Northumbria
University
NEWCASTLE

McKenzie, K., Murray, G.C., Higgon, J. & Matheson, E (1999) Knowledge of learning disability: the relationship with choice, duty of care and non-aversive approaches. Journal of Learning Disabilities for Nursing, Health and Social Care, 3(1); 27-33

The Journal home page is at: http://jid.sagepub.com/

Abstract

The present study examines the relationship between the knowledge of the diagnostic criteria for a learning disability (based on DSM IV criteria), care practices and experience in health care and social care staff. Responses to a questionnaire were analysed in terms of participants emphasis on: recognizing duty of care; enabling choice; non-aversive and aversive strategies. Results indicated that the knowledge of the criteria for a learning disability was limited, with only I6% of the sample correctly identifying all three criteria. There were no significant differences between the two groups in relation to experience or level of knowledge. No clear cut differences were found between the groups in relation to tendency to emphasize a particular management approach, with the strategies adopted appearing to be influenced by vignettes used in this study. Participants tended to give responses that identified both a recognition of their duty of care to clients and the need to enable choice. Limitations of this study are discussed.

INTRODUCTION

Persons professimg skills in working with the handicapped ... should be aware of the characteristics and susceptibilities of the categories of handicap with which they work (Ward 1984, p 57).

A learning disability is defined by three criteria:

- significantly sub-average intellectual functioning, with an IQ of approximately 70 or less
- concurrent deficits or impairments in present adaptive functioning in at least two of the following: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety
- onsets before adulthood (DSM IV, American Psychiatric Association, 1995).

The early 1960s saw the beginnings of a radical shift in the philosophy and policy relating to the care of people with learning disabilities. The longstay institution was to be replaced by a range of community-based services. This resulted in people who did not require specialized medical or nursing care being able to live at home or in small scale homelike units. This changing philosophy of care and resultant change in practice was largely based on the principle of normalization (Wolfensberger 1972). The move from largely medically-orientated institutions to community settings has been paralleled by an increasing focus on the social model of care for individuals with learning disabilities. As a consequence, the day-to-day support of people with learning disabilities changed from being the almost exclusive remit of health professionals to that of social care staff.

Both health professionals and social care staff share the common goal of caring for, and supporting, people with learning disabilities. However, they may differ in the type and amount of training that

they have received. Health professionals working in the field of learning disabilities will have received a formal training in the applications of their particular professional skills to this client group. By contrast, social care staff may not be required to undergo formal specialized training. While many may receive in-service training, some staff may be employed who have no previous experience or knowledge about working with people with a learning disability. Research suggests that misconceptions relating to people with a learning disability are common among the general population (Antonak et al. 1989) and that a lack of knowledge amongst care staff can impact on morale, staff turnover and client behaviour (Allen et al. 1990; Sharrad 1992; Hastings & Remington 1994).

The reaction against medically-orientated institutional care has been paralleled by an increasing focus on the handicapping effect model, whereby the organic deficits (the impairment) results in functional deficits, either behavioural or cognitive (the disability). A person who is identified as disabled is further disadvantaged by negative social attitudes towards the disability (the handicap). Research suggests that both close contact with individuals with a learning disability (Slevin 1995; Hames 1996) and the provision of specific training regarding learning disabilities (Henry et al. 1996) can result in more positive attitudes.

As more individuals with learning disabilities are supported in community homes, the complex nature of the demands placed on both social care staff and health professionals becomes apparent. One of the most important of these is the need to balance a 'duty of care' (McKay 1991) towards the person they support, with a recognition of the individual's rights and choices (O'Brien 1992). In

addition, there is an increasing demand on staff to support individuals with challenging behaviour (Hill & Bruininks 1984).

The understanding and sensible application of concepts such as a service's 'duty of care' to clients and obligation to manage challenging behaviour in non-aversive ways (La Vigna & Donnellan 1986) relies heavily on a basic understanding of the defining characteristics of learning disabilities. For example, if staff are not aware that an individual with learning disabilities by definition does not have the intellectual capacity or skills to make an informed choice, they may not recognize their 'duty of care' to protect or support the individual in that particular area of their life.

DUTY OF CARE

When people with learning disabilities put themselves or others at risk, a duty of care, both ethical and legal, exists with regards to professionals involved in client care, i.e. 'They have a responsibility to take reasonable steps to protect the welfare of that person' (McKay 1991). On occasion, the obligation on staff to intervene in what is deemed to be in the best interests of the client may override the personal preference of the client. Research suggests that the concept of duty of care may go unrecognized or may not be acted upon. Lyall et al. (1995) found that the tolerance of dangerous and antisocial behaviour of clients in some residential and day care provision in the Cambridge health district was high, with theft, criminal damage and sexual assault often going unreported. Similarly, Brown et al. (1994) and McCarthy & Thompson (1997) demonstrated that the sexual abuse of clients with learning disabilities is often dealt with haphazardly because staff are unclear about their roles and responsibilities. In addition, research indicates that care staff do not

always intervene effectively in situations where clients place themselves at risk (Hastings et al. 1995).

Enabling client choice

The recognition of the importance of enabling client choice arose largely from the principle of normalisation (Wolfensberger 1972). Tyne & O'Brien (1981) developed this philosophy in relation to service provision, suggesting that a good service recognized and promoted the five accomplishments, i.e. choice, community presence, relationships, respect, and competence. Services for individuals with learning disabilities are increasingly being evaluated by these criteria (McGowan 1996; Murray et al. 1998). The role of a professional working with clients with learning disabilities may therefore represent a balance between maintaining clients' behaviour within certain parameters (duty of care) and an obligation to make choices available to clients to the extent that they can make valid decisions (enabling choice).

Behavioural management strategies

Increasingly, as individuals with more complex needs or challenging behaviour are discharged from hospitals, the demand on care and professional staff increases (Hill & Bruininks 1984). Modem psychological approaches (e.g. La Vigna & Donnellan 1986) attempt to modify challenging behaviour by the use of non-aversive strategies, for example, by teaching functionally equivalent skills or environmental manipulations. However, research suggests that direct care staff may lack the knowledge and understanding required to successfully deal with complex challenging behaviour. Hastings et al. (1995) found that inexperienced care staff were less likely to be aware of the causes of challenging behaviour and of current behaviour management approaches than experienced staff.

A later study by Hastings (1996) found that immediate interventions by nursing staff were often counter-habilitative.

Summary and aims of present study

Any professional group providing a service to people with a learning disability has a legal (Ward 1994), professional and moral obligation to have a knowledge of the characteristics and needs of that particular client group, as well as an awareness of their professional roles and responsibilities. Health professionals and social care staff constitute two of the largest groups involved in the care of people with learning disabilities. The present study therefore aims to examine the level of knowledge of these two groups in relation to their understanding of the term 'learning disabilities'. In addition, an examination is made of the relationship of this knowledge with (1) staff awareness of issues relating to duty of care and client choice; (2) aversive versus non-aversive behavioural management approaches.

METHOD

The study examined the views of two groups of staff: health care and social care. Health care staff were professionally qualified staff who provided a specialist service to people with learning disabilities within the following service settings:

1. as a part of a community learning disability team

2. a health service challenging behaviour unit

3. health service nursing home provision.

The professional groups included nursing, clinical psychology, psychiatry, speech and language therapy, occupational therapy, and physiotherapy. Social care staff were employed by the independent sector to provide direct day-to-day support for individuals with learning disabilities in

community homes. None of this group held a professional qualification specifically related to working with people with learning disabilities. Thirty-one staff members participated (health care staff = 14, social care staff = 17). All participants were asked to complete the questionnaire that asked the following:

1. how many years have you worked with individuals with learning disabilities?

2. what is your job title?

3. what is your understanding of the term 'learning disabilities'?

STYLE OF MANAGEMENT

The style of management with challenging behaviours was assessed by the use of two vignettes. Staff were invited to comment on how they would manage the two situations described below.

Responses were coded by a rater to assess the extent to which the responses took into account the notion of duty of care and choice and indicated aversive versus non-aversive management techniques. In addition, responses were independently coded by two raters to give a measure of inter-rater reliability. The vignettes are reproduced below:

Vignette I

Mark has a favourite shirt that he likes to wear when he attends the adult training centre. He attends this centre 5-days-a-week. By the end of the week the shirt is dirty and smelly. He is happy for the shirt to be washed at the weekend so that it is clean again for the following Monday. How would you deal with this situation?

Vignette 2

Lucy likes chocolate biscuits and will eat nothing else unless she is coerced. If pressure is put on her

to eat other foods, she screams and bites herself. She is presently healthy and within the limits of normal weight. How would you deal with this situation?

The vignettes were chosen to reflect circumstances where there is a clear duty of care on the carers and the client is also expressing a preference. Raters scored each response to the vignettes in terms of the following:

- whether the respondent's strategy implicitly acknowledged duty of care, client choice or both
- whether the respondent's strategy was aversive or non-aversive.

Some examples of responses coded for each category are illustrated in Table 1.

Table 1: Examples of scored responses

Factor	**Example**
Childhood onset	' Can happen from birth' ' People are born that way'
Low IQ	' Can't understand things the way we do' ' Not as clever as normal people'
Impaired adaptive skills	'Need help with lots of daily tasks' ' Can't cope with everyday things'
Aversive strategies	' Just let her scream for the biscuits' ' Tell him he has to wash it '
Non-aversive strategies	' Buy him five of his favourite shirts' ' Introduce her slowly to a range of foods'
Duty of care	' Make sure she eats other things' ' Wash his shirt quickly each night'
Enabling choice	' Buy him five shirts all the same as his favourite' ' Let her have the biscuits if she is healthy'

Knowledge of the term 'learning disabilities'

Staff's responses to the question 'What is your understanding of the term 'learning disabilities'?' were assessed in relation to DSM IV criteria for learning disabilities, i.e. impaired intellectual functioning, impaired adaptive skills and childhood onset. Examples of acceptable responses in relation to each of the DSM IV criteria are recorded in Table 1.

Method of scoring responses

Each of the variables was assigned either a score of one if the response made reference to it, or zero if it was not referred to. In addition, the three scores relating to the defining features of a learning disability were collapsed to give an overall level of knowledge score; this ranged between zero and three.

RESULTS

Inter-rater reliability

Table 2 illustrates the inter-rater reliability for responses to scenarios 1 and 2 in respect of the identified management approach. As can be seen in Table 2, there was significant agreement between raters when analysing the responses to both scenarios. Table 3 illustrates the inter-rater reliability for responses to the question 'What is your understanding of the term learning disability?'

using DSM IV criteria as a comparator. As can be seen in Table 3, there was significant agreement between raters for all three criteria.

Table 2: Inter-rater reliability for respondents' identified management approach

Management approach	**Scenario 1**		**Scenario 2**	
	Kappa	**Significance level**	**Kappa**	**Significance level**
Recognising duty of care	0.92	<0.01	1.00	<0.01
Enabling choice	0.92	<0.01	1.00	<0.01
Non-aversive strategies	1.00	<0.01	1.00	<0.01
Aversive strategies	1.00	<0.01	1.00	<0.01

Table 3: Inter-rater reliability for respondents' answers to the question 'What is your understanding of the term 'learning disability?' using DSM IV criteria as a comparator.

Criterion	**Kappa**	**Significance level**
Impaired intellectual functioning	1.00	<0.01
Impaired adaptive skills	0.87	<0.01
Childhood onset	1.oo	<0.01

Experience

No significant difference was found between the mean number of years of experience of working with people with learning disabilities between the health and social care groups (t = 1.26; df = 17.22; P = 0.22). The experience of working with learning disabilities for the whole sample ranged from 3 months to 30 years, with a mean of 7 years and a standard deviation of 7 years, 2 months.

Knowledge of the criteria for learning disabilities

Table 4 illustrates the number and percentage of respondents in each staff group identifying each of

the three criteria for a learning disability. A X^2 test demonstrated that the identification of all three criteria was independent of staff group. However, it is important to note that both the childhood onset criteria and the impaired intellectual functioning criteria had expected frequencies of less than five.

Table 4: Number and percentage of respondents in each staff group identifying each of the three criteria for learning disability

Staff group	**Criteria**					
	Impaired intellectual functioning		**Impaired adaptive functioning**		**Childhood Onset**	
	No.	%	No.	%	No.	%
Health	9	64.3	8	57.1	5	35.7
Social	14	82.3	7	41.2	2	11.8
Overall	23	74.2	15	48.4	7	22.6

Table 5 illustrates the number and percentage of respondents in each group identifying 0, 1, 2 or 3 of the criteria for learning disabilities. A Cochrane's Q test illustrated that the frequency of correct responses differed significantly across the three criteria ($Q = 17.45$; $df = 2$; $P < 0.01$). Three pair-wise comparisons demonstrated that significantly more individuals identified the impaired intellectual functioning criteria than the childhood onset criteria (bi-nominal; two-tailed; $P < 0.01$). In addition, significantly more individuals identified the impaired adaptive skills criterion than the childhood onset criterion (bi-nominal; two-tailed; $P < 0.05$). No significant difference was found between staff groups in relation to overall knowledge scores.

Table 5: Number and percentage of respondents in each staff group identifying o, 1, 2 or 3 of the criteria for a learning disability.

Staff group	**Number of criteria identified**							
	0		**1**		**2**		**3**	
	No.	%	No.	%	No.	%	No.	%
Health	3	21.4	4	28.6	3	21.4	4	28.6
Social Care	1	5.9	10	58.8	5	29.4	1	5.9
Overall	4	12.9	14	45.2	8	25.8	5	16.1

Management approach

Table 6 illustrates the number and percentage of respondents referring to each of the following management approaches in vignettes 1 and 2: recognizing duty of care, enabling choice, non-aversive strategies, and aversive strategies.

Table 6: Number and percentage of respondents referring to each management approach

Vignette	**Staff group**	**Management approach**							
		Recognising duty of care		**Enabling Choice**		**Non-aversive strategy**		**Aversive Strategy**	
		No.	%	No.	%	No.	%	No.	%
1	Health	9	64.3	9	64.3	9	64.3	0	0
	Social	14	82.4	13	76.5	14	82.4	1	5.9
	Overall	23	74.2	22	71.0	23	74.2	1	3.2
2	Health	6	42.9	8	57.1	8	57.1	1	7.1
	Social	14	82.4	8	47.1	9	52.9	6	35.3
	Overall	20	64.5	16	51.6	17	54.8	7	22.6

Vignette I

A pair-wise McNemar test demonstrated that significantly more individuals identified a non-aversive strategy than an aversive strategy in response to Vignette 1 (bi-nominal; two-tailed; $P < 0.01$). This also held true for the health care group alone and the social care group alone.

Vignette 2

A pair-wise McNemar test found that, for the health group only, there was a significant difference between those identifying a non-aversive as opposed to an aversive approach (bi-nominal; two-tailed; $P < 0.05$).

A comparison of the responses of the health care staff and social care staff for vignettes 1 and 2 found that for vignette 2 the identification of duty of care was significantly associated with staff group ($X2 = 5.23$; df = 1; $P < 0.05$), with the social care staff being more likely to identify duty of care than the health care staff.

Knowledge of the criteria for alearning disability and management approach

No significant differences were found overall between those identifying a particular management approach in vignettes 1 and 2 and the ability to identify the criteria for a learning disability. This also held true for health professionals alone in vignettes 1 and 2 and with social care staff alone in vignette 1. However, in vignette 2, a significant difference in knowledge of the criteria of a learning disability was found between those social care staff who identified choice and those who did not ($t = 2.17$; df = 15; $P < 0.05$), with those who did not identify choice having identified more criteria of learning disabilities. Similarly, those social care staff who identified more of the criteria for learning disabilities were significantly more likely to identify aversive approaches in vignette 2 ($r = - 2.36$; df = 15; $P < 0.05$).

Experience and management approach

For vignette 1, a significant difference was found between mean number of years of experience of those who identified a non-aversive approach and those who did not ($t = - 2.18$; df = 27.09; $P < 0.05$),

with those who identified non-aversive approaches being more experienced. No significant differences were found for vignette 2.

Experience and knowledge of the criteria for learning disabilities

No significant relationship was found between the years of experience of working with people with learning disabilities and knowledge of the criteria defining learning disabilities.

DISCUSSION

The present study found no significant differences between health and social care staff in respect of their knowledge of the criteria for learning disabilities. The most likely explanation for this finding is that the overall level of knowledge of the defining criteria of learning disabilities was not high in either group with only five respondents being able to identify all three criteria and four respondents being unable to name any. This was despite the scoring criteria erring on the side of allowing any answer that explicitly or implicitly referred to the criteria.

This finding is in keeping with other studies that have found knowledge of relevant aspects of learning disabilities to be low in staff involved in their care (Allen et al. 1990; Sharrad 1992; Hastings & Remington 1994). The present study, however, indicates a lack of knowledge in two groups who exclusively provide a service to people with learning disabilities about the basic defining characteristics of learning disabilities. Around a quarter of respondents were able to identify two of the criteria for learning disabilities, typically impaired intellectual functioning and impairments in adaptive skills. These aspects of learning disabilities are arguably of more practical relevance for those working with clients on a day-to-day basis than the fact that the condition must occur in

childhood. Many current interventions employed in working with people with learning disabilities tend to be of the 'here and now' variety, involving behavioural techniques (e.g. La Vigna & Donnellan 1986) or reflecting the relationship between client and therapist (e.g. McGee et al. 1987). Both of these approaches are essentially ahistorical and would not make reference to developmental aspects of learning disabilities. The salience of particular criteria for learning disabilities may therefore be effected by the interventions that workers use, thus contributing to the relative lack of awareness of childhood onset as a feature of learning disabilities.

In respect of management approaches, the results suggest that the picture is not clear cut, with individuals overall being more likely to adopt nonaversive as opposed to aversive strategies. Social care staff were, however, more likely to identify strategies that recognize their duty of care although this only held true in vignette 2. In addition, no significant differences were found between those identifying a particular management approach and their ability to identify the criteria for learning disabilities. This mixed picture may reflect the fact that the majority of respondents attempted to employ strategies that recognized both duty of care and client choice. Responses also appeared to be affected by the vignettes themselves. In general, carers appeared less confident in managing the behaviour presented in vignette 2 where it is implied that the individual has a more severe learning disability.

Suggestions often centred around trying to 'encourage' the client and were often vague or relied on explanations that a person with severe learning disabilities would be unlikely to comprehend.

Detailed non-aversive behavioural interventions were absent from suggestions made. The fact that social care staff were more likely to identify approaches recognizing their duty of care in vignette 2 may be related to the implied severity of the learning disability and reflect their experience of having to deal with similar situations in a practical manner on a day-to-day basis.

In respect of the knowledge of the criteria for learning disabilities and management approaches, social care staff with greater knowledge of the criteria for learning disabilities were found to be more likely to identify approaches that were aversive in vignette 2. Although initially puzzling, a closer examination of responses illustrated that while the approaches were likely to be perceived as aversive by the client, they were also consistent with psychological approaches. For example, 'limit the number of biscuits that Lucy receives by rewarding her with them when she eats healthy foods' . Such a response recognizes the need to shape new, more adaptive behaviour by using rewards but was defined as aversive because the client would have experienced the removal of her biscuits as a punishment. While it is encouraging that workers attempted to devise strategies that were broadly based upon psychological principles, the application of these were sometimes misconceived.

The experience of staff would also appear to play a key role in relation to the adoption of nonaversive approaches, with those staff who were more experienced being significantly more likely to identify non-aversive approaches. It is unclear, however, if this difference is due to staff having received more training during their career, or whether it is a result of knowledge picked up over time. The fact that few significant relationships were found between knowledge of the criteria for learning disabilities and the adoption of a particular management approach may reflect the general confusion that staff experience about striking the correct balance between recognizing a duty of

care and enabling choice. This difficulty has been highlighted in a number of previous studies. Brown et al. (1994) and Lyall et al. (1995) both found that staff were confused about the correct balance between their roles and responsibilities as carers and the need to facilitate client choice. It may be that the more knowledge an individual has about the nature of learning disabilities, the more confusing these potentially conflicting demands become. This has a number of implications outlined below.

The present study highlighted the low level of knowledge of the defining features of learning disabilities in both health care and social care staff. These two groups are, with the exception of families, the main providers of care and support for people with learning disabilities. While the role of both groups may differ in emphasis, with health professionals tending to provide more specialized and health related input, and social care staff providing direct care and day to day support, it would appear imperative that both groups are aware of the defining features and characteristics of the client group within their remit. As well as being a legal obligation (Ward 1984), this is fundamental to service development and care planning processes.

A lack of knowledge among care staff relating to challenging behaviour has been found to impact on morale, staff turnover and client behaviours (Allen et al. 1990; Sharrad 1992; Hastings & Remington 1994). It is likely that the failure to fully appreciate the cognitive and behavioural limitations which are associated with learning disabilities will make it more difficult for staff to identify how these features impact on the expression of challenging behaviour and everyday client functioning. While the assessment of the criteria that determines the diagnosis of learning disabilities has traditionally

been the remit of psychologists (Burton 1997), the present study would suggest the need to remind all staff involved in the care of people with learning disabilities about the basic defining characteristics of the clients they work with and what this may mean for them in their day-to-day functioning.

The present study does, however, have a number of limitations. Firstly, results were based on respondents written answers in relation to a questionnaire. It is likely that this method accurately reflected respondents' knowledge regarding the criteria of learning disabilities as they would be unlikely to withhold such information. However, the publicly expressed attitudes may not reflect their actual opinions (Aronson 1995). Just as public and private attitudes may differ, so may an individual's attitude differ from actual behaviour (Ajzen & Fishbein 1980). It is assumed in the present study that respondents have described courses of action similar to those that they would follow in real life. However, as noted earlier, many responses were vague or would have been difficult to put into practice. It is likely that a truer picture would have been obtained by observing staff as they worked and relating this to levels of knowledge. The authors hope to adopt such an approach in future studies to help clarify this issue. Finally, the sample sizes of each group may have masked differences between health and social care staff that would be apparent in a larger sample.

In summary, the present study found that knowledge of the criteria for learning disabilities was limited in both health and social care staff. Most respondents attempted to adopt management approaches that reflected both a recognition of a duty of care and the need to enable client choice

and which were non-aversive. No significant differences were found between the two groups in terms of experience or level of knowledge. Overall, few differences were found in relation to the tendency to adopt a particular management approach.

REFERENCES

Ajzen I, Fishbein M 1980 Understanding Attitudes and Predicting Social Behaviour. Prentice Hall

Allen P, Pahl J, Quine L 1990 Care Staff in Transition the Impact on Staff of Changing Services for People with Mental Handicap HMSO, London

American Psychiatric Association 1995 Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. APA, Washington DC

Antonak R F, Fiedler C R, Mulick J A 1989 Misconceptions Relaring to Mental Retardation. Mental Retardation, 27(2)

Aronson J. In: Lyndzey M, Aronson J 1985 Handbook of Social Psychology. John Wiley, Chichester

Brown H, Hunt N, Stem J 1994 Alarming but very necessary: working with staff groups around the sexual abuse of adults with learning disabilities. Journal of Intellectual Disability Research 38(4): 393-412

Burton M 1997 Intellectual disability developing a definition. Journal of Learning Disabilities for Nursing, Health and Social Care 1(1). 37-43

Hames A 1996 The effects of experience and sexual abuse training on the attitudes of learning disability staff. Journal of intellectual disability research 40(6): 34-43

Hastings R P, Remington B 1994 Staff behaviour and its implications for people with learning disabilities and challenging behaviours. British Journal of Clinical Psychology 33: 423-438

Hastings R P, Remington B, Hopper G M 1995 Experienced and inexperienced health care workers beliefs about challenging behaviours. Journal of Intellectual Disability Research 39(6): 22-34

Hastings R P 1996 Staff strategies and explanations for intervening with challenging behaviours. Journal of Intellectual Disability Research 40(2) 166-175

Henry D, Keys C, Balcazar F, Jopp D 1996 Attitudes of community-living staff members towards persons with mental retardation, mental illness and dual diagnosis. Mental Retardation 34(6) 13-19

Hill B K, Bruininks R H 1984 Maladaptive behaviour of mentally retarded individuals in residential facilities. American Journal of Mental Deficiency 88: 380-387

La Vigna G W, Donnellan A M 1986 Alternatives to punishment: solving behaviour problems with non-aversive strategies. Irvington, New York

Lyall I, Holland A J, Collins S 1995 Offending by adults with learning disabilities and the attitudes of staff to offending behaviour. Journal of Intellectual Disability Research 39(6): 22-31

McCarthy M, Thompson D 1997 A prevalence study of adults with intellectual disabilities referred for sex education. Journal of Applied Research in Intellectual Disabilities 10(23): 105-124

McGee J, Menolascino F J, Hobbs D C, Menousek P E 1987 Gentle teaching: a non-aversive approach to helping persons with mental retardation Human Sciences Press, New York

McGowan C 1996 A long way from home. Health Service Journal April: 28-30

McKay C 1991 Sex, laws and red tape: Scots law, personal relationships and people with learning difficulties. Scottish Society for the Mentally Handicapped, Glasgow

Murray G C, McKenzie K, Kidd G R, Lakhani S, Sinclair B 1998 The five accomplishments: a framework for obtaining customer feedback in a health service community learning disability team. British Journal of Learning Disabilities (in press)

O'Brien J 1992 Developing high quality services for people with developmental disabilities. In: Bradley V J, Bersani H A (Eds). Quality Assurance for Individuals with Developmental Disabilities Paul Brookes, Baltimore

Slevin E 1995 Student nurses attitudes towards people with learning disabilities. British Journal of Nursing 4(143): 761-766

Sharrad H E 1992 Feeling the strain: job stress and satisfaction of direct-care staff in the mental handicap service. British Journal of Mental Subnormality 7: 32-38

Tyne A, O'Brien J 1981 The principles of normalisation. Campaign for Mentally Handicapped People Campaign for Mental Handicap Education and Research Association (CCMH/CMHERA), London

Ward A D 1984 Scots law and the mentally handicapped. Scottish Society for the Mentally Handicapped, Enable

Wolfensberger W 1972 The principle of normalisation in human services. National Institute of Mental Retardation, Toronto