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Workforce development: perspectives from people with learning disabilities

Jill Davies and George Matuska

Abstract

Purpose – Research into the skills and competencies required by staff working with people with learning disabilities has concentrated on staff views. The purpose of this paper is to explore what people with learning disabilities want from the workforce supporting them. The evaluation was commissioned by Health Education England working across Kent, Surrey and Sussex (HEE KSS).

Design/methodology/approach – An easy read questionnaire, co-produced with people with learning disabilities, was completed with 70 participants, 65 of whom attended one of 10 workshops. Two questionnaires were also completed by parents on behalf of their child. The workshops also allowed for open discussion.

Findings – People with learning disabilities value a workforce with a positive attitude, with staff who are skilled in supporting people to gain independence and have a voice.

Research limitations/implications – Findings are relevant to staff recruitment, matching of staff to services and staff training.

Originality/value – Although there is some previous research around service user views, this evaluation had a larger sample size. The findings were similar to previous studies, particularly around the kind of qualities required from staff, which were the ability to listen, have trust and be able to learn specific skills. Although the highest representation was from young people and young adults, participants ranged from 12 to over 65 years. Differences in views according to participant age ranges are also noted.

Keywords Learning disabilities, Intellectual disability, Service user voice, Staff qualities, Staff recruitment, Staff skills

Paper type Research paper

Introduction

This paper summarises a consultancy project commissioned by Health Education England working across Kent, Surrey and Sussex (HEE KSS). Health Education England is the national leadership organisation for education, training and workforce development in the health sector. The aim of the project was to gain the opinions and perspectives of individuals who have learning disabilities on the skills and qualities they seek in the workforce who support them.

Most of the research regarding the skills staff need to work with people with learning disabilities has explored professional, support staff and management perspectives (Hatton et al., 2009; Clarkson et al., 2009). There are a small number of studies which have looked at what is important to people with learning disabilities. The Stay Up Late (2016) campaign undertook work with their reference group to find out what made a good support worker. They reported that a good support worker helps, talks and listens, has a good sense of humour, supports people to be independent and keeps the person informed. In other studies, service users valued qualities relevant to good relationship building, specifically honesty, a caring nature, nurturing qualities and calmness (Clarkson et al., 2009; Dodevska and Vassos, 2013), whereas for staff and managers, specific knowledge and practical work skills were deemed as most important.

During the past few decades there has been an increase in people with learning disabilities’ involvement in the recruitment of staff, as recommended in Valuing People...
This involvement can range from sitting on an interview panel, being part of a service user panel or accompanying candidates on a tour of the service. In order to support people to make decisions about the most suitable candidates, some organisations have asked people with learning disabilities to focus on specific areas, such as the qualities desired by service users for a particular post. For example, Hurtado (2014) described the process of recruiting to a psychology assistant post with the engagement of people with learning disabilities. As the service users found it difficult working with open-ended subjects, the author developed a forced choice questionnaire with a focus on asking questions about the personal characteristics of potential candidates.

The aim of the current project was to explore the views of people with learning disabilities on the skills and qualities they require from the workforce who support them.

Method

The consultation took place across Kent, Surrey and Sussex in South-East England. Drawing on previous research, both the personal characteristics and skills and knowledge of the workforce needed to be explored. A mixed methodology was implemented, comprising of a series of workshops incorporating an easy read questionnaire, along with discussions on what people valued most. Workshops were planned in order to reach as many people as possible in a given timeframe. The questionnaire was divided into two sections. Demographic data was collected to ensure the inclusion of a cross section of people across a range of ages, ethnic backgrounds and support received. The second section had a focus on the skills and qualities required from the workforce, as suggested above by Hurtado (2014). A total of 14 skills and eight qualities were included in the questionnaire. This list was not exhaustive but it provided the participants with concrete examples of what might be important. The workshops included discussions about what good care and support looks like to enable the participants to complete the questionnaires based on their own reflections.

Participants

A total of 72 (44 males and 28 females) people took part in this consultation. To capture the views of people with more complex learning disabilities, individual interviews with two parents whose children had complex needs took place, using the questionnaire to facilitate conversation.

Participants’ ages were classified into the following groups: 12–24; 25–34; 35–44; 45–54; 55–64; 65 plus. It was not possible to calculate the mean age because some participants were unsure of their age. Over half of the participants were from Sussex (37), as compared with Kent (18) and Surrey (17). This was due to a school in Sussex arranging for two classes to take part in the consultation workshops.

The majority of the participants were members of seven groups and organisations that took part in the consultation. They ranged from a school, self-advocacy groups and a day service. Some people completed the questionnaire by post.

Ethics

This project was an evaluation rather than research, as it was a consultancy project carried out on behalf of HEE KSS. Ethical approval was not required for this consultation process, however easy read information about the project was sent to each group in advance of the workshop and people could make their own decision whether they wanted to attend. During the workshops participants were told they could leave at any time. Regarding the school that took part, the deputy head teacher sought parental or legal guardian permission for each student. At the end of the project, easy read summaries of the final report were sent to all groups.

Procedure

The easy read questionnaire was co-produced with two consultants with learning disabilities who had extensive experience in making information easy to understand and were experienced in evaluation. It was piloted with a small group of people with learning disabilities, after which major changes were made.
Workshops

Ten workshops were held. There was a set structure, adapted to meet time constraints and the abilities of the participants. The groups lasted from one hour to two and a half hours. The core components of the workshops comprised of:

1. a discussion of what bad and good support looks like;
2. exploration of the skills and qualities required of the workforce;
3. completion of the questionnaire; and
4. at the end of the session, people being asked to name their top three most important skills and two most important qualities.

This order was used consistently in each workshop as the components set the context and built the participants’ knowledge on the key issues being addressed. A range of communication aids were used during the workshop to help understanding, further enhance the flow of conversation and assist with word finding. These included role plays, images of specific and relevant job roles and a visual voting exercise.

Data collection

Questionnaires was collected at each workshop and some were sent by post. Notes were taken during each workshop and interview and later typed up and anonymised.

Data analysis

Data from the questionnaires was used to calculate the most frequently sought skills and attitudes. Further analyses were made by participant age. The notes from the workshops are summarised below. However, further interpretive analysis was not conducted due to resource constraints.

Results

Skills required from workforce

The results from this consultation (Table I) demonstrate that people were very keen to learn a range of practical skills to lead as independent a life as possible. This was particularly important to the younger age groups. One young person commented:

I want to learn to drive as then I can be more independent.

Support for learning to cook, finding a job, using public transport and having more control over finances were consistently mentioned, especially amongst those aged 44 years and younger. The 12–24 age group had lower scores for support with medication (31 per cent) and health needs (28 per cent). Support to use technology was the least important (24 per cent) but many participants were already proficient in using social media.

Again, it was those aged 44 and under that talked about the need for positive risk taking to learn such skills, and a few people described how they had lost some skills due to the risk-averse culture of the home where they lived. Parents felt it was detrimental to their son/daughter’s independence if they were supported by people who lacked the knowledge to encourage and motivate people to maintain or learn skills.

For those aged 44 years plus, the most important skills were focused on health, accessing leisure and the community and keeping in touch with family and friends. Regarding health, those people using medication or with known health problems felt it was very important to be supported by knowledgeable staff and practitioners. They wanted professionals to be experts in their area, as described below:

I need help with many things and need to see different doctors who are expert in what they are helping me with. Should have the best, shouldn’t it?
Being supported by staff to keep in contact with friends and family was extremely important to the participants. As described by one participant:

I want to do more things, go shopping with friends.

Everyone aged 35 years and above said they needed help with this, yet it was not seen as so important to the younger participants. A possible reason for this is that most of the younger people were living in the family home so had immediate access to their family and some friends. In addition most of the young people taking part had the technology skills to use online forums such as Facebook or Instagram to keep in touch with friends and family. Those who were older and had not been taught to use computers and technology at school were unable to keep in contact with their families in this way.

When asked to list the three most important overall skills, having support to learn to use public transport was the highest scoring desired skill (35 per cent), followed by learning to cook (29 per cent), looking after health needs (27 per cent), keeping in touch with friends and family (25 per cent) and support with budgeting (25 per cent), as shown in Figure 1.

### Qualities required from workforce

The most popular qualities chosen from the questionnaire were: look at me/listen to me (77 per cent); be patient (75 per cent); and happy and positive attitude (72 per cent). When asked to verbally choose their top two qualities, a happy and positive attitude was the most important (50 per cent), followed by letting people speak up for themselves (29 per cent) and listening to them (25 per cent), as shown in Figure 2. There was a consensus amongst all age groups, therefore no further analysis by age was required.

Other qualities that were not given as options on the questionnaire emerged during the workshops as being important. These included: keeping promises, encouraging independence, boosting confidence, and having someone with the ability to look beyond the disability to “recognise you as a person and not just your disability”. Some other qualities were explored in more detail as discussed below.

### Table I  Five most commonly required staff skills by age group

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Skill</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>12–24</td>
<td>Support to use public transport</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>Support to manage money</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Find the right home to move into</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Help prepare snacks and meals</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Finding a job</td>
<td>41</td>
</tr>
<tr>
<td>25–34</td>
<td>Understanding health needs</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>Support in using medication</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>Support to keep in touch with friends and family</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>Support in accessing leisure activities</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>Learning to use technology</td>
<td>75</td>
</tr>
<tr>
<td>35–44</td>
<td>Understanding health needs</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Support to keep in touch with friends and family</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Support to be part of the local community</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td>Support in accessing leisure activities</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td>Support to use public transport</td>
<td>89</td>
</tr>
<tr>
<td>45–54</td>
<td>Understanding health needs</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Support in using medication</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Support to keep in touch with friends and family</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Support to be part of the local community</td>
<td>83</td>
</tr>
<tr>
<td></td>
<td>Support with personal care</td>
<td>83</td>
</tr>
<tr>
<td>55–64 years</td>
<td>Understanding health needs</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Support to keep in touch with friends and family</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Support to be part of the local community</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Support in accessing leisure activities</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Support in using medication</td>
<td>67</td>
</tr>
</tbody>
</table>
Communication

Communicating effectively was seen to be highly important by many of the participants. The quote below is from a person who can understand verbal requests providing that people slow down when speaking and that they give visual cues:

He says things to me in stages – not all at once. The old staff didn’t say things in stages. The new staff do and have a board to write things on and put pictures on.

A parent spoke about the link between behaviour and communication:

Communication skills are very important – being able to understand my son’s signing, understanding and reading him in each situation so they can prevent and diffuse difficult situations.
As well as being able to communicate effectively with people with learning disabilities, it was also important to be able to communicate with the family and others supporting the person. One parent commented:

Communication is a huge issue – to be able to communicate with people with learning disabilities, family and carers, and share their knowledge across the team supporting the person.

**Reliability**

Having a workforce able to keep a promise and having trust in those who support them was a recurring theme during the workshops. It was clear that people had often been let down by those supporting them or by the organisations providing support. One lady described how she made an appointment at a new beauty salon on a day when her support worker was allocated to work with her. However, the support worker was unwell and the message did not reach the agency in time for a replacement. She said:

I was too nervous to go by myself.

**Humour**

It emerged through the discussions that humour was important in the relationship with support staff. One person described how her supporter used humour to help learn a new task as it kept her motivated:

She knows how to make me laugh when I’m trying to do something new and it stresses me out.

Parents also highlighted that having a sense of humour helped them in their caring role and in their relationship with their children. One parent, speaking on behalf of their child stated that the workforce:

[... need to have a sense of humour, particularly to deal with certain situations when out with the public – people need to be thick skinned and be ok to be the centre of attention if they go somewhere and an incident occurs.

**Discussion**

This study differs from previous research (Hatton et al., 2009; Dodevska and Vassos, 2013) in that lists of specific skills and qualities were provided to the participants in the questionnaire with the opportunity for the participants to highlight other relevant skills and qualities during the workshop. These lists were devised and tested by adults with learning disabilities.

Previous studies by Clarkson et al. (2009), Stay Up Late (2016) and Bee et al. (2008) indicated that interpersonal skills were considered of high importance by service users. The participants from this study emphasised that support staff need to listen to people with learning disabilities, be able to be trusted and to have a positive attitude. Participants felt that these qualities should be inherent in everyone supporting a person with a learning disability – from a medical consultant or GP through to job coaches and personal assistants.

The importance of support staff having practical skills is also consistent with other research, as highlighted by Clarkson et al. (2009), who reported that direct support has both emotional and practical elements. This evaluation provides more detail on the specific skills and qualities than previous findings as it involved a much larger group of participants and provides variations according to age of participants.

Support with medication and health needs were considered important for all age groups, except younger people. Reasons for requiring support with health may include matters related to syndrome-specific conditions and an increased prevalence of both some physical and some mental health conditions (Grant, 2010). Adults with learning disabilities are also at higher risk of poor health relating to factors such as exercise, diet and socio-economic status (Bigby, 2010).

**Application to practice**

Key qualities identified included being “happy and having a positive attitude” and “letting me speak up for myself”. This implies that health and other staff are likely to be seen more positively if
they have a positive outlook and provide opportunities for people with learning disabilities to express their views, providing good information to individuals and communication support as required.

These findings could also inform recruitment practice and matching of support staff to work with particular individuals. In looking at the findings, employers can assess if their recruitment process allows for the assessment of the skills and qualities highlighted as most important for people with learning disabilities. Do their application forms, testing procedures and interview questions assess for skills in supporting people to understand their health needs and care, to gain greater independence, to access leisure facilities, to make new friends and maintain relationships with existing friends, to be able to visit and spend time with their families? Are marks given for personal qualities deemed important in staff – having a happy and positive attitude, a willingness to work with people rather than doing for, and an ability to listen to people and to allow them to speak up for themselves? How much weight is placed on these skills and qualities during the recruitment process compared to other factors such as qualifications, physical presentation, knowledge of learning disability and experience?

This evaluation also highlighted the importance of staff being able to teach new skills (of various kinds) to people with learning disabilities, a capacity that staff may not routinely have.

Limitations

The evaluation had a number of limitations. The lists of skills and qualities included in the questionnaire were inevitably limited though workshop discussion allowed time to discuss what other skills and qualities were considered important. Time was a factor in some workshops, so information was collected as a group, except for the skills and qualities sections, which were always completed individually.

The substantial variation between the groups may reflect their age and settings. It cannot be assumed that, for example, all 12–24 years olds want the same thing. The groups included people from schools, day services, supported living housing, self advocacy groups and charities, which resulted in a large age range (12 to over 65 years) with the largest group in the 12–24 age range. In light of this, responses may have mainly been drawn from experience with educational and social care staff and reflect more limited experience with health staff. However, during the workshops examples of different types of staff were shown and discussed, including medical practitioners. As people with learning disabilities are more likely to experience additional conditions than the rest of the population, and perhaps medical issues specifically relating to their condition, it is likely that even the younger participants will have had some experience of health care staff. However, further research into the skills and qualities of specific job roles, in particular health staff, is needed.

This evaluation incorporated elements of a participatory qualitative research process which promotes “conducting the research process with those people whose life-world and meaningful actions are under study”, (Bergold and Thomas, 2012, p. 1) but a more in-depth analysis of the qualitative data collected was not possible.

Conclusion

People value a workforce who are patient and kind, have a positive demeanour and ensure the people they support are given a voice. The workforce need to be experts in their area of speciality, which should include understanding health needs (both physical and mental), making connections with family and the local area and encouraging people to be more independent. The variation of the skills required by the various age ranges has implications for the workforce so services need to be aware of these, so they can tailor the support they offer. People had high aspirations and education, health and care providers need to address this.

HEE KSS continues to support the workforce that supports people with learning disabilities through its local programme as well being a partner in the national Transforming Care Programme.
and the Sustainability and Transformation Plans. The report arising from the current project has fed into the local work going forward and the evidence presented will ensure that issues are considered across the life span and different parts of the workforce.

References


Corresponding author

Jill Davies can be contacted at: jill.davies3@nhs.net

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Commentary on “workforce development: perspectives from people with learning disabilities”

Martin Stevens

Abstract

Purpose – The purpose of this paper is to explore links between the staff values and skills identified by Davies and Matuska and other literature. The commentary aims to place these values and skills in the context of established approaches to working with people with learning disabilities, to explore their impact on recruitment and to outline limitations on their applications.

Design/methodology/approach – The commentary explores the implications of Davies and Matuska’s findings, relating these to previous research and policy literature.

Findings – The commentary argues that it is important to stress the complexity of working with people with learning disabilities and the qualities of workers required. In addition, the importance of values-based recruitment (VBR) is also supported. Finally, the commentary points to the importance of creative ways of overcoming the limitations presented by current austerity policies.

Originality/value – The commentary links characteristics and skills of staff valued by people with learning disabilities with person-centred care and VBR.

Keywords Adult social care, Recruitment, Personalization, Profound intellectual and multiple disabilities, Workforce, Intellectual disability

Paper type General review

Introduction

It is obviously important to have an understanding of the qualities and characteristics of staff that are valued by people with learning disabilities and their relatives. As Davies and Matuska indicate, this can apply to staff in all settings, including housing support workers, personal assistants and so on. This commentary will explore how these insights fit with other research and how they fit with a person-centred approach to working with people with learning disabilities. The implications for recruitment will be explored and the limits on their application will be briefly outlined.

Characteristics and skills valued by people with learning disabilities

In the limited research on this topic, there appears to be consensus that adults with learning disabilities value interpersonal skills above knowledge and practical skills (Dodevska and Vassos, 2012; Hatton et al., 2009). Such an emphasis is also found in studies of the preferences of older people (McCormack et al., 2006; Soares et al., 2018). Davies and Matuska identified these characteristics and interpersonal skills as being valued by people with learning disabilities:

- ability and willingness to listen;
- patience;
- happy and positive attitude;

The Social Care Workforce Research Unit is funded under the NIHR Policy Research Programme. The views expressed in this commentary are those of the author and not necessarily those of the NHS, the NIHR, the Department of Health and Social Care, or its arm’s length bodies or other government departments.
- encouraging people to speak up for themselves;
- good communication skills;
- reliability; and
- sense of humour.

All of these qualities and skills may be somewhat culturally specific, as they are all elements of behavioural norms or interactional styles, which vary across cultures. In noting this, Bourgeault et al. (2010) argue that cultural differences can interfere with good communication, for example. Such factors need to be taken into account when recruiting care workers and in allocating work.

Respondents to Davies and Matuska’s consultation also expressed their desire to learn skills, such as cooking, finding a job or use public transport and to live an independent life. They expected staff to help with these goals, which are more likely to be specific to people with learning disabilities. However, staff skills and knowledge in supporting people to learn such practical skills are not the same as the knowledge and skills sometimes valued by managers, such as knowledge of the effects of different syndromes (e.g. Prader Willi), or knowledge of the social care system.

Dodevska and Vassos (2012) also make the point that the knowledge and practical skills privileged by managers are also essential to good practice. Skilled care workers need to be able to employ their knowledge and practical skills as part of positive interpersonal communications (Soares et al., 2018). For example, McCormack et al. (2010) argue that in nursing, the giving of physical care could be an “in” to start developing positive relationships and communication, and the same could well be the case in other aspects of care work with adults with learning disabilities.

Hatton et al. (2009) approach these issues from the standpoint of developing appropriate sets of competences for working with people with learning disabilities that enable staff performance to be measured. They apply the understanding that interpersonal elements such as those identified by Davies and Matuska may have more influence on the quality of service than the skills and knowledge identified by managers, although acknowledge that managers’ requirements for knowledge of the service and aspects of different syndromes (for example) are also important. Hatton et al.’s approach was to use a “worker-oriented job analysis method” (p. 55) rather than a “job focused” analysis, on the basis that care work evolves and changes, making characteristics of the worker more important. The overall aim of Hatton et al.’s work was to develop a means of assessing performance of staff working with people with learning disabilities, which would be informed by people with learning disabilities and their relatives or informal carers.

Dodevska and Vassos (2012) identify a number of difficulties in identifying the perspectives of people with learning disabilities about their staff. As with Davies and Matuska’s evaluation, participants had to be able to take part in an interview, which excludes adults with severe or profound learning disabilities. In addition, it has been shown that people with learning disabilities are often reluctant to criticise their support staff. It would be interesting to see further, perhaps more observational, research being undertaken to explore whether other valued characteristics could be identified, and to identify which were most important to people with more severe or profound learning disabilities.

Person-centred care

Many of the characteristics and interpersonal skills identified by Davies and Matuska fit very well into ideas about person-centred care, in relation to people with learning disabilities as well as older people, disabled people or people with mental health problems. Brown et al. (2016, p. 974) identify key elements of person-centred care as being focused on interpersonal skills and practices:

Effective person-centred practices are based around skilled interactional and interpersonal processes, which focus on the need to understand the individual’s needs, perceptions and motivations in life.

McCormack et al. (2010) outline a framework for person-centred care in nursing, in relation to disability, mental health and older people. The framework covers four domains: three of which,
“pre-requisites”; “care environment”; and “care processes”, influence “outcomes”, the fourth domain. The “care processes” domain highlights factors that chime well with the characteristics valued by people with learning disabilities by Davies and Matuska:

- working with patients’ beliefs;
- engagement;
- sharing decision making;
- having sympathetic presence; and
- providing for physical needs.

The importance of good interpersonal skills is also seen within the “pre-requisites” domain. McCormack et al. (2010) found that all of these aspects were important in promoting good outcomes. They also considered a range of factors going beyond relationships between staff and patients (their study focused on nurses), including elements of the environment, which can promote or inhibit the development and maintenance of good interpersonal interactions valued by people with learning disabilities in Davies and Matuska’s article.

Interestingly, McCormack et al. (2010) make the point that contexts, such as shift patterns, staff relationships and approaches to risk taking, can promote or inhibit nurses’ abilities to encourage self-management and decision making, factors seen as important in Davies and Matuska’s article. Having enough time to develop relationships and practice in a positive way was also an important factor. This places Davies and Matuska’s evaluation within the broader context of factors required in services. Training and education need to encompass the development of these characteristics and skills and support staff to put them into practice effectively, as do organisational support and staffing levels, so that staff have the time to work in a person-centred way.

Recruitment and retention

There are shortages of care workers, across the whole sector, which has higher levels of vacancies and staff turnover rates compared with other parts of the economy. Skills for Care (2017) found turnover rates of 26 per cent in care homes and 33 per cent in home care services, compared with a 15 per cent staff turnover rate in the wider economy. Such high levels of turnover and staff shortages affect learning disability services more keenly than other organisations. In addition to the time and resource needed for recruiting and training new staff, adults with learning disabilities tend to find it difficult to develop trusting relationships with new staff (Bates and Davis, 2004).

Consequently, it is of great importance to ensure that the right kinds of staff are recruited, as they are more likely to stay longer in post, or at least with social care, as found by Moriarty et al. (2017). This places greater emphasis on understanding the most desirable qualities of staff working with adults with learning disabilities, such as those identified by Davies and Matuska. There is evidence that staff who “fit” well within a work environment have higher job satisfaction and therefore be more likely to remain in post (Duffy et al., 2015). It would be plausible to think that ensuring that staff have the characteristics and qualities valued by people with learning disabilities would fit better into the environment and experience greater job satisfaction and be more likely to continue working in the sector.

Many of the factors (e.g. patience or a happy and positive attitude) can be translated into the values of workers. Consequently, a values-based recruitment (VBR) approach could easily incorporate these insights. Consilium Research and Consultancy (2016, p. 1), in the final report of a Skills for Care evaluation of VBR, defined the approach as:

[...] finding and keeping people who have the right values and attitude to work in care and supporting staff to develop their skills and knowledge to enable them to provide high quality care.

Their survey found that almost three-quarters of social care employers claimed to be using this approach to recruitment. In addition, it was reported that almost all employers using VBR were very positive about its impact on the social care workforce. Staff recruited through VBR were believed by
managers to have stronger care values of “respect”, “empathy”, “compassion”; “treating people with dignity”; and “integrity” (Consilium Research Consultancy, 2016, p. 11). All these values are clearly linked to the valued characteristics identified by Davies and Matuska and others.

Moriarty et al. (2017) also found support for VBR from social care managers and noted that these managers often not only described these values as being very important, but also acknowledged that practicalities often meant that recruitment was not completely dictated by this approach because of the limited number of applicants. This could result in a workforce made up of a group of highly dedicated staff, with the right mix of values and skills and another group who were less committed to the work and would be highly likely to move to other kinds of employment, such as retail work, if better paid opportunities existed.

Limitations restricting staff working in valued ways

If a good proportion of social care workers with the characteristics and values seen as important to people with learning disabilities can be recruited, there are a number of factors that limit their ability to enact these values. First, the staff shortages outlined above mean that many are likely to work in understaffed residential services or community support settings. This makes it much harder to work in ways that allow people with learning disabilities to voice their preferences and opinions, which in any event might be hard to support, because of the limited resources. All of these factors have been exacerbated by the period of austerity since 2010, which the LGA (2017) predicts will mean reductions in local council spending on social care of £16bn by 2020. Consequently, there is little scope for increasing social care workers’ pay and, perhaps more importantly, there are restrictions on the amount of support available to people with learning disabilities. Working in accord with the values identified is going to be more difficult in these circumstances.

Conclusion

It seems clear that the values identified by Davies and Matuska fit very well with those found in other research. It is an important reminder about the importance of social care work and its complexity. Working with people whose communication is often limited requires individuals with strong values and characteristics. Seeing these factors within ideas about person-centred care seems to be an important way of promoting their value in social care. One consequence of this is to emphasise the values in recruiting social care workers. Finding creative ways to overcome some of the limitations in the current context will be critical in ensuring that there are sufficient care workers with the necessary, valued characteristics and skills. Further, employing organisations need to find ways to support such staff to employ their skills to the full and work in ways consistent with their values so that people with learning disabilities receive the support they want and need.

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Corresponding author
Martin Stevens can be contacted at: martin.stevens@kcl.ac.uk

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Improving the adoption of PBS and ABA using diffusion of innovations theory

Brent A. Hayward, Shiralee Poed and Lisa McKay-Brown

Abstract

Purpose – The purpose of this paper is to describe and discuss the variables which have contributed to the adoption of positive behaviour support (PBS) and applied behaviour analysis (ABA). Differences and similarities are highlighted, applications to contemporary issues in the UK and Australia are emphasised, and considerations posed for their improved adoption.

Design/methodology/approach – A conceptual framework for diffusion of innovations theory is used to guide the analysis of three sets of articles, and application of the framework is guided by narrative analysis.

Findings – Eight variables from the conceptual framework were identified, and the communication networks for PBS and ABA are argued to be distinct. There has been a positive change in the perception of PBS by the ABA field, but PBS has leveraged diffusion more successfully. ABA appears to have been separated from PBS in the UK while Australia is yet to fully benefit from the contributions of ABA. Those working in the fields of PBS and ABA should further collaborate for their mutual benefit.

Practical implications – Greater attention to the factors which promote diffusion can assist PBS and ABA to improve their adoption.

Originality/value – This is the first paper to use diffusion of innovations theory to analyse the adoption of PBS and ABA.

Keywords Learning disabilities, Positive behaviour support, Diffusion, Intellectual disability, Adoption, Applied behaviour analysis

Paper type Viewpoint

Since it was first described in 1990, positive behaviour support (PBS) has experienced a dramatic surge in its application in practice, particularly in schools in the USA (Kern and Lane, 2018). Applied behaviour analysis (ABA) as a clinical discipline has also experienced significant growth in recent years (Guercio and Murray, 2014). The relationship between PBS and ABA has been discussed at length in the literature, especially within the ABA field. Dunlap et al. (2008) argue that a misunderstanding of PBS by those working in the ABA field has produced confusion and unnecessary division.

Distinguishing between PBS and ABA

ABA is established as a strong applied science and its contributions to problems of human behaviour are significant. It uses the general principles of learning and behaviour to study, predict and control behaviour rather than observing behaviour and drawing inferences (Fisher et al., 2011). PBS on the other hand emphasises “context and the macrovariables that exert pervasive influences on behavior that are relatively difficult to isolate with traditional behavior analytic methodologies” (Dunlap et al., 2008, p. 693). PBS and ABA occupy different roles, with PBS being a supports activity (Grey et al., 2016) and ABA an intervention activity (Moore and Cooper, 2003), but both share a commitment to behavioural science (Dunlap et al., 2009).

Wacker and Berg (2002) describe a tension between the application of models of PBS and ABA with regard to service delivery (though this tension is underpinned by debate about the scientific merit of PBS as an applied science). Around the same time, Carr and Siderer (2002) endorsed PBS as a behaviour analytic service-delivery framework, similar to Wacker and Berg (2002). In addition, contemporary definitions of PBS do not shy away from its role in service delivery
However, PBS goes beyond service delivery per se, by aligning the approach to the values underpinning modern disability service delivery (Grey et al., 2016). There is, however, some evidence of collaboration between PBS and ABA in a service delivery. In 2000, Anderson and Freeman described in detail how PBS is a framework for providing services to people with disability through the teaching of skills using the technology of ABA. This approach was later adapted by Rotholz and Ford (2003) in their description of the state-wide implementation of PBS along with ABA, highlighting the contribution of both to improved service delivery.

Method

Approach

Innovations such as PBS and ABA are communicated through particular channels (messages about the innovation are sent and received) over time among the members of a social system (individuals, informal groups, organisations and subsystems). This communication process is termed diffusion by Rogers (2003) and he argues that communication is the central mechanism contributing to the exchange of information and new ideas. These elements provide a model which one can apply to the development and application of PBS and ABA over time, to identify the influencing factors on their adoption. Using Rogers’ theory of diffusion of innovations, the development of PBS and ABA can be constructed beyond simply justifying their origins, describing the events and developments which occurred. Further, opportunities can be identified for improving their adoption in policy and practice.

This paper examines the elements of diffusion in three sets of articles, published between 2006 and 2017, about ABA and PBS from a US context. Two articles were selected because they were published in behaviour analytic journals and represent a variety of perspectives on the relationship between PBS and ABA, and they have published replies. This is somewhat unique because of ABA’s historically negative view of PBS (Dunlap et al., 2008), an issue which will be explored below. The third article was selected because, while it briefly references PBS, its value lies in its consideration of factors for the successful diffusion of ABA, which are also appropriate considerations for PBS. The paper ends with an exploration of the context of PBS and ABA in the UK and Australia and makes suggestions for improved, collaborative adoption.

Conceptual framework

The claims in each article are examined using Wejnert’s (2002) conceptual framework (Table I). This framework integrates 12 variables of diffusion contained within three components: characteristics of the innovation itself which modulate the process of diffusion, characteristics of those adopting the innovation and the ecological and cultural context of adopting the innovation. These describe how innovations, in this case PBS and ABA, are diffused, or spread, from a source to an adopter. A narrative approach, influenced by Chatman’s (1978) concept of story, is used to apply the components of the framework to the articles. The story concept comprises a summary of events, establishes the time, situation, setting and participants, actions, resolutions and return to the present. The variables in the conceptual framework can be directly applied to the elements present in each “story”. This paper does not claim to be a comprehensive narrative analysis. Instead it focusses on two aspects of the narrative analysis as described by Lieblich et al. (1998): first, coherence: how parts of the analysis fit together and how they fit with existing theories and previous research. This is achieved by applying the diffusion theory and a conceptual framework. Second, insightfulness: originality in the presentation of the story and in the analysis of it. This paper is the first to discuss and present the relationship between PBS and ABA in this way and to offer suggestions for further, successful diffusion.

Findings

Article 1

Johnson et al.’s (2006) paper is a lengthy critique of PBS which provided an evaluation of the reasons why PBS has been successful compared with ABA in North America. The authors state that PBS has been successful in garnering the support of federal agencies and marketing
the model to disability and educational services (p. 63). This is representative of what Wejnert calls “the social entity of innovators”. Here, PBS was adopted by large collective adopters (federal agencies) with public consequences to the adoption (change in disability and school practices). The successful adoption of PBS was due to the influence of federal agencies changing school policy and legislation, and the promotion of PBS by disability advocacy groups (e.g. Horner and Dunlap, 2012). Johnson et al. also note that Federal and state statutes and regulations include PBS as the approach of choice (p. 63). While this is evidence of “political conditions” in Wejnert’s framework, the influence of Wejnert’s “societal culture” variable in diffusion is also relevant here. For example, how PBS has positively influenced family engagement with schools (Garbacz et al., 2016), and demonstrated effectiveness of supporting people with disabilities and challenging behaviour in the community rather than institutions (LaVigna and Willis, 2012), both of which are valued by society. The influence of “global uniformity”, another variable in Wejnert’s conceptual framework for diffusion, on the adoption of PBS is significant. Reactions to the use of aversive interventions in institutions (see Repp and Singh, 1990) were important in the development of positive approaches to supporting people with challenging behaviour, contributing to the development of the PBS framework. Johnson et al. (pp. 64–6) also highlight:

- PBS leaders developed close relationships with federal agencies, especially the US Department of Education, pursued federal funding which permitted widespread dissemination, and focussed on dissemination through bureaucratic processes. These are further examples of the “political conditions” in the ecological component of Wejnert’s framework influencing the adoption of PBS.

- The service model of PBS appeals to potential users through promoting common values. The promotion of common values is evident for both disability services (Gore et al., 2013), and schools (Scott, 2007) and is representative of “societal culture” in the cultural component of Wejnert’s framework.

- PBS is an organisational focus on service delivery rather than a research agenda. Wejnert’s “private consequences” variable relates to adopting innovations which, in the case of PBS, reform social or organisational structures. Because PBS is a systems approach which is designed to account for the organisational system in which support is provided (Dunlap et al., 2009), the focus of PBS is on promoting practices that can be done by typical people in typical contexts (Horner and Sugai, 2018). Conversely, ABA is promoted as an applied scientific technology with an international certification process to protect it from bogus practitioners (Shook and Johnson, 2011).

Table I  Wejnert’s (2002) conceptual framework for diffusion of innovations

<table>
<thead>
<tr>
<th>Component</th>
<th>Variable</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characteristics of the innovation</td>
<td>Public vs private consequences</td>
<td>The impact of adoption of the innovation on an adopter or other person</td>
</tr>
<tr>
<td></td>
<td>Benefit vs cost</td>
<td>Variables relate to monetary and nonmonetary, direct and indirect costs or risks associated with the adoption of the innovation</td>
</tr>
<tr>
<td></td>
<td>Social entity</td>
<td>The nature of adopting the innovation is different for an individual person compared to a group of persons</td>
</tr>
<tr>
<td></td>
<td>Familiarity with the intervention</td>
<td>The familiarity with the innovation relates to how radical or novel it is</td>
</tr>
<tr>
<td></td>
<td>Status characteristics</td>
<td>The prominence of a person’s relative position within a group</td>
</tr>
<tr>
<td></td>
<td>Socioeconomic characteristics</td>
<td>The characteristics of an individual, not the conditions in the environment external to the individual</td>
</tr>
<tr>
<td></td>
<td>Position in social networks</td>
<td>The variables that mediate the transmission and absorption of information about the innovation between members of societal structures</td>
</tr>
<tr>
<td></td>
<td>Personal characteristics</td>
<td>The “psychological strength” of individuals who adopt the innovation</td>
</tr>
<tr>
<td></td>
<td>Geographical settings</td>
<td>Geography and ecology of the adopter’s environment</td>
</tr>
<tr>
<td>Environmental contexts affecting the adoption of the innovation</td>
<td>Societal culture</td>
<td>The aspects of societal culture which affect adopters</td>
</tr>
<tr>
<td></td>
<td>Political conditions</td>
<td>The regulations and norms that control adopters</td>
</tr>
<tr>
<td></td>
<td>Global uniformity</td>
<td>Collective development and uniform evolution of global practices which affect adopters</td>
</tr>
</tbody>
</table>

Note: Variables marked with a are discussed in the text
Responding to Johnson et al., Filter (2007) argued that a strong relationship between ABA and PBS may accomplish broad dissemination of behavioural technology and access to political communities which ABA has struggled to influence. He further suggests ways of enhancing the relationship between PBS and ABA:

- presenting PBS research at ABA conferences;
- publishing data-based studies of PBS in ABA journals; and
- PBS professional organisations adopt policies that increase ties with ABA.

These comments draw attention to the way in which ABA and PBS practitioners constitute separate networks of communication. Homophilous networks constitute persons who are similar in some attribute, and in the case of ABA, such attributes may be standardised training, education and certification (through the Behavior Analyst Certification Board; www.bacb.com). On the other hand, PBS practitioners are from heterophilous networks reflecting their different attributes such as epistemology and philosophical viewpoints. Rogers (2003) argues that homophilous networks are a barrier to diffusion because new ideas usually enter the network through persons with greater power, status or expertise. These persons mainly interact with one another and therefore set the standard for what information will flow into the network. This is demonstrated in the initial strict criteria for ABA and the initial criticism of PBS by the ABA community. While communication in homophilous networks is generally more effective because attributes are shared between those communicating, heterophilous communication is advantaged by linking dissimilar individuals in a network which permits new, innovative ideas to be more easily communicated (Rogers, 2003). This is demonstrated through the relative rapid international adoption of PBS amongst seemingly disparate groups of professionals and service sectors. So, if practitioners from one network can effectively communicate in the other, ABA and PBS can more efficiently diffuse. A more harmonious relationship between PBS and ABA is now evident through exploration of similar perceptions of practice (Brown et al., 2008), and dual professional memberships and special interest groups (Dunlap et al., 2008). More recently, Dillenburger et al. (2014) has outlined how ABA can be an appropriate conceptual framework for multidisciplinary practice, and the Coalition of Behavioral Science Organizations (2018), which is inclusive of the fields of PBS and ABA, has published joint values and guiding principles.

Article 2

The second debate is in the May 2015 edition of the journal Behavior Analysis in Practice. It included a special section on positive behaviour interventions and supports (PBIS; also known as PBS) featuring a primary paper by Horner and Sugai (2015) which attracted a number of responses. Kincaid et al. (2016) highlight that, historically, PBS has stressed and prioritised different characteristics of definitions and as such, their published definition of PBS was careful to distinguish PBS from approaches which are not PBS, including ABA. Continuing the commentary, Critchfield (2015) criticises ABA’s unwavering commitment to what he terms “baerwolfrisleying”: the specified criteria for ABA according to the original definition of ABA. Critchfield questions the assumption that practices that correspond to the original ABA criteria are essentially good, and those which do not are bad. He further challenges the ABA community by stating that the reason for ABA’s disregard for PBS is that PBS was engineered for scaling-up while ABA (according to the original criteria) is not. This comment by Critchfield reflects the differences in the “social entity” (see Wejnert, 2002) of PBS and ABA, the former which promotes team and system approaches (see Gore et al., 2013) and ecological validity (Carr et al., 2002), while the latter predominantly focusses on interventions delivered by certified individuals (Normand and Kohn, 2012).

Article 3

The third debate was in 2017, when the journal The Behavior Analyst published a paper by Critchfield and Reed which critically examined the fundamental features of ABA. The Critchfield and Reed article contributes a critique of the features which influence the
adoption of ABA. The authors make explicit reference to target audiences for research including mainstream researchers, funding agencies and policy makers, directly referring to those persons or organisations which are not only important to the adoption of ABA, but also integral to the adoption of PBS. But for ABA, it is Wejnert’s “familiarity with the innovation” variable which is of relevance here. This element explains that the rate of adoption of ABA – all other factors being equal – increases as its novelty decreases. ABA has an overt scientific basis, and this requires audiences to “consume” ABA, but they can only do so when information is presented to them in ways they can understand. But Noone and Chaplin (2017) argue that ABA is presented in a dispassionate and impersonal way, thereby risking accurate understanding. Familiarity is also acquired by observing the outcomes of innovations for those who have adopted them (Wejnert, 2002). This is one aspect which places PBS at a particular advantage over ABA. PBS’s commitment to ecological validity necessitates “ordinary people […] in ordinary settings under natural conditions including multiple demands, times of stress and the presence of interfering variables” (Singer, 2000, p. 123). Conversely, ABA continues to experience tension with ecological validity, at least with respect to functional analysis methodology (Lloyd and Kennedy, 2014). The importance of ecological validity in the “scaling-up” of interventions used in typical contexts has been emphasised by Ledford et al. (2016) and remains an issue for ABA in order for it to maximise its diffusion.

These debates have highlighted seven of Wejnert’s conceptual framework variables: political conditions, societal culture, global uniformity, private consequences, familiarity with the intervention, benefit vs cost and social entity. These represent all three main components of Wejnert’s conceptual framework suggesting that the framework was successful in identifying the variables seen as contributing to the diffusion of PBS and ABA in these articles. These debates also evidence a change in the perception of the ABA community towards PBS, with PBS more frequently defended within these ABA publications in later years, but they also demonstrate how PBS has leveraged diffusion more effectively than ABA.

Application to the UK and Australian contexts

This review has drawn primarily upon a North American perspective because of the predominance of authors from this continent; nevertheless, PBS is gaining increased attention in the UK through its recommendation in several policies and professional guidelines. However, there remains an inherent conflict between ABA and PBS which has evolved outside traditional academic debate. National Institute for Health and Care Excellence (NICE) (2017) is artificially separating ABA from PBS despite the two being inextricably related. This is not a new observation; NICE’s failure to recognise ABA has been evident since at least 2011 (Dillenburger et al., 2014). Murphy (2017) summarises the development of NICE guidelines and highlights that the guidelines pay particular attention to systematic reviews and randomised controlled trials (RCTs). Murphy reminds us that RCTs are not prevalent in the field of learning (intellectual) disabilities. This point has also been noted by Keenan and Dillenburger (2011) in relation to autism, and by Smith (2013) for behaviour analysts. Sturmeys (2014) points out the constraints of systematic reviews and RCTs of the intellectual disability literature, giving examples of methodological limitations. The lack of acknowledging ABA in the guidelines can be interpreted through Wejnert’s (2002) variable “benefits vs costs” (see Table I). Here, NICE is concerned with the absence of what it perceives to be quality evidence from RCTs and systematic reviews (the “benefit”). This absence invokes concern with making recommendations for ABA (the “cost”). This situation has undoubtedly influenced the development of the guidelines because of the limitations of the evidence that can be considered, yet the guidelines borrow heavily from ABA, referencing functional assessment, functional analysis, behaviour support plans and motivating operations. Conversely, the focus on PBS in the UK following the public broadcast of acts at “Winterbourne View” is now extensive (Allen and Baker, 2013). In fact, PBS has been exploited by government in the wake of “Winterbourne View” with the intention to improve the lives of vulnerable people with intellectual disability without an agreed and defined theory nor competencies for PBS (Allen and Baker, 2013).

The PBS Academy (pbsacademy.org.uk) has established a PBS competency framework and standards for training and practice. A recent evaluation of the academy identified a need for
improved attention to “supporting an increase in knowledge and practice of PBS and connecting more with other professional organisations and family carers” (Denne, 2017, “Impact of the PBS Academy: Key findings and implications”, para. 2). These recommendations can be addressed by designing for diffusion which considers how an innovation is noticed, positively perceived, adopted, adapted and implemented (Dearing and Cox, 2018).

It is generally recognised that Australia has had few promoters of behaviour analysis (see Jones and Mazzucchelli, 2018) and up until 2018, there was no approved provider of ABA coursework in Australia for behaviour analysts. Feasibly, this is why Australia still has low numbers of Board Certified Behaviour Analysts (Association for Behaviour Analysis Australia, 2018). Because Australia is relatively geographically isolated and home to few behaviour analysts, communication and personal interactions about ABA are limited. These are evidence of the eighth variable in Wejnert’s (2002) conceptual framework: “geographical settings”. This variable hampers the diffusion of ABA in Australia. Programmes in Australia using ABA are predominantly autism- and childhood-aligned, expensive and frequently parent directed rather than service directed (Couper, 2004). ABA in Australia has been described as a private market (Valentine, 2010), whereby perhaps protecting it from hype and scepticism often experienced in other jurisdictions because those who choose it inherently believe in its evidence and suitability. ABA is recommended in Australia for children with autism (Prior et al., 2011) but there are no formal recommendations for any other demographic group. Conversely, PBS is well publicised in Australian disability policy, but it is inaccurately represented and is overtly aligned with behaviour support plans and restrictive interventions (Hayward et al., in press). The authors argue that PBS in Australian disability services was adopted through coercion and imitation, evidence of “political conditions” in Wejnert’s (2002) conceptual framework.

Conclusion

Wejnert’s (2002) conceptual framework for the integration of diffusion variables uses three components to describe how innovations are diffused (spread) from a source to an adopter. The three components are: characteristics of the innovation itself which modulate the process of diffusion, characteristics of those adopting the innovation and the ecological and cultural context of adopting the innovation. These components are evident in the discussion of ABA and PBS in the literature. There are differences in the structure of communication networks, with PBS having a heterophilous network for communication contributing to its improved diffusion while the diffusion of ABA has been hampered by what appears to be a more homophilous network.

The challenge for PBS appears to be sustaining and scaling its use, while for ABA the challenge appears to be with productive collaboration and funding support. Comparing the adoption of PBS with ABA suggests that continued attention to the following issues may encourage the systemic adoption of both disciplines and meet these challenges:

1. promotion to large collectives, i.e. political groups, organisations, communities and social movements;
2. inclusion within laws, regulations, policies and guidelines;
3. matching with the values of society;
4. consider the requirements for education and training as potential barriers;
5. focus on service delivery using team and system approaches; and
6. behavioural science should present evidence to the committees and organisations which are responsible for endorsing practices and interventions to directly influence the inclusion of studies using alternative evidence-based methodologies, for example, single-subject experimental designs.

The professional divide between PBS and ABA has dramatically narrowed since Johnson et al.’s (2006) paper. PBS openly acknowledges the influence of ABA on its development and has included behavioural science as a core feature since its inception. More recent publications recognise that ABA’s initial disregard for PBS was in error, and it has much to learn from PBS’s
success in marketing. Both PBS and ABA can now focus on collaboratively improving their adoption, guided by diffusion of the innovations theory. The successful adoption of both PBS and ABA has obvious benefits for service users, and Dunlap et al. (2008) summarise this well: 

[...] it is important to emphasize that the distinctions between PBS and ABA do not reflect an adversarial relationship. On the contrary, PBS and ABA occupy somewhat different niches, and it is expected that the products of the two approaches will result in mutual benefits. (p. 693)

ABA has guided PBS towards behavioural science; PBS can now guide ABA towards wider adoption.

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Corresponding author

Brent A. Hayward can be contacted at: hayward.brent@gmail.com

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Addicted to PBS? CBT can fix that: commentary on improving the adoption of PBS and ABA using diffusion of innovations

Jonathan Mason

Abstract

Purpose – The purpose of this paper is to provide a commentary to Hayward, Poed and McKay-Brown’s article by expanding upon some of the reasons for the apparent dominance of Positive Behaviour Support (PBS).

Design/methodology/approach – The commentary notes the rise and dominance of Cognitive behaviour therapy (CBT) over a similar time frame, and uses both this and ideas from the literature to examine the reasons for, advantages and consequences of PBS’s dominance.

Findings – The paper identifies three overlapping reasons for the comparable rise of PBS and CBT, and examines the impact that their dominance has had on attempts to manage quality, improve outcomes and train staff.

Originality/value – Establishing the reasons for the success of a theoretical approach can assist with the development of other effective interventions.

Keywords Effectiveness, Innovation, Positive behaviour support, Cognitive behaviour therapy, Popularity, Diffusion of ideas

Paper type Viewpoint

Introduction

In the previous article, Hayward, Poed and McKay-Brown use Wejnert’s (2002) and Rogers’ (2003) theories on the Diffusion of Ideas to explain some of the apparent popularity of Positive Behaviour Support (PBS) over the scientific approach that it originated from – Applied Behaviour Analysis (ABA). In this paper, I explore the parallel between the widespread adoption of PBS and the dominance of another approach in human services – Cognitive behaviour therapy (CBT). It is suggested that both, grew from similar scientific roots, were popularised over a similar time frame and have had a similarly dramatic impact on the human services landscape. Three shared reasons for their adoption are suggested, and the implications briefly explored.

The parallel rise of PBS and CBT

The rise of PBS has been dramatic. Emerging in the mid-1980s as an alternative to behaviour modification approaches which often relied on the use of aversive conditioning strategies (Repp and Singh, 1990), PBS quickly evolved from its early scientific roots in ABA to include a diverse set of techniques for assessing and reducing challenging behaviour. Carr et al.’s (2002) definition of PBS described it as an “applied science” that aimed to improve quality of life and
minimise problematic behaviours, and it has quickly evolved into a dominant but variously defined and practised approach in human services across many countries. Kincaid et al.’s (2016) attempt to refine the definition of PBS, in acknowledging the fact that it has become something of an umbrella term, moved away from the description of PBS as an applied science and focussed instead on the application of the broader scientist-practitioner model whereby those engaging with PBS use “research-based assessment, intervention, and data-based decision making” (Kincaid et al., 2016, p. 71).

Meanwhile, by the time I finished my training in 2002, CBT had become a dominant discourse in clinical psychology. Initially dispensing with the then-popular behavioural and psychanalytic approaches, Beck’s ground-breaking book in the late 1970s on treating depression (Beck et al., 1979) using an approach focussed on modifying dysfunctional automatic thoughts about the self, the world and the future and drew widespread acclaim. Subsequent iterations of the theory re-introduced the role of behavioural psychology by emphasising the reinforcing role of certain behaviours in maintaining dysfunctional thoughts across a wide range of emotional disorders, and by the mid-1990s, CBT had become the dominant psychological intervention, at least in the UK. As Roth and Fonagy (1998, 2006) noted in their influential meta-analyses at the time, accurately defining “CBT” was already becoming increasingly difficult, largely because it had now begun to accept the influence of several different theoretical approaches.

So, why have PBS and CBT become so influential in such a relatively short period of time?

Both have found broad policy-based acceptance

Like the use of CBT with a wide variety of mental disorders or unhelpful behaviours, PBS has become a dominant approach for addressing a broad range of situations in human services, particularly in the intellectual disability (ID) sector and with those who have behaviour that challenges. In some jurisdictions, this has led to its adoption not just in policies and guidelines (see, for example, guidance produced by the National Institute of Health and Care Excellence, which also widely supports the use of CBT: www.NICE.org.uk), but in actual legislation (see, for example, the Queensland Disability Services Act 2008, which legally requires the development of a PBS plan for some clients with ID). A detailed examination of the underlying reasons for the popularity of both approaches with policy makers and legislators is beyond the scope of this paper, but it is interesting to note that both offered a new approach to scale (CBT offered results in as few as ten sessions, and PBS allowed clinicians to work with multiple individuals by using positive programming and ecological techniques). Furthermore, both approaches re-focused many clinicians on the internal experience of the people they were working with; psychologists using CBT become interested in cognitions and emotions, not just behaviour and those using PBS similarly became interested in the way in which the individual felt about their lives and their living circumstances. Put differently, both approaches were perhaps seen as being more person-centred than their predecessors, offering greater opportunities for inclusion. Thus, both CBT and PBS have become dominant discourses at least in part by finding their way into the policies, procedures and legislation that guide the work of many health and disability professionals, sometimes at the expense of other, perhaps equally effective, approaches.

Both offer significant flexibility to adopters

Baer et al. (1968) describe ABA as a discipline rather than a Box of Tricks (p. 96) – an interesting distinction, intended to make the point that ABA is a body of technology, bound by a theoretical model, that can be used to both explain and modify human behaviour in a way that enables it to be precisely replicated. The question then arises as to whether PBS is in fact a Box of Tricks, and – if so – is that such a bad thing? As a keen student of CBT, I was often reminded by supervisors and lecturers to arm myself and my clients with a tool kit, and as clinical research has developed over the past 15 years or so, the tools available have multiplied. So-called second and third wave cognitive approaches have brought increasing variations on, among other things, the use of exposure, mindfulness and attentional control. Similarly, PBS offers those using it significant flexibility. Whilst some clinicians or circumstances may call for the adoption of a version of PBS that focusses more prominently on functional analysis and the manipulation of
contingencies and reinforcers to change a behaviour, others may require a version that focusses
on the development of strategies to enhance quality of life, reduce exposure to the triggers of
challenging behaviour and improve the client’s living circumstances. Thus, both PBS and CBT
permit their users to make broad choices about how the intervention is structured, which in turn
has made both more attractive to adopters.

Both are effective in a wide range of circumstances

In an era in which evidence-based practice is rightfully important, the effectiveness of both CBT
and PBS are well established. Both CBT and PBS have been shown to be effective in
addressing an increasingly wide range of target problems, both in people with intellectual and
developmental disabilities and the neurotypical population, and in adults and children. Whilst it
is beyond the scope of this commentary to review the clinical and economic effectiveness of
both PBS and CBT, interested readers might consult Marquis et al.’s (2014) excellent
meta-analysis of the effectiveness of PBS, and Roth and Fonagy’s (2006) meta-analytic
review of the effectiveness of psychological therapy for an introduction to the literature in
this area.

PBS appears to have the added advantage of being relatively straightforward to train large staff
groups to use. In their systematic review, MacDonald and McGill (2013) concluded that PBS
training had a positive impact on the knowledge, emotional responding and attributions of staff,
as well as reducing behaviour that challenged. Whilst it is hard to compare the baseline skill levels
of people who undertake CBT and PBS, it seems likely that the training required to become
competent in delivering CBT is more intensive and potentially involves more rigorous quality
assurance processes through universities and colleges. Nonetheless, both CBT and PBS have
become ubiquitous enough that finding training in either is relatively straightforward, and
combined with the clear effectiveness of both approaches with a broad range of presenting
issues, their continued popularity seems assured.

Some implications

Inevitably, the very factors that have contributed to the widespread adoption and success of both
PBS and CBT have created their own difficulties. The lack of a formal, universally adopted set of
definitions, principles and practices for PBS has allowed interested professionals and
organisations to implement their own versions of PBS, contributing at least in part to its rapid
adoption across human services in many countries. However, as with CBT, the very pragmatism
that has enhanced the adoption of PBS has brought several less desirable consequences. For
example, the diversity of practice undertaken in the name of both PBS and CBT makes it hard for
adopters to be sure that they are applying the most appropriate evidence-based intervention,
reflecting what Roth and Fonagy (2006) identify as the narrow methodological approach used in
outcomes research, whereby clients, therapists and intervention strategies are carefully selected
and controlled.

Furthermore, whilst attempts have been made to introduce a quality assurance framework by
accrediting CBT therapists (see, for example, the British Association of Behavioural and Cognitive
Psychotherapy; www.babcp.com), there can be a little doubt that there are many allied health
professionals, including psychologists, practicing CBT with little specialised training. Similarly,
whilst the Behaviour Analyst Certification Board (www.BACB.com) provides oversight of the
training and subsequent accreditation and quality control of certified behaviour analysts,
practitioners undertaking PBS, like those undertaking CBT, have a variety of backgrounds and
skills that they make use of in a largely unregulated marketplace. Whilst organisations such as the
PBS Academy in the UK (www.pbsacademy.org.uk) and the Association for PBS (www.apbs.org)
in the USA have begun the process of introducing a quality control framework to PBS, this
approach has yet to gain significant traction. Given the widespread adoption of PBS across the
human service and education sectors, it seems likely that retrospective efforts to introduce quality
control systems and processes will need to be cleverly marketed and voluntarily adopted, and are
unlikely to lead to universal uptake. In this regard, as far as PBS and CBT are concerned either the
Genie is out of the bottle, or the horse has bolted, depending on whether you are an optimist or pessimist.

Finally, as Hayward, Poed and McKay-Brown point out, the view that ABA is less effective than PBS is in many cases erroneous, reflecting a general concern that alternatives to dominant approaches like PBS and CBT are supressed. It is potentially unhelpful that, for some allied health and disability professionals, PBS is now the legally required theoretical and scientific response to behaviour that challenges, regardless of whether ABA (or perhaps some other intervention, such as psychological therapy or speech and language therapy) might present a more practical or effective alternative. Similarly, students leaving postgraduate clinical psychology training courses often leave with few skills in approaches other than CBT, and with limited understanding of the effectiveness of alternatives to CBT. Whilst research into the active ingredients of successful psychological therapy suggests that as little as 15 per cent of the positive change that clients experience is attributable to the specific techniques that therapists use (e.g. Asay and Lambert, 1999), it would surely be in a client’s best interest for their therapist to be knowledgeable and competent in the delivery of a range of theoretical approaches.

Conclusion

PBS and CBT appear to share similar roots and developmental trajectories, and it is argued that there are overlapping reasons for this similarity. Their success can be attributed, at last in part, to their acceptance by policy makers, flexibility and effectiveness. Their dominance comes at some cost, however, including the challenge this presents for quality assurance and the use of evidence-based alternatives.

References


Further reading


Corresponding author

Jonathan Mason can be contacted at: jmason3@usc.edu.au
Promoting positive communication environments: a service evaluation

Kunden Patel, Laura Roche, Nicola Coward, Jacqueline Meek and Celia Harding

Abstract

Purpose – The purpose of this paper is to present an evaluation of a programme of training and support provided to staff, which aimed to encourage supported communication environments for people with learning disabilities.

Design/methodology/approach – Training, monitoring and support for communication, specifically augmentative and alternative communication (AAC) strategies, was provided by speech and language therapy staff to two residential services over 46 weeks. Staff and service user communications were observed pre- and post-intervention.

Findings – In one provision there was an increase in service user initiations and the use of some AAC strategies by support staff. In the other provision there was no change in service user initiations and a decrease in the range of AAC strategies used. It appears that some forms for AAC remain challenging for staff to implement.

Originality/value – This evaluation explores ways of using specialist support services to improve communication environments for people with learning difficulties. Possible reasons for differences in the outcome of the intervention are discussed. Future research into the types of communication interactions experienced by people with learning disabilities across the range of communication styles may be useful so that support staff can be better helped to provide sustained and enriched communication environments.

Keywords Learning disabilities, Community living, Training, Augmentative and alternative communication

Paper type Research paper

Introduction

The communication skills of people with learning disabilities are varied, although many will need some form of support for their communication skills (Gillberg and Soderstrom, 2003). For people with profound and multiple learning disabilities, skills may range from pre-intentional to intentional pre-verbal abilities (Coupe-O’Kane and Goldbart, 1998). Many people with learning disabilities may need additional augmentative and alternative communication (AAC) strategies to support receptive and expressive communication and social interaction. The types of AAC used with this population may include Objects of Reference (Park, 1997), use of signs such as Makaton (Walker, 1977), natural gestures and visual supports such as symbols and pictures (Harding et al., 2011).

People with complex communication needs who use AAC have reduced social opportunities and are at risk of isolation (Goldbart and Caton, 2010). In some instances, communication partners may be uncertain as to how to use the necessary AAC strategy and may lack the necessary skills, having not had any training (Baxter et al., 2012). Confidence with using and understanding the rationale for a particular AAC approach may also influence the use of AAC (Norburn et al., 2016).

Supporting staff and carers to use communication strategies

The skills and attitudes of those supporting the person with learning disabilities may influence how strategies are used in everyday contexts (Bunning et al., 2013). Graves (2007) discuss that diversity in the working context, possible values conflict between the SLT and the carer, team
willingness to collaborate and support for the implementation of strategies, and SLT doubts about the value of formal communication training are factors which may influence effective intervention. Lewer and Harding (2013) identified that building strong working relationships with support staff enabled understanding of values, attitudes and roles which impact on success with intervention. Communication partners and support staff need training to enable them to interact and support people with additional communication needs, in particular, people with learning disabilities (Trief, 2007).

Training support staff to develop consistent communication strategies is reported as a method of improving the quality of service user – staff interactions (Owen et al., 2008). However, there is limited evidence available to support the notion that training staff improves communication; in general, support staff tend to use AAC when there is an acute need, rather than in a functional interactive way across many contexts (Rombouts et al., 2017).

**Using AAC with people who have learning disabilities**

Support staff who support people who are AAC users often find it hard to adapt and use relevant strategies such as Makaton with modified spoken language, for example, thereby reducing the effectiveness of the recommended AAC approach (Healy and Noonan Walsh, 2007). Inconsistent use of AAC and a limited understanding of how it could improve or enable communication opportunities could lead to an AAC system being abandoned or used inconsistently (Blackstone and Berg, 2009). Communication partners need to be given a clear rationale for the method of AAC suggested, to ensure effective use and implementation of the recommended style of communication into everyday contexts (Martin and Alborz, 2014). Anecdotally, it is often assumed that provision of training for support staff working with adults with learning disabilities is effective. However, outcomes from such studies are varied and cultural and motivational factors are difficult to quantify (Iacono et al., 2018).

**An inner city service evaluation**

This paper presents an inner city learning disability partnership team’s project aimed at improving communication support for people with learning disabilities. Speech and language therapy intervention had been provided on an individual session basis with an agreed number of sessions for the key worker, adult with learning disabilities and SLT to work together. The Supporting Teams to Adopt Recommended Strategies (STARS) project was developed as a method of addressing the need to improve communication environments by changing the way communication intervention by the SLT members of the team was currently provided. It also aimed to address the roles highlighted in the National Learning Disability Senate (2015) report, specifically enabling others to be effective in the communication support they were offering, and being able to provide specialist therapeutic support to enhance communication opportunities for people with learning disabilities in their everyday environments. The emphasis of this intervention was specifically providing training and ongoing support for staff supporting service users in their residential homes (rather than to family members) as it had been recognised that staff needing to confidence and skills in using AAC.

The STARS project adopted the Royal College of Speech and Language Therapists (2013) five communication standards for support staff to work towards when working with the residents. These communication standards are:

- there is a detailed description of how best to communicate with individuals;
- services demonstrate how they support individuals with communication needs to be involved with decisions about their care and their services;
- staff value and competently use the best approaches to communicate with each individual they support;
- services create opportunities, relationships and environments that make individuals want to communicate; and
- individuals are supported to understand and express their needs in relation to their health and wellbeing.
STARS aimed to support staff to implement communication interventions including use of AAC. Support to implement interventions was offered not just during the initial training (as in previous interventions) but throughout the 46 weeks, supporting staff to gain confidence with using various AAC strategies to interact with service users. The intervention initially focussed on two residential homes; one with four residents with profound and severe learning disabilities (Provision A), and another for four residents with moderate learning disabilities (Provision B). The speech and language therapy team provided specialist advice working directly alongside staff to support them to implement a range of different AAC strategies.

It was predicted that by undertaking the STARS project as a joint intensive intervention, communication environments for people with learning disabilities would be improved.

Method

Study design

Phase 1 (weeks 0–4) of the project included:
1. Agreeing project commitments with staff, (i.e. that the main focus of the project was to provide staff support and training).
2. Person-centred goal planning for the service users of both provisions with the managers and staff of both residences.
3. Identification of staff strengths and areas of development needs. If a service user in either provision was not known to the SLT team, then an assessment and observation of communication skills and interactive style was completed.

Phase 2 (weeks 4–10) involved training staff about AAC use to support both receptive and expressive language and the diversity of communication styles used, both by people with learning disabilities generally and by service users in that setting. Therapists also provided staff with support, and resources and templates for visual materials such as timetables, symbols, etc. Training was provided in specific two-hour workshops as well as direct support within the home. Direct support in the home included modelling specific strategies, observing service users and supporting staff to use the AAC resources confidently.

Phase 3 (weeks 10–14) involved staff receiving ongoing training in providing a total communication environment, meetings with staff to discuss progress and problems, and the instigation of a positive interaction communication board where successful interactions were celebrated. Makaton training was offered once a fortnight.

Phase 4 (weeks 14–18) involved long distance support through phone consultations as requested by the home. Mid-way observations of service user progress was also carried out.

For Phase 5 (weeks 18–24) staff did not receive any therapy input directly, but could contact the team to discuss issues relating to communication, or to request a visit as necessary. Phase 6 took place between weeks 24–42. This involved further service user observations, with direct input offered if staff requested support. Phase 7 involved the final evaluation of the project.

Outcomes were assessed through observations of service users and staff during breakfast and lunch times. These times were chosen as it was felt that service users would be home and available to be observed.

Participants

Participants in this service evaluation were service users and support staff. There were four service users with profound and severe disabilities (Provision A), and four service users with moderate learning disabilities (Provision B). The service users in Provision A were aged between 55–79 years. Two service users were non-verbal and two service users had very limited
verbal skills. The service users in Provision B were aged between 47–72 years. One service user was non-verbal, one service user had very limited verbal skills and two services were being verbal. Both provisions took part in the project as they had requested additional support from services. Staff in Provision A were reported as being a newly formed team. Provision B had a more established staff group.

Data
Data were collected through use of observations of service users and staff. Observations included the number of service user initiation of communication attempts, staff initiation of communication with service users, and the number of responses or misses by staff to service user communication initiations. These were recorded in separate 15 min observation slots per service user completed by an SLT or an SLT assistant. Observations of service users and staff were completed before the programme, mid-way through the programme and at the end of the programme. As part of the service evaluation, staff were also asked to informally comment on their confidence with using AAC to facilitate communication with the service users they supported.

Ethics
This study was a service evaluation designed to investigate a collaborative approach to supporting staff to improve communication environments and interactions for people with learning disabilities. Staff were informed that the service evaluation was part of a service improvement project. The study design met the criteria of a service evaluation using the Health Research Authority decision tool.

Results
Service user initiation attempts
For provision A, there were an average of 28 initiations pre STARS increasing to an average of 41 initiations mid-way and to an average of 77 initiation attempts at the end. In Provision B, there were an average of 50 initiations pre STARS, 43 initiation attempts mid-way and 50 initiations at the end (Figure 1).

Interaction events initiated by support staff
For Provision A, there were an average of 50 initiation from all service users pre STARS, 43 initiation attempts mid-way and 50 initiation attempts at the end. For provision B there

![Figure 1](image-url)
were an average of 23 initiations pre STARS, 31 attempts mid-way and 18 initiation attempts at the end.

**Number of service user initiations missed by support staff**

In provision A there were an average of 12 missed service user initiations pre STARS, 17 mid-way and 18 at the end.

Provision B staff missed an average of 19 service user initiations pre STARS, 9 mid-way and 13 at the end.

**Pre-mid-way and post-intervention range of communication strategies used by staff**

In provision A, Staff increased their use of verbal interaction, Objects of Reference, touch and gestures (Figure 2). They reduced use of Makaton, eye contact, body language and facial expression. None of the staff used visual aids (pictures /symbols), communication passports or visual stories.

In provision B, Overall, there were decreases in use of all but one strategy by the end of the service evaluation period. During the mid-way service evaluation, there were increases in use of Makaton, verbal language and gestures, but these increases were not sustained by the end of the 46 week period (though Makaton use was slightly higher at the end of the intervention.

**Staff confidence in using AAC Staff completed a pre- and post-STARS confidence scale in the use of AAC**

*Provision A.* Staff had low confidence in using Makaton, both before the intervention started, and throughout the duration of the STARS project. Some staff had not used Makaton in previous roles or were unsure of specific Makaton signs. Staff reported awareness of other communication strategies such as gesture, Objects of Reference, etc., and also commented that they felt more confident about using AAC post the STARS intervention. Staff elected a Makaton champion to motivate staff to use Makaton with service users and to be a resource if unsure of a sign.

Use of verbal support, Objects of Reference, touch and natural gestures increased during the intervention. However, eye contact, body language and facial expression decreased. There were no observed use of visual aids, visual stories or communication passports.

*Provision B.* Pre STARS, staff reported that they felt confident in using visual timetables, communication passports and visual stories but this was not observed in practice, with no use of visual supports observed at all. They felt less confident with using Makaton, although use increased mid-way, and then decreased. Post the service evaluation, staff reported that they continued to feel confident in communicating with their service users. Despite an increase in service user Makaton use, staff did not increase their use of Makaton.

**Discussion**

The purpose of this service evaluation was to review a targeted training approach provided by speech and language therapists to improve communication environments by providing intervention to support staff. This training and subsequent support over 46 weeks was provided in two residential provisions (Provision A and Provision B) in an inner city area.

The service users in each provision differed. Those in Provision A had more profound and severe needs, whereas those in Provision B had more moderate needs. There was an increase in service user initiations in Provision A, but no change in Provision B. Staff in Provision A initiated more communication with services users, compared to Provision B. In fact, in Provision B, the number of staff initiations decreased over the 46 week period. It was noted that the staff in Provision A were new, and were learning to work together as a team, as well as getting used to the service users. This could be one factor which contributed to an increase in initiations from service users as staff became more familiar with their
methods of communicating. It could be that the service users had a greater repertoire of communication skills in Provision B, so therefore, staff did not need to initiate communication opportunities in comparison to Provision A.

Service users in Provision A required greater support to create communication opportunities within their everyday environment meaning that staff needed to have a clearer recognition of each individual’s unique communication style. However, as communication attempts by service users were missed by staff, it is possible that each individual’s communication style were not consistently recognised by all staff. It is also possible that the greater demands of physical care might inhibit opportunities
to identify more subtle communication signs (Bunning et al., 2013). However, within Provision A although the number of missed communication attempts rose, there was also an increase in service user initiations.

Surprisingly, communication attempts were missed within Provision B, which given that the service users had a higher level of communication competence, would not be anticipated. Further investigations that explore the nature of the communication interactions that take place may help to understand the dynamic that is occurring in these contexts.

The range of AAC strategies used both initially and by the end of the service evaluation varied. In Provision A, a decrease was seen in use of facial expression, body language, eye contact and Makaton. Increases were seen with use of verbal language, Objects of Reference (Park, 1997), touch and use of gestures. Interestingly, no one was observed using) visual supports such as visual stories. It was noted that Intensive Interaction (Nind and Hewett, 2001) was used as a communication approach during observations in Provision B when staff were attempting engage with service users, but not Provision A. In previous training, support workers had been encouraged to use Intensive Interaction to engage with a service user who might be experiencing difficulties initiating interaction. Typically, Intensive Interaction (Nind and Hewett, 2001) is used with those service users who have more complex, profound and multiple needs, and it would be interesting to explore with support staff in Provision A whether the strategies they typically used on a daily basis were more functional. It may be that a key worker who uses an approach such as Intensive Interaction with a service user with complex communication needs could feel that they are gaining a more positive engagement in comparison to when attempting to use specific AAC strategies. Similarly, use of visual timetables for service users in Provision A might have been too difficult. Both provisions found Makaton hard to use, and both were seen to have varied use of Makaton despite the use of a Makaton Champion to support staff within each site. Difficulties in using Makaton have been found in previous studies (Healy and Noonan Walsh, 2007). Interestingly, a decrease was noted in a wide range of strategies in Provision B. There is not enough evidence from this service evaluation to speculate as to why some forms of AAC are more challenging than others. However, further investigations are warranted which could investigate whether some types of AAC are harder to use than others.

There are a number of limitations to this evaluation. The number of service users observed was very small and the observations were conducted in small 15 min slots and at different times. Context of the observations was not recorded. Observations over a wider range of situations and for longer periods of time would have been helpful. In addition, it was not possible to complete reliability checks on the observations made. Future studies would need to include more exploration of appropriate observations to make, specific training on categories to be observed and reliability of these tested. It would also have been useful to have gained more insight into the staff group motivations and expectations of the service evaluation. This would contribute to our understanding of how best to support staff in residential settings and how to use the small resource learning disability services have to most effect.

Conclusion

People with learning disabilities, specifically those with more profound needs are highly dependent on those who work with them to access systems (Harding et al., 2011). This service evaluation found that providing ongoing monitoring and support for staff who care for people with learning disabilities in their residential settings through use of the STARS approach did not enable support staff to provide a consistent communication environment. Data was not collected on factors such as work place culture, resources and impact of leadership or management. Future studies should investigate these factors in more depth, in relation to identifying whether particular factors would enable support staff to implement and maintain AAC. Further exploration of support staff understanding of the rationales underpinning communication strategies would be useful and may help to understand why some AAC strategies are more readily used than others.
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Corresponding author

Celia Harding can be contacted at: c.harding@city.ac.uk

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Commentary on “promoting positive communication environments: a service evaluation”: the communication partnership as a focus for change

Karen Bunning

Abstract

Purpose – The purpose of this paper is to debate the complexities of intervening with adults with learning disabilities and support staff in the natural environment and challenges of evaluating change.

Design/methodology/approach – A critical review of the relevance and amenability of communication partnerships for interventions that promote communication growth in context was carried out. Particular consideration was given to the mechanism for change and implications for research design.

Findings – The communication partnership is a reasonable focus for interventions aiming to promote the communication of adults with learning disabilities. Combining instructional training with in situ coaching appears to provide the most effective approach. Bringing about change within the dynamic context of communication is challenging and may benefit from an open, investigative design.

Originality/value – This paper synthesises the available evidence on intervening in the communication environment and debates the potential of realist evaluation as a context-focused research design.

Keywords Learning disabilities, Training, Support staff, Realist evaluation, Communication environment, Communication partnership

Paper type Viewpoint

Harding et al., reported an evaluation of a service-based intervention that enskilled support staff to facilitate communication with adults with learning disabilities. A dynamic process, communication occurs within the social space occupied by people, such as residential, day and educational settings, where information is shared, relationships develop and interactions proliferate for multiple purposes. Thus, the natural environment where communication actually happens, referred to as the communication environment, would seem to be an appropriate place to bring about change to the experiences of adults with learning disabilities and the social opportunities available for them. Back in the 1990s, Ware (1996, p. 1) summarised the good communication environment as one where “[…] people get responses to their actions, get the opportunity to give responses to the actions of others, and have the opportunity to take the lead in interaction”. Thus, the communication relationships experienced by individuals and the people who support them, referred to as communication partners, are of interest.

Bi-directional influences

The communication process is subject to bi-directional influences. Any difficulties that arise in communication do not derive solely from people with learning disabilities, but rather are viewed as outcomes of the interactional process (Nind et al., 2001). The competencies that each person brings to a partnership are mutually influential: the contributions of one affects
the other, and vice versa. Around 20 years ago, Kagan (1998, p. 817) captured the communication partnership as an “equation” made up of the skills and experiences of the participants and the availability and use of resources, where differences exist between the interactants, the equation is susceptible to imbalance, with the locus of control likely to be centred on the more able person (Bunning, 2011). Depending on the skill set of the person with particular communication needs, the communication partner is required to shape and adapt their usual way of communicating to achieve a more balanced interactional relationship. Simmons-Mackie and Kagan (1999) observed that it is possible to promote, or alternatively cast in doubt, the communication skills of the individual through partner skills usage. Two main types of communication error may occur in the communication partnership (Bunning, 2011). The first error type is when the partner fails to recognise and respond to the language and communication skills of the person. Referred to as a “cycle of devaluation”, the individual has few, meaningful opportunities to participate, which effectively hides their true competence. Joshua was a young man with intellectual disabilities and cerebral palsy who was dependent on a wheelchair for his mobility needs. He attended a day service where he was supported to take part in a range of activities. He communicated through facial expression, vocalisations, hand gestures directed to things in his immediate environment and jerking movements of his torso. Joshua was able to communicate his agreement or disagreement to various propositions but relied heavily on his support worker to interpret his meanings. The formal assessment of his communication skills revealed a large receptive vocabulary and understanding for complex concepts and structures. However, the communication environment was geared towards the more limited communication skills of the majority and provided him with few opportunities to use his natural competence. The second error type, referred to as a “cycle of inflation”, assumes a higher level of communicative competence in the person than is really the case. Eloise had understanding for single concrete ideas and experienced difficulties maintaining her attention. The support staff made no adjustment to utterance complexity and communication rate when communicating with her. Eloise typically sat on the margins of the conversation, unable to access turns and to use her available skills.

Earlier research found that direct support staff were not always prepared sufficiently to provide skilful communication support for the wide range of individual needs they encountered in their work (see Bradshaw, 2001; McConkey et al., 1999). Not restricted to individuals with more complex needs, disparities in the communication process between staff and individuals with borderline-mild learning disabilities have been reported, affecting the synchrony of verbal and non-verbal aspects (Reuzel et al., 2013a) and the pattern of turn occupation by staff where direct questions dominated and there was neglect of some spontaneous contributions by service users (Reuzel et al., 2013b). Dalton and Sweeney (2013) reported that whilst support staff acknowledged the importance of good communicative support to the improved quality of life amongst people with learning disabilities, they also recognised their own lack of knowledge and poor availability of specific resources as problematic. However, a lack of congruence between staff identification of preferred communication strategies and their observed usage suggested that increasing knowledge was not sufficient to alter practice (Healy and Walsh, 2007). Furthermore, interventions involving classroom-based learning did not transfer automatically into everyday use (Chadwick and Joliffe, 2009; McLeod et al., 1995). Other approaches have attempted to circumvent the problem of transfer through situated learning: problem-solving in life-simulated scenarios (e.g. MacMillan et al., 2000); classroom-based instruction with partnership practice or an immersion approach where the natural environment is targeted and staff act as agents for change (e.g. Meuris et al., 2015); video playback, guided observation and verbal feedback (e.g. McConkey et al., 1999; Money, 1997; Purcell et al., 2000); training in the form of prompts given to support staff via one-way radio in situ (Zoder-Martell et al., 2014). In a comparison of three models of speech and language therapy service delivery, combining staff training and direct work with service user and staff member was found to be more effective than either approach in isolation (Money, 1997). More recently, a systematic review of training initiatives delivered to support staff concluded that programmes incorporating opportunities for trying out communication strategies and for receiving feedback on progress were associated with positive outcomes for service users.
Thus, it would seem logical that any attempt to improve the social experiences of people with particular communication needs necessitates intervening at the level of the communication partnership in practice.

One size fits all?

Given the diversity of communication skills amongst adults with learning disabilities, a “one size fits all” approach to promoting skilful communication support amongst staff is probably not useful. Training in particular alternative and augmentative communication methods, such as manual signing, may be more straightforward because of the universal code, i.e. sign, which is being introduced to the communication environment. Even then, individual learning and the nature of accessible communication opportunities will vary from person to person. An earlier study by Purcell et al. (2000) involved a work-based training programme that was specifically designed around the assessed needs of people with learning disabilities and their support staff. It involved video recordings taken before and after the intervention. Reported gains in staff responsiveness correlated significantly with an increase in client communication acts. The mechanisms underlying the changes centred around the work-based, client-centred, “mentor-guided” approach that was implemented. A number of factors are critical here: comprehensive assessment of individual communication needs used to inform the content of the skills development programme, an intervention situated in the natural environment where communication takes place and a mentoring approach designed to encourage staff, provide feedback and support a change process. Using a nuanced approach that combined direct instruction with an immersion approach, Meuris et al. (2015) demonstrated not only increased manual sign production by both staff and adults with intellectual disabilities, but also growth in communicative functions used in narratives. Whilst the changes occurred 12 months after the start of the intervention, questions of maintenance and recapitulation of learning remained. The latter point is particularly relevant to what constitutes a trigger for re-referral: the support needs of a service user or the skill needs of a staff member?

Potentially more challenging is the type of support suited to people with severe-profound and multiple intellectual disabilities, where communication relies on subtle body behaviours, such as fleeting eye gaze, minor body movements and vocalisations (Grove et al., 1999). The communication partner is required to observe the individual closely, to detect changes in behaviour, to recognise gestures that are often idiosyncratic and to make the best interpretation of meaning as possible. In so doing, the communication partner draws on knowledge and daily experiences of the individual, observes contextual factors apparently connected to the individual’s behaviour, tries out a response and checks the person’s reaction as a guide to the relevance of the interpretation. In terms of staff training, this is a complex proposition, because it requires training in close observation of and support for the individual’s repertoire of communication behaviours. Two different interventions provide examples of this type of approach. Intensive interaction (Nind and Hewett, 2001) coaches partners to observe and tune-in to the individuals they support, developing playful interactional sequences in the here and now. Advancing communication towards something more purposeful is afforded by narrative-based approaches that reference events outside of the moment. Storysharing®, focused on the development of personal narratives combines instructional training and immersive activities that train staff to recognise the real-life experiences of the people they support; develop the narrative in partnership practice using communicative scaffolding; to work as a partnership in retelling the story to others (Grove and Harwood, 2013). Reported outcomes include a more complete narrative and a discourse structure that demonstrates a greater balance of contributions (see Bunning et al., 2017).

Realist evaluation

Having established the relevance of intervening in the communication partnership, there is an issue of evaluation. Observation methodologies offer useful ways to capture critical features of partnership interactions, provided that the phenomena of interest are defined clearly and any coding frameworks have proven reliability. Structured approaches have been used to quantify
the range and frequency of communication characteristics: communicative modalities employed by partners (e.g. Bailey and Bunning, 2011); discourse initiations and responses and pragmatics (e.g. Bunning et al., 2017). A more inductive approach is provided by conversational analysis to investigate talk-in-interaction, typically focusing on communication breakdown and repair (e.g. Finlay and Antaki, 2012). Such methods are labour intensive and require trained observers with time to carry out transcriptions that adhere to the appropriate conventions and analysis framework. Regardless of the method of choice, however, attention needs to be given to the attribution of change: how do we explain changes from baseline measures? Diversity of communication needs associated with learning disabilities and the range of staff skill sets challenge the evaluation process. Some contextual factors may trigger particular mechanisms that contribute to positive outcomes, whilst others may inhibit. For example, the dynamic of the staff team, the available skill mix of individuals, their experience and education, may variously affect staff responses to the training.

Realist evaluation, drawn from Pawson and Tilley’s (1997) seminal work, recognises that the interaction between context and mechanism is constant, and any impacts or outcomes stem from that interaction. It also recognises that what appears to work in one context, may not be replicated in another because of differences in the mechanisms for the change. Such an approach assumes that delivery of any intervention is testing a theory about the change process. This is done by testing clearly articulated hypotheses asking how the intervention works and for whom. In addition to collecting data for computing change pre- to post-intervention and carrying out a process evaluation (e.g. staff attendance of training events, compliance with programme requirements), data on specific aspects of the context that might influence outcomes and the particular mechanisms that might be creating change are also collected. Thus, the realist evaluation encourages address of the question: why has the intervention worked in this setting as opposed that one? In this way, a more complete understanding of ecologically focused interventions, particularly ones that are concerned with human communication, may be supported.

Conclusions

Given the diversity of communication skills and needs in the population with learning disabilities, what is the key to establishing communication growth in the environments where they live, work and socialise? First, we need to place equal value on the different ways people communicate in any given setting. We need to recognise that whilst speech, which is usually at the top of the human communication hierarchy (Flewitt, 2006), is the most immediate form of communication for most people, for some individuals it is other forms, such as objects, body gestures, sign and graphic symbols. Second, beyond the form of the communication is the process whereby meanings are co-constructed within the communication partnership. With reference to the communication equation (Kagan, 1998; Simmons-Mackie and Kagan, 1999), any assessment of the individual’s communicative skills needs to include a detailed analysis of partnership interactions, which means drawing on the frameworks of applied linguistics (see Bunning et al., 2017). The resulting profile will not only inform a more nuanced approach to the immersive training but provide a baseline from which to compute changes. Third, increasing the knowledge of support staff is not sufficient on its own. The most effective approaches appear to combine instruction with in situ practice. Opportunities are provided to try out new strategies and techniques, to receive feedback and to feedforward. Fourt, the challenge of evidencing and explaining change highlights the need for data collection beyond the observed skills of the communication partners (after Pawson and Tilley, 1997). This mean capturing contextual data: in this case the communication environment composed of the support staff – their skill sets, experience and personal attributes; the physical setting in terms of space and resources; the setting culture made up of organisational values, staff practices and managerial direction. Finally, it needs to be borne in mind that a re-referral to activate another cycle of the intervention is not only concerned with the changing needs of the adult with learning disabilities, but may be triggered by any aspect of the communication environment, including changes to the staff team, the adults with learning disabilities, the service organisation and management.
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Corresponding author
Karen Bunning can be contacted at: K.Bunning@uea.ac.uk

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School absences and exclusions experienced by children with learning disabilities and autistic children in 2016/17 in England

Chris Hatton

Abstract

Purpose – The purpose of this paper is to examine data on absences and exclusions from school amongst children with learning disabilities and autistic children in England in 2016/2017.

Design/methodology/approach – Data were drawn from Department for Education statistics for the school year 2016/2017 on school absences (authorised and unauthorised) and school exclusions (fixed-period and permanent) for children in the primary special educational needs categories of moderate learning difficulty (MLD), severe learning difficulty (SLD), profound and multiple learning difficulty (PMLD) and autistic spectrum disorder (ASD).

Findings – Authorised school absence rates were higher for all groups of children investigated compared to children without special educational needs, primarily due to illnesses and health-related appointments. Rates of unauthorised school absences were low. Rates of fixed-period and permanent school exclusions were higher for children with MLD and ASD compared to children without SEN, and lower for children with SLD and PMLD. Reasons given for exclusions were similar across children (persistent disruptive behaviour, physical assault against a pupil, verbal abuse against an adult), although physical assault against an adult was also commonly mentioned for children with SLD, PMLD or ASD.

Social implications – Reducing school absences for children with learning disabilities and autistic children will involve co-ordination of health and social care support arrangements to ensure they are convenient and efficient for children and families. In terms of exclusions, schools need to consider the extent to which they are making reasonable adjustments for children with learning disabilities and autistic children.

Originality/value – This paper presents in one place statistics concerning school absences and school exclusions for children with learning disabilities and autistic children in England.

Keywords Autism, Learning disabilities, Education, Intellectual disability, School exclusion, School absence

Paper type Research paper

Introduction

There are ongoing concerns about children with learning disabilities and autistic children in England in terms of absences from school and school exclusions.

Research has suggested that a wide range of socio-economic, family, school, and child factors (including special educational needs (SEN)) are associated with permanent school exclusion by the age of 16 (Ford et al., 2018; Paget et al., 2018). School exclusions can also have wide-ranging negative impacts on the child and their family in the short and long term (e.g. Berridge et al., 2001; Parker et al., 2016; Pirrie et al., 2011). Rates of absence from school have also been noted as higher for children with SEN (Hatton et al., 2016).


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Data sets

Information on the education of children with SEN associated with learning disabilities is provided in a series of annual reports published by the DfE. The Special Educational Needs (Information) Act 2008 requires the Secretary of State for Education to publish information about pupils in England with SEN each calendar year in order to help improve the wellbeing of these pupils. This requirement has led to the publication between 2009 and 2014 of the annual series “Children with Special Educational Needs: An Analysis” (see Hatton et al., 2016, for details and references). In 2015, the reporting format changed to a summary with extensive signposting of potential users to relevant source data, the most recent of which is available for 2017 data (Department for Education, 2017).

The primary source of information for reporting on SEN is the DfE’s National Pupil Database. Children with SEN in this database are identified through the school census. This survey, undertaken each school term, collects information on all children enrolled in all English state funded schools and non-profit making independent special schools during that term. Schools have a statutory responsibility to return school census data under section 537A of the Education Act 1996.

Children not included in the school census include those being educated at home, in independent (non-state funded) mainstream schools or in for-profit independent special schools. It has been estimated that the school census includes information on approximately 97 per cent of English children of statutory school age (Emerson, 2012).

The most recent statistics available are for 2016/2017, for school absences (Department for Education, 2018a) and school exclusions (Department for Education, 2018b).

Absences are recorded as authorised or unauthorised:

- Authorised absence involves permission from a teacher or other authorised representative of the school for absences for which a satisfactory explanation has been provided.
- Unauthorised absence includes all unexplained or unjustified absences. Arriving late for school, after the register has closed, is recorded as unauthorised absence.

Information is available on fixed period and permanent exclusions. A “fixed period exclusion” is recorded when a child is excluded from a school but remains on the register (as they are expected to return once the exclusion period is over). A “permanent exclusion” is recorded when a child is excluded from a school and their name removed from the register.

In both school absence and school exclusion statistics concerning specific SEN categories, children are included if they have been identified as having a primary SEN in that category, and if they have either an Education, Health and Care Plan (EHCP) or are being supported at the equivalent level to School Action Plus (a broader level of support than EHCPs but less broad than the general SEN Support level). This paper will include information on four separate SEN categories as defined in DfE statistics: moderate learning difficulty (MLD); severe learning difficulty (SLD); profound and multiple learning difficulty (PMLD); and autistic spectrum disorder (ASD).

Findings

School absences

Information on authorised and unauthorised school absences for children with SEN is reported in terms of the percentages of school half-day sessions missed over the course of the school year, broken down by primary SEN. These figures are for children aged 5–15 years old, enrolled in schools.

Figure 1 shows this information for children with MLD (235,680 children), SLD (25,120 children), PMLD (8,260 children), ASD (93,710 children) and children with no identified SEN (5,803,795 children).

Figure 1 shows that for authorised absences, compared to children without SEN (3.1 per cent authorised absences), children with MLD (4.2 per cent authorised absences), SLD (6.4 per cent authorised absences), PMLD (13.2 per cent authorised absences) and ASD (5.0 per cent
authorised absences) all experienced more authorised absences from school. In any one year, a child with PMLD was likely to miss 25 days of school due to authorised absences.

Rates of unauthorised absences were much lower than rates of authorised absences. For unauthorised absences, compared to children without SEN (1.1 per cent unauthorised absences), children with MLD (2.1 per cent unauthorised absences) and ASD (1.5 per cent unauthorised absences) reported slightly higher rates of unauthorised absences, and children with SLD (1.0 per cent unauthorised absences) and PMLD (1.0 per cent unauthorised absences) reported equivalent rates of unauthorised absences. For children with MLD, with the highest rates of unauthorised absences, this equates to missing four school days per year.

DfE statistics also report the proportion of children in each SEN category defined as “persistent absentees” – these are children who have missed 10 per cent or more of school sessions over the school year 2016/2017 whether these absences are authorised or unauthorised. On this definition, 17.9 per cent of children with MLD were “persistent absentees”, as were 22.3 per cent of children with SLD, 43.2 per cent of children with PMLD and 17.3 per cent of children with ASD.

In terms of the reasons for absences, a detailed analysis of this for children with SEN was last conducted for 2013/2014 data (Department for Education, 2016). Illness and medical/dental appointments accounted for 57 per cent of absences of children with MLD, 72 per cent of absences of children with SLD, 43.2 per cent of children with PMLD and 64 per cent of absences of children with ASD.

**School exclusions**

Information on school exclusions is reported separately for fixed-period and permanent exclusions across the school year 2016/2017. Statistics are reported in two ways. First, the rates of school exclusions are reported (the total number of school exclusions divided by the total number of children enrolled in school), broken down by category of SEN. However, a single pupil can undergo more than one school exclusion within a school year, a particular issue for fixed-period exclusions. Therefore, for fixed-period exclusions the number of pupils undergoing at least one fixed-period exclusion in the school year is also reported.

Figure 2 shows the rates of fixed-period and permanent school exclusions for the year 2016/2017, for children with a primary SEN of MLD, SLD, PMLD and ASD, and for children with no identified SEN.
Figure 2 shows that, as percentages of the number of pupils with each type of SEN, annual rates of fixed period exclusions were 10.5 per cent for children with MLD and 9.6 per cent for children with ASD – more than three times greater than children with no identified SEN (3.1 per cent). Children with SLD (2.5 per cent) and PMLD (1.0 per cent) were reported to experience low rates of fixed-period exclusions.

The proportions of children experiencing fixed-period exclusions (as children may experience more than one in a school year) mirrored the findings on rates of fixed-period exclusions, with proportionally more children with MLD (4.5 per cent of all children with MLD) and ASD (4.5 per cent of all children with ASD), and proportionally fewer children with SLD (1.2 per cent of all children with SLD) and PMLD (0.5 per cent of all children with PMLD), experiencing fixed-period exclusions compared to children with no identified SEN (1.6 per cent of all children with no SEN).

DfE statistics also report the reasons given by schools for fixed-period exclusions. For children with no identified SEN, the reasons identified for 10 per cent or more of fixed-period exclusions were persistent disruptive behaviour (27.8 per cent of fixed-period exclusions), physical assault against a pupil (17.8 per cent) and verbal abuse or threatening behaviour against an adult (17.8 per cent). For children with MLD, the most common reasons for fixed-period exclusions were persistent disruptive behaviour (32.0 per cent), verbal abuse or threatening behaviour against an adult (15.0 per cent). For children with SLD, the most common reasons for fixed-period exclusions were physical assault against an adult (26.1 per cent), persistent disruptive behaviour (20.1 per cent), physical assault against a pupil (17.6 per cent) and verbal abuse or threatening behaviour against an adult (15.2 per cent). For children with PMLD, the most common reasons for fixed-period exclusions were physical assault against an adult (42.9 per cent), persistent disruptive behaviour (14.3 per cent) and verbal abuse or threatening behaviour against an adult (14.3 per cent). Finally, for children with ASD, the most common reasons given for fixed-period exclusions were physical assault against an adult (21.5 per cent), persistent disruptive behaviour (21.0 per cent), physical assault against a pupil (17.7 per cent) and verbal abuse or threatening behaviour against an adult (16.8 per cent).

Figure 2 also shows information on the much lower rates of permanent school exclusions. Higher percentages of children with MLD (0.18 per cent) and ASD (0.12 per cent) were reported to experience permanent exclusions than children with no identified SEN (0.06 per cent). Lower percentages of children with SLD (0.05 per cent) and PMLD (0.04 per cent) were reported to experience permanent exclusions.

DfE statistics also report the reasons for permanent exclusions recorded by schools. For children with no identified SEN, the reasons identified for 10 per cent or more of permanent exclusions were persistent disruptive behaviour (33.3 per cent of permanent exclusions), physical assault against a pupil (14.3 per cent) and drug/alcohol related reasons (10.8 per cent). For children with
MLD, the most common reasons for permanent school exclusion were persistent disruptive behaviour (41.9 per cent), physical assault against a pupil (11.8 per cent) and physical assault against an adult (10.8 per cent). For children with ASD, the most common reasons for permanent school exclusion were physical assault against an adult (32.0 per cent), persistent disruptive behaviour (28.0 per cent) and physical assault against a pupil (16.0 per cent). The numbers of permanent school exclusions for children with SLD and children with PMLD in 2016/2017 were too small for an analysis of reasons for permanent exclusion.

Discussion

In 2016/2017, rates of authorised school absences were higher for all the groups of children investigated compared to children without identified special education needs (SEN), particularly amongst children with PMLD. Reasons for authorised absences for all groups primarily concerned illnesses and health-related appointments. Rates of unauthorised school absences were much lower for all groups, although slightly higher for children with MLD and children with ASD compared to children without SEN.

These findings on school absences clearly show the importance of better co-ordination of family support across health, social care and education, to ensure that the time children spend out of school for health and other appointments is minimised (Barnard-Brak et al., 2017). These absences, rather than unauthorised absences, are the major contributor to the higher level of school absences amongst children with learning disabilities and autistic children.

Rates of fixed-period school exclusions were at least three times higher for children with MLD and ASD compared to children without SEN, and lower for children with SLD and PMLD. Rates of permanent school exclusions were two to three times higher for children with MLD and ASD compared to children without SEN and children with SLD and PMLD. Reasons given for exclusions were broadly similar across groups of children (principally persistent disruptive behaviour, physical assault against a pupil, or verbal abuse against an adult), although for children with SLD, PMLD or ASD physical assault against an adult was also a common reason given for school exclusion.

These findings reinforce the urgent need for schools to adopt more reasonable adjustments to meet the needs of children with learning disabilities and autistic children, as part of a package of measures to reduce rates of school exclusions and thereby minimise their negative impact. Early intervention and public health measures are also needed as part of a preventive strategy to reduce school exclusions.

References


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Corresponding author

Chris Hatton can be contacted at: chris.hatton@lancaster.ac.uk

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