for existing team of professional carers
- Debriefing needs to be conducted by trained competent, engaged and emotionally available professionals with reference to evidence based practice

Key ingredients for red ucing restrictive practice

- Leadership
- Consumer involvement
- Development of acceptabl ents
- Devel
- Individualis
- Clear crisis mana
- Staffing
- Workforce develop
- Processing after th
- Data driven pract



Allen (2011)

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p.a.baker@kent.ac.uk

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