

Experiences of working in residential care

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Thesis submitted in partial fulfilment of the requirements of
Staffordshire and Keele Universities for the jointly awarded
degree of Doctorate in Clinical Psychology

September 2016

Word Count (excluding references and appendices):17,637

Acknowledgements

Firstly, I would like to thank the academic staff at Staffordshire University. Thank you to Dr Helen Combes for your research supervision and to Dr Helena Priest for always answering my questions and providing support.

I would also like to thank Ken Timms and Professor John Rose who were incredibly helpful when I needed them. Both of them have inspired me and influenced the way I've thought about the research.

I am extremely grateful to Professor Nigel King of the University of Huddersfield. Although I have never met him, I could not have done this without his video clips and website pages on Template Analysis.

Thank you also to everyone at the organisation where I completed my empirical study and to my placement supervisor there for your support and encouragement.

Most of all, thank you to the people who gave up their time to take part in my research, who were willing to share their experiences and who provided valuable insight which will certainly influence my practice.

On a personal level, thank you to Stephanie and Lisa for your constant support and occasional well-timed distraction. Thank you also to my mum and family, and to my fiancé Tom for bearing with me through all of it, for reassuring me that I could do it and for making the difficult days worthwhile. Lastly, I am extremely thankful for my faith and to God for the miracles that allowed me to get this completed in time.

Please note that the author completed the empirical research whilst on clinical placement within a residential service. As they had dual roles within the service, it was important to reflect on both of these roles in paper 3 (the reflective paper), and the author would prefer this content not to be made public. For this reason, reflections on this work have been removed after completion of the thesis.

Contents

Overall Abstract	5
Paper 1: Literature Review: ‘Supporting People with Intellectual Disabilities: A Review of Daily Practice Issues’	6
1.1. Abstract	7
1.2. Introduction	8
1.3. Method	9
1.4. Results	16
1.5. Discussion	27
1.6. References	32
1.7. Appendices	36
Appendix A: Further search information	36
Appendix B: Quality framework	37
Appendix C: Author guidelines for journal submission	38
 Paper 2: Empirical Report:	 47
‘Working with children with intellectual disabilities in residential care: staff views on challenges and support needs’	
2.1. Abstract	48
2.2. Introduction	49
2.3. Method	51
2.4. Results	54
2.5. Discussion	62
2.6. References	69
2.7. Appendices	72
Appendix A: Participant information sheet	72
Appendix B: Consent form	77
Appendix C: Interview Schedule	80
Appendix D: Initial template (1 and 2) and final template	84
Appendix E: Author guidelines for journal submission	94
Appendix F: Statements of ethical approval and amendments	103

Paper 3: Commentary and Reflective Review	107
3.1. Introduction	108
3.2. Methodological critique	108
3.3. Ethical issues	111
3.4. Reflexivity	112
3.5. Learning	114
3.6. Implications	115
3.7. Final thoughts	116
3.8. References	117

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Abstract

Government initiatives over the last fifteen years have emphasised a need to promote high standards within residential care for people with intellectual disabilities (ID). Emphasis has been placed on ensuring a competent workforce so as to promote high-quality support and prevent abuse. Clinical psychologists provide consultation and training to staff teams and have an important role to play in the care of people with ID.

Despite the focus on competence, residential staff continue to have few qualifications and training opportunities. They are also poorly paid, which suggests that they are not valued as highly as other professions, despite doing a very demanding job. These issues pose the question of what has changed since government papers of the last decade and what issues remain.

A literature review was completed to explore staff practice and factors that help and hinder competent working. Studies showed that staff faced daily dilemmas between policy and practice and that support from psychologists could be experienced as unhelpful.

In order to ensure high-quality care for people with ID, it is essential that practice is informed by appropriate policy and theory. Since research was grounded in adult services, the empirical study sought to explore these issues further in a sample of ten staff members working with children with ID. Using semi-structured interviews and template analysis, the study aimed to identify whether or not these staff members experienced the same challenges with policy and theory and what support they wanted.

It was found that very similar challenges were experienced when working with children. Participants provided further insight into these challenges and the support they needed. Findings are discussed in the context of how psychologists

and policy-makers can be more useful. Following this, a reflective commentary is presented, offering reflections on the research process.

Paper One: Literature Review

Supporting People with Intellectual Disabilities: A Review of
Daily Practice Issues

Word count (excluding references and appendix): 6,971

Abstract

Background

Government initiatives since 2001 have emphasised the need for a skilled, competent workforce supporting people with intellectual disabilities in residential care. This review seeks to explore the ensuing literature on staff practice and support needs, with the aim of identifying factors that assist and hinder competent practice.

Method

Databases were searched for UK articles on staff practice from 2009 onwards. Nine studies met criteria; all were qualitative.

Results

The studies highlight a gap between policy and practice, with staff facing dilemmas and conflicting agendas which interfere with the application of policy. Similarly, practice is not always informed by theory, since training is valued less than direct experience. Findings also emphasise the impact of power imbalances and relationship issues on staff practice.

Conclusions

Consideration needs to be given to the utility and applicability of policy, training and professional support to the realities of everyday practice. Current approaches are unrealistic.

Key words: intellectual disabilities, residential care, staff practice

Introduction

Despite government initiatives promoting community living, the number of adults with intellectual disabilities (ID) living in residential care was reportedly as high as 31,150 in England between 2012 and 2013 (Hatton et al., 2014). A need to 'drive up standards' of the people working in residential care was emphasised fifteen years ago in the government white paper, 'Valuing People' (Department of Health, DoH, 2001, p.22). Eight years later, this was reiterated in 'Valuing People Now' (DoH, 2009), with an emphasis on improving training and qualifications and enabling staff to become more confident and competent in their roles. 'Getting good support' was also identified as one of six main areas of concern for people with ID in a report by Williams et al. (2008). The authors outlined several important topics for the research agenda, including identifying what competences workers need to be able to provide good support.

Although there has been a clear drive towards enhancing the workforce, the role of Support Worker (SW) continues to be very low-paid (Pennycook, 2013), offers little training (e.g. Campbell, 2010) and requires few qualifications (Ekosgen, 2013). The role can also be very demanding and challenging behaviour is high in residential services (e.g. National Institute for Health and Care Excellence, NICE, 2015; Campbell, 2010). This can be difficult for staff, leading to stress and burnout (e.g. Devereux et al., 2009; Skirrow & Hatton, 2006; Hastings, 2002). Burnout and low morale may in turn increase the risk of abuse, and it is therefore important that clinical psychologists and other professionals seek to address such issues (Chamberlain & Davies, 2013).

In 'valuing' people with ID (DoH, 2001, 2009), it is essential to also value the people who support them, since this has significant implications for the well-

being of both parties. A report by The Point of Care Foundation (2014) stated that supporting and valuing healthcare workers is a critical factor in ensuring service user satisfaction and high-quality care. It is therefore important to gain a deeper understanding of the issues they face in their work.

Since the role of SW or similar is so important, it is essential that that research seeks to examine how well the recommendations of the previous decade have translated to practice (DoH, 2009; Williams et al., 2008). It is unclear how well research and practice have supported the drive towards a competent, skilled and confident workforce supporting people with ID in residential settings. It is also unclear what this actually entails: what is needed in order for staff to be competent and skilled in their role, and what are the barriers to this?

Aims

This review examines the literature that has emerged since the recommendations of Valuing People Now (DoH, 2009) in relation to the ID workforce. Although there has been extensive research on certain staff-related topics, such as responses to challenging behaviour (e.g. Philips & Rose, 2011; Ravoux, et al., 2012; Campbell, 2010) and staff burnout (e.g. Devereux et al, 2009), a review is needed of research into staff practice, training and support needs, in order to answer the questions above.

Method

Search

The following databases were searched using EBSCOhost in November 2015: Academic Search Complete, CINAHL Plus with Full Text, eBook Collection (EBSCOhost), MEDLINE, PsycINFO, SPORTDiscus with Full Text, and PsycARTICLES. ISI Web of Science was then searched using the 'Web of Science Core Collection'.

The search terms were:

- [Staff OR support worker* OR care worker* OR care assistant* OR residential worker* OR personal assistant* OR workforce]
- AND [learning disab* OR intellectual disab*]
- AND [culture OR practice* OR train* OR skill* OR belie* OR expect* OR perceptions OR perceive OR value* OR competenc* OR competent OR qualification* OR develop* OR confiden* OR abilit* OR equip* OR experience*].

The limiter 'NOT' was also used for several terms, based on the exclusion criteria. Details are given in Appendix A.

Inclusion and exclusion criteria

Articles were included if they:

- Were published between January 2009 (when *Valuing People Now* was published) and November 2015;
- Were UK-based articles (since *Valuing People Now* is a UK policy);
- Focused on aspects of staff practice for those working with adults with ID, such as staff experiences or views of the role, challenges, training and support needs. This could include anything that focused specifically on the work of residential care staff. Articles involving service users' views were also included if they focused on issues relating to the practice of staff and the support they received.
- Focused on the above issues within residential settings, including residential care, group homes and supported living. Studies focusing on Personal Assistants (PAs) supporting people in their own homes were also included since this could provide insight into differences in staff practice.

Articles were excluded if they:

- Focused on specific issues or problems, such as supporting people with bereavement, sexuality, medical issues, or ageing;
- Focused on specific interventions or tools, such as behaviour management interventions, therapies or the evaluation of measures;
- Focused on staff burnout rather than practice;
- Involved psychiatric settings rather than community learning disability services;
- Presented opinions or theory rather than research findings (i.e. opinion papers, book reviews and editorials), since the aim was to investigate original research contributions since 2009.

Articles retrieved

Figure 1 shows the number of articles retrieved. Fourteen relevant articles remained initially; the references of these were searched, leading to two additional relevant studies. Through closer reading, six articles were excluded due to not meeting the criteria and a total of ten remained. Since two articles were based on the same data (Williams et al., 2009, 2010), these were combined, giving a total of nine. The studies are summarised in Table 1.

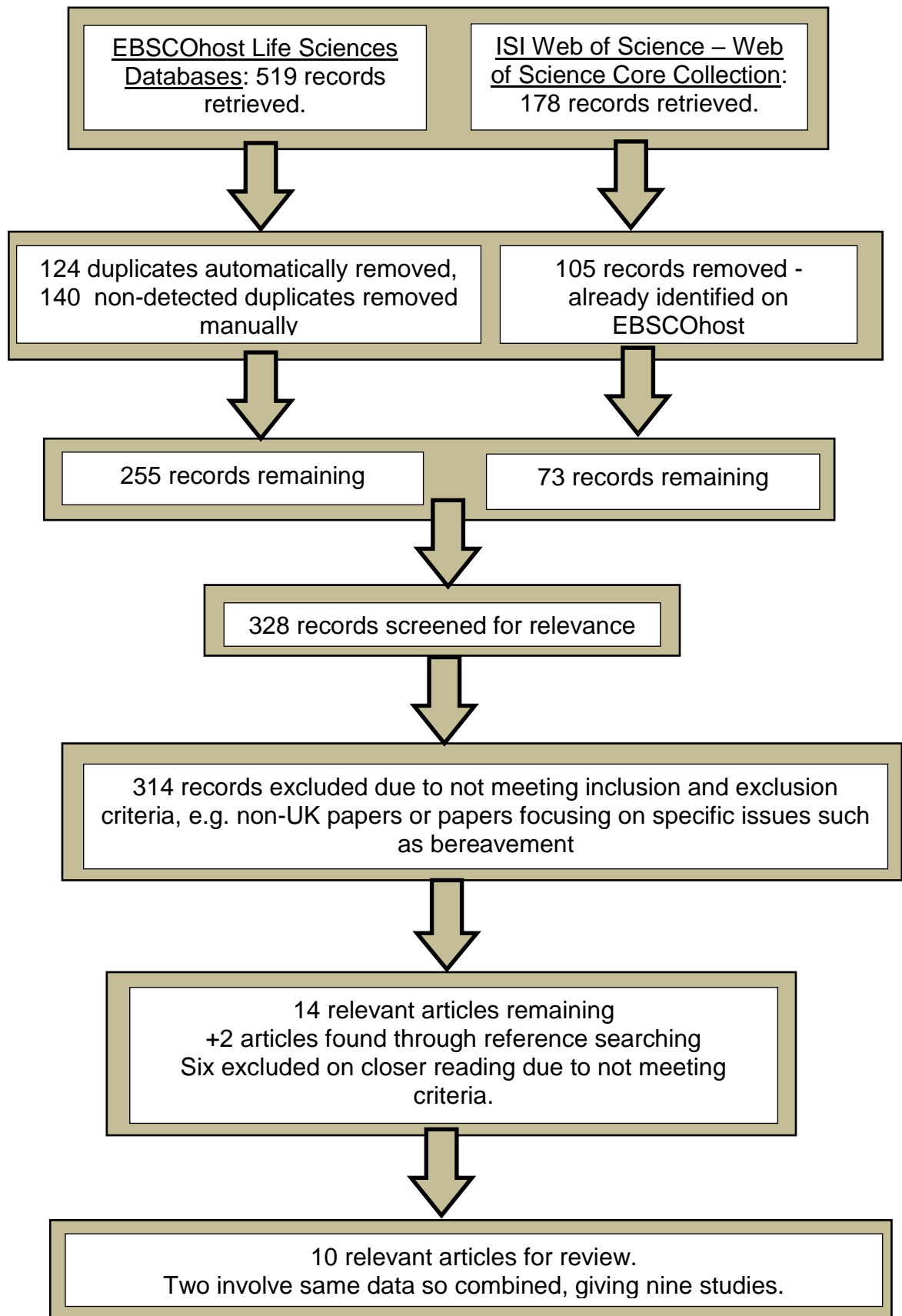


Figure 1. Flowchart showing articles retrieved and included/excluded

Table 1. Studies reviewed

Authors	Summary of Study
Antaki et al. (2009)	<p>Focus: Choice, control and empowerment</p> <p>Aim: To explore how staff offer service users choices in everyday practice</p> <p>Method: Observations and recordings of conversations between staff and service users in two residential services</p> <p>Analysis: Conversational Analysis</p>
Bradshaw & Goldbart (2013)	<p>Focus: Staff views and experiences in relation to training, support and aspects important to the role</p> <p>Aim: To explore staff views and experiences in relation to their support needs</p> <p>Method: Interviews with care staff (n=14) in three residential services</p> <p>Analysis: Thematic network analysis</p>
Dunn et al. (2010)	<p>Focus: Choice, control and empowerment</p> <p>Aim: To explore how staff make substitute decisions on behalf of service users</p> <p>Method: Observations and interviews (n=21) with care staff in three residential services</p> <p>Analysis: Constructivist Grounded Theory</p>
Hutchinson & Stenfert-Kroese (2015)	<p>Focus: Staff views and experiences in relation to training, support and aspects important to the role</p> <p>Aim: To understand staff experiences in making sense of varying standards of care</p> <p>Method: Interviews (n=6) with unqualified care staff (recruited via online forums and snowball sampling)</p> <p>Analysis: Interpretative Phenomenological Analysis</p>

Authors	Summary of Study
Jingree (2015)	<p>Focus: Choice, control and empowerment</p> <p>Aim: To explore how staff construct arguments about choice and control offered in practice</p> <p>Method: Interviews with care staff (n=15) working for one trust supporting people with ID and epilepsy</p> <p>Analysis: Critical Discursive Psychology</p>
Jingree & Finlay (2013)	<p>Focus: Choice, control and empowerment</p> <p>Aim: To explore how people with ID express and construct complaints and disagreement in relation to choice and control and the support they receive from staff</p> <p>Method: Interviews with people with ID (n=11) about the degree of choice and control they had</p> <p>Analysis: Critical Discursive Psychology, Discourse Analysis</p>
Monaghan & Cumella (2009)	<p>Focus: Staff views and experiences in relation to training, support and aspects important to the role</p> <p>Aim: To explore and describe the experiences of a SW</p> <p>Method: Undisclosed participant observation and life history methods</p> <p>Analysis: Thematic organisation of written notes</p>
Williams et al.(2009, 2010)	<p>Focus: Choice, control and empowerment and what people with ID want from their support staff</p> <p>Aim: To explore how Personal Assistants (PAs) interact with people with ID and to identify what people with ID want from their PAs.</p> <p>Method: Observations and audio recordings of people with ID (n=14) with their PAs</p> <p>Analysis: Conversational Analysis</p>

Authors	Summary of Study
Windley & Chapman (2010)	Focus: Staff views and experiences in relation to training, support and aspects important to the role Aim: To explore staff views and experiences in relation to their support needs Method: Interviews (n=5) and a focus group (n=3) with care staff in one health and social care service Analysis: Phenomenological (unspecified)

Results

Overview

Government initiatives and legislation have focused on promoting choice and control for people with ID over their own lives (DoH, 2009; 2005). Four of the nine studies explored how this is done in practice and the issues that are experienced for staff and service users (Antaki et al., 2009; Dunn et al., 2010; Jingree, 2015; Jingree & Finlay, 2013). One study also focused on choice, control and empowerment but also explored what people with ID view as ‘good’ and ‘bad’ support (Williams et al., 2009, 2010). The other four studies focused on staff views and experiences in relation to training, support and aspects important to the role (Monaghan & Cumella, 2009; Bradshaw & Goldbart, 2013; Windley & Chapman, 2010; Hutchinson & Stenfert-Kroese, 2015). The aims and methodology of all studies are stated in Table 1.

Appraisal of quality

All of the studies used qualitative methods. Meyrick (2006) described two key principles that are important when evaluating qualitative research: ‘transparency’ and ‘systematicity’. To evaluate the quality of the studies, a quality framework was developed, based on these concepts along with the Critical Appraisal Skills Programme Qualitative Research Checklist (Public Health Resource Unit, 2006) and guidelines on evaluating qualitative research developed by Yardley (2000). Details of the framework and criteria are presented in Appendix B. A ‘traffic light’ system was used, whereby criteria were judged to be either met (green), partly met (amber) or unmet (red). The principles of transparency and systematicity both consisted of eight factors for consideration. Tables 2 and 3 show the quality of the studies using this framework.

Only two studies fully met over half of the criteria for transparency, with a total of seven met factors (Dunn et al., 2010; Hutchinson & Stenfert-Kroese, 2015). Authors tended to be vague about the procedures they used for recruitment, data collection, analysis and interpretation, limiting the replicability of these studies. Dunn et al. (2010) met seven of the factors for systematicity. Three others met

Table 2. Quality Review of the Nine Studies, According to the Principle of 'Transparency'

	Antaki et al. (2009)	Dunn et al. (2010)	Jingree (2015)	Jingree & Finlay (2013)	Williams et al. (2009, 2010)	Monaghan & Cumella (2009)	Bradshaw & Goldbart (2013)	Windley & Chapman (2010)	Hutchinson & Stenfert Kroese (2015)
Aims and rationale	Met	Met	Partly	Met	Met	Met	Met	Met	Met
Sampling and recruitment	Unmet	Met	Partly	Met	Partly	Met	Met	Met	Met
Data collection	Partly	Met	Met	Met	Met	Partly	Met	Partly	Partly
Data analysis	Unmet	Met	Met	Partly	Met	Partly	Met	Partly	Met
Interpretation	Met	Met	Met	Met	Partly	Partly	Partly	Partly	Met
Ethical issues	Unmet	Met	Unmet	Unmet	Met	Met	Met	Met	Met
Reflexivity	Unmet	Partly	Unmet	Partly	Partly	Partly	Met	Partly	Met
Applicability / usefulness	Partly	Met	Partly	Met	Partly	Met	Met	Met	Met
Total number of factors met (out of 8)	2	7	3	5	4	4	7	4	7

Table 3. Quality Review of the Nine Studies, According to the Principle of 'Systematicity'

	Antaki et al. (2009)	Dunn et al. (2010)	Jingree (2015)	Jingree & Finlay (2013)	Williams et al. (2009, 2010)	Monaghan & Cumella (2009)	Bradshaw & Goldbart (2013)	Windley & Chapman (2010)	Hutchinson & Stenfert Kroese (2015)
Aims and rationale	Met	Met	Met	Met	Met	Met	Met	Met	Met
Sampling and recruitment	Partly*	Met	Partly	Met	Partly*	Met	Met	Met	Partly
Data collection	Met	Met	Partly	Met	Met	Partly	Met	Partly	Partly
Data analysis	Met	Met	Met	Partly	Partly	Partly	Met	Partly	Met
Interpretation	Partly	Met	Met	Partly	Partly	Partly	Partly	Partly	Met
Ethical issues	Met	Met	Partly	Partly	Met	Partly	Met	Met	Met
Reflexivity	Unmet	Unmet	Unmet	Unmet	Met	Met	Partly	Unmet	Met
Applicability / usefulness	Partly	Met	Partly	Partly	Met	Partly	Partly	Met	Partly
Total number of factors met (out of 8)	4	7	3	3	5	3	5	4	5

*Partly due to seeming appropriate but difficulties in transparency

over half of the systematicity factors, with five out of eight (Williams et al., 2009; Bradshaw & Goldbart, 2013; Hutchinson & Stenfert-Kroese, 2015).

Although qualitative research generates rich in-depth findings about people's views, experiences and behaviour (Ormston, et al., 2014), it is difficult to ensure quality and quantity at the same time and therefore all studies have the limitation of involving small samples and specific services or organisations, which may be unrepresentative of other SWs and services.

The majority of studies used only one method, such as observations or interviews. Utilising more than one method can increase the robustness of the research and increase the validity and reliability of findings. Difficulties with relying on interviews include the fact that there can be differences between what people say and what they do in practice and participants may give responses that they deem desirable or appropriate. Similarly, the use of observations alone does not allow participants to explain or discuss their practice or behaviour, and therefore interviews might add greater depth to observation data.

Dunn et al. (2010) utilised both methods, using observations to generate their interview questions. This study demonstrated a high level of quality, meeting seven out of eight of the criteria for transparency and systematicity. However, one limitation was that the authors did not reflect on their own impact on the study, thus increasing the likelihood of subjectivity in interpretation. This was true for the majority of studies, since the authors did not consistently demonstrate reflexivity, which is an important aspect of qualitative research (e.g. Watt, 2007).

The studies by Williams et al. (2009, 2010) had the advantage of having people with ID on the research team, which adds credibility to the findings. However, their study was again limited by a lack of reflexivity, since the authors did not reflect on their potential biases and how their own personal experiences might have affected data collection and interpretation.

Similarly, the study by Monaghan & Cumella (2009) was co-authored by someone who had actually worked as a SW. Monaghan used undisclosed participant observation and life history methods to discuss her experience of working as a SW in eight services. This study provides insight into the experiences

and challenges of being a SW. However, such an account is open to observer bias and difficulties recalling information retrospectively. Furthermore, Monaghan completed this research as part of her MSc in Learning Disability Studies, thus her experiences and interpretations may not be representative of SWs who have not completed this level of education. However, collectively, the studies in this review have the advantage of highlighting both staff and service user views and issues observed in everyday practice.

Key themes

A thematic analysis was completed of the key findings of each study and five themes were identified: the gap between policy, theory and practice; conflicting agendas and driving forces; power dynamics; personhood and relationships, and; areas for improvement. Each study's key findings are displayed in Table 4, along with the themes that related to them. Since all studies resulted in suggestions for areas for improvement and many of these arose from the findings themselves, areas for improvement have not been included in Table 4.

Table 4. Key findings for each study and the themes that relate to each study (excluding theme 5)

Authors	Key findings	Themes
Antaki et al. (2009)	Despite choices being offered, these inadvertently promoted institutional, managerial objectives rather than choice and control. The staff also faced dilemmas in wanting to promote choice yet feeling they had a duty to encourage socially-appropriate behaviour. They therefore posed choices to encourage service users to behave more appropriately.	1, 2, 3
Bradshaw & Goldbart (2013)	The main themes were: skills are developed from experience; service aims inform service delivery, and; practice is more important than theory. The authors focused on the first theme in this article. Staff expressed that they had developed skills through working directly with service users and building a relationship with them. Central to this was the idea that one cannot understand someone unless they have actually spent time with them. They viewed this relationship as crucial yet	1, 2, 3, 4

they described a conflict between ensuring a close relationship while also setting boundaries so that they were not 'taken advantage of'.

Some participants were concerned about their lack of training and described having to learn as they worked. However, staff expressed that the training they had received had not been helpful. Receiving advice from people who did not work directly with service users was described as 'patronising' by one respondent. Staff viewed training as useful when it centred on a particular individual and was delivered by people who knew the service user well. They also valued observing colleagues, although they acknowledged that they could adopt bad habits.

Dunn et al.(2010)	SWs made substitute decisions within a moral framework of seeking to support people with ID to 'live a life like ours'. Staff viewed service users' lives as narrow and 'out of the ordinary'. In order to promote ordinariness, SWs drew upon their own personal experiences and routines, considering what they would do in a particular situation. They also took risks and defied service policies to support service users to engage in activities they considered meaningful. This led to a sense of making a difference to people's lives. Staff made decisions based on their own personal values rather than those of service users and did not fully consider capacity.	1, 2, 3, 4
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Hutchinson & Stenfert-Kroese (2015)	<p>Staff highlighted the importance of reciprocal relationships with other staff members, managers and service users. They viewed relationships with managers more positively when they felt listened to and encouraged to contribute. Some staff felt disregarded and powerless. Similarly, they described relationships with colleagues as either close, equal and collaborative, or distant and isolated. Close relationships increased job satisfaction and reduced sickness. A lack of team meetings and unwillingness of senior staff to share information were seen as barriers to collaborative working.</p> <p>It was important to participants to feel like they were 'getting something back' from their interactions with service users, and to be able to relate to them as equals and individuals. Participants also referred to the degree to which their roles fitted with their personal values and enabled them to receive intrinsic reward, which involved enjoyment, satisfaction and a sense of achievement. However, staff expressed that intrinsic motivation is difficult within this role.</p>	3, 4
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Jingree (2015)	SWs positioned themselves as responsible and in a position of granting, withholding or influencing service users' choices, with service users positioned as lacking capacity and needing staff input. The respondents used interpretive repertoires about 'duty of care' and safety in order to justify their position of restricting choices. Participants made judgements without fully	1, 2, 3
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considering capacity.

Approximately 30% of participants drew upon repertoires relating to normalisation (Wolfensberger, et al., 1972), claiming that they had a responsibility to influence choice-making when service users' actions were socially inappropriate.

Jingree & Finlay (2013)	Service users felt they had little choice and control and some of their choices were viewed as inappropriate and overruled by staff. Participants expressed dissatisfaction with several aspects of their lives, yet they feared that they would be 'in the wrong' if they complained. They drew upon repertoires of competence in relation to themselves and positioned staff as controlling and over-protective. For example, one person explained that they were not allowed to use sexual innuendoes in front of other service users. Staff seemed to prioritise their duty to protect service users over promoting choices.	1, 2, 3
Monaghan & Cumella (2009)	A lack of training had a negative impact on the care that SWs provided due to them not understanding service users' behaviours. Person-centred care was not consistently implemented, despite policy, with only two organisations having personalised plans for service users. Plans tended to be outdated and were only updated when an inspection was due, since practices were driven by routine rather than service user needs. Monaghan described how the stress of support work was increased by a lack of training. She argued that stress could be reduced through regular team meetings, supervision, effective communication and involving staff in making decisions. She added that away days might help staff to feel valued. Monaghan also explained that there are certain personal qualities needed for the role of SW, including being empathic, patient, and a skilled communicator.	1, 2, 3, 4
Williams et al. (2009, 2010)	<p>The authors considered 'good' PAs to be attuned to the individual, responding sensitively to their needs and providing support in the background. They compared this with how staff sometimes 'take over' tasks in residential settings. Williams et al. argued that being respectful involves using an adult-like tone rather than child-like speech, taking what the person says seriously, being curious rather than patronising, and following the person's lead. Williams et al. also identified how 'good' PAs reminded people when they could make a choice rather than simply following routines.</p> <p>PAs tended to use shared referencing, referring to something that both people knew about without being explicit. This positioned both parties as equal within a close and friendly relationship. PAs also sometimes spoke about their personal lives, with the example of a PA who referred to her daughter and husband by name, without needing to explain who these people were.</p>	3, 4

Windley & Chapman (2010)	<p>Participants felt unable to offer service users as much choice as they would have liked due to insufficient resources and risk management. Participants viewed service users as vulnerable and felt that there was the potential to dictate service users' lives. They expressed that the promotion of choice was restricted due to insufficient resources and risk management. They also experienced conflicts between different approaches, such as some staff members prioritising a tidy environment over actual support of service users.</p> <p>Participants used 'trial and error' methods and observed other staff. They viewed training as important, particularly when it focused on specific service users, but found it difficult to apply. Participants expressed that open communication and involvement of staff in planning interventions was key to good professional support. Obstacles to effective working included poor communication and not being able to meet as a staff team.</p> <p>Participants viewed their role as maximising quality of life, supporting service users to engage in meaningful activities and to develop skills and autonomy. This led to staff enjoyment and satisfaction. Participants also described certain qualities that were important to their role: being caring, empathic and having the 'right temperament'.</p>	1, 2, 3, 4
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1. Gap between policy, theory and practice. Across these studies, there was a theme of policy and theory not translating to the realities of everyday practice. The articles that focused on choice, control and empowerment found that that despite the government drive towards choice for people with ID (DoH, 2001, 2005, 2009), those living in residential services continue to have greatly restricted choices (Antaki et al., 2009; Dunn et al., 2010; Jingree, 2015; Jingree & Finlay, 2013). Jingree (2015) and Dunn et al. (2010) also found that staff members made decisions on behalf of service users without fully considering capacity under the Mental Capacity Act (MCA, DoH, 2005). However, the study by Dunn et al. (2010) was carried out while the MCA was still being implemented and none of the SWs had received MCA training, which might have changed their decision-making.

Nevertheless, their findings suggest that staff will overlook service policies in order to support people with ID to engage in activities that the staff personally consider meaningful.

Similarly, two studies found that theory delivered through training tends to be difficult to apply and may be viewed as unhelpful. Bradshaw and Goldbart (2013) found that staff valued learning from experience and observing their colleagues. In contrast, theory or advice from professionals could be perceived as 'patronising'. Similar findings were reported by Windley and Chapman (2010), although some of their arguments were not supported by the data presented.

2. Conflicting agendas and driving forces. The presence of competing agendas was referred to in six of the articles. Findings from the articles that focused on choice, control and empowerment suggested that drives towards the promotion of choice can be in conflict with the notion of 'duty of care' and the responsibility of staff to promote service users' safety. SWs described needing to protect service users and manage risks. In doing so, they felt that they needed to influence or restrict choices (Antaki et al., 2009; Jingree, 2015). Staff were also driven by the principles of normalisation (Wolfensberger et al., 1972) and saw themselves as having a responsibility to help service users to be 'normal' or 'ordinary' and to show appropriate behaviour. Service users' choices were sometimes seen as undesirable and therefore staff tried to restrict or influence their decision-making (Jingree, 2015; Jingree & Finlay, 2013; Antaki et al., 2009).

Monaghan and Cumella (2009) also reported that staff practice was driven by routine rather than service user needs. Person-centred planning was not a priority and therefore related paperwork was only completed when an inspection was due. Similarly, the findings of Antaki et al. (2009) also suggest that managerial and organisational motives impact on the level of choice that service users receive, whereas Dunn et al. (2010) found that the personal agendas of staff in relation to their own values influenced how they made decisions on behalf of service users.

Windley and Chapman (2010) found that staff members disagreed on what to prioritise in their work, with some preferring to spend time on quality support and others prioritising the tidiness of the environment (Windley & Chapman, 2010). Bradshaw and Goldbart (2013) also highlighted a conflict between SWs wanting to have a close relationship with service users yet also wishing to maintain

boundaries. Lastly, another conflict was the impact of insufficient resources on the ability to promote choice (Windley & Chapman, 2010).

3. Power dynamics. Power issues were highlighted across all studies.

Staff were positioned as being able to influence or restrict choice based on a duty to protect service users and they sometimes controlled agendas based on organisational or personal factors (Antaki et al., 2009; Dunn et al., 2010; Jingree, 2015; Jingree & Finlay, 2013). In contrast, people with ID were seen as vulnerable, lacking capacity and needing input (Jingree, 2015; Jingree & Finlay, 2013; Windley & Chapman, 2010). In Jingree and Finlay's (2013) study, service users feared expressing their dissatisfaction because they thought they would be 'in the wrong'. This illustrates a concerning power differential between staff and service users. Interestingly, staff in another study were concerned about service users being too powerful, and felt they needed to be clear about boundaries so as to prevent service users taking advantage of them (Bradshaw & Goldbart, 2013).

In contrast, the two articles by Williams et al. (2009, 2010) described a very different relationship, with the person with ID being the employer of their PAs. The authors highlighted the importance of this relationship being equal and collaborative, with the PA following the service user's lead, using an adult tone and reminding them that they could make their own choices.

Issues of power were also discussed in relation to staff and their colleagues and managers. For example, Hutchinson and Stenfert-Kroese (2015) highlighted the importance of these relationships being reciprocal and equal, with staff being listened to and involved in decision-making, which was also highlighted by Monaghan and Cumella (2009). When relationships did not have these qualities, SWs felt disregarded and powerless.

4. Personhood and relationships. Findings from across these studies

suggest that staff practice is closely grounded in their relationships with service users, colleagues and managers. Having a close relationship with a service user and understanding them as an individual was viewed as critical (Bradshaw & Goldbart, 2013; Windley & Chapman, 2010; Hutchinson & Stenfert-Kroese, 2015; Williams et al., 2009, 2010), thus, direct experience of working with a service user

was considered more helpful than training (Bradshaw & Goldbart, 2013; Windley & Chapman, 2010; Hutchinson & Stenfert-Kroese, 2015).

Particular personal qualities were viewed as important to practice, and these were also grounded in relationships, such as being empathic and an effective communicator (Williams et al., 2009; 2010; Monaghan & Cumella, 2009; Windley & Chapman, 2010). Staff were guided by their values and what they viewed as meaningful in their own lives, which influenced how they supported service users (Dunn et al., 2010; Hutchinson & Stenfert-Kroese, 2015). They discussed obtaining enjoyment and satisfaction from seeing service users progressing and experiencing meaningful activities (Windley & Chapman, 2010; Dunn et al., 2010; Hutchinson & Stenfert-Kroese, 2015). Adopting more of a personal approach with less professional distance was considered empowering by Williams et al. (2009, 2010).

Receiving support from colleagues and managers was also important to the staff in these studies (Bradshaw and Goldbart, 2013; Windley & Chapman, 2010; Hutchinson & Stenfert-Kroese, 2015).

5. Areas for improvement. The majority of studies referred to training as an area for improvement . One message was that for training to be useful it needs to be centred on a particular service user and that the trainer needs to know the service user and have spent time with them (Bradshaw & Goldbart, 2013; Windley & Chapman, 2010). Training also needs to consider the realities of staff practice and competing agendas (Antaki et al., 2009; Jingree, 2015; Dunn et al., 2010). Bradshaw & Goldbart (2013) also suggested that trainers need to consider how to combine the experiential knowledge of staff with their evidence-based knowledge. Learning from other staff members was also viewed as helpful (Bradshaw & Goldbart, 2013; Windley & Chapman, 2010; Monaghan & Cumella, 2009).

The findings of Williams et al. (2009, 2010) suggest that PAs also need better training. A training pack was developed as a result of their study, drawing on video extracts and stories of good support. These were developed so that people with ID could train their own PAs.

In addition to training, some researchers noted that SWs can engage in reflective practice when given the opportunity (Antaki et al., 2010) and that time to reflect on their values and practice is important (Dunn et al., 2010; Jingree, 2015). Regular supervision and team meetings were also considered important, along with effective communication and support from colleagues and managers (Monaghan & Cumella, 2009; Windley & Chapman, 2010; Hutchinson & Stenfert-Kroese, 2015). Collaborative relationships were viewed as critical, with staff feeling able to contribute to decision-making (Hutchinson & Stenfert-Kroese, 2015; Monaghan & Cumella, 2009). Away days and social activities were considered beneficial for enabling staff to feel valued and supported (Monaghan & Cumella, 2009; Hutchinson & Stenfert-Kroese, 2015).

Discussion

This review aimed to explore the literature on staff practice, training and support needs, in relation to the question of what SWs need in order to do their job competently and what the barriers are. Five key themes were identified across the studies and these will now be discussed, concluding with implications for practice and future research.

Findings from the nine studies suggest that staff practice is not consistently informed by relevant policy and that conflicting agendas may hinder the application of policy in practice. Clearly there is a gap between policy and practice in terms of the level of choice and control that people with ID have, since several studies showed that service users had greatly restricted choices despite the drive towards choice and empowerment (DoH, 2009; 2005). In making sense of this, it seems that policies and guidance fail to consider everyday dilemmas that staff face, with several agendas appearing to conflict with each other. In particular, SWs perceive their 'duty of care' and responsibility to protect service user safety to conflict with the promotion of choice, since service users' choices could be perceived as risky and increasing their vulnerability.

Similarly, staff may perceive their duty of care to include a responsibility towards social appropriateness and helping a service user to 'fit in', which again

results in staff limiting service users' own choice-making. Regulatory bodies may also play a significant part in these notions. For example, the Care Quality Commission (CQC) impose high standards and these often conflict with the promotion of choice (e.g. CQC, 2010). With the aims of ensuring safety, cleanliness, and social appropriateness, it can be difficult to enable service users to have choice and control over their lives.

In the absence of clear guidance that translates to practice, residential staff may find the multiple duties and responsibilities they face confusing and contradictory, causing them to make their own judgements about the 'right' thing to do. This may increase the risk of abuse and power exploitation. It is therefore essential that policies take into account the dilemmas that staff face in practice and provide clearer guidance.

Insufficient resources and risk management were also identified as factors that hinder the promotion of choice. This has certainly been observed in the present author's practice, with SWs referring to staff shortages, limited access to transport, and risk of challenging behaviour as barriers to promoting choice. These factors make it difficult to follow policy and guidance in practice. However, it is important that managers and supporting professionals encourage staff to be more flexible in their thinking about how choices can be offered in spite of these restrictions.

In addition to policy not translating to practice, two studies in this review highlighted difficulties with implementing theory. The tendency of staff towards valuing learning from experience and observing colleagues over training has important implications for psychologists and other professionals who work with staff teams. For training and advice to be valued and implemented by staff, professionals need to ideally know the service users well and tailor the training and support to the particular individual. It might also be more helpful to encourage colleague modelling rather than relying on staff to implement professional recommendations.

Another factor that was identified in relation to staff practice was the issue of power dynamics. Working with vulnerable people naturally involves a power imbalance and this is likely to be exacerbated when practice is not informed by

relevant policy and theory, since staff may be more subjective in how they support service users. The studies in this review showed that staff tend to view people with ID as vulnerable, lacking capacity and needing protection or staff input, causing them to restrict service users' choice and control. Other studies have found similar findings (Parley, 2010; Petner-Arrey & Copeland, 2014). Although staff intentions may be well-meaning, positioning service users in this way may again make abusive practices more likely. Clinical psychologists and other professionals have a responsibility to promote safe, non-abusive practice (Chamberlain & Davies, 2013) and one way of doing so may be supporting staff to reflect on power differentials in their work.

The studies by Williams et al. (2009, 2010) show that the relationship between a person with ID and their PA can be very different to the relationship they might have with a SW in residential care. They suggest that a closer, more personal relationship, based on shared knowledge and experience, positions both parties as equal and empowers the person with ID to take more control of their lives. Although this could be seen as unprofessional, Williams et al. argued that PAs were professional and skilled in responding sensitively to people's needs, performing personalised support based on knowledge of the individual and shared experiences. A training pack was developed from these studies so that people with ID could train their own PAs on what constitutes 'good' and 'bad' support. Similar materials could be developed in residential settings in order to promote service users' choice and control and enhance staff practice.

In addition to the power imbalances between staff and service users, the studies in this review also highlighted power issues in staff relationships with colleagues and managers. It is important to staff that they feel listened to and involved in decision-making rather than feeling disregarded and powerless, which would likely impact on their morale and practice. Feeling disempowered may also make it difficult to be empowering in their relationships with service users, and therefore modelling equality and collaboration may be a way for managers to promote empowerment of both staff and service users.

Overlapping with power issues in these studies was the theme of personhood and relationships. It seems important to staff that they know service

users well as individuals and that they can relate to them, and also that supporting professionals know the service users well (e.g. Bradshaw & Goldbart, 2013). Positive, collaborative relationships with colleagues and managers also seem to be very important to staff. Services need to be mindful of the significant relational component to the role of SW and the challenges that may arise when SWs do not experience these relationships positively. It is clear from the studies that SWs bring a lot of themselves to the role, drawing on personal qualities, their own values, and personal comparisons about what they would want in their own lives. It is therefore important that they are given adequately supported, since this is likely to be linked with increased emotion and stress. There tends to be an emphasis on professionalism within care services and an avoidance of emotion (e.g. Ravoux et al., 2012), thus staff might not receive the support they need. Supervision and reflective practice are critical in order to help staff to be aware of the impact of their values on their practice and to be able to manage difficult feelings that might arise in their work.

Lastly, several areas for improvement were identified and many of these have already been discussed. To summarise, some of the key areas for improvement are training, supervision and support between colleagues and managers, enabling staff to feel valued through away days and social activities, and promoting reflective practice. Supporting professionals need to be aware of the value staff place on relationships and therefore knowing the service user well and tailoring support to the individual will make it more likely that staff will apply theory and recommendations in practice. It is also important to be aware of the realities of everyday practice and the dilemmas that staff experience with conflicting agendas. Policy, training and professional support need to take into account of these issues so that theory and policy can be easier for staff to apply in practice.

Conclusion and implications for future practice and research

This review set out to identify what the current literature shows about what SWs need to be able to do their job competently and what things get in the way. The nine studies in this review suggest that relational aspects are important to doing the job well, such as having supportive, collaborative relationships with colleagues. Values, personal qualities and power dynamics are also important. Theory delivered through policy and training does not always translate to practice and there can be multiple demands and dilemmas that get in the way of 'competent' theory-informed practice. Future policy, training and professional support need to reflect these issues in order to be helpful to staff.

Future research needs to explore relational issues further, such as how the PA literature can be applied to residential care, and how staff values and personal experiences can be incorporated safely into their work, as well as how staff can be more closely involved with, and supported by, their colleagues and managers.

Another key area for future research is the overarching issue of the mismatch between theory and practice. Research needs to explore the views of staff in greater depth in relation to how theory can be more useful and applicable. Furthermore, research needs to identify whether or not the same issues are experienced by those supporting children and young people with ID as well as adults, since different policies apply and there are far less studies in this area. Such research is important for both government policy and the support and training provided by psychologists and other professionals. It is essential that we seek to understand and implement what is useful for staff, rather than imposing theory that will not be applied.

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Appendix A: Further details of search

Databases searched under 'Web of Science Core Collection':

consisting of the following databases: Science Citation Index Expanded (1970-present); Social Sciences Citation Index (1970-present); Arts & Humanities Citation Index (1975-present); Conference Proceedings Citation Index- Science (1990-present); Conference Proceedings Citation Index- Social Science & Humanities (1990-present); Book Citation Index– Science (2005-present); Book Citation Index– Social Sciences & Humanities (2005-present); Emerging Sources Citation Index (2015-present). The following databases were excluded: Current Chemical Reactions (1993-present)(*Includes Institut National de la Propriete Industrielle structure data back to 1840*); Index Chemicus (1993-present).

Details of 'NOT's used in search, based on high number of articles retrieved from initial searches:

[dementia OR azheimer* OR nurs* OR ageing OR aging OR older OR death OR dying OR bereavement OR palitative OR child* OR adolescen* OR school OR student* OR education OR disease* OR cancer* OR end of life OR dysphagia OR prader* OR autis* OR down syndrome OR down's syndrome OR sex* OR medic* OR diet* OR health OR depress* OR mental illness OR mental health OR mentally ill OR hospital OR restrain* OR medicat* OR prison* OR forensic OR crime OR offend* OR pain OR anger OR signing].

Appendix B: Quality framework

	Transparency	Systematicity
Aims and rationale	Are the aims and rationale for the study clear?	Is there a thorough discussion of relevant literature? Do the aims and rationale link clearly with the literature? Does the study seem relevant?
Sampling and recruitment	Is the method of recruitment clear? Are details given of inclusion and exclusion criteria? Are there details of participant demographics?	Is the method of recruitment appropriate to the research aims? Is the sample appropriate?
Data collection	Is it clear how the data was collected? Are there sufficient details?	Is a qualitative method appropriate? Is the particular method of data collection appropriate and sufficiently rigorous? Does the researcher(s) justify the methods chosen?
Data analysis	Is it clear how the data was analysed? Are there sufficient details?	Is the method of analysis appropriate and sufficiently rigorous?
Interpretation	Are the findings clear? Is it clear how the researcher(s) has arrived at their interpretation (e.g. themes)? Are there clear examples to illustrate the interpretation?	Has the researcher(s) considered the credibility of their interpretation? Have they used respondent validation or other methods? Does the researcher link their interpretation to the original aims of the study?
Ethical issues	Is there a statement relating to ethical approval? Has the researcher discussed relevant ethical issues? Is it clear how the research was explained to participants?	Does the research appear to have been conducted ethically? Does the reader have any concerns?
Reflexivity	Does the researcher(s) state their epistemological position? Does the researcher(s) discuss their own potential biases and impact on the research?	Does the researcher(s) draw on methods of compensating for their own potential biases (e.g. having more than one analyst)?
Applicability and usefulness	Is the researcher explicit about the limitations of the study? Are there clear implications for practice and/or future research?	Can the findings be generalised to other similar populations (within the limits of qualitative research) or is the sample too limited? Does the researcher(s) consider alternative arguments? Is the study useful?

Appendix C: Author guidelines for the Journal of Applied Research in Intellectual Disabilities

Present author's note: these have been followed as closely as possible and the in-text citations will differ to APA format due to the journal requirements. However, figures and tables have been kept in the main body for ease of navigation.

Edited By: Chris Hatton and Peter Langdon; Founded by Professor David Felce

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1. GENERAL

The *Journal of Applied Research in Intellectual Disabilities* is an international, peer-reviewed journal which draws together findings derived from original applied research in intellectual disabilities. The journal is an important forum for the dissemination of ideas to promote valued lifestyles for people with intellectual disabilities. It reports on research from the UK and overseas by authors from all relevant professional disciplines. It is aimed at an international, multi-disciplinary readership.

The topics it covers include community living, quality of life, challenging behaviour, communication, sexuality, medication, ageing, supported employment, family issues, mental health, physical health, autism, economic issues, social networks, staff stress, staff training, epidemiology and service provision. Theoretical papers are also considered provided the implications for therapeutic action or enhancing quality of life are clear. Both quantitative and qualitative methodologies are welcomed. All original and review articles continue to undergo a rigorous, peer-refereeing process.

Please read the instructions below carefully for details on submission of manuscripts, the journal's requirements and standards as well as information concerning the procedure after a manuscript has been accepted for publication. Authors are encouraged to visit <http://authorservices.wiley.com/bauthor/> for further information on the preparation and submission of articles.

All manuscripts must be submitted solely to this journal and not published, in press, or submitted elsewhere.

2. ETHICAL GUIDELINES

Acceptance of papers is based on the understanding that authors have treated research participants with respect and dignity throughout. Please see Section 2.2 below.

2.1 Authorship and Acknowledgements

Authorship: Authors submitting a paper do so on the understanding that the manuscript has been read and approved by all authors and that all authors agree to the submission of the manuscript to the journal. ALL named authors must have made an active contribution to the conception and design and/or analysis and interpretation of the data and/or the drafting of the paper and ALL authors must have critically reviewed its content and have approved the final version submitted for publication. Participation solely in the acquisition of funding or the collection of data does not justify authorship.

It is a requirement that all authors have been accredited as appropriate under submission of the manuscript. Contributors who do not qualify as authors should be mentioned under Acknowledgements.

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2.2 Ethical Approvals

Research involving human participants will only be published if such research has been conducted in full accordance with ethical principles, including the World Medical Association Declaration of Helsinki (version, 2002 www.wma.net) and the additional requirements, if any, of the country where the research has been carried out. Manuscripts must be accompanied by a statement that the research was undertaken with the understanding and written consent of each participant (or the participant's representative, if they lack capacity), and according to the above mentioned principles. A statement regarding the fact that the study has been independently reviewed and approved by an ethical board should also be included.

All studies using human participants should include an explicit statement in the Material and Methods section identifying the review and ethics committee approval for each study, if applicable. Editors reserve the right to reject papers if there is doubt as to whether appropriate procedures have been used.

Ethics of investigation: Papers not in agreement with the guidelines of the Helsinki Declaration as revised in 1975 will not be accepted for publication.

2.3 Clinical Trials

Clinical trials should be reported using the CONSORT guidelines available at www.consort-statement.org. A CONSORT checklist should also be included in the submission material (www.consort-statement.org).

The *Journal of Applied Research in Intellectual Disabilities* encourages authors submitting manuscripts reporting from a clinical trial to register the trials in any of the following free, public trials registries: www.clinicaltrials.org, www.isrctn.org. The clinical trial registration number and name of the trial register will then be published with the paper.

2.4 Conflict of Interest and Source of Funding

Conflict of Interest: Authors are required to disclose any possible conflict of interest. These include financial (for example patent ownership, stock ownership, consultancies, speaker's fee). Author's conflict of interest (or information specifying the absence of conflict of interest) will be published under a separate heading.

The *Journal of Applied Research in Intellectual Disabilities* requires that sources of institutional, private and corporate financial support for the work within the manuscript must be fully acknowledged, and any potential conflict of interest noted. As of 1st March 2007, this information is a requirement for all manuscripts submitted to the journal and will be published in a highlighted box on the title page of the article. Please include this information under the separate headings of 'Source of Funding' and 'Conflict of Interest' at the end of the manuscript.

If the author does not include a conflict of interest statement in the manuscript, then the following statement will be included by default: 'No conflict of interest has been declared'.

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Submissions are now made online using ScholarOne Manuscripts (formerly Manuscript Central). To submit to the journal go to <http://mc.manuscriptcentral.com/jarid>. If this is the first time you have used the system you will be asked to register by clicking on 'create an account'. Full instructions on making your submission are provided. You should receive an acknowledgement within a few minutes. Thereafter, the system will keep you informed of the process of your submission through refereeing, any revisions that are required and a final decision.

4.1 Manuscript Files Accepted

Manuscripts should be uploaded as Word (.doc) or Rich Text Format (.rft) files (not write-protected) plus separate figure files. GIF, JPEG, PICT or Bitmap files are acceptable for submission, but only high-resolution TIF or EPS files are suitable for printing.

To allow double-blinded review, please upload your manuscript and title page as **separate** files.

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Original Articles, Review Articles, Brief Reports, Book Reviews and **Letters to the Editor** are accepted. **Theoretical Papers** are also considered provided the implications for therapeutic action or enhancing quality of life are clear. Both quantitative and qualitative methodologies are welcomed. Articles are accepted for publication only at the discretion of the Editor. Articles should not exceed 7000 words. Brief Reports should not normally exceed 2000 words. Submissions for the Letters to the Editor section should be no more than 750 words in length.

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Keywords: Up to six key words to aid indexing should also be provided.

Main Text: All papers should have a structured abstract (maximum 150 words) as follows: Background, Method, Results, and Conclusions. The abstract should provide an outline of the research questions, the design, essential findings and main conclusions of the study. Authors should make use of headings within the main paper as follows: Introduction, Method, Results and Discussion.

Subheadings can be used as appropriate. All authors must clearly state their research questions, aims or hypotheses clearly at the end of the Introduction. Figures and Tables should be submitted as a separate file.

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- Do not use the carriage return (enter) at the end of lines within a paragraph.
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Spelling should conform to *The Concise Oxford Dictionary of Current English* and units of measurements, symbols and abbreviations with those in *Units, Symbols and Abbreviations* (1977) published and supplied by the Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE. This specifies the use of S.I. units.

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- Emerson E. (1995) *Challenging Behaviour: Analysis and Intervention in People with Learning Disabilities*. Cambridge University Press, Cambridge.
- McGill P. & Toogood A. (1993) Organising community placements. In: *Severe Learning Disabilities and Challenging Behaviours: Designing High Quality Services* (Eds E. Emerson, P. McGill & J. Mansell), pp. 232-259. Chapman and Hall, London.
- Qureshi H. & Alborz A. (1992) Epidemiology of challenging behaviour. *Mental Handicap Research* 5, 130-145

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Paper 2: Empirical Report

Working with children with intellectual disabilities in residential care: staff views on challenges and support needs

Word Count: 6,998

Abstract

Background

A clear gap exists between policy and practice in residential care. Government initiatives overlook the daily challenges that staff face when supporting people with intellectual disabilities (ID). Additionally, training provided by multidisciplinary professionals, such as psychologists, is often experienced as unhelpful and difficult to apply. This study explores these issues within a large residential service for young people with ID.

Method

Semi-structured interviews were carried out with 10 staff members. Participants were asked about daily challenges and experiences of policies, training and contact with professionals. Template Analysis guided the development of themes.

Results

Three themes were identified: being able to do the job with fewer constraints, being supported and valued, and being seen and understood. Participants described a range of difficulties with applying theory from psychologists and policies or legislation.

Conclusions

Findings are discussed in terms of how theory can be more helpful to staff in their work.

Keywords: intellectual disabilities, residential care, staff experiences

Introduction

The government white paper 'Valuing People' (Department of Health, DoH, 2001) emphasised the importance of four key principles for people with intellectual disabilities (ID): rights, independence, choice and inclusion. However, people with ID continue to have greatly restricted choice and control in residential care settings (Antaki et al., 2009; Dunn et al., 2010; Jingree, 2015; Jingree & Finlay, 2013). Furthermore, people with ID can sometimes be subjected to punitive and abusive practices, which was the case at Winterbourne View (Flynn, 2012). Such abusive treatment has led to an emphasis on the importance of ensuring compassionate care for those receiving services (DoH, 2010) and this is an important responsibility for clinical psychologists and other professionals working in ID settings (Chamberlain & Davies, 2013).

The British Psychological Society (BPS, 2011) provided clear guidance for commissioners on what to expect from clinical psychologists in ID services and highlighted the unique contribution that these professionals can offer in terms of promoting choice and control for people with ID, playing a major role in assessments of capacity and best interest meetings and supporting staff to understand service users as individuals. Clinical psychologists also use approaches that aim to reduce restrictive practices in residential care, such as Positive Behaviour Support, which is recommended by the DoH (2014).

Supporting staff to apply relevant policy and theory is crucial to good practice and good outcomes for people with ID. However, research shows that applying theory and policy in practice is actually very complex (Whittington & Burns, 2005; Antaki et al., 2009; Dunn et al., 2010; Petner-Arrey & Copeland, 2014; Jingree, 2015). For example, despite clear drives towards choice and control (DoH, 2001, 2005, 2009), staff often struggle with conflicts between promoting choice and having a 'duty of care' to protect service users' safety and to promote appropriate behaviour (Jingree, 2015; Petner-Arrey & Copeland, 2014; Jingree, 2015). It can therefore be difficult to know what to do in practice (e.g. Whittington & Burns, 2005). When facing such dilemmas, it is likely that staff will adhere most closely to organisational drives (Antaki et al., 2009) or their own personal values and beliefs (Dunn et al., 2010).

In addition to difficulties with policy, studies show that staff also find psychological theory and recommendations difficult to apply. Staff tend to place high value on the relationship they have with service users and on their direct experience of working with them (Windley & Chapman, 2010; Bradshaw & Goldbart, 2013; Hutchinson & Stenfert Kroese, 2015) and consequently they value 'on-the-ground' experience over training initiatives and psychological theory (Bradshaw & Goldbart, 2013; Windley & Chapman, 2010; Hutchinson & Stenfert Kroese, 2015). Staff also learn through observing their colleagues (Monaghan & Cumella, 2009; Windley & Chapman, 2010; Bradshaw & Goldbart, 2013), whereas receiving advice from people who do not work directly with service users can be experienced as patronising (Bradshaw & Goldbart, 2013).

For clinical psychologists and other professionals to effectively support good practice in residential care, they need to understand the daily challenges that staff experience in their work (Chamberlain & Davies, 2013) including the issues they face with policy and theory. Without this understanding, support may be experienced as unhelpful and therefore recommendations will not be implemented and practice will be more open to subjectivity and abusive practices. In order to promote a skilled and competent workforce as recommended in *Valuing People* (DoH, 2001, 2009), it is important to understand the daily challenges and what support staff actually want, rather than providing support that is experienced as unhelpful. Research also needs to explore these issues in child ID services, since much of the literature relates to adult settings.

Aims

The present study aims to explore the views and experiences of child residential care staff in relation to daily challenges and their experiences of training, policy and contact with multidisciplinary professionals.

The central research questions are:

1. Do staff in child ID settings experience similar challenges with implementing policy and theory?;
2. What do staff see as important in terms of the support they need?

Method

Research setting

Participants were recruited from a large residential service in England. The service provides residential care and/or educational provision to children and adolescents aged between 6 and 19 years of age, all of whom have complex learning needs and/or autism. The first author was undertaking a placement at the service within an embedded psychology and therapies team. Ethical approval was obtained from the university ethics committee.

Recruitment

Recruitment involved advertising in the weekly newsletter and via email. This information consisted of a brief summary of the research, explaining that it was seeking the views and experiences of staff on their role and that it was part of the researcher's clinical training, external to their role at the service but which would also be shared with the organisation for service development. Staff were invited to contact the researcher for further information, at which point they were given full details of the study to consider. This consisted of a full information sheet (see Appendix A). Staff could then re-contact the researcher if they were happy to take part or if they wanted any further information. Immediately prior to each interview, participants were given another copy of the information sheet to read through and they were asked to sign a consent form (see Appendix B).

Participants had to have a minimum of one year's experience of working in residential care. The study was open to those working in directly supportive roles with the children, including care support workers, senior care support workers and team leaders. Care managers were also eligible to take part since care managers have almost always worked as support workers themselves and can therefore draw on their personal experience of the role and their experience of overseeing a high number of support workers. In this service, the care managers also had regular contact with the children.

Participants

Ten people took part; nine females and one male. Four of these were care support workers, three were more senior staff working directly with the children, and three worked in care management roles. Participants had worked in

residential care for between 1 and 36 years, with a mean of 12.5 years. Further demographic information is given in Table 1.

Table 1. Participant characteristics

Job Title	Care Support Worker						4
	Senior Care Support Worker						1
	Assistant Team Leader						1
	Team Leader						1
	Care Manager						2
	Director of Care						1
Gender	Male						1
	Female						9
Age*	Range						23 – 53 years
	Mean						33.3 years
Ethnicity	White British						9
	Black British/Jamaican						1
Years of experience in residential care	Range						1 – 36 years
	Mean						12.5 years
Total number of care services worked in	Range						1 – 10
	Mean						3
Educational Level* (number of people with these qualifications)	GCSE or CSE	O level	A level	Diploma	Foundat-ion Degree	Degree	Professio-nal e.g. NVQ
	9	2	4	2	1	3	7

* One participant chose not to state their age and educational level. The figures for these characteristics are based on the nine participants who did provide this information.

Procedure

Semi-structured interviews were carried out during participants' working hours. Interviews lasted between 18 minutes and 1 hour, 43 minutes, with a mean of 59 minutes; some interviews were shorter due to staff time constraints.

Participants were asked about their experiences of the role, training, policies and legislation, and contact with multidisciplinary professionals. An interview schedule is provided in Appendix C. Interviews were audio-recorded and transcribed by the researcher.

Analysis

The research and analysis were conducted from a contextual constructivist position (Madill et al., 2000), assuming that multiple interpretations are possible. Reflexivity was important throughout the research and a reflective diary was kept during the process. Reflections were also recorded and considered during coding and interpretation.

Template Analysis was used (King, 2012), which involves developing an initial coding 'template' based on both a-priori codes that are expected to be important, and initial themes identified from a small number of transcripts. The template is then developed as analysis continues, with the researcher adding and developing codes and rejecting ones that no longer fit the data. This type of analysis is considered to be helpful for applied research in real-world settings (Brooks & King, 2012).

An initial template was developed based on the interview questions and relevant literature and this was applied to the first two transcripts. As few codes as possible were included to promote openness to the data. After the first two templates were coded, the initial template was revised considerably. The remaining transcripts were then coded with the template alongside, revising it as necessary in accordance with the data. King (2004) argues that frequency does not tell us anything meaningful about textual data and therefore the template included both factors that were common across transcripts and factors that were particularly important to individual participants; frequency counts will not be provided. A clear audit trail was kept, saving each revised version of the template and documenting the process of analysis. The initial and final templates can be found in Appendix D.

Results

Three themes were considered to be central to participants' accounts:

1. Being able to do the job with fewer constraints;
2. Being supported and valued;
3. Being seen and understood.

These themes were closely related and some issues overlapped between themes. For example, staffing issues were reported both as a direct constraint impacting on their ability to do the job (theme one) and also as a factor that impacted on participants' sense of being supported and valued (theme two).

All names have been changed to preserve anonymity.

Theme 1: Being able to do the job with fewer constraints

A salient theme across participants' accounts was their desire to have greater freedom to interact naturally with the children. They described a range of daily challenges which interfered with their ability to do this, including the absence of resources and the presence of competing demands and conflicts in their work:

Isla: I would like to be able to do the job that I was recruited to do. I wouldn't want to be *fire-fighting* like I think that we are. I'd like us to have the resources to do what we need to do.

Issues with resources included not having access to vehicles or enough staff, which reduced opportunities to do activities with the children:

Samantha: It is having that support and that freedom to be able to do things... sometimes there have been situations where you've offered them something and you found out you can't do it because you haven't got a vehicle or something... and suddenly you're having to take that away.

Competing demands included having to attend meetings, send emails, attend to managerial duties and complete paperwork. Edward described a conflict between seeking to provide care and yet needing to spend time away from the children to evidence this via paperwork, as required by their regulatory body, Ofsted:

Edward: The biggest one would be paperwork... that's what absolutely gets in the way, needing to stop being with the child to go and write about what it was like to be with the child, it seems really mad.

Similarly, Jodie explained how policies and legislation impacted on her overall ability to care and be natural in her interactions with the children:

Jodie: I'd like it to be a bit more relaxed really, or that you can actually care. Sometimes that goes out of it I think, you know, 'cause there is so many policies, there's so many legislation and that you know it's kind of like you can't really be natural anymore. You have to make sure you don't say anything wrong, don't do anything wrong... you have to be really careful, which you are anyway, but it just takes that naturalness out of it.

Five participants viewed natural innate abilities as central to their role. Jennifer expressed her frustrations with Ofsted's emphasis on all staff needing to have qualifications; she felt that natural caring ability was more critical than qualifications and explained how this emphasis had led to experienced staff resigning:

Jennifer: We've lost some really good staff this week that haven't got level 3, they're older, they don't want to do the QCF... so we've lost a *valuable* asset for the sake of they've got NVQ 2... I just think that sometimes it's you've either got it or you haven't and you can have the paper qualification and not be able to care for these students because you haven't got a clue, whereas anybody could actually sit down and get a paper qualification but it's how they interpret it after...it's a *caring job*, you can do this job without a paper qualification.

Participants also felt that certain regulations conflicted with their duty of care. The most salient example was the issue of being unable to hold a door between themselves and a child when extreme challenging behaviour was displayed. This is considered a restrictive practice, not to be used without Deprivation of Liberty Safeguards (DoLS, 2009). Although staff conformed to the regulations, they found the reasoning difficult to understand because they viewed the alternative of physical intervention as more restrictive than door-holding and more distressing for the child:

Samantha: It's our duty of care to you know keep a child safe and not feel scared and if they're being held in a restraint all day, then surely that's like their anxiety is just going to go through the roof. Surely we should be able to offer them something else.

They also felt that these regulations were blanket strategies that failed to take into account the needs of individual children:

Edward: There should be a panel where an individual circumstance can be talked about... so a much more formulaic approach to OK here's a child that doesn't seem to be able to be managed by anybody without shutting a door and allowing you to be able to do this to look after them, so how do we fix this part of the legislation to accommodate that child... rather than people kind of very stubbornly going 'but that's not the regulation', in for that child that regulation is most unhelpful.

Linked with policies and legislation were daily challenges for staff in knowing what they should or should not do. For example, staff discussed boundaries and different opinions amongst staff about how they behaved with the children:

Mary: Being greeted with a hug, though I did get told that that was not the right thing to do... I didn't say anything at the time but I went away and I looked into it and had it confirmed that I was correct – that I can, because it's not the chronological age of the child, it's the developmental stage and age.

Participants also described being fearful of doing the wrong thing and getting into trouble due to a spate of safeguarding issues:

Misha: I worry all the time, like I was with George the other day and we were in a restraint and I caught him with my ring, and then I was paranoid. I thought I need to check the back of his leg in case I've marked him, and you go home thinking 'oh god'... you can get in terrible trouble for so much here, like you put a foot wrong.... you just worry about what if you're doing the right thing and if you know sometimes you get confused well am I meant to be doing, am I meant to be doing this or... and it's just draining.

Norma described how this impacted on the children and the care they received, with staff being afraid to be away from them:

Norma: They're kind of stuck to them like glue, they're not giving a child time to breathe, because they're so scared of if there's an incident because then they'll get told off because you're on two-to-one and why has he had an incident.

In judging what was right and wrong, participants referred to policies and managers but also talked about doing the right thing for the child, making a moral decision, which often involved thinking about how they would like to be treated or how they would like their child to be treated:

Misha: Staff down there had been told not to let Mohammed sleep in the day, but he'd been up from one o'clock... staff weren't meant to allow him to go back to bed but well it's his human rights if he's tired, you can't keep him up, it's like abuse... if that was my child and they were tired I'd allow 'em to go to sleep no matter what time of the day it was.

Theme 2: Being supported and valued

Central to all participants' accounts was the need to feel supported and valued; this was related to the emotional impact of working in residential care:

Norma: I've had some really difficult times with this job, I've been *hurt* physically, emotionally, but I think if you feel *valued, supported*, it's a lot easier.

Having a supportive team was considered to make a huge difference to both the staff and the children:

Anita: But they *do* care up here... it makes a difference to the kids as well, you know, their quality of life's better, they're not as anxious.

Jennifer: Some of the other houses have got far more difficulties than we've got on *here*, but I think we have less difficulties *because* the way the team works.

Supporting each other was linked with learning from colleagues, through observing, seeking their advice and adopting aspects of their practice:

Isla: If they've led on something and the outcomes have been really *positive*... I'll say to them 'god you managed that really well' and I will take that away, think about it and perhaps even use those skills that I've observed.

However, Norma described how it was difficult to have a supportive and consistent team due to the staff being frequently moved to cover on other houses:

Norma: I don't think teams can gel, I think we're always in that norming, storming, forming because they're moved around so often.

She also felt that staffing issues led to staff members feeling devalued:

Norma: Because we're an organisation and 'cause of cost, they'll send staff all around the place but that doesn't make them feel valued.

Participants also talked about how low pay and low expectations contributed to feeling devalued:

Norma: We've got a lot of care workers that are paid fifteen grand, not expected to do medication, not expected to key-work, yet they- they're the people on the floor working with the kids... some of them support workers could have been here for three years and actually they're a valued member of staff... but they're not going to access the training that everybody else does because they're only a care worker.

Participants emphasised their knowledge of the children and the relationships they had with them. However, they did not feel that their expertise was valued despite the fact that they knew the children well and worked with them every day. They described issues with communication and not being involved in decision-making:

Lucy: How often can a care support worker come to a [team around the child: TAC] meeting? It's at times where we can't facilitate that... and actually very little of that trickles down to house, that's all people sitting in an office somewhere... while we have no idea what's going on and we're the people who are hands-on every day.

Mary: I think sometimes, and I've actually said this to my team leader, that sometimes I feel undervalued and – what was the other word I used – because I'm bottom of the pile... people talk, they have meetings, I know there's things I'm not involved in or whatever, but it's all team around the child so I think we should all be included and things that I do with the students sometimes they don't see because they are in meetings.

Participants also felt devalued by psychologists and felt they overemphasised their qualifications. They expressed that psychologists sometimes imposed suggestions without involving them and that they needed to work more collaboratively to combine their expertise:

Misha: I felt like I was getting from 'em 'well I've got the degree, I've got the qualifications'... 'we know best' kind of thing and it's like yeah fair enough you've got all the theory and that and you know you've got to have experience but you need to listen to the care staff. You need to like don't undermine us, like listen to us, because we do know 'em better, I mean we spend day-in day-out with them, we know how they work... you know combine our- what we're saying, our experiences with yours and then work together that way.

Theme 3: Being seen and understood

Participants referred to a need for others to see the daily issues in order to understand the difficulties they faced:

Lucy: You can sit up there and say it's not too bad but when you're going home and you've got, you know, black eyes, cracked ribs, you've got the bruises, you're telling me it's not too bad... and it's very nice getting the 'you're all doing very well' email every now and then but actually come down to house and see what we're doing.

They also felt that Ofsted did not see and understand daily practice issues and therefore their regulations were unhelpful and unrealistic:

Jodie: Yeah sometimes you know it's somebody from above somewhere saying 'oh that shouldn't be done', 'that shouldn't be done', 'that shouldn't be done', whereas in practic- practically you know it's very different isn't it.

Anita: I don't feel Ofsted understand our children's needs to be honest, / *really don't*... as a parent I would not want my son or daughter to be held bodily to the floor by eight men for over an hour sometimes. I'd, you know, rather they're in a safe space in their room so they can just calm down, ten minutes later they're calm they come out.

Participants also felt that the psychologists working with them needed to see the children and the daily issues in order to understand. They argued that other sources of information would not lead to the same understanding:

Lucy: You're not gonna get the understanding of him. You can come in and say 'are you OK George', have a day like 'yeah fine great thank you' and have a day where he can't- he's so low that he can't even look at you... unless you see that, unless you are physically there and see it, you can read all the reports you like, you're not gonna have any understanding of it...

Without seeing and understanding, it was felt that support and advice would be unhelpful. Participants felt that psychologists suggested what they were already doing, as well as things that would not work with particular children, and things that were not practically possible:

Anita: We all kind of felt it was kind of being taught to suck eggs by someone who wasn't seeing the kids. You know if you're not going to spend time with the child, don't try and tell me how to- you know if they spent time with them, fair play, you know, say if they could say from that incident I saw I've taken this and this is what I suggest different or you know that would be fair enough... it's just that you know see it, at least see it.

Isla: Some of the strategies that come back aren't achievable if there is like 'well so and so needs to have two-to-one to go and do this and we need to increase this'. Well that's great and would be lovely in an ideal world but realistically they're not funded two-to-one and we can't identify that as a strategy if somebody's not got the resources at this present time to do it.

In addition to wanting to be seen and understood, there was a sense of wanting to see things themselves to understand the role these things could play. For example, participants talked about psychologists needing to be visible to themselves and the children:

Jennifer: It'd be nice a bit for them to be more visible to the students. We get quite a lot of input with speech and language and [Occupational Therapy]. We see quite a lot of them because they do specific sessions... it's not often that we see the psychologists unless meetings are set up.

Edward discussed how staff experiences of psychologists and therapists might have been related to proximity and the fact that the therapy offices were located at the top of the main building, far away from staff:

Edward: I also thought about where [psychology and therapies] is located in the building and how many people walk up the stairs... I wonder how much unconscious messages are going to the teams about being unapproachable... one of the things that is constantly said is it's really good to see you and, you know, it's funny how it's said – it's not about 'thanks for visiting'... it's very much the wording, it's good to see you... and the further away from the work, the children, the people who need that support, the further you are away from those, the less visible you appear to them, and therefore it might be really hard to hold you in mind.

He also referred to the work of psychologists and therapists being unseen in terms of a focus on abstract ideas:

Edward: We often deal with the unseen, what's communicated on an unconscious level and a subconscious level if you like, and people find it really hard to hold on to...because it's not always a tangible labelled piece of equipment that people can go 'there it is'.

Similarly, participants talked about valuing tangible resources:

Jennifer: Speech and language we've *always* supported because they take the time to put things in place... when they opened the café, they do [the organisation's shop], and I think if people are putting those things in place for ours and the students' benefits and it makes such a difference to have that facility that yeah we embrace all those things.

Samantha: [The psychologist] done like a family kind of timeline with the parent, so they'd then learnt a lot from the family and that it all linked... and we were given an actual family tree that had been created as well so that was really great.

Finally, participants also valued seeing and experiencing in order to learn, preferring to learn from observing their colleagues, experiencing and doing or being shown:

Norma: Somebody will say well that information's on the care drive or whatever but you can read it and it goes right out your head can't you whereas if somebody's showing you, more likely to stick in.

Discussion

This study aimed to explore the experiences of staff working in residential care with children with ID. Specifically, the aim was to identify whether or not staff in these settings experience the same daily challenges with implementing policy and theory from multidisciplinary professionals in their work (e.g. Dunn et al., 2010; Bradshaw & Goldbart, 2013). Further, a second aim was to identify what is important to staff in terms of their support needs. Three key themes were found to be important to this sample of staff members: being able to do the job with fewer constraints, being supported and valued, and being seen and understood. Participants discussed a range of issues with implementing policy and theory. These will now be discussed in relation to the wider literature. As this study was grounded in practice issues, implications for practice will be discussed throughout.

Working in residential care is inherently challenging due to the emotional and physical demands of working for long hours with vulnerable people. However, in addition to these challenges, participants in this study described a range of other issues that made the job more stressful and restricted what they could do with the children. One of the main issues was staffing difficulties, including not having enough staff and being allocated staff that were not appropriately trained or familiar with the children. Due to the challenging nature of the work, recruiting and retaining staff can be difficult and this is an issue in both child and adult settings

(Department for Education, 2015; Care Quality Commission, 2015). More work needs to be done around recruitment and retention and preventing staffing difficulties. A report published by Skills for Care (Ekosgen, 2013) suggested that employers need to be mindful of ensuring that workers have realistic expectations at recruitment and that services need to consider ways of improving the working hours, shift patterns, training and communication systems in order to retain staff.

Ofsted's requirement for staff to evidence their practice through paperwork was also cited as something which took staff away from the children. Paperwork is also experienced as inconvenient in adult settings and regulatory bodies can sometimes be the sole reason for its completion, including with personalised plans for service users (Monaghan & Cumella, 2009). It might be beneficial to find more creative and convenient ways of documenting such as through the use of videos or photographs, although consent would need to be obtained.

Regulations were also perceived to conflict with how staff viewed their role. Some expressed the view that the role requires natural caring ability and should not require qualifications. Studies have found a similar preference for direct experience and natural qualities over training and theory in adult ID and dementia settings (Windley & Chapman, 2010; Bradshaw & Goldbart, 2013; Hutchinson & Stenfort Kroese, 2015; Smythe, et al., 2015). This has implications for psychologists and training providers as this belief may lead to less value being placed on what they have to offer and ultimately theory not being applied in practice.

As with the adult literature, participants in this study also described conflicts they faced in relation to policies and legislation and competing duties. Regulations relating to DoLS (2009) and the Mental Capacity Act (DoH, 2005) around not being able to hold a door between themselves and the child were seen as conflicting with their duty of care, since the alternative of restraining somebody could be distressing for the child. Adult studies have shown similar conflicts, such as that between promoting choice and having a duty of care to protect service users' safety and to promote appropriate behaviour (Antaki, et al., 2009; Petner-Arrey & Copeland, 2014; Jingree, 2015). Participants in this study believed that regulations should be more flexible and judged on an individual basis for each child. Similar arguments have been made in adult studies (Dunn et al., 2010).

Similarly, participants faced daily challenges in knowing what to do and being afraid of doing something 'wrong'. These issues were exacerbated by the fact that several safeguarding issues had been reported in the organisation. This was associated with stress and low morale. Participants drew upon moral decision-making, considering their personal values and how they would like to be treated. This echoes the findings of Dunn et al. (2010) who reported that staff similarly made decisions based on personal comparisons and values. As Dunn et al. highlighted, policies and legislation often do not reflect the realities of daily practice and moral aspects of the role. Whilst making moral judgements is open to a high level of subjectivity and inconsistency, working in care is highly relational in nature and therefore dependent on flexibility and intuitiveness as well as rules and boundaries. Rather than dismissing this, it might be more appropriate to enhance the utility of staff judgements by having ethical codes or frameworks that staff could use to guide their thinking. Ethical frameworks are often drawn on in psychology and other interpersonal professions.

Additionally, services need to be aware of the impact of safeguarding issues on staff stress and morale, providing containment and learning opportunities around these issues rather than increasing fear of blame. Having regular time to reflect on practice is an important preventative strategy, since staff can consider and address practice issues before they become safeguarding concerns. Psychologists are well-equipped to facilitate this. The use of video-recording has been suggested as one way in which staff members are able to critically reflect on their practice (Antaki et al., 2009; Finlay et al., 2008).

Being supported and valued was important to all participants in this study. Due to the emotional impact of working in care and the impact that this can have on their practice (e.g. Hastings, 2002), staff need to be supported to practice emotional regulation techniques and self-care. Stress management training has been identified as important to staff working with adults (Windley & Chapman (2010) and such training should equip staff with the tools they need to cope. Supervision is also important (e.g. Monaghan & Cumella, 2009) and psychologists could play a role in enhancing the quality of this supervision through working with care managers and supervising or training them to provide more reflective emotion-focused supervision. Other ways of supporting staff include ensuring they have appropriate staffing and consistent teams, promoting collaborative working

with senior staff and professionals, and making time for regular team meetings, away days and team-building activities, as suggested in adult studies (Monaghan & Cumella, 2009; Hutchinson & Stenfert-Kroese, 2015).

Having supportive, collaborative relationships with colleagues and managers was important to the staff in this study and these findings echo those in the adult literature which show that colleague relationships have a significant impact on staff practice and morale (e.g. Hutchinson & Stenfert-Kroese, 2015). Participants also cited observing and seeking advice from colleagues as a key source of learning, which again reflects staff in adult settings (Bradshaw & Goldbart, 2013; Windley & Chapman, 2010; Monaghan & Cumella, 2009). It would be beneficial for employers, psychologists and training providers to utilise this and encourage staff to model and explain approaches to their colleagues.

Relating to being supported, participants described feeling devalued by psychologists and therapists. Adult studies have shown that staff value 'on-the-ground' experience and relationships with service users over theory (Windley & Chapman, 2010; Bradshaw & Goldbart, 2013; Hutchinson & Stenfert Kroese, 2015) and this was also the case for the participants in this study. In addition to issues with theory, participants felt that psychologists over-emphasised their qualifications and this led to a battle of expertise between staff and psychologists. These findings suggest that in order for staff to value psychological input, they need to feel valued themselves and to be involved in collaborative working.

Participants also expressed the belief that psychologists and other professionals need to see things in order to get a true understanding of them. They did not feel that reading reports or speaking with staff led to sufficient understanding. With the increasing focus on the provision of consultation and advice to staff teams (e.g. Green, et al., 2013), clinical psychologists often seek to develop an understanding through talking with staff and asking staff to complete measures and recordings. However, staff might not view this as helpful due to their emphasis on seeing; such processes might therefore be viewed as wasting their time and subsequently staff will be less inclined to complete recordings with accuracy. Whilst psychologists often carry out observations to supplement their understanding, spending a large amount of time inside care homes is difficult due to high caseloads. Psychologists are also expensive professionals and this might not be viewed as the best use of their time. However, without this, it is unlikely that

psychologists will have credibility to care staff, and therefore time may be wasted anyway in making suggestions that will not be implemented. Psychologists therefore need to consider ways of increasing their presence in residential services. One option might be having allocated regular slots where psychologists visit the home. Alternatively, more assistant psychologists could be employed to spend allocated time in the houses.

Similarly, issues of proximity were discussed and the location of the psychology office is an important consideration, particularly in an organisation that employs its own psychologists. Having an office at the very top of a building or at the far end of the site might have implications for how visible and approachable psychologists seem. Furthermore, psychologists may be 'unseen' due to the way they work, dealing with abstract ideas around thoughts and feelings, and using skills to encourage people to reflect and come up with their own ideas. Such ways of working are unlike those employed by other professionals such as speech and language therapists and occupational therapists who often provide tangible resources for staff to use. Psychologists need to find ways of making their work more visible, drawing on seeing and experiencing rather than holding things in mind. The use of tools like timelines and family trees appear to have greater impact on staff, as highlighted by 'Samantha' in this study. Training and suggestions should also draw on experiential learning and showing or modelling, which participants valued.

Lastly, participants also felt that Ofsted or the actual policy-makers needed to see the issues they faced in practice in order to understand the reality of why certain regulations might be difficult or unrealistic in practice. This links with points made earlier about a need for policies and legislation to be more flexible and to take into account the dilemmas and challenges that staff members face in their work.

Limitations and issues of reflexivity

The findings of this study are limited to one particular service and might therefore be unique to the particular culture of this organisation. This service also had its own embedded psychology and therapy department and different findings might have emerged in services that receive external support. Additionally, the issues discussed may not be representative of those staff members who did not volunteer to take part. However, many parallels have been found with the adult literature, which suggest that these issues do arise in other services.

The researcher's influence is another important consideration. As they were working within the service, their involvement might have affected both what participants were willing to say and how it was interpreted. This is something that was continually reflected on throughout the process, through completing a reflective diary after interviews and recording reflections during analysis. Having a deeper understanding of the issues that staff discussed may also have enhanced the research.

The researcher was aware of having a particular interest in people's experiences of psychology and this could have impacted on their interpretation. They reflected on this continuously and ensured that they covered all topics on the interview schedule equally and that they were not over-encouraging of responses relating to psychology. The researcher continually reflected on their impact on participants and on their interpretation. One issue that the researcher noticed whilst coding the transcripts was that they had not responded with follow-up questions about an issue that had been mentioned by one participant. This participant expressed the view that psychiatric support and medication would be more beneficial for children than psychological support. This is something that the researcher strongly disagrees with because of their position as a psychologist. They noticed that due to this discomfort, it had not been followed up with further questioning, which may have prevented further insight into the participant's views and experiences. The researcher ensured they spent adequate time reflecting on this and in thinking carefully about interpretation so that the information the participant gave was not ignored.

Areas for future research

Future research would benefit from service evaluations or studies that illustrate good working relationships between psychologists and care staff and give examples of what works in practice.

Additionally, beliefs about whether or not you need to see something to understand it might differ amongst other professionals, particularly psychologists who often work with abstract ideas and approaches. Even when working therapeutically in one-to-one therapy, psychologists rarely ever see the issues a client talks about. Further research could explore differences in these beliefs.

Conclusion

This study aimed to explore the experiences of staff working in residential care for children with ID, and to consider how theory from psychologists, policies and training can be more helpful. Template analysis identified several important issues for staff, which were all underpinned by a need to be able to do their job with fewer constraints, to feel valued and supported and to be seen and understood. Many parallels were drawn with the adult literature, suggesting that similar challenges are experienced. The findings suggest that for theory to be useful to staff, policies and legislation need to be more flexible and to be based on a deeper understanding of the daily challenges and the importance of relational and moral aspects in the work. Furthermore, for psychological theory and interventions to be valued and supported by staff, psychologists need to show that they value the expertise of staff and promote more collaborative working. Participants also expressed a clear belief that those providing theory and support cannot truly understand staff issues unless they see and experience them. Psychologists therefore need to be mindful of this belief and find more effective ways of working with staff.

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Appendix A:
Participant Information Sheet

Staffordshire & Keele Universities

Doctorate in Clinical Psychology

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Experiences of the Residential Support Worker

A Research Study Information Sheet (February 2016, v2)

The Research Study:

The aim of this study is to gain a better understanding of what residential support workers draw on to help them in their work. We know that working in these settings can be very challenging. Psychologists and other professionals often provide advice and support to staff and service users, but they might not always fully understand the daily challenges that residential workers face. This might mean that their suggestions are less helpful than they could be and advice may just not work out in practice.

Through exploring the views and experiences of people in these positions, we can get a better understanding of the daily challenges. It is hoped that this will lead to ideas about how psychologists and other professionals can provide support that is more helpful and beneficial to staff and service users.

Why am I being invited to take part?

You are being invited to take part in this study because you work in a residential service with children who have autism and/or learning disabilities. We are interested in your views and experiences of this role.

What will the study involve?

This study will involve being interviewed by the researcher. They will interview approximately 10-14 staff members individually. They will ask questions about what you do and what the role is like for you personally. This will be a semi-structured interview, meaning that the researcher will have some key areas/questions written down to discuss but that they will also ask other questions as follow-up questions to your responses. Each interview will be carried out in a quiet space in the home that you work in or in an alternative discrete location at [RESEARCH SITE]. It should last no longer than one hour.

What will I have to do?

If you choose to take part in the interviews, you will be asked to spend around an hour with the researcher, talking about your experiences and answering some questions. The interview will be audio-recorded.

Do I have to take part?

No, you do not have to take part; it is your decision.

What happens if I change my mind?

If you change your mind and decide you do not wish to take part, please let the researcher or your manager know. The researcher will no longer interview you. They will also destroy any data they have relating to interviews with you if you wish. If you do change your mind, please let the researcher know so that they can do this for you.

How will my information be kept confidential?

Everything you say to the researcher or in the presence of the researcher will be kept confidential. The researcher will not repeat anything to your manager or anyone else. The only exception to this would be if the researcher was concerned about the safety or well-being of a staff member or service user.

This is an external research project that is separate from the researcher's work at [RESEARCH SITE]. However, it will be useful to feed back the findings to the operational leadership team (OLT) as it may also help them to consider ways of supporting staff. Please be assured that the OLT will **not** be made aware of which people have taken part or who has said what. Similarly, the psychology and therapies (P&T) team will not be told what people have said and your involvement in this research will in no way affect the support you receive from P&T.

The researcher will store all information in a locked filing cabinet and on a password-protected encrypted laptop. They will not store personal information like names and contact details.

Why are you doing this research?

The researcher is carrying out this study as part of their training in clinical psychology. They are completing a Doctorate in Clinical Psychology and research is an important part of this. The researcher has chosen this particular topic because they have a special interest in learning disabilities and supporting staff in residential services. They have personal experience of working in various roles in a residential

service, including the role of support worker, and they would like to contribute to knowledge in this area.

How will this benefit me?

There will probably be no direct benefit to you personally, but it is hoped that this research will provide an understanding of the role of support worker so that professionals and researchers can have a better idea of how to support people in residential services.

What are the disadvantages of taking part?

If you were to take part in the interviews, this would involve you giving up some of your time. The interview might take up to one hour. Talking about your job and personal experiences might also be difficult or demanding. However, you would not have to talk about anything you felt uncomfortable with.

It must also be noted that if the researcher were to hear about any practice that concerned them with regards to the safety or well-being of service users, they would have to report this to the home manager. Please be assured that this would not be done lightly and the researcher aims to work with you rather than against you. However, the service users' well-being is most important and therefore this risk must be considered.

What will happen when you have interviewed?

The researcher will transcribe all interviews and then look for themes across what people have said. The researcher will use quotes as examples of what they found. Any identifiable information will be removed or changed so that data is anonymous. Any names will be replaced with pseudonyms.

The researcher will write up what they have found so that this can be submitted both to their university and also to an academic journal for publication. If the research gets published, this will mean that it will be in the public domain and may be used to improve support to staff members in residential services. Findings might also be presented at conferences or similar events if appropriate. Data will be stored for 10 years at Staffordshire University.

Who is funding this study?

This study is being completed as part of the researcher's doctoral training in clinical psychology. The researcher is employed by the NHS but also attends Staffordshire and Keele Universities. This study is being carried out in partnership between the NHS and the Staffordshire and Keele Doctorate in Clinical Psychology programme.

I have another question but it's not on here. Who do I contact?

If you have any questions, please contact the researcher, Abbye Andrews. See contact details below.

Abbye Andrews, Trainee Clinical Psychologist

E-mail: [\[RESEARCHER'S EMAIL ADDRESS AT RESEARCH SITE\]](#) OR a030767c@student.staffs.ac.uk

Address: Staffordshire and Keele Universities Doctorate in Clinical Psychology
R101, Faculty of Health Sciences, Staffordshire University, Science Centre, Leek Road,
Stoke-on-Trent, ST4 2DF

Telephone number: [RESEARCH SITE PHONE NUMBER AND RESEARCHER'S EXTENSION] Or university number 01782 294007 (please leave a message).

You can also contact **Dr. Helen Combes**, who is a Clinical Psychologist who is supervising this project. She can be contacted via the address or telephone number given above. Alternatively, her email address is h.a.combes@staffs.ac.uk.

Appendix B:
Participant consent form

Staffordshire & Keele Universities

Doctorate in Clinical Psychology

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CONSENT FORM

Title: Experiences of the residential support worker

Name of Researcher: Abbye Andrews

Please
initial box

- I confirm that I have read the information sheet dated February 2016 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐
- I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐
- I give my consent to be interviewed by the researcher about my experiences. ☐
- I give my consent for the researcher to use anonymised quotes from what I have said during the interview in the write-up of the study. ☐
- 6. Please initial if you would like to receive details about the findings of this research once it is complete. Please give an email or postal address below for the information to be sent to: ☐

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

Appendix C:

Interview schedule

Opening

Thank you for agreeing to take part in this study. As you are aware, the aim of this research is to gain a better understanding of what people draw on to help them in their work in residential care. I am interested in your experiences of your role and the things you see as important for doing your job. I would also like to know about your experiences of receiving support and training from other professionals and how this could be more helpful for you.

I will be recording this interview on the audio recorder so that I can transcribe it and look for themes along with the other interviews that I will be conducting. I expect this interview to last no longer than one hour, but if you would like to stop at any time please let me know. I'd also like to assure that you don't have to answer anything that you don't want to.

Please be as honest as you can. Everything you tell me will be treated confidentially.

Are you ready to start?

Interview

A) The role

1. So firstly I'd love to hear about your role as _____. What would you say are the best things about your job?
2. And what would you say are the worst, or least positive aspects?
3. What are the main challenges or difficulties that you face in your role? (what do you find most difficult personally?)

4. And what would you say are the challenges, if any, that prevent you from being able to do your job as well as you might like?
5. In your opinion, what are the skills or qualities that you need to be able to do your job?
6. Thinking about your colleagues, what do you notice in those that you admire or respect? What is it about them that makes them good at their job?)
7. I'd like you to think about what influences you when doing your job day-to-day – who or what influences you. What things do you draw on to help you do your job?
8. And what things do you draw on, or see as important, for *learning* in your role?
9. If things could be better in your role, what would be different?
 - If you had a perfect day at work, what would you notice that was different to another day?
 - Is there anything you think that would help you, in the past, or currently, to carry out your job more easily or do the parts of your job that are difficult?

B) Contact with professionals like psychologists and therapists

10. What are your experiences of contact with psychologists and other multidisciplinary professionals, such as occupational therapists, speech and language therapists or emotional therapists?

- *What have you found helpful?*
- *What have you found unhelpful?*
- *Were the suggestions easy to use in practice?; If not, why not?*
- *How did you feel about the advice/suggestions?*

11. What are your views and experiences of reflective work with psychology?

- *Is this helpful in your work?*
- *What has been helpful?*
- *What has been unhelpful?*
- *How useful would it be to have time away from house to think about your work with others in your team? (with or without psychology)*

12. What would you like to see from future contact with psychologists and other professionals? (How could they be more useful?)

C) Training

13. Now I'd like to hear about your experiences of training. Could you tell me about the training you have received and how this has been for you?

- *How much have you had? How helpful has it been?*
- *What have you found helpful?*
- *And what have you found unhelpful?*

- What are your experiences of using things from training in your day-to-day work?

14. What would you like to see in future training sessions?

D) Policies and legislation

15. How important are policies and legislation in your day-to-day work? To what degree to these influence your practice?

16. What are the barriers, if any, to applying policies or legislation in your work?

17. How could these things be more useful or accessible?

Closing

18. Lastly, is there anything else you would like to say about any of the issues we have discussed or anything else that you feel is important?

That's all of the questions I have for you. Thank you so much for your time and for sharing your views and experiences with me. Do you have any questions for me?

Appendix D: Part 1. Initial Template version 1

This template included a-priori codes based on the literature and interview schedule

Initial Template

1. Experiences of the role

1. Positive aspects of the role
 - Enhancing quality of life

2. Challenges

- Challenging behaviour
- Emotional impact
- Constraints/things that get in the way

3. Relationships



- With the service users (children)
- Support from colleagues and managers
- Power dynamics
 - Feeling empowered or powerless in relationships with managers and colleagues
 - Empowering or disempowering service users (children)
 - Boundary issues with service users (children)

4. What is needed to do the job well

1. Personal qualities
 - Natural ability to care
 - Values

- Specific qualities
2. Support
 - Collaboration and involvement
 - Feeling valued
 - Support from managers
 - Support from colleagues
 3. Practical issues/resources
 - Access to material resources (e.g. transport)
 - Staffing

5. Contact with psychology and other multidisciplinary professionals

-  Knowing the service users (children)
-  Applicability/relevance to practice

6. Training

1. Applicability/relevance to practice
2. Need for more training

7. Policies and legislation

1. Applicability/relevance to practice
2. Dilemmas and conflicts

Appendix D: Part 2. Initial Template version 2

This was developed based on the initial template version 1 and the first two participant transcripts, to be used as the template to apply to further transcripts

1. Positive aspects of working in care	1.1. Having a positive impact on the children	1.1.1. Seeing the children progress
	1.2. Enjoyment of working with children	
	1.3. Manager-specific experiences	
2. Challenges	2.1. Challenging behaviour	
	2.2. Constraints/things that get in the way of doing the job	2.2.1. Staffing issues
		2.2.2. Competing demands
		2.2.3. Not having enough time
	2.3. Inconsistency and differences between departments	
	2.4. Knowing what's right and what's wrong	
3. Relationships	3.1. Relationships with the children	3.1.1. Parenting and nurturing
		3.1.2. Knowing the children
		3.1.3. Interacting on the child's level
	3.2. Relationships with colleagues	
	3.3. Relationships in the context of P&T (Discuss under P&T but keep here also)	3.3.1 With the children
		3.3.2 With the staff team
4. Emotions	4.1. Impact of the work on emotions	
	4.2. Impact of emotions on the work	
	4.3. Being in control of your emotional well-being	
	4.4. Personal lives have an impact	
5. What staff bring to the role	5.1. Natural innate qualities	
	5.2. Specific skills and qualities	
	5.3. Making personal comparisons	

Continued overleaf...

6. Contact with psychology and therapists	6.1. Relationships	6.1.1. With the children - Knowing the children - Seeing them and their behaviour in different settings
		6.1.2. With the staff - Working collaboratively, as a team - Understanding the daily issues - Issues of status, respect and equality - Blame
		6.1.3. One-off work is unhelpful
		6.1.4. Spending time in the houses
	6.2. Expectations	
	6.3. Inconsistency/unfairness	
	6.4. Proactive versus reactive support	
	6.5. Applicability of suggestions	
	6.6. Reflective sessions with psychology	
	6.7. Positive experiences	
	6.8. Other factors impacting on quality of support	
7. Learning	7.1. Sources of learning	7.1.1. Learning from experience
		7.1.2. Learning from colleagues
		7.1.3. Independent learning
		7.1.4. Training
	7.2. Factors affecting the application of learning	7.2.1. Individual choice and openness to change

		7.2.2. Whether or not the skills and learning are used and practiced
		7.2.3. Interest and enjoyment
		7.2.4. Whether or not training is a one-off or on-going
	7.3. Other issues with training	7.3.1. Having to repeat training
8. Policies and legislation	8.1. Importance	
	8.2. Difficulties with policies	8.2.1. Accessibility
		8.2.2. Formality

Appendix D: Part 3. Final Template

This is the final template, following many successive revisions of the initial templates

Final Template

First-Order Codes	Second-Order Codes	Third-Order Codes
1. Positive aspects of working in care	1.1. Having a positive impact on the children	1.1.1. Seeing the children progress 1.1.2. Making a difference 1.1.3. Having relationships with the children 1.1.4. Seeing the children happy
	1.2. Enjoyment of working with children	
	1.3. Manager/team leader-specific experiences	1.3.1. Working with staff teams 1.3.2. Having an overview of the organisation
	1.4. Gaining reward out of challenging work	
	1.5. Trying new things	
	1.6. Positive aspects about the work place itself	
2. Challenges	2.1. Challenging behaviour	2.1.1. Being physically hurt 2.1.2. Being emotionally hurt 2.1.3. Impact on activities
	2.2. Constraints/things that get in the way of doing the job	2.2.1. Staffing issues 2.2.1.1. Not having enough staff - Sickness/absences/staff retention - Staff having to cover elsewhere 2.2.1.2. Not having the right staff: - Staff who don't know the children - Staff who need supervision/extra support, e.g. people on risk assessment - Lack of male staff - Young and inexperienced staff - Unconfident staff - Staff who the children target - Staff who are not appropriately trained in physical intervention 2.2.1.3. Having too many staff 2.2.1.4. Too many staffing levels 2.2.1.5. Not being able to build a consistent Team 2.2.2. Competing demands

		2.2.2.1. Paperwork and emails
		2.2.2.2. Meetings
		2.2.2.3. Managerial duties
		2.2.3. Not having enough time
		2.2.4. Access to vehicles
	2.3. Inconsistency and differences	2.3.1. Different approaches across the organisation
		2.3.2. Conflict between different departments
	2.4. Knowing what's right and what's wrong	2.4.1. Knowing what to do
		2.4.2. Different opinions about what is right and wrong
		2.4.3. Boundaries and appropriateness
		2.4.4. Fear and blame
		2.4.5. Checking what is correct
		2.4.6. Doing what's right for the child
	2.5. Pressure	
	2.6. Long hours and few breaks	
	2.7. Communication issues	2.7.1. Care support workers do not receive information
		2.7.2. Lack of communication within teams
		2.7.3. Negative messages spread across site
	2.8. Finances	2.8.1. Low pay
		2.8.2. Organisational finances
	2.9. Low status and value placed on staff	
	2.10. Low morale	
3. Relationships	3.1. Relationships with the children	3.1.1. Parenting and nurturing
		3.1.2. Knowing the children
		3.1.3. Interacting on the child's level
	3.2. Relationships with colleagues, seniors and wider staff	3.2.1. Support is important
		3.2.2. Being a team
		3.2.3. Respect and involvement versus feeling devalued
	3.3. Personal relationships and support networks	
4. Emotions	4.1. Impact of the work on emotions	4.1.1. Children's emotions impact on staff emotions
		4.1.2. Strong feelings for the child (and their parents)
		4.1.3. Impact of challenging behaviour
		4.1.4. Work spilling over into personal life
		4.1.5. Emotional impact of other aspects of the job
	4.2. Impact of emotions on the work	4.2.1. Impact of low morale and not feeling safe
		4.2.2. Impact of emotions relating to the children
		4.2.3. Children pick up on staff emotions
	4.3. Being in control of your emotional well-being	4.3.1. Using techniques in your work
		4.3.2. Seeking support
		4.3.3. Taking time to think rather than being reactive
		4.3.4. Having a work-life balance
		4.3.4.1. Switching off on days off
		4.3.4.2. Self-care and enjoying yourself outside of work
	4.4. Personal lives have an impact	
5. What staff bring to the role	5.1. Natural innate qualities	
	5.2. Specific skills and qualities	5.2.1. Being calm and confident
		5.2.2. Caring and relational qualities
		5.2.3. Supportive and trustworthy

		5.2.4. Coping skills
		5.2.5. Motivation
		5.2.5.1. Child-centred, in it for the right reasons
		5.2.5.2. Seeing the role as a career not a job
		5.2.6. Thinking skills
		5.2.7. Energy and stamina
		5.2.8. Personality: sense of humour and being fun
		5.2.9. Good at paperwork, evidencing, report-writing and key-working
		5.2.10. Leadership and management skills for seniors
	5.3. Drawing on personal comparisons in how you would like to be treated	
6. Contact with psychology and therapists	6.1. Relationships	6.1.1. With the children
		6.1.1.1 Knowing the children
		6.1.1.2. Seeing them and their behaviour in different settings
		6.1.2. With the staff
		6.1.2.1. Working collaboratively, as a team
		6.1.2.2. Understanding the daily issues
		6.1.2.3. Issues of status, respect and equality
		6.1.3. One-off work is unhelpful
		6.1.4. Spending time in the houses
	6.2. Expectations	6.2.1. Unclear expectations
		6.2.2. Not meeting expectations
		6.2.3. Psychologists' and therapists' expectations of staff
	6.3. Inconsistency/unfairness	6.3.1. Support needs to be consistent across settings and time
		6.3.2. Not providing what the organisation 'sells'
		6.3.3. No input without a referral
	6.4. Proactive versus reactive support	
	6.5. Usefulness of suggestions and support	6.5.1. Imposing without understanding
		6.5.2. Strategies are not always achievable
		6.5.3. Strategies are not always in tune with the emotional context
		6.5.4. Suggesting what is already being done
		6.5.5. Suggesting things that will not work with a particular student
		6.5.6. Response/advice comes too late
		6.5.7. Use of jargon makes it difficult to understand
	6.6. Reflective sessions with psychology	6.6.1. What is helpful
		6.6.1.1. Shared thinking
		6.6.1.2. Proactive working when people are in a

good place

		6.6.2. What is unhelpful
		6.6.2.1. Unhelpful during times of crisis
		6.6.2.2. Staff feeling patronised
		6.6.3. Practicalities
		6.6.3.1. Having time
		6.6.3.2. Finding suitable times
		6.6.3.3. Arranging cover
	6.7. Positive experiences	6.7.1. Involvement and collaboration
		6.7.1.1. Working as a team
		6.7.1.2. Involvement due to staff having related roles, e.g. Communication Rep
		6.7.2. Positive qualities of psychologists and therapists
		6.7.3. Sharing of information and expertise
		6.7.4. Setting up facilities for the staff and children
		6.7.5. Variety of therapies and sessions for the children
	6.8. Other factors impacting on quality of support	6.8.1. Who is involved (staff and therapists)
		6.8.2. Supervision and support for the therapist
		6.8.3. Caseload and amount of work
		6.8.4. Context of where the staff and students are at
7. Learning	7.1. Sources of learning	7.1.1. Learning from experience
		7.1.1.1. Learning from the children, getting to know them as individuals
		7.1.1.2. Learning from mistakes and challenges
		7.1.1.3. Learning from past experiences in different scenarios and settings
		7.1.1.4. Learning by doing and practicing
		7.1.2. Learning from colleagues
		7.1.2.1. Learning from observing others
		7.1.2.2. Learning from other people's experiences
		7.1.3. Independent learning
		7.1.3.1. Online learning
		7.1.3.2. Reading
		7.1.3.3. Looking at other organisations, politics and wider issues
		7.1.3.4. QCF
		7.1.4. Training
		7.1.4.1. Confirming/naming what you are doing
		7.1.4.2. Increasing empathy
		7.1.4.3. Reflecting on past training and experience in relation to current practice
		7.1.4.4. Reviewing the impact of training
		7.1.4.5. Learning from a child's history
		7.1.4.6. Specific training that is helpful
		7.1.5. Learning from 1:1 coaching/teaching
		7.1.6. Learning through spiritual and personal development
	7.2. Factors affecting the application of learning	7.2.1. Individual choice and openness to change
		7.2.2. Whether or not the skills and learning are used and Practiced
		7.2.3. Interest and enjoyment
		7.2.4. Whether or not training is a one-off or on-going
		7.2.5. Individual learning needs
		7.2.6. Relevance to practice
	7.3. Other issues with training	7.3.1. Having to repeat training

8. Policies and legislation	8.1. Importance	7.3.2. Having greater choice and interesting workshops is helpful
		7.3.3. Training can come too late
		7.3.4. Specific training that would be helpful
		8.1.1. People know what they can and cannot do
	8.2. Difficulties with policies and legislation	8.1.2. Everyone is doing the same thing
		8.1.3. Safety and containment
		8.2.1. Accessibility
		8.2.2. Formality
		8.2.3. Frequency of change
		8.2.4. Conflict between policy and practice
		8.2.4.1. Providing quality care versus having to spend time evidencing it via paperwork
		8.2.4.2. Duty of care and protecting a child's safety versus not being able to deprive them of their liberty
		8.2.4.3. Qualifications versus experience and being good at the job
		8.2.4.4. Inflexibility and lack of individualisation:
		8.2.4.3.1. Not taking individual child's needs into account
		8.2.4.3.2. Not considering the staff
		8.2.4.5. Regulatory bodies don't understand the Issues
	8.3. Suggestions for improvement	8.3.1. Ways of making policies and legislation more Accessible
		8.3.2. Greater flexibility within policies and legislation, accounting for individual needs
		8.3.3. Regulatory bodies need to see what happens in Practice
9. Expectations	9.1. Staff expectations: knowing what to expect from the job	9.1.1. Having clear expectations when recruited
		9.1.2. Coping with unexpected ways of working is difficult
	9.2. Organisational expectations of staff	9.2.1. Low expectations
		9.2.2. Expecting too much

Appendix E: Author Guidelines for the Journal of Applied Research in Intellectual Disabilities

Present author's note: these have been followed as closely as possible and the in-text citations will differ to APA format due to the journal requirements. However, figures and tables have been kept in the main body for ease of navigation.

Edited By: Chris Hatton and Peter Langdon; Founded by Professor David Felce

Impact Factor: 1.137

ISI Journal Citation Reports © Ranking: 2014: 31/55 (Psychology Educational); 38/70 (Rehabilitation (Social Science))

Online ISSN: 1468-3148

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1. GENERAL

The *Journal of Applied Research in Intellectual Disabilities* is an international, peer-reviewed journal which draws together findings derived from original applied research in intellectual disabilities. The journal is an important forum for the dissemination of ideas to promote valued lifestyles for people with intellectual disabilities. It reports on research from the UK and overseas by authors from all relevant professional disciplines. It is aimed at an international, multi-disciplinary readership.

The topics it covers include community living, quality of life, challenging behaviour, communication, sexuality, medication, ageing, supported employment, family issues, mental health, physical health, autism, economic issues, social networks, staff stress, staff training, epidemiology and service provision. Theoretical papers are also considered provided the implications for therapeutic action or enhancing quality of life are clear. Both quantitative and qualitative methodologies are welcomed. All original and review articles continue to undergo a rigorous, peer-refereeing process.

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All manuscripts must be submitted solely to this journal and not published, in press, or submitted elsewhere.

2. ETHICAL GUIDELINES

Acceptance of papers is based on the understanding that authors have treated research participants with respect and dignity throughout. Please see Section 2.2 below.

2.1 Authorship and Acknowledgements

Authorship: Authors submitting a paper do so on the understanding that the manuscript has been read and approved by all authors and that all authors agree to the submission of the manuscript to the journal. ALL named authors must have made an active contribution to the conception and design and/or analysis and interpretation of the data and/or the drafting of the paper and ALL authors must have critically reviewed its content and have approved the final version submitted for publication. Participation solely in the acquisition of funding or the collection of data does not justify authorship.

It is a requirement that all authors have been accredited as appropriate under submission of the manuscript. Contributors who do not qualify as authors should be mentioned under Acknowledgements.

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Research involving human participants will only be published if such research has been conducted in full accordance with ethical principles, including the World Medical Association Declaration of Helsinki (version, 2002 www.wma.net) and the additional requirements, if any, of the country where the research has been carried out. Manuscripts must be accompanied by a statement that the research was undertaken with the understanding and written consent of each participant (or the participant's representative, if they lack capacity), and according to the above mentioned principles. A statement regarding the fact that the study has been independently reviewed and approved by an ethical board should also be included.

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2.3 Clinical Trials

Clinical trials should be reported using the CONSORT guidelines available at www.consort-statement.org. A CONSORT checklist should also be included in the submission material (www.consort-statement.org).

The *Journal of Applied Research in Intellectual Disabilities* encourages authors submitting manuscripts reporting from a clinical trial to register the trials in any of the following free, public trials registries: www.clinicaltrials.org, www.isrctn.org. The clinical trial registration number and name of the trial register will then be published with the paper.

2.4 Conflict of Interest and Source of Funding

Conflict of Interest: Authors are required to disclose any possible conflict of interest. These include financial (for example patent ownership, stock ownership, consultancies, speaker's fee). Author's conflict of interest (or information specifying the absence of conflict of interest) will be published under a separate heading.

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Submissions are now made online using ScholarOne Manuscripts (formerly Manuscript Central). To submit to the journal go to <http://mc.manuscriptcentral.com/jarid>. If this is the first time you have used the system you will be asked to register by clicking on 'create an account'. Full instructions on making your submission are provided. You should receive an acknowledgement within a few minutes. Thereafter, the system will keep you informed of the process of your submission through refereeing, any revisions that are required and a final decision.

4.1 Manuscript Files Accepted

Manuscripts should be uploaded as Word (.doc) or Rich Text Format (.rft) files (not write-protected) plus separate figure files. GIF, JPEG, PICT or Bitmap files are acceptable for submission, but only high-resolution TIF or EPS files are suitable

for printing.

To allow double-blinded review, please upload your manuscript and title page as **separate** files.

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1. Your manuscript without title page under the file designation 'main document'.
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All articles submitted to the journal are assessed by at least two anonymous reviewers with expertise in that field. The Editors reserve the right to edit any contribution to ensure that it conforms with the requirements of the journal.

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Original Articles, Review Articles, Brief Reports, Book Reviews and **Letters to the Editor** are accepted. **Theoretical Papers** are also considered provided the implications for therapeutic action or enhancing quality of life are clear. Both quantitative and qualitative methodologies are welcomed. Articles are accepted for publication only at the discretion of the Editor. Articles should not exceed 7000 words. Brief Reports should not normally exceed 2000 words. Submissions for the Letters to the Editor section should be no more than 750 words in length.

6. MANUSCRIPT FORMAT AND STRUCTURE

6.1 Format

Language: The language of publication is English. Authors for whom English is a second language must have their manuscript professionally edited by an English speaking person before submission to make sure the English is of high quality. It is preferred that manuscripts are professionally edited. A list of independent suppliers of editing services can be found at http://authorservices.wiley.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

6.2 Structure

All manuscripts submitted to the *Journal of Applied Research in Intellectual Disabilities* should include:

Cover Page: A cover page should contain only the title, thereby facilitating anonymous reviewing. The authors' details should be supplied on a separate page and the author for correspondence should be identified clearly, along with full contact details, including e-mail address.

Running Title: A short title of not more than fifty characters, including spaces, should be provided.

Keywords: Up to six key words to aid indexing should also be provided.

Main Text: All papers should have a structured abstract (maximum 150 words) as follows: Background, Method, Results, and Conclusions. The abstract should provide an outline of the research questions, the design, essential findings and main conclusions of the study. Authors should make use of headings within the main paper as follows: Introduction, Method, Results and Discussion.

Subheadings can be used as appropriate. All authors must clearly state their research questions, aims or hypotheses clearly at the end of the Introduction. Figures and Tables should be submitted as a separate file.

Style: Manuscripts should be formatted with a wide margin and double spaced. Include all parts of the text of the paper in a single file, but do not embed figures. Please note the following points which will help us to process your manuscript successfully:

- Include all figure legends, and tables with their legends if available.
- Do not use the carriage return (enter) at the end of lines within a paragraph.
- Turn the hyphenation option off.
- In the cover email, specify any special characters used to represent non-keyboard characters.
- Take care not to use l (ell) for 1 (one), O (capital o) for 0 (zero) or ß (German esszett) for (beta).
- Use a tab, not spaces, to separate data points in tables.
- If you use a table editor function, ensure that each data point is contained within a unique cell, i.e. do not use carriage returns within cells.

Spelling should conform to *The Concise Oxford Dictionary of Current English* and units of measurements, symbols and abbreviations with those in *Units, Symbols and Abbreviations* (1977) published and supplied by the Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE. This specifies the use of S.I. units.

6.3 References

The reference list should be in alphabetic order thus:

- Emerson E. (1995) *Challenging Behaviour: Analysis and Intervention in People with Learning Disabilities*. Cambridge University Press, Cambridge.
- McGill P. & Toogood A. (1993) Organising community placements. In: *Severe Learning Disabilities and Challenging Behaviours: Designing High Quality Services* (Eds E. Emerson, P. McGill & J. Mansell), pp. 232-259. Chapman and Hall, London.
- Qureshi H. & Alborz A. (1992) Epidemiology of challenging behaviour. *Mental Handicap Research* 5, 130-145

Journal titles should be in full. References in text with more than two authors should be abbreviated to (Brown *et al.* 1977). Authors are responsible for the accuracy of their references.

We recommend the use of a tool such as EndNote or Reference Manager for

reference management and formatting.

EndNote reference styles can be searched for here:

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6.4 Tables, Figures and Figure Legends

Tables should include only essential data. Each table must be typewritten on a separate sheet and should be numbered consecutively with Arabic numerals, e.g. Table 1, and given a short caption.

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Appendix F: Part 1. Statement of original ethical approval subject to amendments



Faculty of Health Sciences

ETHICAL APPROVAL FEEDBACK

Researcher Name:	Abbye Andrews
Title of Study:	Supporting people with intellectual disabilities
Status of approval:	Approved subject to amendments

Thank you for submitting your application which the panel has now considered. The panel's recommendation is that your application is approved subject to amendments. See below for details.

Detail required:

This is a challenging study, dealing as it does with support workers of vulnerable adults. There are practical difficulties about getting the right sorts of consent from the right people at the right time for what is, necessarily, an open-ended and loosely-formulated study. Within those limitations, the student has thought through the process carefully and foreseen most of the issues. I suggest the following minor amendments:

1. Section 2(b). Here you say that you will select participants from interview from those who you have observed, whereas on the info sheet (app B) you say that the worker can agree to interview without agreeing to be observed. Please clarify.
2. Section 2 (c). You are, rightly, explicit here about the possible consequences for the SW if you observe them doing something that may cause harm. You are much less explicit in your info sheet in App. B. Although you do not need to repeat all of 2 (c) in the info sheet, you should mention that by fulfilling your duty to report you may open the SW to risk of sanctions.
3. Section 2(c) you mention a form that the participant may sign if they wish to receive info about the study once complete. You do not include this form in the Appendices. We suggest that instead you include a tick box on the Consent form so that they may indicate whether they wish to receive further info or not.
4. Section 3(b). If you are saying that you will not observe anybody if they are in the presence of somebody who has not themselves consented to be observed, then you will have to halt your research if a single resident or SW enters the room. This seems impractical and unnecessary. If you are clear you are only ever observing and gathering data on a single individual (although, incidentally, they will be interacting with others) then it may be enough to secure their consent. Your status in relation to the other people in the room will be similar to that of any other guest who has been given permission by the management to visit the unit. Consider reworking.

5. Section 3(h). This is just a suggestion. Clearly, the research design makes it impossible for individuals to keep their non/participation confidential. But it may reduce the risk of positive or negative peer pressure if you ask for completed consent forms to be mailed directly to you rather than collected in person?
6. Section 4(f). Check the length of time you intend to keep the data. If you are planning to *publish* the research, it will need to be extended to 9 or 10 years
7. Appendices B and F – Info Sheet. Give the length of time that you expect to keep the data for (and see above for a query about that).

App.A: while we understand that the interview questions would be added to/refined following the observation and subsequent to other interviews, an initial interview schedule (based on the rationale, researcher's aims/ expectations, literature etc.) needs to be included.

Information sheets should contain a deadline for withdrawal ('as soon as possible' is a little vague) and explicit information on how data will be anonymised (e.g. use of pseudonyms).

We were a little concerned about the researcher asking questions during observation, as this may impact on the interaction between the carer and service user. Perhaps the researcher could make a note of any questions arising, and ask them afterwards?

Action now needed:

Please revise your proposal to take account of the feedback provided by the ethics committee which is listed above.

You should arrange to meet with your supervisor as soon as possible to discuss the revision of your proposal. When you have addressed all the comments, please **email the revised form**, and a **covering letter** indicating how you have addressed the points raised to Karen.Rodham@staffs.ac.uk.

Please make sure that **all appropriate signatures** (Researcher Signature and Supervisor Signature) are included on the amended Ethics Form.

You are reminded that you cannot commence the implementation phase of your study until you have received a written response from the Faculty Panel confirming approval.



Signed: Professor Karen Rodham
Chair of the Faculty of Health Sciences Ethics Panel

Date: 30th June 2015

Appendix F: Part 2. Statement of ethical approval following a response to original comments and an amendment (interviews only instead of observations and interviews)



Faculty of Health Sciences

ETHICAL APPROVAL FEEDBACK

Researcher name:	Abbye Andrews
Title of Study:	Supporting people with intellectual disabilities: experiences of the residential support worker
Award Pathway:	Professional Doctorate in Clinical Psychology
Status of approval:	Amendment approved

Dear Abbye,

Thank you for responding to the reviewer comments. Thank you also for detailing and justifying the changes you wished to make to your original application.

I can confirm that the ethics committee has reviewed your application and has approved it.

There is however one issue which we would urge you to consider further, and this concerns the process of withdrawal. At present you state that participants can withdraw at any time. We recommend that you give participants a specific time by which they must withdraw if they wish to. This protects you from facing the unpleasant situation of submitting your thesis, or publishing a paper and having to remove a person's data.

You do not need to respond to this point unless you decide to amend the withdrawal statement. Should you wish to amend this statement, you will also need to amend the information and consent forms, and send them to the Chair of Ethics for approval.

Your amended application is approved. We wish you will with your research.

Action now needed:

Your amendment has now been approved by the Faculty's Ethics Panel.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel in writing of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site

Signed: Prof Karen Rodham
Chair of the Faculty of Health Sciences Ethics Panel

Date: 16th October 2015

Appendix F: Part 3. Statement of approval following an amendment (participants to include care managers rather than solely support workers)



Faculty of Health Sciences

ETHICAL APPROVAL FEEDBACK

Researcher name:	Abbye Andrews
Title of Study:	Supporting people with intellectual disabilities: experiences of the residential support worker
Award Pathway:	Professional Doctorate in Clinical Psychology
Status of approval:	Amendment approved

Thank you for your correspondence requesting approval of a minor amendment to your project in order to include care managers as well as support workers in your interview sample. I have reviewed the reasons given in your email of 20th March 2016 and am satisfied with the reasons for the change.

Your amended application is approved. We wish you well with your research.

Action now needed:

Your amendment has now been approved by the Faculty's Ethics Panel.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel in writing of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site

Signed: Dr Peter Kevern
Chair of the Faculty of Health Sciences Ethics Panel

Date:

Paper Three: Commentary and Reflective Review

Word Count: 3,373

Please note that the author completed the empirical research whilst on clinical placement within a residential service. As they had dual roles within the service, it was important to reflect on both of these roles in paper 3 (the reflective paper), and the author would prefer this content not to be made public. For this reason, reflections on this work have been removed after completion of the thesis.

