Clinical effectiveness of training staff in positive behaviour support for challenging behaviour in adults with intellectual disability: findings and insights from a cluster RCT

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Disclaimer:

The views and opinions expressed therein are those of the author(s) and do not necessarily reflect those of the HTA, NIHR, NHS or the Department of Health.
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- Professor Mike Crawford
- Ms Rachael Hunter
- Dr Ian Hall

**Collaborator**
Dr William Howie
The group were updated about the progress of the study
Will be involved in writing about the project
Helped us with choosing the right photosymbols
Will present at conferences/local seminars
Will prepare materials for disseminating the study to the service users and carers
Content

- The main study
- Health economics
- NHSE training initiative
Clinical and cost effectiveness of staff training in Positive Behaviour Support (PBS) for treating challenging behaviour in adults with intellectual disability: a cluster randomised controlled trial

Angela Hassiotis, Andre Strydom, Mike Crawford, Ian Hall, Rumana Omar, Victoria Vickerstaff, Rachael Hunter, Jason Crabtree, Vivien Cooper, Asit Biswas, William Howie and Michael King

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Abstract

🔗 Open Peer Review reports

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METRICS
Article accesses: 4671
Challenging behaviour has serious consequences (pharmacotherapy, hospital admissions, abuse, loss of home/community) for the person and their family.

Costs of care for challenging behaviour are high.

PBS is widely used.

Training in PBS of community ID services staff maybe a solution to improved management of adults with ID and challenging behaviour.

Evidence for efficacy by non independent researchers.

Evaluation of effectiveness needed.
What is PBS?

- PBS is an applied science that uses educational methods to expand an individual's behavior repertoire and systems change methods to redesign an individual's living environment to:
  1. enhance the individual's quality of life and, 2. minimize his or her challenging behavior (Carr et al 2002)

- Delivery of behavioural services known as positive behavior support (PBS) has emerged as a highly visible movement (Johnston et al 2006)

- Moreover, PBS may be cost effective (Grey & McClean 2007)
Specific staff competencies are a crucial factor in maintaining improvements in behaviour.

About half of patients in need of PBS may be treated at any time.

Specialist teams may have long waiting lists e.g. six months and may or may not be available.

Some evidence from training paid carers suggested reductions in challenging behaviour.

“Testing training in PBS at scale”
Study components

- Evaluation of clinical effectiveness of training
- Assessment of treatment fidelity and process evaluation
- Evaluation of cost effectiveness
- Pre-specified patient group analysis (ASD)

- Hypothesis
  Participants in the intervention arm would show significant reductions in challenging behaviour compared with participants in the control arm (TAU) at 6 and 12 months.

- Naturalistic 32 month follow up (study extension)
Questionnaires

- **Challenging behaviour**: Aberrant Behaviour Checklist-Community (ABC-C)
- **Mental Health**: Mini-Psychiatric Assessment Schedules for Adults with Developmental Disabilities (Mini PAS-ADD)
- **Community participation**: Guernsey Community Participation and Leisure Activities Scale (GCPLAS)
- **Family carer burden**: Uplift/Burden Scale
- **Paid carer burden**: Caregiving Difficulty Scale—Intellectual Disability (CDS-ID)
- **Family carer psychiatric morbidity**: General Health Questionnaire (GHQ-12)
- **Health Related Quality of life**: EuroQoL Health Questionnaire (EQ-5D)
- **Service use**: Client Service Receipt Inventory (CSRI)
ABC-C

- Informant/caregiver administered
- Captures symptoms on 5 domains (58 items)
- 0-3 (no severe problem)
- Widely used to monitor treatment effects

- Total score
  - Irritability (15)
  - Lethargy (16)
  - Stereotypy (7)
  - Hyperactivity/noncompliance (16)
  - Inappropriate speech (4)
Inclusion/exclusion criteria

**Participants**
- Eligible to receive care from ID services
  - Mild to profound ID
- Aged 18 years and over
- Total ABC score of at least 15

**Service**
- Willing to participate
- Availability of at least two staff members willing to train

**Participants**
- Primary clinical diagnosis of personality disorder or substance misuse
  - Relapse in pre-existing mental disorder
    - Decision by clinical team that a referral to the study would be inappropriate

**Service**
- There are no team members willing to train
  - The service already implements accredited PBS
Training in PBS

Target competencies

- Able to complete and interpret a brief functional behavioural assessment
- Ability to assess family/paid carers competency to implement the plan and provide interventions as appropriate
- Able to conduct an initial assessment of plan effectiveness
- Able to identify and overcome problems in implementation

- 3 x 2 day training sessions over 14 weeks
- Two cohorts of: Community nurses, clinical psychologists, Speech and language therapists, Occupational therapists, Consultant psychiatrists
- Supervision/mentoring
- Monthly teleconferences
- Site visits twice
TAU (2012/13)

A range of broadly defined behavioural, psychosocial and pharmacological interventions. The latter may be influenced by or broadly based on treatment guidelines published by professional bodies and may have elements of PBS

- 6/23 mentioned a challenging behaviour pathway based on national guidance (RCPsych reports, Mansell etc)
- Psychology, psychiatry and nursing most frequently mentioned professions managing cases
- In one case a behavioural team was disbanded
- Techniques
  ABC (antecedents-behaviour-consequences)
  ABA
- Training
  Several England and Wales based programmes
  Cert/Dipl/MA/MSc/Short course
  Variable proportion of trained staff (0-all)
  Of those trained several had moved on
Methods

- Cluster RCT with active recruitment
- Web-based randomisation system
- Random permuted blocks on 1:1 allocation
- In or out of London and ratio of team size (number of full-time equivalent staff) to number of service users registered per team.
- Rater blinded
- Sample size calculation suggested n=246 and min of 19 teams
Analysis

• Means, SDs and proportions as appropriate.
• Three level regression model adjusting for baseline ABC measurements, time period and effects of clustering by services and accounting for repeated measures within subjects
• Missing data
• Sensitivity analysis
• Subgroup analyses
CONSORT diagram

Number of teams recruited, \(N_r=28\)

Teams Excluded
- Refuse to take part, \(N_r=5\)

Number of teams, \(N_r=23\)
Service users screened, \(N_u=382\)

Service User Excluded, \(N_u=136\)
- Reached recruitment target: 52,
- No consent provided: 42,
- Ineligible: 22,
- Moved out of area: 7,
- Adverse event: 5,
- Uncontactable: 4,
- Not screened in time: 4

Service users recruited, \(N_u=246\)

Service User Excluded
- Ineligible, \(N_u=1\)

Allocated to Intervention
- \(N_r=11\)
- \(N_u=108\)
- \(N_{pc}=89; N_{kc}=19\)

Lost to follow up; refused, \(N_{af}=3\)
Follow up too early/late, \(N_{af}=7\)

Allocated to TAU
- \(N_r=12\)
- \(N_u=137\)
- \(N_{pc}=86; N_{kc}=50\)

Lost to follow up; refused, \(N_{af}=3\)
Follow up too early/late, \(N_{af}=17\)

Time 2 (6 months) assessments
- \(N_u=98\)
- \(N_{pc}=81; N_{kc}=17\)

Lost to follow up; refused, \(N_{af}=1\)
Follow up too early/late, \(N_{af}=3\)

Time 3 (12 months) assessments
- \(N_u=100\)
- \(N_{pc}=84; N_{kc}=16\)

Time 2 (6 months) assessments
- \(N_u=117\)
- \(N_{pc}=76; N_{kc}=39\)

Lost to follow up; refused, \(N_{af}=2\)
Follow up too early/late, \(N_{af}=5\)

Time 3 (12 months) assessments
- \(N_u=125\)
- \(N_{pc}=82; N_{kc}=42\)
### Demographics

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Total (n=245)</th>
<th>TAU (n=137)</th>
<th>PBS (n=108)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age, years (Median, IQR)</strong></td>
<td>37 (25-51)</td>
<td>33 (24 – 51)</td>
<td>42 (27 – 51)</td>
</tr>
<tr>
<td><strong>Gender, Male</strong></td>
<td>157 (64)</td>
<td>90 (66)</td>
<td>67 (62)</td>
</tr>
<tr>
<td><strong>Ethnic origin, White</strong></td>
<td>176 (72)</td>
<td>95 (69)</td>
<td>81 (75)</td>
</tr>
<tr>
<td><strong>Service reported level of ID</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>41 (17)</td>
<td>17 (12)</td>
<td>24 (22)</td>
</tr>
<tr>
<td>Moderate</td>
<td>77 (31)</td>
<td>46 (34)</td>
<td>30 (28)</td>
</tr>
<tr>
<td>Severe</td>
<td>127 (52)</td>
<td>73 (53)</td>
<td>54 (50)</td>
</tr>
<tr>
<td><strong>ABS(median, IQR)</strong></td>
<td>48 (29,68)</td>
<td>42 (25,64)</td>
<td>55 (35,72)</td>
</tr>
<tr>
<td><strong>WASI, Full scale IQ 4 (n=95)</strong></td>
<td>44 (40,52)</td>
<td>43 (40,50)</td>
<td>46 (41,51)</td>
</tr>
</tbody>
</table>

### Current accommodation

<table>
<thead>
<tr>
<th>Accommodation</th>
<th>Total (n=245)</th>
<th>TAU (n=137)</th>
<th>PBS (n=108)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential</td>
<td>105 (43)</td>
<td>52 (38)</td>
<td>53 (49)</td>
</tr>
<tr>
<td>Supported living</td>
<td>69 (28)</td>
<td>36 (27)</td>
<td>33 (30)</td>
</tr>
<tr>
<td>Family home</td>
<td>64 (26)</td>
<td>47 (34)</td>
<td>17 (16)</td>
</tr>
<tr>
<td>Own flat/house</td>
<td>7 (2)</td>
<td>2 (1)</td>
<td>5 (5)</td>
</tr>
</tbody>
</table>

### Clinical

<table>
<thead>
<tr>
<th>Measure</th>
<th>Total (n=245)</th>
<th>TAU (n=137)</th>
<th>PBS (n=108)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ABC (median, IQR)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total score</td>
<td>64 (44,86)</td>
<td>68.5 (47,87.5)</td>
<td>60 (43,86)</td>
</tr>
<tr>
<td>Irritability</td>
<td>20 (13,29)</td>
<td>21.5 (15,29)</td>
<td>18 (11,26)</td>
</tr>
<tr>
<td>Lethargy</td>
<td>12 (7,21)</td>
<td>13 (6,5,21)</td>
<td>12 (7,21)</td>
</tr>
<tr>
<td>Stereotypy</td>
<td>5 (2,10)</td>
<td>5.5 (2,10)</td>
<td>4 (2,9)</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>20 (12,26)</td>
<td>21 (13,28)</td>
<td>18 (11,24)</td>
</tr>
<tr>
<td>Inappropriate speech</td>
<td>4 (1,8)</td>
<td>4 (1,8)</td>
<td>5 (1,8)</td>
</tr>
</tbody>
</table>

### Medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Total (n=245)</th>
<th>TAU (n=137)</th>
<th>PBS (n=108)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any medications</td>
<td>220 (90)</td>
<td>124 (91)</td>
<td>96 (89)</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>165 (67)</td>
<td>91 (66)</td>
<td>74 (69)</td>
</tr>
<tr>
<td>Other psychotropic</td>
<td>180 (73)</td>
<td>96 (70)</td>
<td>84 (78)</td>
</tr>
</tbody>
</table>

### Mini-PASADD

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Total (n=245)</th>
<th>TAU (n=137)</th>
<th>PBS (n=108)</th>
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<tbody>
<tr>
<td>Common mental disorder</td>
<td>117 (49)</td>
<td>61 (46)</td>
<td>56 (52)</td>
</tr>
<tr>
<td>Severe mental illness</td>
<td>47 (20)</td>
<td>27 (20)</td>
<td>20 (19)</td>
</tr>
<tr>
<td>Autistic spectrum</td>
<td>50 (21)</td>
<td>31 (23)</td>
<td>19 (18)</td>
</tr>
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</table>

### Physical health problems

<table>
<thead>
<tr>
<th>Problem</th>
<th>Total (n=245)</th>
<th>TAU (n=137)</th>
<th>PBS (n=108)</th>
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</thead>
<tbody>
<tr>
<td>Mobility*</td>
<td>64 (36)</td>
<td>38 (36)</td>
<td>26 (36)</td>
</tr>
<tr>
<td>Sensory</td>
<td>43 (24)</td>
<td>29 (27)</td>
<td>14 (19)</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>67 (37)</td>
<td>42 (39)</td>
<td>25 (34)</td>
</tr>
<tr>
<td>Incontinence</td>
<td>78 (43)</td>
<td>46 (43)</td>
<td>32 (44)</td>
</tr>
<tr>
<td>Other</td>
<td>103 (57)</td>
<td>63 (59)</td>
<td>40 (55)</td>
</tr>
</tbody>
</table>
## Total ABC-C score

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>IQR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TAU</td>
<td>136</td>
<td>69</td>
<td>29.0</td>
<td>69</td>
<td>47 - 88</td>
</tr>
<tr>
<td>PBS</td>
<td>107</td>
<td>62</td>
<td>27.7</td>
<td>60</td>
<td>43 – 80</td>
</tr>
<tr>
<td><strong>6 Months</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TAU</td>
<td>116</td>
<td>61</td>
<td>32.6</td>
<td>54</td>
<td>37 - 81</td>
</tr>
<tr>
<td>PBS</td>
<td>98</td>
<td>55</td>
<td>32.5</td>
<td>51</td>
<td>30 – 75</td>
</tr>
<tr>
<td><strong>12 Months</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TAU</td>
<td>125</td>
<td>59</td>
<td>28.8</td>
<td>55</td>
<td>42 – 75</td>
</tr>
<tr>
<td>PBS</td>
<td>100</td>
<td>54</td>
<td>32.1</td>
<td>49</td>
<td>32 – 73</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Mean adjusted difference</th>
<th>95% CI</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total ABC</td>
<td>-2.14</td>
<td>(-8.79, 4.51)</td>
<td>0.528</td>
</tr>
</tbody>
</table>
ABC-C Domains

Irritability

Lethargy

Hyperactivity

Follow up time point - months

ABC score

Control

Intervention
<table>
<thead>
<tr>
<th>Model</th>
<th>Difference</th>
<th>95% CI</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sensitivity analyses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary model</td>
<td>-2.14</td>
<td>(-8.79, 4.51)</td>
<td>0.528</td>
</tr>
<tr>
<td>Area deprivation</td>
<td>-2.39</td>
<td>(-9.19, 4.41)</td>
<td>0.491</td>
</tr>
<tr>
<td>Completed by family/paid carer</td>
<td>-1.21</td>
<td>(-8.20, 5.79)</td>
<td>0.735</td>
</tr>
<tr>
<td>Missing data (BOCF)</td>
<td>-1.83</td>
<td>(-8.42, 4.76)</td>
<td>0.586</td>
</tr>
<tr>
<td>Heteroscedastic model</td>
<td>-2.35</td>
<td>(-9.24, 4.55)</td>
<td>0.505</td>
</tr>
<tr>
<td>Imbalance in baseline characteristics</td>
<td>-0.81</td>
<td>(-7.95, 6.32)</td>
<td>0.824</td>
</tr>
<tr>
<td>% of participants who had at least one intervention component</td>
<td>1.41</td>
<td>(-15.5, 18.3)</td>
<td>0.870</td>
</tr>
<tr>
<td><strong>Multivariate analysis (ABC-C subdomains)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irritability, Agitation, Crying</td>
<td>-0.041</td>
<td>(-0.22, 0.14)</td>
<td></td>
</tr>
<tr>
<td>Lethargy, Social Withdrawal</td>
<td>-0.016</td>
<td>(-0.22, 0.19)</td>
<td></td>
</tr>
<tr>
<td>Stereotypic Behavior</td>
<td>-0.050</td>
<td>(-0.25, 0.14)</td>
<td></td>
</tr>
<tr>
<td>Hyperactivity, Non-compliance</td>
<td>-0.049</td>
<td>(-0.23, 0.13)</td>
<td></td>
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</tbody>
</table>
Subgroup analyses
Medication use over 12 months

<table>
<thead>
<tr>
<th>Medications</th>
<th>N (%)</th>
<th>N (%)</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Any medications</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>124 (91)</td>
<td>106 (86)</td>
<td>118 (91)</td>
</tr>
<tr>
<td>Intervention</td>
<td>96 (89)</td>
<td>90 (87)</td>
<td>89 (86)</td>
</tr>
<tr>
<td><strong>Antipsychotics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>91 (66)</td>
<td>68 (55)</td>
<td>85 (65)</td>
</tr>
<tr>
<td>Intervention</td>
<td>74 (69)</td>
<td>66 (64)</td>
<td>66 (63)</td>
</tr>
<tr>
<td><strong>Other psychotropic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>96 (70)</td>
<td>88 (72)</td>
<td>99 (76)</td>
</tr>
<tr>
<td>Intervention</td>
<td>84 (78)</td>
<td>75 (73)</td>
<td>75 (72)</td>
</tr>
</tbody>
</table>
Conclusions

• Pragmatic trial close to current clinical practice
• Adequately powered
• Staff training in PBS as delivered in this trial does not improve challenging behaviour above TAU
• Staff training in PBS as delivered in this trial does not lead to changes in mental health, carer burden or activities
• Main limitations: 1. low dose of PBS; 2. possibly TAU was too similar to PBS; 3. some other variable that could have responded to PBS was not measured
Further thoughts

• Community ID teams are likely to have improved over time.
• Staff training in PBS requires further refinement to link with implementation.
• Our results vis a vis existing literature based on non-controlled designs, enthusiastic advocates of the intervention or specific service conditions/resource availability.
## Negative trial

<table>
<thead>
<tr>
<th>Discrepancy</th>
<th>Possible reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Differences in study design</td>
<td>Including, but not restricted to, differences in: outcome measures, control treatment, primary end point</td>
</tr>
<tr>
<td>False ‘positive’ result in the exploratory trial</td>
<td>Positive result produced by chance, Positive result reflects bias, Positive result reflects imbalance between study arms (confounding), Positive findings resulted from powerful placebo effects resulting from enthusiasm and sometimes pioneering efforts of researchers and therapists</td>
</tr>
<tr>
<td>False ‘negative’ result in the phase III trial</td>
<td>Negative result generated by chance (phase III study was underpowered), Negative result arises from failure to deliver treatment as intended (in terms of treatment content or context), Phase III trial recruited a population less likely to benefit from the intervention, Negative result relates to measurement error (imprecise data on patient outcomes)</td>
</tr>
<tr>
<td>Intervention has efficacy but is not clinically effective</td>
<td>Typical therapists cannot deliver the quality of treatment over time that was provided by specialist centres during the first phase of developing the intervention, Typical patients are unwilling to adhere to treatments to the extent that people do during short-term trials in specialist centres, Treatment context (administrative support, out-patient care, transportation etc.) needed to ensure success of the intervention is not available in the wider healthcare system</td>
</tr>
</tbody>
</table>

http://bjp.rcpsych.org/content/bjprcpsych/209/1/6.full.pdf
2008 and 2014: 71% (35 of 49) of trials of complex interventions returned negative results compared with 58% (21 of 36) for trials of drugs and other ‘simple’ interventions.

Moreover, negative results were returned in a greater proportion of phase III trials of complex interventions in mental health (80%, 12 of 15) than other medical fields (68%, 23 of 34).

Although not a statistically significant difference, the failure of so many complex interventions in mental health trials is striking, especially given the promising results of the exploratory trials that often preceded them.
Cost of challenging behaviour

• Evidence on the relationship between challenging behaviour and cost
  – Knapp et al (2005): higher cost due to challenging behaviour. Pre DH guidance on person centred care. May no longer apply
  – Others have found no relationship or that higher costs were because of area placements or more complex needs.

• Claim: behavioural interventions = reductions in behaviour that challenges = reduction of cost of care
  – More likely to move from residential to community placements
  – Less support required

• Problem: No evidence. Is dependent on community services being available
Health economic evaluation

• Costs of intervention
• Resource use (3 timepoints for previous 6 months)
• Cost utility
• Societal costs
HE Findings

• Cost per participant: £397 (£1500 including delivery by therapist)

• Resource use: mean difference -£346 (95% CI -£1518 to 825)

• Societal costs: mean difference -6 hours (95% CI -4 hours to 15 hours)

• QALYs: 0.076 in favour of the intervention (95% CI 0.011 to 0.140)
Combination of costs and quality of life

Difference in costs

NW

Cost

Benefit

+ Cost

Benefit

NE

SW

Cost

Benefit

SE

Decision rule required
Threshold of £20,000 to £30,000 commonly used; intervention is £17k per QALY.
Conclusion

• Training in PBS appeared to result in a QALY gain. Could be a chance finding ($p=0.02$)
• Training in PBS is cost-effective based on a threshold of £20,000 per QALY gained
• Training in PBS was not cost-effective when accommodation and criminal justice were included.
• No health care cost savings observed
• No change in accommodation observed
NHSE training in PBS (Dr Ashok Roy)

The Positive Behavioural Support and Autism Training Fund was funded by the ‘positive and safe programme’ for:

• Developing ‘skills around the person’
• Interagency / multi agency work at a person centred level
• Providing training in line with PBS competency framework and good autism practice
• Contribution to the discharge or avoided likely admission
Aims of the Fund

▪ To support people with LD and employers of service providers
▪ To foster innovation in providing PBS and Autism skills and knowledge, and skills in delivering training in these topics
▪ To learn from others and share good practice
▪ To promote and explore person-centred, multi agency workforce development
Monitoring and Evaluation

- To monitor the progress of the funds distributed
- To assess the actual delivery against that planned
- To assess the costs of training
- To provide an opportunity for early feedback on the impact of the training
- To measure short term outcomes of the funding programme
Participants completed two separate questionnaires online; Monitoring questionnaire (immediately after delivery)

Evaluation questionnaire (around 3-4 months after delivery)

<table>
<thead>
<tr>
<th>No. grants awarded</th>
<th>No. of organisations</th>
<th>Monitoring responses</th>
<th>Evaluation responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>169</td>
<td>65</td>
<td>63</td>
<td>57</td>
</tr>
</tbody>
</table>
Summary

• 169 grants were awarded to 65 organisations spread across England

• The fund provided an estimated 2,900 training interventions for a total investment of £557,600 (average of £191 per intervention)

• The interventions were undertaken by social care and health workers at all levels and by individuals’ family carers.

• For most, the anticipated costs were accurate

• Most people had built in review or evaluation of the training
All who had conducted evaluation had considered the training to be a success.

- Positive feedback from learners (n=20)
- Improved skills and knowledge (n=17)
- Improved practice (n=12)
- Increased confidence (n=7)
- Team building (n=3)
Findings – The impact of training on the person

<table>
<thead>
<tr>
<th></th>
<th>Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved quality of life through better relationships and reduced isolation</td>
<td>81%</td>
</tr>
<tr>
<td>Supported better communication in daily lives</td>
<td>77%</td>
</tr>
<tr>
<td>Reduced use of any form of restrictive practices</td>
<td>74%</td>
</tr>
<tr>
<td>Reduced frequency, duration or intensity of incidents of challenging behaviour</td>
<td>72%</td>
</tr>
<tr>
<td>Helped support independent living in community and engagement with meaningful activities</td>
<td>68%</td>
</tr>
<tr>
<td>Supported transition in living arrangements</td>
<td>55%</td>
</tr>
<tr>
<td>Increased contact with family and friends</td>
<td>49%</td>
</tr>
<tr>
<td>Helped move toward reduction in medication used</td>
<td>47%</td>
</tr>
</tbody>
</table>
Findings - Impact of training on learners

- Reduce stress at work: 98%
- Improve person centred care: 98%
- Better multidisciplinary working: 96%
- PBS competence level A: 91%
- PBS competence level B: 88%
- Improve career progression: 88%
- Increase train the trainer confidence: 86%
- PBC competence level C: 81%
Findings – Impact of the Training on the Organisation

- Improved quality of services delivered: 96%
- Improved staff practices: 96%
- Improved efforts to share learning with others: 92%
- Shared vision and language: 69%
- Increased compliance with regulations and policy: 63%
- Reduction in staff burnout, injury or sickness: 62%
- Better organisational working: 60%
- Better staff retention: 54%
- Review of organisation policies etc: 50%
- Cost savings to organisation: 50%
Thank you

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