Challenging behaviour: a unified approach

Clinical and service guidelines for supporting people with learning disabilities who are at risk of receiving abusive or restrictive practices

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Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists

'Instead of responding to the person we typically react to the behaviour'

'Most of what passes as assessment seems to be denial about the mutuality of our common condition'

Herb Lovett

'Our job is not to fix people, but to design effective environments'

Rob Horner

'Difficult behaviours are messages which can tell us important things about a person and the quality of his or her life'

David Pitonyak

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Foreword

I am very pleased to have been asked to write the foreword to this important publication. One of the most important principles underpinning the *Valuing People* White Paper is that all aspects of the policy apply to all people with learning disabilities. Although we have made some good progress over the past 5 years, there is evidence that people with the most complex needs have not been benefiting as much as others from the changes in services, ways of working and, most importantly, culture and attitudes. This was neither the intention of the policy, nor is it a natural consequence of an initiative fundamentally concerned with people's rights as citizens and their place in society. To the contrary, it is arguably the extent of our success in meeting the needs of those who are most challenging to support that should be the measure of our achievements. When I was managing services in London in the late 1980s and early 1990s, one of the most rewarding achievements was to see how people who had previously been 'written off' by services could achieve a positive place in society (including paid employment) as a result of creative and courageous work by local staff (in partnership with the Special Development Team from what is now the Tizard Centre).

In this context, I particularly welcome the move to redefine the use of the phrase 'challenging behaviour'. The way in which that terminology has become a label to describe either a diagnosis or a problem owned by an individual has become an obstacle to the provision of appropriate and effective support. The real challenge to abilities and capacities is to those responsible for planning, commissioning, managing and providing services for people with such complex needs. It has been our historic failure to do that successfully that has resulted in people being excluded from mainstream society and segregated into inappropriate services. The acceptance of that ownership by ourselves rather than attributing the outcome to the individual's behaviour is an important step towards achieving better outcomes for all people.

Those outcomes could and should include participation in all aspects of life and society. In order to do that, appropriate investment in skilled health professionals is an essential but not the only component. If support to people who challenge services is interpreted as only being the business of the National Health Service, then achieving those wider goals and aspirations will be impossible. Partnership between all people concerned with the lives of people with learning disabilities and a shared vision to end the exclusion from mainstream society of people who are described as challenging services is the only effective way forward. I hope that this document is widely used as an important contribution towards that aspiration.

Rob Greig
National Director: Learning Disabilities

Purpose of this report

This report is the result of a joint working group of the learning disability faculties of the British Psychological Society and the Royal College of Psychiatrists, in consultation with the Royal College of Speech and Language Therapists.

Although there are many good examples of integrated and multidisciplinary working between health professionals in the field of learning disability, there are often, in the background, dynamics that tend towards a splitting of professional groups and what then appear to be polarised and antagonistic views and approaches. Yet, in the increasing joint working between the professions, it is clear that we share more common ground than we have differences and that our greatest effectiveness is when we work in close and coordinated collaboration.

One of the main functions of learning disability teams in the UK is to work with people with a learning disability whose behaviour presents a challenge. Considerable resources of professional time, support, managerial planning, strategic thinking and research have been committed over the past two decades or more to the development of service responses to the challenges presented by a significant number of people with learning disabilities. Though effective responses are essentially multidisciplinary and involve a wide range of individuals including carers and families, it has tended to be the professions of clinical psychology and learning disability psychiatry that have taken the lead in the development of theoretical and clinical paradigms, models of service provision, planning, and research.

There is a growing interest in the concept of 'complexity' in healthcare and it can be seen that challenging behaviour presents a complex and often paradoxical entity. The term was originally developed to describe the interaction between the behaviour of a person with a learning disability and the environment around them (see Chapter 3). Thus the term incorporates a multiplicity of biological and psychological characteristics, predisposing, precipitating and maintaining factors in the individual, the carers and the environment that cannot be conceptualised in terms of linear or simple cause-and-effect models. These multiple factors and the systems in which they operate are all interrelated and cannot be readily analysed or understood without reference to the others. 'New conceptual frameworks that incorporate a dynamic, emergent, creative, and intuitive view of the world must replace traditional "reduce and resolve" approaches to clinical care and service organisation' (Elsek & Greenhalgh, 2001).

One of the paradoxes in this complexity is the balancing of the need for consistent standards of evidence-based practice with an analysis and response to the unique circumstances and structures in existence for the individual at a particular point in time.

It is with these concepts in mind that this report has been produced, with the following aims:

- to revise and develop the interpretation of the term challenging behaviour
- to bring together relevant, available, evidence-based practice with a consensus of clinical opinion and experience
- to provide a unified framework for good practice in multidisciplinary clinical and social interventions
- to encourage the development of creative, flexible and effective responses to individuals who present behavioural challenges
- to provide guidance for service developers and commissioners
- to inform and empower service users and their carers
- to provide a set of standards of good practice against which service provision can be benchmarked and audited
- to promote the development of comprehensive and effective local services and to reduce the number of individuals who are failed by the current service provision
- to provide a framework for training of health and social care professionals and paid support staff and carers
- to guide future research and development.

The unifying principle is to improve the quality of life of people whose behaviour challenges services.

Within the constraints of time and practicality it has not been possible to produce a report that addresses every aspect of challenging behaviour across the whole spectrum of age and degree of learning disability. Our main focus has been upon adults who are vulnerable to restrictive interventions and abuse as a consequence of their limited capacity to make choices for themselves about where they live or work, and how they are supported. Specifically we have not addressed the needs of children, older people or those who commit offences (forensic). We readily acknowledge that the issues for these groups are integrally related to the groups covered in this report; for example, behaviour that is severely challenging in adults is likely to have its origins in childhood and early intervention to prevent 'challenging careers' is essential. There are, however, fundamental concepts and principles that are applicable to all population groups and the services that work with them. Not least, the core framework of creating capable environments as a response to challenging behaviour is one that should be universal in this field. The needs of particular groups may be the work of further publications or of more localised responses to the guidance given in this report.

The report was produced through the combined work of the members of the working group and drew on a number of key publications already in existence or in preparation at the time; we have also carried out a wide-ranging consultation process (see Acknowledgements). Although the disciplines of psychology and psychiatry were originally tasked to provide the main guidance for the working group focus and process, we have also sought the particular expertise of speech and language therapy, being aware that there is a body of professional research in this area. Challenging behaviour, however, requires a multidisciplinary and multi-agency approach and therefore this report has also been produced with the intention that it will be relevant and useful to a wide range of health and social care

professionals, family and paid carers, service providers and commissioners. In order to achieve its aims, this document needs to be alive, active and responsive. It is intended to provoke action as much as to inform, to encourage local and national debate, analysis, review and response. It aims to instigate further thought and guidance for the groups of people with learning disabilities whose needs are not addressed specifically in this report.

Finally, the report hopes to complement other publications and guidance in this area and overall to further a reinvigorated and unified approach to supporting people whose behaviour is experienced as challenging. The importance of this is particularly emphasised following the Healthcare Commission reports into services in Cornwall Partnership NHS Trust (Commission for Healthcare Audit and Inspection, 2006) and Sutton and Merton Primary Care Trust (Commission for Healthcare Audit and Inspection, 2007).

Executive summary

This report concerns standards of clinical practice in supporting people with learning disabilities who present behavioural challenges. It unites the clinical theory and practice of health professions that have specific models for the assessment and management of challenging behaviour. The fundamental unifying principle is to improve the quality of life for people whose behaviour challenges others.

The report focuses primarily on adults with moderate to severe learning disabilities, although the broad principles outlined are applicable to children and adults of all degrees of intellectual disability. People with learning disabilities who present behavioural challenges are often marginalised, stigmatised, disempowered and excluded from mainstream society.

The term challenging behaviour has become distorted from its original meaning, and has come to be misused as a diagnostic label. The report redefines challenging behaviour, building on past definitions and focusing on the responses that the behaviour evokes in others, including those that are punitive or restrictive.

There is a diversity of learning disability policy throughout the UK. Despite shared commitments to support ordinary lives in the community and to a range of generic and specialist supports, there has been a growth in the provision of long-stay residential provision in the independent/private sector and in the number of individuals in out-of-area placements.

LEGISLATION

UK legislation varies between the different legislatures and is continually changing. Clinicians must remain informed on how this affects their practice. Professionals making treatment decisions for adults with learning disabilities are guided both by the law and by professional guidelines. The development and enactment of mental capacity legislation is clarifying the principle of best interests and the process of decision-making for adults who lack capacity.

People who pose severe behavioural challenges are more likely to be subjected to procedures which are directly or indirectly regulated by legislation, i.e. detention and treatment under the provision of the Mental Health Act 1983, informal detention of incapacitated people (Bournewood; Department of Health 2006*a*), physical interventions, seclusion.

FOCUSING ON THE INDIVIDUAL

Challenging behaviour is socially constructed and is a product of an interaction between the individual and their environment. Assessment and

intervention must therefore address the person, the environment and the interaction between the two.

Behaviour can be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion.

The person with a learning disability may be expressing unhappiness in their current environment through their behaviour and clinicians may be expected to provide interventions in environments that are inadequate to meet the person's needs. A balance must be struck between best practice and pragmatic measures to pre-empt a crisis that could have more deleterious impact on the individual. In less than optimal circumstances, the clinician may need to adopt a strong clinical advocacy role.

A comprehensive assessment should address: a functional assessment of behaviour, underlying medical and organic factors, psychological/psychiatric factors, communication and social/environmental factors. Detailed functional assessment and diagnosis are both integral features of an assessment of challenging behaviour and should lead to a clear formulation of the presenting problem.

Interventions should be delivered in a person-centred context and a framework of positive behavioural support. They should include proactive and reactive strategies. Interventions described include psychotherapy, communication, positive programming, physical and/or medical and psychopharmacological.

It is important that all interventions be routinely evaluated for their effectiveness; those that are more thoroughly evaluated are more likely to show a positive outcome.

Communication and feedback between professionals, carers and service users, and the timely sharing of information is an essential component at all stages of care.

CAPABLE ENVIRONMENTS

Challenging behaviour is more likely to be encountered in the family home, in small scale community settings or in environments that are poorly organised and unable to respond well to the needs of the person. It has been shown that people who present behavioural challenges can be effectively supported in ordinary housing in the community. When an individual's living situation breaks down it is generally not the behaviour but rather the service response that is the critical determinant.

There is often a mismatch between the level of need of people with learning disabilities and the range of available service provision with the capacity to work with behavioural challenges. As a result, out-of-area placements are widely used as a solution, at the expense of local resource development.

There may also be a mismatch between the expectations of professional staff and of staff providing direct support to individuals in community settings; the latter saying that professionals do not understand the constraints under which they work and produce advice that they cannot

implement. Clinicians report that staff are unable to carry out necessary assessments and interventions.

To improve services for people who present behavioural challenges and to enable them to remain in their own homes and communities requires the creation and support of capable environments. Competency-based training and professional support is required for all carers together with the promotion of creative solutions to the challenges faced.

The quality of staff support provided should be focused on enabling the individual to engage in meaningful activity and relationships at home and in the community. Staff should be skilled and well-organised to deliver active support.

CREATIVE COMMISSIONING

Commissioners should have a clear basis on which to develop and select competent providers. An alternative route to market development may be through the establishment of personal budgets and independent brokerage. They need to manage the market they have created in order to sustain the capacity of local services to meet the needs of everyone with learning disabilities. This involves encouraging service providers to cooperate, under-pinning service competence through training and service development and reshaping specialised challenging behaviour services to support effective local placements. There are not enough services that can provide skilled support in each local area and commissioners therefore have an important role in developing the new kinds of services that will be required.

Services need to be refashioned to give closer integration between care managers, care standards inspectors and members of community learning disability teams or specialist challenging behaviour teams. Staff training and support to local services should be a core role of specialist health professionals and clarity over outcomes and clearly defined service provision should increase the quality of services available to people who challenge services.

Commissioners will need to be aware of best practice in intervention, the outcomes achieved by interventions (and these may be broader than behavioural change) and the difficulties in predicting how long an intervention will take, as intervention is complex and may involve many different parties.

FUTURE DIRECTIONS

Future work needs to address the issues of challenging behaviour and early intervention in children.

The service user perspective needs to be emphasised and it is hoped to achieve this through the development of a charter outlining what standards of service provision people should expect.

A set of good practice standards is provided against which local services and stakeholders can audit and evaluate their current service provision and to assist in service planning and development.

A number of other initiatives are suggested for joint professional working, research, evaluation and audit.

Definitions and scope

This document is concerned with standards of clinical practice and how best to support people with learning disabilities who also present challenging behaviour. In practice both of these terms, challenging behaviour and learning disability, are applied with wide variation and inconsistency and often in ways that are idiosyncratic to service geography and structure, professional backgrounds and theoretical perceptions.

People with learning disabilities do not constitute a uniform group. Epidemiologically and diagnostically, the definitions of mental retardation in the *ICD–10 Classification of Mental and Behavioural Disorders* (World Health Organization) or *Diagnostic and Statistical Manual of Mental Disorders* (DSM–IV; American Psychiatric Association, 1994) are generally used. In practice, however, the eligibility criteria for access to services vary considerably and do not adhere to consistent operational definitions. However, it is generally accepted that the common criteria of learning disability centre on significant impairment of intellectual and social functioning that occurs before adulthood.

The focus of this report is primarily on adults with moderate to severe learning disabilities. The rationale behind this is to focus the scope of the guidance to those circumstances where it is likely that the individuals themselves may be excluded from receiving other forms of intervention and support aimed at ameliorating challenging behaviour.

This report also focuses on guidance to professionals and services. It does not include the additional guidance that will be necessary for work with forensic populations (where additional specific psychological techniques would need to be included); or the additional guidance necessary for working with people with significant depression, anxiety, anger management difficulties etc., all of these would also require additional guidance, much of which is now being dealt with within the National Institute for Clinical Excellence frameworks. This is not to say that the guidance regarding medication, behavioural intervention, environmental support and commissioning is not relevant to these additional groups. Its focus, however, remains on those people who are more likely to be excluded from the broader range of psychological and psychiatric interventions.

We acknowledge that there will be specific issues of diagnosis, aetiologies, treatment options, and legal frameworks for children and older adults. However, we believe that there are fundamental principles, values and guidance that are applicable across all groups who present behaviours that are challenging.

We believe that it is also important to note that people with learning disabilities who present challenging behaviours are often marginalised, stigmatised, disempowered and excluded from mainstream society. They suffer similar disadvantages to other groups who are discriminated against

in society for reasons of ethnic origin, religion or sexuality for example. It is important to be particularly aware of those who are also from minority or stigmatised groups and may be doubly disadvantaged.

Challenging behaviour is a term that was originally adopted from use in the USA by The Association for Severe Handicaps (TASH), where it had been introduced in order to transfer the demands for change from the individual with severe behaviour problems to the organisation around them. The challenge was to carers, services and professionals to find more effective ways of understanding the origins and meaning of a person's behaviour and to find creative ways of responding to this challenge in order that the behaviour ceased to fulfil the same function and would therefore diminish. The most widely used, formalised definition has been that of Emerson:

> 'culturally abnormal behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities'. (Emerson, 1995)

All behaviour has meaning or function and does not occur in isolation. There are likely to be a number of underlying causes of a behaviour that are a challenge to others. As well as functional determinants, precipitants and maintaining factors, aetiologies may include:

- physical: discomfort, pain, malaise, physiological disturbance (e.g. thyroid disorders)
- mental illness: mood disorders, psychosis, anxiety, obsessive–compulsive disorders
- neuropsychiatric disorders: epilepsy, Gilles de la Tourette syndrome, attention-deficit hyperactivity disorder (ADHD), dementia
- pervasive developmental disorders: autism
- phenotype-related behaviours: Prader-Willi syndrome, Lesch-Nyhan syndrome, Williams syndrome
- psychological trauma: reaction to abuse or loss
- communication difficulties: hearing loss, unclear communication, insufficient vocabulary or means of expression, difficulties understanding communication of others.

Through attempts to define the term challenging behaviour more consistently for the purposes of service provision, service development and research, the emphasis has moved away from its origins as a socially determined concept to a diagnostic entity. Attempts have been made to define challenging behaviour in terms of the behavioural characteristics, aetiologies, quantifiable frequencies or severities. As a result, the term in practice has been increasingly used as a diagnostic label, a means of describing groups of individuals or groups of behaviours. It has also been used to describe specialist services or service elements and professional roles, with the result that people with learning disabilities become labelled by association. The temporal and situational elements of the term also seem to have been lost; rather than challenging behaviour being a description of an interaction in a certain place at a certain time, the term becomes diffuse (if one aspect of a person's behaviour is challenging then all their abnormal behaviours receive the same label) and lasting ('once a challenging behaviour always a challenging behaviour'). The attribution for responsibility for the behaviour and therefore for its change has unfortunately gravitated away from carers, services and professionals back to the individual.

One of the reasons for the adoption of the term challenging behaviour was to provide a reminder that severely problematic or socially unacceptable behaviour should be seen as a challenge to services rather than a manifestation of psychopathological processes. In order to respond to this challenge, services need to promote positive behavioural development, reduce the occurrence of damaging behaviour and maintain people's access to a decent quality of life despite continuing behavioural difficulties.

It is our belief that there needs to be a firm reaffirmation of the term in its original context and a clear shift of emphasis back to the responsibilities for change being with the systems around the individual. We believe that 'challenging behaviour' is a socially constructed and dynamic concept. In order for an individual's behaviour to be viewed as challenging, a judgement is made that this behaviour is dangerous, frightening, distressing or annoying and that these feelings invoked in others are in some way intolerable or overwhelming. The impact on others, and therefore the characteristics of the observer(s) have to be incorporated in the application and understanding of the term challenging behaviour.

We propose the adoption of a modified definition that builds on that of Emerson:

> Behaviour can be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion.

Quality of life and physical safety of the person and those around them is a focal concept of this definition. It has also moved from thinking in terms of the qualitative aspects of the behaviour of the person, to those of the responses of individuals and services. The actual nature of the behaviours therefore should be defined separately, for example: self-injury, assault, socially inappropriate behaviour. We believe that behaviour should be regarded as challenging when responses that are neglectful, socially and morally unacceptable, abusive or restrictive are being used to manage it; particularly so when basic human rights are being contravened (Commission for Healthcare Audit and Inspection, 2006, 2007).

Thus the prevalence of challenging behaviour can be conceptualised within such parameters as

- number of individuals excluded from local services
- number of individuals in 'out of area' placements
- number of individuals not receiving day services, employment opportunities, education, respite or home support
- service responses involving
  - seclusion
  - restraint
  - locked doors
  - abuse
- clinical responses involving
  - inappropriate prescribing of drug treatments
  - punitive and aversive behavioural interventions
  - risk avoidance rather than risk management.

It is clear therefore that the label of challenging behaviour becomes less appropriate once the consequences and the responses of others change to

being non-punitive, non-restrictive and socially enabling rather than restricting. The nature and even the severity and frequency of the behaviour may remain unchanged and yet it ceases to be seen as challenging when carers, professionals and services are able to respond in positive, inclusive and enabling ways. An analogy can be drawn with a chronic medical condition such as insulin-dependent diabetes; the control of blood sugar and the avoidance of the complications of the condition require daily and lifelong treatment with insulin and appropriate adjustments to diet and lifestyle. While this treatment is available and able to be adhered to the individual can usually live a normal life, however, in the absence of these daily supports the condition represents a significant threat to their health, well-being and survival.

Scope

The underlying factors in an individual's behaviour that challenges others may have a range of aetiologies and may be complex. The individuals on whom they impact and the contexts in which they occur are also varied. Family and paid carers are usually those who primarily have responsibility for supporting the individual who presents challenges. The responsibility for designing interventions and support packages has tended to be within health services for people with learning disabilities and also within specialist groups or individuals within those services. Clinical psychologists, psychiatrists, speech and language therapists, learning disability nurses and occupational therapists have been in the forefront of service provision and development. There are many other individuals from different professional backgrounds however who work with people who present challenges and have acquired skills and experience in this area, for example psychotherapists, art therapists, physiotherapists and social workers.

This document aims therefore to have relevance to all professionals who work with people with learning disabilities, although it is written primarily from the perspective of clinical psychologists and psychiatrists and with a significant contribution from speech and language therapists. Our process of consultation has endeavoured to incorporate a wider view, although we accept that it is unlikely that we have been all-inclusive and hope that this document will promote further discussion, research and contributions to future revision.

The focus of the definition of challenging behaviour is on service and systemic responses. This report will aim therefore, above all, to inform and guide those who are policy makers and those who provide and commission services for people with learning disabilities in the statutory, voluntary and independent sectors. Our intention is that organisations that are charged with purchasing, commissioning or regulating services will use the standards outlined in the document in order to assess the appropriateness and quality of the services for which they are responsible.

Context

UK LEARNING DISABILITY POLICY

The context of service provision for people with learning disabilities has been changing. With the closure of large hospital institutions, the emphasis for professional intervention has moved to a community, multidisciplinary

and multi-agency base, with an intent to utilise mainstream health services wherever possible and with the lead for specialist learning disability services coming from the local authority. Working with individuals who present challenging behaviour has to take place in the context of their home, their daily activities and support networks. These involve carers and supporters from a variety of backgrounds and employing agencies. Although the NHS long-stay hospital provision has almost disappeared, there has been a growth in the provision of a wide variety of residential and long-stay care, particularly in the independent sector. This growth may bring with it potential compromises to the values and principles of enabling people with learning disabilities to live ordinary, non-segregated lives.

Some of the biggest challenges have been in the sustained development and provision of specialist services or service elements, and in the training and support available to families, carers, advocates or non-specialist professionals. When families want to continue to care for the person at home, they are frequently faced with a lack of practical, financial, specialist, responsive or flexible supports that would enable this to happen. Too often the only real alternative is for the relative they are caring for to leave the family home, whether or not they wish this to happen.

Supporting people who challenge services needs to be seen within the current policy context, primarily national but also local. National policy has also undergone changes within the past 20 years with the devolution, in varying degrees, of responsibilities for health and social care provision to national administrations in Wales, Scotland and Northern Ireland.

England and Scotland have seen the launch and implementation of high profile national strategies for people with a learning disability, *Valuing People* (Department of Health, 2001) and *The Same as You?* (Scottish Executive Health Department, 2000).

Valuing People aims 'to provide new opportunities for children and adults with learning disabilities to live full and independent lives as part of their local communities'. It also recognises that one of the major issues for learning disability services is the provision and commissioning of services for those who present challenging behaviour.

The Same as You? emphasises that while challenging behaviour services should not be separate from general provision for people with learning disabilities, it is important to recognise the need for a range of specialist clinical services and treatments to be available including psychotherapy, cognitive–behavioural approaches and behaviour analysis; 'the aim of the specialist services should be to support mainstream services and to help people stay in their own homes as far as possible'.

The Welsh Assembly Government responded to the report of an advisory group on learning disability, *Fulfilling the Promises* (National Assembly for Wales, 2001), by restating its commitment to the All Wales Strategy of 1983 and its update in 1994. In August 2004 the Assembly issued Section 17 Guidance on Service Principles and Service Responses for Adults with Learning Disabilities. The principle for people with challenging behaviour states that 'People with learning disabilities who present challenging behaviour should receive evidenced-based care and treatment appropriate to their needs in their home or as close as possible to their home, irrespective of the severity of the level of challenge'. The service responses again emphasise the need for specialist expertise to support the work of learning disability and mainstream services.

Although they highlight the importance of services for people who show challenging behaviour and reaffirm commitment to their provision

and development, these strategies do not contribute anything new or innovative in the field. Indeed, by highlighting challenging behaviour as a separate entity, paradoxically they may have contributed further to a lack of integration of understanding and approach, and an emphasis on symptoms rather than cause. Too often challenging behaviour has become regarded as synonymous with risk and thus services have become structured to reflect a hierarchy of risk management or risk containment. This hierarchy often ascends from the level of basic core skills within members of multidisciplinary teams, through specialist practitioners, specialist teams, assessment and treatment units up to low and medium secure units and forensic provision. Service responses to challenging behaviour are often, therefore determined primarily by the nature and availability of fixed resources and, again, the challenge is located within the individual who is then judged against eligibility or admission criteria for these services. Perversely, the nature and degree of challenging behaviour may also become labelled in terms of the nature of the service response e.g. 'he is a forensic problem', 'her challenging behaviour can only be managed in a medium-secure unit', 'they need to be on the challenging behaviour ward'.

CHALLENGING BEHAVIOUR POLICY

Following the publication of *Facing the Challenge* by the Kings Fund (Blunden & Allen, 1987) and *Meeting the Challenge* (Allen *et al*, 1991) one of the most influential drivers of strategic change has been the Mansell Report, *Services For People With Learning Disabilities And Challenging Behaviour Or Mental Health Needs* (Department of Health, 1993). More recent learning disability strategies have not fully addressed the vital connection between challenging behaviour and mental health, emphasising instead issues of access to generic provision for all health needs; challenging behaviour has remained, without clear direction, within the specialist remit of learning disability services. Also lost is the charter for people with learning disabilities who have challenging behaviour or mental health needs contained in Appendix 4 of the Mansell Report (Department of Health, 1993) which states that:

- standards and charters applying to other people shall also apply to people with learning disabilities and challenging behaviour or mental health needs
- services will ensure that each person is treated as a full and valued member of their community, with the same rights as everyone else and with respect for their culture, ethnic origin and religion
- services will be individually tailored, flexible and responsive to changes in individual circumstances and delivered in the most appropriate local situation
- services will strive to enable people to live in ordinary homes and enjoy access to services and facilities provided for the general community
- services will be provided by appropriately trained, qualified and experienced staff who will help the people they serve to develop fully in all aspects of their lives
- services will be delivered in the least restrictive manner capable of responding to individual need
- services will strive to continually improve, using the latest research to provide the best treatment, care and support.

British Psychological Society: clinical practice guidelines

The British Psychological Society (2004) published guidance for clinical psychologists who provide psychological interventions to people with learning disabilities who also display behaviours that severely challenge services. Although aimed at psychologists, and drawing largely on the evidence-base contained in the psychology literature, it was intended that other professionals, service providers and purchasers may also find them helpful in clarifying what to expect from psychologists. Many of the guidelines contained in the document are equally applicable to other professionals and they have provided the impetus for this collaborative report, which aims to build on the evidence-base, by producing a consensus position statement on best practice for those clinicians who provide services to this group of people. The guidelines are not fully reproduced in this report but contain a more extensive review of the evidence base with respect to positive behavioural support and applied behavioural analysis. This report recommends that these guidelines are adhered to as appropriate in clinical practice.

Legislation

England, Ireland, Scotland and Wales have differing legislation and this legislation is in a continual process of change. All clinicians need to keep themselves informed as to how current local legislation and related practice guidelines affect their own practice. For the sake of brevity, this chapter is based on legislation that covers England and Wales. Clinicians in other jurisdictions will need to interpret the principles outlined in this section in light of their own national legislative framework.

CONSENT TO TREATMENT AND BEST INTERESTS

Professionals deciding on the appropriate treatment for adults with learning disabilities are guided by both the requirements of the law (and supplementary codes of practice or guidance) and of professional practice guidelines. The implementation of the Mental Capacity Act in 2007 and the Code of Practice 2007 (Department for Constitutional Affairs, 2007) has clarified the position in relation to decision-making on behalf of incapacitated adults.

The law in relation to treatment is based on the principle that 'every person being of adult years and sound mind has a right to determine what shall be done with his own body' (Per Cardozo [1914]). This principle of autonomy is fundamental, whereby people have the right to refuse treatment, even if others think it will benefit them. However, many individuals with learning disabilities and challenging behaviour would not be able to exercise such autonomy, as they might lack decision-making capacity. Those who lack capacity have been defined as:

> '...a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain'. (Mental Capacity Act 2005)

The Mental Capacity Act has further defined incapacity as:

> '...a person is unable to make a decision for himself if he is unable:
> (a) to understand the information relevant to the decision
> (b) to retain that information
> (c) to use or weigh that information as part of the process of making the decision, or
> (d) to communicate his decision (whether by talking, using sign language or any other means.)' (Mental Capacity Act 2005).

In relation to decisions about treatment for mental disorder, the Mental Health Act 1983 allows for treatment to be given for mental disorder (to

those detained) under part IV (sections 56–64). The Mental Capacity Act allows for the majority of other decisions to be made on behalf of an incapacitated adult.

There is also a presumption of capacity, and anyone wishing to treat a person has to prove lack of capacity before proceeding to treat without consent. This places requirements on those treating individuals who present challenging behaviour to assess capacity in relation to the decision that needs to be made. There is a requirement that information is presented in a way that is accessible to the person, and that simplified language, visual aids or other communication methods should be used if appropriate. Clinicians will therefore have to present information about medication or psychological interventions in a way which is accessible to the individual, assess whether or not they have understood and can remember it and whether they have used the information to arrive at a decision. The decision should be voluntary.

If the person does not have capacity to consent, then any treatment must be in their 'best interests':

> (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity)

> (b) the beliefs and values that would be likely to influence his decision if he had capacity, and

> (c) the other factors that he would be likely to consider if he were able to do so. (Mental Capacity Act 2005)

The 'best interests' provisions also place an obligation on the clinician to consult those involved in the care of the person (which can be both family and carers), anyone appointed by the court as a deputy for the person, and anyone appointed by the person themselves. This encompasses more than medical best interests, and also considers emotional, social and welfare issues. They should also be the 'least restrictive alternative' for the person; this can be particularly relevant for people who present behavioural challenges, as it is recognised that they may be placed in more restrictive environments and may have a more restricted range of opportunities available to them. The Code of Practice to the Mental Capacity Act 2007 provides more guidance on the issue of best interests.

Informal detention of incapacitated people

Another significant issue is the extent to which any placement might be sufficiently restrictive that it could be considered to amount to a deprivation of liberty for that individual. The case law on this issue derives from a ruling in the European Court of Human Rights, known as the Bournewood judgment (HL v. United Kingdom). This highlighted that detained patients have an automatic right of review of their detention, those who are not detained but unable to exercise their right to leave however do not have the same protection. The Mental Capacity Act is being amended to ensure that these rights are clear in law.

There are also implications for the treatment of incapacitated people in relation to the nature of the services in which they are placed, in that services that are unnecessarily restrictive of an individual's freedom could be

in breach of the European Convention on Human Rights; this could include practices such as locking doors and restrictive care practices. It is likely that people whose behaviour is challenging could be especially susceptible to such regimes, and professionals may also need to pay attention to these issues when considering placements or, indeed, providing clinical input to such placements.

Physical interventions

It is suggested that approximately half of people with learning disabilities whose behaviour is challenging will have physical interventions used on them at some point in their lives (Emerson, 2003). In the absence of a lawful reason, using force, or threatening to use force, could give rise to a criminal charge, as could locking someone in their room. The Mental Capacity Act defines the unlawfulness, and the appropriate penalties for actions of ill-treatment or neglect.

A physical intervention in relation to challenging behaviour is described by the British Institute for Learning Disabilities (Harris *et al*, 1996) as

'A method of responding to the challenging behaviour of people with learning disability and/or autism which involves some degree of direct physical force which limits or restricts the movement or mobility of the person concerned.'

They define three types of physical intervention

- direct physical contact between a member of staff and a service user: for example holding a person's arms and legs to stop them attacking someone
- the use of barriers such as locked doors to limit freedom of movement: for example placing door catches or bolts beyond the reach of service users
- materials or equipment that restricts or prevents movement: for example placing splints on a person's arms to restrict movement.

It is recognised that there may be occasions where the risk posed by an individual's behaviour necessitates the use of physical intervention as a reactive management strategy. Those individuals who possess capacity should be fully involved in planning all aspects of their care. In situations where the individual lacks capacity a care plan should be constructed which is considered to be in the best interests of that person and which utilises the least restrictive alternatives.

Clinicians working with individuals with learning disabilities whose behaviour is challenging are less likely to be required to participate in physical interventions involving direct physical contact, but may be required to advise on their use. They may also be involved in risk assessment regarding restricting an individual's freedom of movement and may be involved in interventions with individuals who self-injure where restraint is being considered as an option. The importance of acting in the best interests of the person and of ensuring that the other, less intrusive means are tried before resorting to physical interventions has been emphasised in a number of reports (British Psychological Society, 2004; National Patient Safety Agency 2004; Royal College of Psychiatrists, 2005).

The Department of Health/Department for Education and Skills guidance (2002) outlines the requirements when physical intervention are planned and these include

- agreement by the multidisciplinary team, including consultation with others as appropriate
- put in writing, together with the behavioural plan (they should never be the only plan for managing behaviour)
- be supervised by appropriately trained staff
- be recorded, so that the circumstances of any physical intervention and methods used can be monitored.

This guidance also emphasises that the physical interventions should

- be used as infrequently as possible
- be in the best interests of the service user
- be part of a broader treatment strategy
- not cause injury
- maintain the person's dignity.

In addition, The Mental Health Act Code of Practice (Department of Health & Welsh Office, 1999) provides guidance for the use of restraint within in-patient mental health settings. This contains similar recommendations in as much as the purpose of restraint is for an emergency response to end or reduce danger; should be individually planned; only used as a last resort; and should use the minimum amount of force for only as long as is necessary. The code recognises that situations may arise whereby non-compulsory detained individuals might need to be restrained as an emergency. If this occurs, especially on a repeated basis, consideration should be given to whether formal detention under the Mental Health Act is appropriate.

The Mental Capacity Act provides protection to carers from liability in regard to certain acts performed in connection with the personal care, healthcare and treatment of a person lacking capacity. The use of restraint is permitted only under specific circumstances and carers will be provided with protection from liability providing they believe that the restraint was necessary in order to prevent harm to the person lacking capacity and that the restraint was proportionate. This section does not allow the restraint in order to prevent harm coming to another person; Jones (2005) noted, however, that the common law could allow for the prevention of assault on another. Clinicians should be guided by the Department of Health/ Department for Education and Skills guidance (2002) and the Mental Capacity Act Code of Practice.

Seclusion

The Mental Health Act Code of Practice (1999) also contains guidance on the use of seclusion, defining seclusion as 'supervised confinement in a room, which may be locked'. The Code states that it should be used as a last resort and for the shortest period of time and not be used as a punishment or threat, as part of a treatment programme, because of shortage of staff or where there is any risk of suicide or self-harm.

The Department of Health/Department for Education and Skills guidance (2002) clearly states that the use of seclusion outside the Mental Health Act should only be considered in exceptional circumstances and should always be proportional to the risk presented. The guidance also makes a useful distinction between seclusion and withdrawal, whereby withdrawal is removal of a person from a situation that causes anxiety

or distress to a location where they can be continuously observed and supported until they are ready to resume their usual activities. Seclusion should similarly be considered to be a physical intervention, and its use outside the Mental Health Act should not occur.

Placement breakdown

Section 35 of the Mental Capacity Act provides for the appointment of an independent mental capacity advocate if there is to be a change in the provision of accommodation to a service user. These provisions apply if there is no one else available to consult. The change in accommodation must be for a specified length of time, and does not apply if the person is accommodated under the provisions of the Mental Health Act.

Focusing on the person

The term challenging behaviour is socially constructed. It represents the interaction of both individual and environmental factors, and the relationship between them. Any assessment and intervention for challenging behaviour must include these three elements (see Fig. 1).

Individual factors include
- degree and nature of learning disability
- sensory or motor disabilities
- mental health problems
- physical problems, including pain and/or discomfort
- communication difficulties, personal history of relationships and experiences.

Environmental factors will include the characteristics of services:
- number of staff
- training and experience of staff
- consistency of staff provision and approach
- the working relationship with the client
- working relationship between staff
- quality of the material environment
- opportunities available
- ability of the service to understand and respond to unique needs of individuals

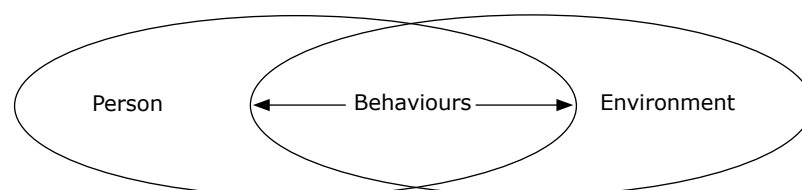Person ◄—— Behaviours ——► Environment

Fig. 1   The relationship between the elements of assessment and intervention in challenging behaviour.

A poor fit between the individual's needs and their environment may result in limited opportunities to
- gain social attention
- escape from or avoid excessive demands

- gain access to preferred activities or objects
- gain alternative forms of sensory feedback
- reduce arousal and anxiety by other means
- exert choice or control over environment
- understand and communicate with the person.

Individual risk factors (such as communication difficulties or a history of abuse) are widespread among people with learning disabilities; environmental risk factors (such as poorly organised and inadequately trained staff) are widespread among services. To design effective supports for people who challenge services, these factors need to be considered on an individual basis within a context that is based on strong ethical standards and values.

Where individuals are cared for in environments that do not respond appropriately to their needs, challenging behaviours are likely to develop and then remain in the person's repertoire. Many people encountered by clinicians who have been asked to intervene in their challenging behaviour are unhappy in their current environment and are powerless to do anything about it other than expressing their plight through their behaviour. Clinicians need to be aware that they may be expected to provide interventions in environments that are inadequate to meet the person's needs. They must strike a balance between best practice and pragmatic measures to pre-empt a crisis that could have more deleterious impact on the individual. A detailed functional assessment may help to demonstrate why the behaviour is occurring, and hence what needs to be altered in order to bring about service change. In considering interventions in less than optimal circumstances, the clinician may need to adopt a strong 'clinical advocacy' role, through communication with the relevant agencies, commissioners and regulators, in order to try to bring about the necessary environmental changes.

A CONTEXT FOR DELIVERING INDIVIDUALISED SUPPORTS

People with learning disabilities are generally disempowered and potentially vulnerable to abuse or neglect. Their lack of power reduces their ability to challenge poor practice and restricts their access to redress. In order to support this group of people a strong set of ethical standards and values is required.

Effective and ethical work must focus on individual needs and circumstances; person-centred values have been adopted as the cornerstone of *Valuing People, The Same as You?* and the Welsh Assembly Government's response to *Fulfilling the Promises*. This approach is not only important in terms of values but also outcomes for interventions. The Department of Health (2006*b*) White Paper *Our Health, Our Care, Our Say* sets out the Government's policy of designing services around the individual. Failure to individualise an assessment of the function of a person's behaviour can potentially lead to increases in the severity of a problem behaviour. For example, two of the common functions of challenging behaviour are social contact and social avoidance. These are opposites and to provide the same response to the behaviour, regardless of the person and the context, could result in completely different outcomes.

Within this document, we promote the approach that is increasingly referred to as positive behavioural support (Carr *et al*, 2002). This approach has emerged from three main sources

- applied behaviour analysis
- the normalisation/inclusion movement
- person-centred values.

Positive behavioural support integrates the following components into a cohesive approach
- comprehensive lifestyle change
- a lifespan perspective
- ecological validity
- stakeholder participation
- social validity
- systems change
- multi-component intervention
- emphasis on prevention
- flexibility in scientific practices
- multiple theoretical perspectives.

ASSESSMENT

Assessment is the process of collecting and evaluating relevant information about the person, the social, interpersonal and physical environment, as well as the behaviour that is challenging. Information about the person should include medical and psychological/psychiatric factors.
The purposes of assessment are
- to collect enough information to lead to a coherent formulation or diagnosis
- to lead to an intervention plan which fits the person and their environment, and leads to an improvement in their quality of life
- to establish a baseline that enables subsequent evaluation of effectiveness.

The focus of the assessment should be determined by the impact of the behaviour on the individual and those around them, including
- the degree of physical harm to the person and others
- the risk of loss of access to opportunities for development and participation
- the levels of distress being experienced by the person and others
- the capacity and motivation for change in the person and in their environment.

WHAT SHOULD BE ASSESSED?

The British Psychological Society's clinical practice guidelines on challenging behaviour (British Psychological Society, 2004) and the report on the use of medication for the management of behaviour disorders among adults with a learning disability (Deb *et al*, 2006) provide detailed frameworks for the assessment of challenging behaviours. In summary, an assessment should address both the individual and their behaviour in the context of
- underlying medical and organic factors (including medical examination and investigations)

- psychological and psychiatric factors
- social and environmental factors
- the interaction of these factors.

Pre-assessment and preliminary risk evaluation

Before any clinician begins to carry out an assessment of a person's challenging behaviour, they should perform a pre-assessment. This preliminary information gathering shapes the initial focus of an intervention and will include information that will assist the risk screening process, the setting of priorities and provides some direction for the subsequent assessment. The information should be provided by someone who knows the person well. If there is continuing family involvement, family members should be consulted.

Pre-assessment information should include
- descriptions of the challenging behaviour
- circumstances in which the behaviour occurs
- frequency and severity of the behaviour
- sensory impairments
- the person's communication style
- communication typically used by other people
- specific disabilities, including aetiology of intellectual impairment
- medical problems
- current medication
- setting in which the person lives/works
- previous interventions
- risks to the person or to others
- existing risk management strategies
- capacity to consent to current and potential interventions.

Risk assessment

Risk is an inherent and fundamental aspect of behaviour that is described as challenging and its assessment and management should therefore be an integral part of all aspects of intervention and support. Although there tends to be greater concern regarding risks of physical harm to others and/or to the individual, there are significant risks to loss of the various elements that make up quality of life (rights, choice, independence, citizenship, participation, inclusion etc.). Risk assessment should constitute a specific, documented component of the process. There should be an agreed multidisciplinary and multi-agency framework for description and evaluation of risk. This should include
- a precise description of the behaviours including frequency, duration and intensity and an indication of who or what is at risk
- identification of any behavioural precursors displayed by the individual that may indicate the probability of escalation of risk
- identification of aspects of the environment that are associated with increased likelihood of the behaviour.

The identification of these indicators should lead to planned early intervention aimed at diffusing and altering the course of potential incidents.

The risk assessment must be mindful of the person's aspirations and wishes as documented in their person-centred plan. Risk assessment should not be used as an excuse to adopt a 'risk averse' stance that then severely restricts a person's life further, with the potential consequence of inadvertently increasing their level of risk (Allen, 2002).

There may be rare situations where the risk assessment indicates that support staff will need to physically intervene in order to manage risk (see chapter on legislation).

Clearly, in an emergency situation it may not be possible to carry out a full and detailed assessment before having to initiate some intervention to protect the individual or others (LaVigna & Willis, 2002). Documentation in such circumstances should detail what information was obtained to validate the intervention, a projected timescale for the emergency measures and a clear indication of when and how a full assessment will be completed.

Assessing the function of behaviour

Functional assessment

This is a specific behaviour-analytic procedure, where structured observation and other methods of assessment (for example interview of people in frequent contact with the person or use of standardised questionnaires) are employed to generate hypotheses about the challenging behaviour, antecedents which might be acting as stimuli for the behaviour and consequences which may be reinforcing it. These hypotheses are then tested out by experimental trial in either a real life or a more controllable analogue setting. The hypotheses that can be supported by experimental evidence are then used to derive interventions to reduce or eliminate the challenging behaviour.

It is essential that an assessment attempts to establish the function of challenging behaviours, in order to determine the correct basis for an intervention. The terms functional assessment and functional analysis are used interchangeably by some clinicians. Generally, functional assessment is a more inclusive term that refers to a range of approaches to establish the function of the behaviour, while functional analysis refers to more structured techniques that may include manipulating antecedents and consequences in order to establish their functional relationships (for example analogue assessment, Iwata *et al*, 1990).

The evidence-base supports the use of functional analysis for interventions where the primary focus is the reduction or elimination of severely challenging behaviours in people with moderate, severe or profound learning disabilities. A correlation has been found between carrying out a functional analysis and successful outcome, measured by reduced challenging behaviour (Scotti *et al*, 1991; Didden *et al*, 1997; Ager & O'May, 2001). This should therefore be the approach of choice where challenging behaviour is severe and the most urgent target for intervention.

A functional analysis should follow three stages (Horner, 1994; Repp, 1994; Toogood & Timlin, 1996)

- stage 1 – hypothesis development: interviews or rating are used to generate hypotheses or rule out areas for further investigation
- stage 2 – hypothesis testing: direct observation and more detailed interviews are used to assess the accuracy of the hypotheses and identify contextual factors
- stage 3 – hypothesis refining: either experimental analysis is used to refine the working hypothesis or there is a direct move to intervention

strategies that are used to check the accuracy of the hypothesis about the function of the behaviour.

ASSESSMENT OF PHYSICAL DISORDER

In some individuals, challenging behaviour may be associated with a physical disorder, particularly one that causes pain or physical discomfort. This may commonly include

- headaches and migraine
- cerebrovascular and epilepsy-related events
- earache and toothache
- eyesight disorders
- gut-related pain: gastro-oesophageal reflux, colic, peptic ulcers and constipation
- urinary tract infections and prostatism
- bone and joint pain
- neoplasms
- wounds and fractures.

Clinicians should actively consider the role of possible physical disorders and/or the iatrogenic effects of treatment and whether a more detailed physical assessment is merited; referral for further assessment and investigations should be supported where necessary.

ASSESSMENT OF PSYCHIATRIC DISORDER

In some individuals, challenging behaviour may be associated with psychiatric disorder (Borthwick-Duffy, 1994). Different types of mental health problems may lead to different patterns of behaviour and consequently a variability of challenges both between individuals and within the same person. For example depression may be associated with apathy, withdrawal and self-neglect or it may lead to severe agitation, irritability and repeated attempts at self-harm or suicide. Mania on the other hand may be associated with uncontrollable overactivity, impulsiveness and recklessness, irritability, sexual disinhibition, aggression and violence. Individuals with a cyclical or bipolar mood disorder therefore may present a variety of behavioural challenges at different times and for varied durations.

Xenitidis *et al* (2001) presented schematically the relationship between challenging behaviour and psychiatric disorders across the spectrum of intellectual ability. This indicates that not all people with a learning disability will show behaviour that is challenging; not all people who present behaviour that is challenging have a learning disability; there is an overlap between autism and psychiatric disorder, but neither necessarily leads to behaviour that is challenging (see Fig. 2).

Emerson *et al* (1999) outlined three ways in which psychiatric disorders may be associated with behaviours that present a challenge; we have developed these and added a fourth:

1. Behaviour as the symptomatic presentation of a psychiatric disorder: psychiatric disorders may present in atypical ways among people with highly restricted linguistic and adaptive behaviours: for example some forms of self-injurious behaviour may constitute the atypical
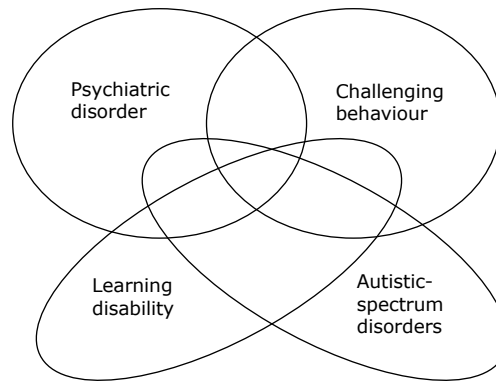
Fig. 2   Relationship between psychiatric disorder and challenging behaviour.

presentation of obsessive–compulsive disorder among people with severe learning disability (King, 1993).

2. Behaviour as a secondary feature of a psychiatric disorder: a range of problem behaviours, including aggression and self-injury may occur as secondary features of affective disorders among people with severe learning disability (Sovner & Hurley, 1983; Reid 1992), for example somatic symptoms such as headache and abdominal pain, agitation, and disturbances of physiological functions such as sleep, appetite and bowel movements may occur in people with severe learning disabilities who are depressed and unable to express their feelings verbally (Reid, 1992).

3. As a motivational basis for the expression of previously established behavioural patterns: The presence of a psychiatric disorder might establish the conditions for certain behavioural responses that themselves become reinforced and maintained by other environmental or internal factors. Apathy and low motivation in depression, for example, may be associated with an unwillingness to participate in educational or social activities. The avoidance of these activities may be negatively reinforcing, or the comfort of remaining at home with carers may positively reinforce this withdrawal from previous activities. Previous association of challenging behaviour with positively or negatively reinforcing events may lead to an increase in these behaviours at times of mental ill health.

4. As an iatrogenic effect of medication: medication for the treatment of psychiatric disorder may result in unwanted effects. These may include: akathisia from neuroleptics, disinhibition from benzodiazepines, selective serotonin reuptake inhibitor- (SSRI-)induced anxiety, excessive sedation and constipation. When a person with learning disabilities also has a mental health problem (dual diagnosis) it is essential to have a clear understanding of the emotional, cognitive and behavioural impact of the psychiatric disorder on the person with a learning disability.

Psychiatric disorders such as acute psychosis, depression, anxiety disorders and phobias should always be considered in a person with a learning disability who shows behaviour problems. Conditions such as autism (Bhaumik et al, 1997) and attention-deficit hyperactivity disorder (ADHD) (Biederman, 2005) are more common among adults with learning disability

compared with their peers without learning disabilities. Both autistic disorders and ADHD are associated with high rates of behaviour problems.

The assessment process should also consider enduring abnormalities of personality that result in difficulties in interpersonal, occupational and social functioning; examples being borderline, paranoid or dissocial personality disorders. The term personality disorder however should be used with care; it can be used pejoratively in people whose behaviours are intractable, are considered socially unacceptable, or invoke strong emotional responses in others. Although it may be used to describe a pattern of behaviour in people with mild to moderate learning disability it is more difficult to be applied conceptually in adults with severe and profound learning disability.

The assessment and diagnosis of psychiatric disorders in people with learning disabilities can be complex and difficult and, in the UK, is usually the domain of psychiatrists in the specialty of learning disability. It is essential to note, however, that this process is not solely the domain of psychiatrists. A thorough approach to diagnosis and formulation should bring together relevant information, observations and specific assessments from a range of sources and clinical disciplines. Careful distinction should be made between behaviours associated with the symptoms of psychiatric disorder and those related to the underlying developmental disorder. Changes in behaviour, where clear symptoms and signs of psychiatric disorder are not evident, should not be assumed to be due to a psychiatric disorder. Guidelines exist for the assessment and diagnosis of mental health problems in people with a learning disability (Deb *et al*, 2001; see also http://www.estiacentre.org). For example, an adult with learning disabilities who appears to be having a conversation with themselves or is raising their fist at unseen 'objects' should not be assumed to be experiencing hallucinations unless there is further, more detailed evidence that can distinguish this as a hallucinatory phenomenon rather than a behaviour that is consistent with the individual's cognitive or developmental level. Similarly, the disorders of communication and behaviour in autism, if taken at face value and without an understanding of the underlying neuropsychological processes, could be mistaken for thought disorder, hallucinations or delusions. Clinicians and carers should also be aware of the phenomenon of 'diagnostic overshadowing', the tendency to attribute behavioural patterns to the person's pre-existing learning disability, thereby failing to consider the presence of a psychiatric disorder superimposed on the person's learning disability.

The clinical team should also be aware of other contributory psychological and emotional factors that may initiate and/or perpetuate behaviour problems. For example

- bereavement
- psychological trauma
- specific environmental stressors (new, ongoing or recurrent)
- relationship difficulties
- loss of self esteem
- isolation.

ASSESSMENT OF COMMUNICATION

There is clearly a link between communication difficulties and challenging behaviour. Desrochers *et al* (1997) found that only 32% of service users whose behaviour severely challenged and were referred to challenging

behaviour services were able to communicate most or all wants and desires. Research has shown that challenging behaviours typically increase in frequency, intensity or duration when communication difficulties increase (Talkington *et al*, 1971; Chamberlain *et al*, 1993; Cheung *et al*, 1995; Bott, 1997). Most research to date has focused on the link between expressive communication skills and challenging behaviour but the role of understanding is also vital. For example challenging behaviour may result from the individual not understanding what is expected of them (Clarke-Kehoe & Harris, 1992; Bradshaw, 1998, 2002; Kevan, 2003).

Communication must be viewed within a partnership (Bartlett & Bunning, 1997) in both assessments and interventions, where the contributions of both the person presenting challenging behaviour and their communication partners are included.

A detailed communication assessment is needed to give information about the communication skills of the individual, their communication environment (including the communication partners) and the ways in which these are utilised within their daily lives (Bradshaw, 2002; Royal College of Speech and Language Therapists, 2003). This should also include an assessment of hearing skills.

There are also some specific communication considerations within a functional assessment; for example, considering the role that communication may have played within an analysis of antecedents, behaviours and consequences.

ASSESSMENT IN AUTISM

The principles above also apply to understanding the behaviour of people with autism. It is essential that an objective and comprehensive assessment of all individual and environmental factors is carried out. Assumptions should not be made about the experiences, perceptions, understandings or beliefs of the individual; many of the projections clinicians may make based on their own internal experiences about sensations, communication, social rewards and routines, are inappropriate or inaccurate when applied to people with autism.

Autism is a neurodevelopmental disorder and its 'causes' are associated with a wide range of neuropsychological and interactional difficulties that vary between individuals. Thus the clinician actively needs to consider evidence of sensory as well as processing and motor anomalies; such factors as sensory overload, for example, can produce extreme behavioural changes.

Although communication difficulties may be easily diagnosed, it is often difficult to assess the person's specific difficulties; which is why communication problems are a common aetiological factor of challenging behaviour in people with autism. Communication difficulties can also severely hamper the elucidation of physical and mental health problems.

In addition, the assumption that the person desires social interaction can be erroneous since many people with autism have interests and fascinations that do not include interacting with people other than to help with these interests.

FORMULATION AND DIAGNOSIS

Formulation is best regarded as an hypothesis, or set of interconnected hypotheses, about the nature of the presenting problem and its

development. It usually contains informed 'ideas' about causal or functional relationships between variables / events and the central problem. It has two main functions

■   to guide clinical intervention within an explicit rationale

■   to aid the establishment of criteria for evaluation of the intervention.

Functional assessment and diagnosis are both integral features of the assessment of challenging behaviours that should be carried out by all clinicians, either individually or in collaboration.

Formulation is a component of both psychological and psychiatric interventions. It occurs as part of the process of assessment, diagnosis and treatment planning, in psychiatric and psychotherapeutic practice. The establishment of a diagnosis of psychiatric illness, pervasive developmental disorder, behavioural phenotype or specific cognitive impairments should not in any way limit or unduly dominate all other factors in a complete functional assessment.

There is no one single 'correct' way to carry out a formulation; method and form will depend upon the context, the theoretical model being utilised, and the particular purpose of the formulation (Harper & Moss, 2003).

Psychiatric diagnosis is sometimes viewed as an unnecessary 'double stigmatisation' of the person already stigmatised by a label of learning disability. This view is untenable since appropriate psychiatric diagnosis based on a comprehensive assessment of all aspects of the individual can enhance the assessment process and help to clarify possible aetiological factors, prognosis and the nature of interventions and expected outcomes.

INTERVENTIONS

Interventions should be delivered in a person-centred context. While the detailed assessment and formulation process outlined above should result in clear intervention strategies, these must be tailored to the individual, their personal characteristics, environment and available resources for support. Multi-agency and multidisciplinary involvement should occur in close partnership with families and other carers. Detailed information concerning the nature and outcome of previous interventions should be obtained and taken into account.

A number of therapeutic modalities are described below which may be delivered in combination (e.g. medication and family therapy). Whenever possible, interventions should be introduced one at a time in order to enable clearer evaluation of outcome. Depending on the findings of the risk assessment described above, the therapeutic interventions may need to take place in an environment in which safety and security can be offered.

Within the positive behavioural support framework, the plan should include both proactive strategies for reducing the likelihood of the occurrence of the behaviour, and reactive plans for managing the behaviour when it does occur (Allen *et al*, 2005).

PROACTIVE STRATEGIES

Proactive strategies address the goodness of fit between the individual and their environment. These strategies would be expected to reduce the frequency, intensity or duration of the challenging behaviour by either

- adjusting aspects of the environment in order that they are more supportive, or
- attempting to address individual factors such as skills and tolerances via systematic skills building, or
- addressing physical health problems via medical intervention.

Reactive strategies

Reactive strategies are designed to deal with specific incidents. This may involve

- early intervention when signs are present that challenging behaviour may be about to occur. This will involve identification of environmental triggers known to be associated with the behaviour and behavioural precursors that might indicate that the individual may be becoming agitated. The aim here would be to diffuse the situation in order to prevent escalation of the behaviour
- physical management of the individual in order to ensure the safety of all those involved. This would be a last resort and thus a relatively rare occurrence and be in keeping with the relevant legal frameworks and principles of good practice reported elsewhere in this document.

Psychotherapeutic interventions

The underlying aetiology of challenging behaviour may relate to psychological trauma, such as a past or ongoing history of abuse, losses or bereavement (Hollins & Esterhuyzen, 1997), problems in sexuality and intimate relationships, intra-familial and inter- and/or intra-personal conflict. While interventions may initially focus on the immediacy of the challenges being presented, it is also essential to understand and to work to resolve some of these underlying conflicts or traumas. The importance of these aetiological factors in people with learning disabilities has increasingly been recognised (Sequeira & Hollins, 2003).

Psychotherapeutic interventions, having for many years been denied to people with learning disabilities, are increasingly being validated as applicable and effective (Royal College of Psychiatrists, 2003). Cognitive behavioural approaches either individually or in groups have been applied to problems of anxiety, anger, aggression and offending; psychodynamic approaches may be effective in reducing psychological distress and interpersonal problems and increasing self-esteem as well as reducing offending behaviour (Hollins & Sinason, 2000; Beail, 2003; Wilner, 2005). Although much of the current evidence-base relates to people with mild learning disabilities, many clinicians are adapting cognitively based interventions in order to make them more available to people with more significant learning disabilities.

The group analytic approach in particular has been used extensively in generic forensic mental health settings and has also been applied with offenders with learning disabilities in secure settings (Xenitidis, 2005). Moreover as the role of personality disorder is increasingly being explored in adults with learning disabilities (Flynn *et al*, 2002) psychodynamic formulations and psychotherapeutic interventions are likely to become more widely used.

Families and carers can encounter personal and interpersonal stressors and conflicts that may benefit from psychotherapeutic intervention and support using family, systemic or group analytic models. The services,

agencies and wider organisational structures involved in supporting individuals who present severe challenges may also become dysfunctional and thereby contribute to the failure to meet the challenges presented by the individual. Systemic, organisational or other psychotherapeutic approaches can contribute to recognising and addressing these issues at this wider level (Baum & Lyngaard, 2006).

Assessments and interventions for supporting the individual with challenging behaviour should therefore always consider the potential role of psychotherapeutic models in enabling formulation and/or diagnosis and treatment at a number of levels.

COMMUNICATION INTERVENTIONS

There are a number of communication-focused approaches to challenging behaviour which have been reported in the literature (Bradshaw, 1998; Brown, 1998; Chatterton, 1998; Dobson *et al*, 1999; Thurman, 2001). These have typically attempted to improve the communication skills of both the person with a learning disability and/or their communication partners and communication environments. This may include interventions designed to increase the communication skills of the individual, for example

- increasing the effectiveness of existing communication skills (e.g. increasing clarity of communication)
- teaching the individual more ways of communicating (additional/ vocabulary or forms of communication such as signs or symbols)

and/or the skills of the communication partners, for example

- improving recognition and understanding of the individual's communication skills (both in terms of what they understand and how they express themselves)
- assisting communication partners to provide appropriate models of communication
- facilitating communication partners' use of appropriate forms of communication, such as use of signs, symbols and objects, in addition to spoken communication
- structuring partner communication so that it is within the individual's understanding

and the wider communication environment, for example

- promoting good listening environments (e.g. reducing distractions and background noise)
- providing individuals with opportunities to take part in a range of communication acts (e.g. to ask questions, comment etc.)
- increasing the amount of good quality communication.

Communication-based interventions may also be challenging behaviour-specific, such as those found within the literature on functional communication training. Once the function(s) of behaviours have been assessed, attempts are then made to replace these behaviours with a functionally equivalent communicative response. For example, teaching the person to use a Makaton sign for 'break' to replace behaviour that serves the function of avoiding demands. Such interventions have been shown to reduce the level of behaviours that are challenging (Carr & Durand 1985; Carr *et al* 1991; Durand & Carr, 1991; Carr, 1994; Carr *et al*, 1994).

POSITIVE PROGRAMMING

One of the central components of positive behavioural support (Horner *et al*, 1990) is to enable the person to engage in meaningful activities and relationships. Changes in a person's quality of life are both an intervention and a measure of the effectiveness of an intervention. Interventions are frequently delivered through, and in partnership with, a range of different mediators (families, support workers etc; Lucyshyn *et al*, 1997). Mediators need to be both skilled in the delivery of positive interventions, and organised and supported in such ways that they can support people positively.

Specific approaches to 'positive programming' may be required if mediators are to be supported to deliver positive interventions. One such approach is active support (Jones *et al*, 1999) a package of procedures which includes activity planning, support planning and training for providing effective assistance. Such approaches have been shown to increase the levels of assistance that individuals receive and their engagement in everyday activities.

PHYSICAL AND/OR MEDICAL INTERVENTIONS

If assessment indicates that a behaviour is a consequence of an underlying medical condition (for example chest infection, dehydration, epilepsy) that requires medication or other physical treatment, then this should be addressed promptly within the treatment plan and reassessment made in the light of response to treatment. There is good evidence that common and treatable medical conditions often go undiagnosed and untreated in people with learning disabilities (Hatton *et al*, 2002).

PSYCHO-PHARMACOLOGICAL INTERVENTIONS

A medication treatment plan should be drawn up that explicitly addresses the following

- the name of the medication and who is to prescribe it
- a clear indication of how dosage will be titrated cautiously according to individual response and susceptibility to side-effects
- whether physical examination and investigations are required prior to treatment and as part of ongoing monitoring
- desired outcome of treatment, assessment methods and timescales
- Potential adverse effects, including effects on quality of life of the individual and their carers, how these adverse effects should be monitored and the action to take if they occur.

Although psycho-pharmacological treatments have been widely used in the management of behaviour there is a meagre evidence-base for their effectiveness; there are very few studies comparing different medications for the management of specific behaviour problems. Specific treatments cannot therefore be recommended for specific behaviour problems.

It is however appropriate to consider medication as an important component in the management of psychiatric disorders and aetiological or contributory psychiatric symptoms. Thus an underlying depression may require treatment with antidepressants, a cyclical mood disorder with mood stabilisers or a psychotic disorder with an antipsychotic drug. Obsessive–compulsive disorder, panic or generalised anxiety that results in

or exacerbates challenging behaviour may benefit from treatment with an SSRI. High levels of arousal and anxiety contributing to aggression in an individual with autism may respond to the tranquillising or anxiolytic effects of an antipsychotic or to other drugs used in the treatment of anxiety (Einfield, 2001).

Pharmacological treatment in people who present challenging behaviour should only be initiated following a thorough process of assessment, diagnosis and formulation that has clearly established either

■   that an identifiable psychiatric disorder is present

or

■   that there are significant psychiatric symptoms

and

■   these are an aetiological or contributory factor in the behaviour which is presenting a challenge

and

■   the medication proposed can be expected to improve the psychiatric disorder or symptoms identified (if the medication is not licensed for the disorder then there must be an established literature giving a rationale for the proposed medication).

Other factors to be taken into account should include

■   inadequate response to other non-drug interventions
■   likely speed of response to different interventions
■   significant risk or evidence of harm and/or distress to the individual
■   significant risk or evidence of harm and/or distress to others
■   high frequency and/or severity of behaviour problems
■   good response to previous drug interventions
■   possibility of greater effectiveness of, or enhanced ability to deliver, other interventions as a result of drug treatment.

Medication should not be planned and delivered in isolation, it should be an integral part of a comprehensive intervention strategy and should be regarded as adjunctive or complementary to other non-drug interventions planned and delivered by various members of the multidisciplinary team (Deb *et al*, 2006, see http://www.ld-medication.bham.ac.uk). It is important to bear in mind that medication may be recommended by a psychiatrist but prescribed by an individual's general practitioner. The initiation, discontinuation or alteration of medication may therefore occur without the specialist team's knowledge. It is essential that there is active dialogue between the responsible clinicians in primary, secondary and specialist health services.

Prior to initiating medication the prescribing clinician, in consultation with the person, their family and carers and other members of the multidisciplinary team, should therefore address the following

■   what range of management options has been considered?
■   what medication is the individual already prescribed?
■   have there been any past adverse reactions to medication?
■   does the formulation include a clear rationale for the proposed drug treatment?
■   what is the likely effectiveness of the proposed treatment?
■   is there a clear, objective method of assessment of outcome and adverse effects?

- have issues of capacity and consent been fully taken into account and recorded?
- is the proposed treatment in the best interests of the individual, considering all alternative interventions?
- is the proposed treatment and its implementation consistent with relevant legal frameworks?
- is the dose and planned duration of treatment within British National Formulary and other good practice prescribing guidelines and dose recommendations?

As well as the general intervention documentation described above, a medication treatment plan must be written that explicitly addresses the following

- the name of the medication and who is to prescribe it
- how the dose should be titrated, and over what period of time
- whether physical examination and investigations are needed prior to treatment and as part of the ongoing monitoring
- potential adverse effects, including effects on quality of life of the individual and their carers, how these adverse effects should be monitored and what action should be taken if they should occur.

The use of medication makes it even more important that the intervention plan clearly records

- the working formulation including rationale for medication
- desired outcome of treatment, assessment methods and timescales
- consent to treatment (if the person lacks capacity to consent, then the rationale for its administration and the views of others).

There are occasions where the intensity of an individual's behavioural disturbance (aggression, anxiety, agitation) may require urgent intervention for the protection of the individual or of others. In these circumstances clinicians should follow an established 'rapid tranquillisation policy' for example those produced by the National Institute for Clinical Excellence (2005) or the Bethlem and Maudsley Prescribing Guidelines (Taylor *et al*, 2001), modified if necessary to take account of increased vulnerability of people with learning disabilities to adverse effects of medication. Such interventions, however, should be followed immediately by a multidisciplinary review and assessment as outlined above to determine the longer-term role of drug interventions for the individual.

Initiating intervention plans

Before commencing any intervention, it is important to bring together all the elements of assessment described above into a coherent and concise treatment plan. This plan should be developed and agreed by the multidisciplinary team, the individual and carers. The relevant roles and responsibilities of all involved, including a named professional and process for coordination, should be clarified, documented and agreed.

Evaluation

Clinicians are under an ethical obligation to measure the impact of their interventions on the target behaviour, because the nature of challenging

behaviour is such that, by definition, there is a threat to the health and well-being of the person concerned or those close to him or her.

All interventions should be routinely evaluated for their effectiveness and this evaluation should be planned at the point of initiation of the intervention. There is evidence to suggest that those that are more thoroughly evaluated are more likely to demonstrate a positive outcome (Scotti *et al*, 1991; Didden *et al*, 1997).

An evaluation will usually repeat baseline measures from the start of an intervention and look for any evidence of change. The measurement of challenging behaviour alone, is an inappropriately narrow focus and as a minimum, the evaluation should consider

- the severity, frequency and duration of the target challenging behaviour
- the person's quality of life and range of activities or opportunities
- the person's development of positive skills and abilities
- the person's well-being and satisfaction with the intervention
- the well-being and satisfaction of carers or family members in close contact with the person.

Adverse effects of the intervention should also be carefully monitored. Follow-up assessments should always consider withdrawal of medication (if medication has been a component of the intervention strategy) and be incorporated with an introduction of alternative non-drug managements.

The clinician needs to make a specific evaluation of those factors that he or she is attempting to change. If an intervention attempts to teach new skills, for example, then the acquisition of those new skills should be measured. If the intervention is hoping to change an environment, then measures of the environment need to be taken before and after the intervention.

The evaluation should also include a review of the initial formulation. There is significant evidence that demonstrates the potential persistence of challenging behaviour over long periods of time. It is, therefore, essential that progress is monitored repeatedly over extended time periods, thus allowing

- measurement of the impact of interventions
- early identification of potential deterioration or relapse.

Work on relapse prevention with people with learning disabilities is at a very early stage but the literature suggests that relapse is a very real problem, 'patterns of severe challenging behaviour do not simply disappear' (Anderson *et al*, 1993).

COMMUNICATION AND FEEDBACK

Communication between professionals, carers and service users, and the timely sharing of information is an essential component of care. Many services have guidelines on the timeliness and content of reports and letters, which need to be adhered to as an essential element of good practice. It is likely that many people will be the subject of the care programme approach or some other system of care coordination and it is essential that such mechanisms are properly utilised.

The term 'feedback' should also be understood more broadly to include verbal and informal communication. Feedback should be provided at several stages, as follows

- at the end of the assessment period and when the formulation has been produced
- following interventions, whether or not these are successful
- when there is a substantial revision to the formulation or the proposed intervention plan
- on completion of work with the individual or care team.

Feedback should also be given to the person with learning disabilities in an understandable and respectful form.

People involved in the assessment or intervention should receive regular and routine feedback, as should the referrer and other important people in the life of the person with learning disabilities. This, of course, is dependent upon appropriate consideration of issues of confidentiality (see below).

There is some evidence for the effectiveness of presenting feedback in different modalities or formats. Visual presentations, for example, may be important for people with autism (Clements, 1987; Mesibov *et al*, 1988). The use of video feedback to help a person understand their own behaviour can also be helpful.

The most important factor in providing feedback for staff and families appears to be 'goodness of fit' with the environment, recognising the skills, preferences and styles of the people with whom one is communicating. For example, the use of visual representations (graphs, bar charts, pie charts or scatter plots) can be very helpful for some people, while others find numbers or narrative easier.

Clinicians must ensure that they respect the confidentiality of the person with learning disabilities when they are giving feedback. It is particularly important for clinicians working with people who are not socially valued and often not seen as active agents in their own lives to be mindful of the requirement to respect confidentiality. There is anecdotal evidence to suggest that breaches of confidentiality are more likely to occur with more disabled and more disadvantaged groups of people.

Sometimes clinicians are perplexed about whether family members or paid carers should be provided with personal information about the person with learning disabilities. The following factors should be considered

- the person with a learning disability should be asked, where possible, what information they do or do not wish to have shared with other specified people. It is important to allow for the tendency of people with learning disabilities to be acquiescent to requests of this sort in assessing consent to sharing information
- partnership working with close family members is often of central importance in the life of a person with learning disabilities. The clinician needs to consider this when making a decision to share or to withhold information. It is likely to be necessary to work alongside the family to strengthen relationships so that they can offer mutual trust, safety and the capacity for development
- there is no obligation to pass on information unless there is a serious risk to a person or others. A parent, for example, does not have a right to know everything about their adult son or daughter
- where there is a serious risk to the person with a learning disability or others, the clinician has an obligation to share information with those who need to know in order that they can take steps to protect others or themselves

■ it may be helpful to consider what information would be shared in similar circumstances if the person did not have a learning disability.

As well as providing feedback to others, the clinician should also ask for feedback from others on his or her own performance, establishing a two-way process that can modify or improve their clinical practice, personal development and professional revalidation.

INTERVENING IN 'LESS THAN OPTIMAL' SERVICES: CLINICAL ADVOCACY

Given the nature of challenging behaviour, appropriate intervention will usually involve some combination of changing the situation the person is in (for example who they live with, how staff support them, what they do) and intervention with the person themselves (for example developing functionally equivalent alternatives to challenging behaviour or treating underlying mental health problems). If services are poorly set up (for example too many people living together, not enough staff, too far from shops and amenities) then the environmental aspects of change may include redesigning the service.

In practice, clinicians may often be asked to intervene in services that are ill-conceived, badly set up, under-resourced, and where staff or managers are not sufficiently skilled or motivated to implement effective means of working with people. The services may, for example

■ not be able to provide all the support that is required
■ be unable or unwilling to carry out recommended interventions
■ have poor levels of knowledge or skills
■ have a high staff turnover
■ be using aversive or punitive measures to control the individual.

It may also be the case that services or organisations do not change despite interventions, reports or advice.

In these 'less than optimal' situations, clinicians face a dilemma; if they recommend interventions which they believe represent best practice in addressing the problem, they may not be carried out or not carried out sufficiently well. Intervention may become discredited, staff demoralised and potentially the clinician is blamed for unrealistic expectations. The person receiving services suffers from inadequate and incompetent intervention and may end up gaining a reputation of 'being beyond help' when in fact it is services that have failed them.

On the other hand, if clinicians acknowledge the deficiencies of the service they are working with, they may need to propose pragmatic interventions which deal with the short-term crisis but leave the underlying problems untouched. The service, and the commissioners and care managers who assess and plan for the individual, are therefore not enabled to learn from the problem and develop the service, so that the risk is that the problem will recur again and again. The individual person receives less effective intervention than they need and may suffer more restrictive intervention than would be needed in a better situation.

Given scarce resources and the urgency of the request for help, clinicians may feel that they have to 'do something' and may end up

delivering less than optimal interventions themselves; for example, medication being prescribed in the absence of other interventions as a result of these being unavailable or undeliverable in the particular setting. Alternatively they may refuse to intervene in settings that are unsafe or unable to change. Neither approach should be acceptable; professional ethics and codes of practice make it clear that as well as a duty to do their best to meet the needs of the individual, the clinician has a duty to point out when they believe that the client is suffering unduly as a result of service deficiencies or bad practice (Royal College of Psychiatrists, 2004; British Psychological Society, 2006). Facing this dilemma, clinicians have two responsibilities – these are not alternatives: both have to be done:

■ to do their best with the resources that are available to meet the needs of the person concerned

■ to draw to the attention of the responsible authorities that the service the person is receiving is unsatisfactory, to indicate in what respects it is deficient and to spell out the negative consequences of these deficiencies on the quality of life of the person concerned.

A role of 'clinical advocate' may need to be adopted in which the clinician, within the appropriate boundaries of confidentiality, works together with the service user to ensure that their needs are clearly outlined and communicated to relevant managers, commissioners or inspectorates. A detailed, recorded, functional assessment, formulation and diagnosis, together with a risk assessment are vital in not only highlighting individual, environmental and systemic issues, but also the impact on the individual and those around them, of a failure to respond appropriately and adequately to their needs.

Clinical advocacy must not be confused with 'shroud waving'. The clinician does not refuse responsibility for trying to help the person, nor do they make general claims beyond that which the evidence supports. They maintain a degree of objectivity at the same time as illuminating the personal and human facets of the situation that the person is challenging. Where possible, more than one potential solution should be sought in order to help those responsible for managing, developing and commissioning services to find creative and flexible responses within the system in which they work.

We acknowledge that this is a difficult area and one where clinicians need to maintain appropriate and safe boundaries in their clinical relationship with the service user. They may also need to make service providers and commissioners aware of their professional duty to point out problems with the way services are set up and run. However, clinicians cannot escape this responsibility. They will often be the most highly-trained resource the service user has and their potential influence is considerable.

Capable environments

In recent years, increasing numbers of people whose behaviour challenges services have moved from institutional settings to a range of places in the community (Mansell *et al*, 2002). Demonstration projects have shown that people can be well supported in the community (Felce *et al*, 1994; Mansell, 1994, 1995; Horner *et al*, 1996; Mansell *et al*, 2001), but the learning from these has not become embedded nationally as models for service delivery. Three problems commonly exist

- family support and local placements can break down, and there are rarely local alternatives or supports that are of sufficient quality
- out-of-area placements then become the most likely alternative. A study in the West Midlands, for example, shows a steep rise in the number of people placed out-of-area in recent years (Ritchie *et al*, 2005, p.45). Such placements are often both expensive, and a long way from the person's family and community (Mitra & Alexander, 2003; Beadle-Brown *et al*, 2006)
- despite the national requirements for inspection and monitoring, there still exist institutional services where restrictive and abusive practices persist (Commission for Healthcare Audit and Inspection, 2006, 2007). These are often in larger settings where every resident demonstrates behavioural challenges (Robertson *et al*, 2004)

Where these problems exist in a locality at a significant level, they can produce two further consequences

- the process of care planning can become overwhelmed by crises and short-term reactive responses which are almost entirely concerned with finding placements to take people whose existing arrangements have broken down
- the overall cost of services increases, since the new placements for people whose behaviour is challenging are able to command higher fees. Despite these higher costs, the new placements are often of poorer quality, not only because they often remove people from their local communities, but also in terms of care practices (Emerson *et al*, 1992; Robertson *et al*, 2004).

REASONS FOR BREAKDOWN, OUT-OF-AREA PLACEMENT AND POOR QUALITY SERVICES

It is important to recognise that the reason for the breakdown of local placements is generally not the behaviour itself. Local services can successfully support people who present a wide range of challenges (Mansell

et al, 2002). Rather, the reason lies in the way typical services respond to people who present challenges.

As outlined in the previous chapter (Focusing on the person), the term 'challenging behaviour' is socially constructed. The term represents the interaction of both individual and environmental factors, and the relationship between them (see Fig.1).

When people are supported in services that are unable to respond appropriately to their needs, it is more likely that the person will develop patterns of behaviour that are then responded to in ways that will maintain that behaviour. If services are poorly organised, it is more likely that they will be challenged by the behaviours and that the behaviours will then persist (Department of Health, 1993).

In the past, there have been some naïve beliefs that simply by discharging people from institutional settings into community placements, there would be an increase in their opportunities, and a consequent decrease in behaviours that challenge. A change of model by itself is insufficient to bring about a change of behaviour (Emerson & Hatton, 1994).

Another persistent belief is that behaviour can be eliminated through appropriate biomedical or psychological treatment alone. Biomedical interventions may be effective in changing behaviours where the underlying cause has a physical basis that is amenable to medication (Deb *et al*, 2006). Successful psychological interventions (British Psychological Society, 2004) are frequently not maintained, due to a lack of the required level of consistency by the support team (Oliver *et al*, 1987).

Rather than relying on attempts to alter a person's behaviour by changing service models, or through 'treatment', it is evident that commissioners and managers should be designing services that promote a person's quality of life in spite of the intensity or frequency of their behaviour.

Staff teams should not be looking for quick solutions to what may be lifelong patterns of behaviour. They need to be trained, supported and managed in such a way that they can promote positive interactions that may bring about increased participation, independence, choice and inclusion within local communities. Limitations in 'placement competence' appear to reflect a lack of training, or relevance of training, and 'practice leadership' (Mansell, 1996; Jones *et al*, 1999), as well as a lack of knowledge (Hastings, 1996), value conflicts (McGill & Mansell, 1995) and different perceptions by front-line staff about the priorities in their work (Mansell & Elliott, 2001). The rhetoric of 'treatment', in which challenging behaviour is seen as entirely located within the individual and amenable to medical or psychological treatment, actually helps perpetuate unsophisticated support for individuals presenting challenging behaviour in residential care or in their family homes. The requirement for staff to work in skilled and well-organised ways is diminished by the belief that the problem lies in the person and that they can be cured, usually somewhere else.

At this point in the development of community-based services, commissioners are typically paying for large numbers of residential care places that can support individuals who do not present particular challenges, and only a few places that can support people with more complex needs (and these places are not always of good quality). There is a mismatch between the level of need in the population of people with learning disabilities and the range of available provision. Fig. 3 illustrates how, for an increasing level of need for responsive, resourced and skilled support and intervention, there is not an equivalent capacity to deliver these in the

majority of services. Within a small service sector there is a concentration of skills and resources only for those who present the greatest challenge (or risk) or who have been rejected by local services. In the majority of local community-based service provision, the capacity and capability to respond appropriately to behavioural challenges is generally low. When a certain threshold of tolerability is exceeded then a specialist and resource intensive solution is sought, increasingly within the independent sector and away from the individual's place of origin.

SUPPORT FOR PLACEMENTS

In the situation described above, people who may present a significant challenge to services which are not really staffed, trained and organised to respond to their needs are likely to be excluded. The ideological commitment to supporting people in the community, so widely evident in learning disability services, breaks down under pressure.

Even if the services concerned wished to continue to support individuals presenting major challenges, there is often not enough capacity to do so. Within staff teams, there is typically little expertise. Most staff are untrained, staff turnover is high, and what training people have received is likely to have been restricted to reactive management methods rather than proper preventive and ecological strategies. Once challenging behaviour escalates to a frequent, severe problem the staff may not be able to cope.

The major source of the expertise needed to work with people presenting challenging behaviour is located in professionals, typically employed by the health service and organised in multi-professional teams. These teams include nurses, psychologists, speech and language therapists,
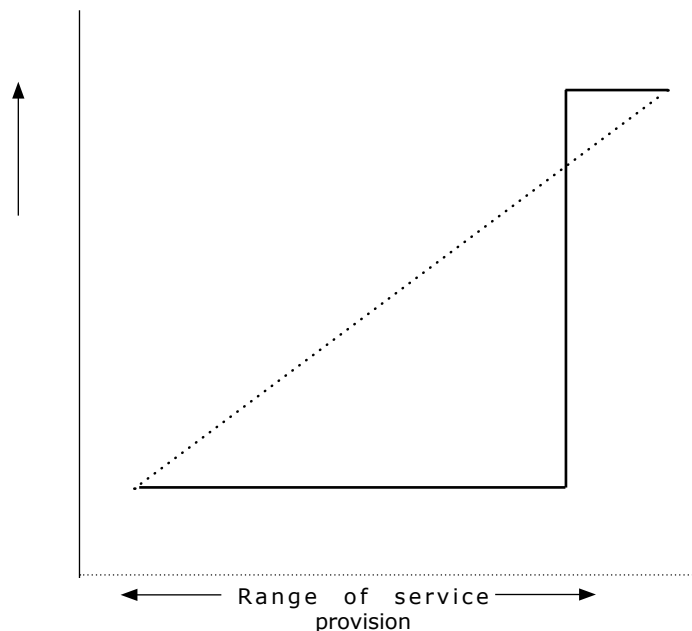

Range of service provision

Fig. 3 Need and capability in services for people with learning disabilities. ————— , capability of service to respond; ·············· , individual demand on service

physiotherapists, psychiatrists, occupational therapists, social workers and other therapists. There are major shortages of some of these groups.

Yet these professionals face substantial problems even where they do exist. Basing their approach on recent research and development, they expect to analyse the challenging behaviour in the situation in which it is occurring and develop a package of intervention components which include

- ecological manipulation: managing the situation to avoid triggering challenging behaviour while still supporting people to engage in meaningful activity and relationships
- positive programming: helping the individual learn functionally equivalent alternatives to challenging behaviour to get what they need
- direct treatment: responding to the challenging behaviour in a way that will reduce its functional effectiveness
- reactive management: how to work with the person safely during episodes of challenging behaviour (Donellan *et al*, 1988).

This kind of approach requires careful, consistent, sustained implementation by staff, often over many days or weeks. They will need to work together as a team, to understand the principles underlying the professionals' recommendations so that they can sensibly adapt to changing circumstances, to manage their interaction with the focal service user and record events and incidents.

Given the level of training, turnover and the prevailing ethos in learning disability services, staff are rarely able to respond to these demands. A common reaction therefore is a kind of stand-off. Staff providing direct support to people with learning disabilities often say that professionals do not understand the practical constraints they face and generate action plans that are impossible to implement. Meanwhile, clinicians report that staff are simply not able to carry out necessary assessments and intervention (Beadle-Brown *et al*, 2006). They may lower their expectations but thereby run the risk of their plans being ineffective.

Difficulties of implementation are exacerbated during periods when the individual's behaviour is most challenging. Questions then arise about the ability of the staff team to sustain the action plan. Once a few staff have been injured or incapacitated there may not be enough skilled staff within the team to carry on. Nor can help usually be found from other local services because of the scarcity of expertise of the level required and the inability to deploy staff between different providers. The gap between relatively unsophisticated and effective services is too great to be bridged, especially in a crisis.

Given these difficulties, providers often feel that they have no choice but to exclude individuals from their services. Facing a shortage of services that will take people with serious challenging behaviour, care managers are then often obliged to place people in settings out-of-area, away from any local links the person may have.

Specialist challenging behaviour placements

Once their existing placements break down, people are often moved to special 'challenging behaviour' services. These may be assessment and treatment services, of which there are estimated to be about 60 in England. This arrangement reflects the dominant 'treatment' paradigm in which particularly complex individuals are referred to more specialised services, which group people with more challenging problems together and deploy

rarer expertise to assess, treat and if not cure, at least ameliorate people's problems to the extent that they can return to less specialised services.

In some cases the greater skill and organisation in the special unit is indeed effective at helping to reduce the severity and impact of the individual's challenging behaviour. This might be because of particular clinical skills (Murphy & Clare, 1991; Mansell *et al*, 1994*a*) identifying the causes of challenging behaviour and the best ways of responding to it. It might also more simply reflect better training and organisation of staff, so that they provide a more consistent approach than was possible in the former placement.

In these cases the issue then becomes how easy it is to transfer the knowledge and skill of the staff in the specialist service to the person's original home since, in most cases, maintenance of improvement will require changes in how staff there provide support. This requires exactly the same kind of organisation as when external professionals advise staff, and faces all the same problems described above. Thus, in practice, units for the short-term assessment and treatment of challenging behaviour often face difficulties in providing a way back for individuals, who become de facto long-term residents (Beadle-Brown *et al*, 2006) and clinicians report concerns as to whether some specialist units do in fact offer greater skill and organisation themselves or rather simply refer to their local learning disability teams following admission.

In units that are partly or wholly providing long-term care, there is an uneasy relationship between the ideology of short-term assessment and treatment, and providing support to people in their long-term home. The focus on assessment and treatment can mean that insufficient attention is given to the quality of people's lives throughout the day, with a primary focus for staff attention on control and on challenging behaviour. Practices which might be tolerable for a short stay are not acceptable when people are more-or-less permanent residents, and there is a risk that the environment and staff practices degenerate to a lowest common denominator because of the wide variety of challenging behaviour that occurs over time. Thus, for example, furnishings become barren as individuals damage them and they are not replaced for reasons of health and safety, behaviour management or economy; resident access to their rooms and communal spaces is controlled and choice is reduced to fit in with the regime. In so far as special units are separate, geographically, organisationally and socially, from ordinary learning disability services and the wider community, isolation and norm drift can occur. There is evidence that special challenging behaviour units, and other residential services which group together people whose behaviour challenges services, provide less good quality of care than community services (Mansell, 1994, 1995; Robertson *et al*, 2002; Mansell *et al*, 2003).

Excluding people from their home and sending them to a special challenging behaviour unit also risks creating several perverse incentives at service system level for the providers of support and accommodation to people with learning disabilities. It can confirm the reputation of the individual concerned as 'impossible', making it harder to set up a new placement locally. Potentially, it rewards weak management and training and represents a failed opportunity for developing the capacity and skill of local services. It could reward a strategy of allowing situations to worsen, rather than taking preventative action as early as possible, and it perpetuates 'passing the buck' as a service response.

If present arrangements continue, one might expect to see the growth of new institutions for people with learning disabilities. Although there

are now only 700 people with learning disabilities living in NHS long-stay hospitals, there are 3700 places in private nursing homes and hospitals, many of which will be for people who present challenging behaviour (Department of Health, 2004).

STRATEGIES FOR IMPROVING SERVICES

CREATING CAPABLE ENVIRONMENTS

How might services be improved to enable people with learning disabilities who present challenging behaviour to remain in their own homes and communities, in services which provide a good quality of life? Providing more resources for the existing arrangements is not necessarily going to help; more specialist teams and units would not address the reasons why existing teams and units have limited effectiveness. The analysis presented above offers some obvious alternative indications for action to improve services. Fundamentally, the aim of service providers and commissioners should be to increase the capability and capacity of the environments in which people ordinarily live, in order to enable them to respond appropriately to individual need.

The focus of the challenge presented by the behaviour(s) of an individual can be conceptualised as occurring at the interface between the characteristics of the environment in which the individual lives and the services available. The capacity and/or competence of the environment to respond to challenging behaviour is determined by a number of factors among which we would see the following as being salient

- organisational structure
- appropriateness of response
- flexibility of response
- delivery of service
  - o staff number
  - o staff skills
  - o staff deployment
- attitudes and attributions (culture and values)
- stability and focus.

Within this environment there should be a range of skills available, ranging from those core skills held by all carers, support staff and professionals, to those highly specialised skills in the fields of mental and physical health, psychological therapies, communication and behavioural skills.

A model of competency-based training can be applied to skills acquisition by support staff. Skills related to the understanding, assessment and management of challenging behaviour can be developed in the same way as that described for psychological therapies in the NHS (National Health Service Executive, 1996):

- type A: fundamental – those integral to all work with people with learning disabilities. This may include basic understandings of person-centred approaches, psychological and/or behavioural interventions, signs and symptoms of mental illness, values and principles of understanding and supporting people whose behaviour is challenging.

- type B: specialised – specific skills in the assessment, diagnosis/formulation and management of mental and behaviour disorders and how they may underlie challenging behaviours. All learning disability psychiatrists, psychologists, speech and language therapists, nurses and other members of the multidisciplinary health team should possess these skills to different degrees.
- type C: highly specialised – specialised skills in the assessment, formulation and management of challenging behaviours. These can be held by a variety of professionals with specific experience and training and may be delivered as part of specialist challenging behaviour services.

The point of intersection of these two parameters, capacity/competence and skills, is where the focus of interaction with the individual with a learning disability is located. It is at this locus that we concentrate our efforts to understand the person and the meaning of their behaviour through

- listening and asking questions ('Why are you doing this?', 'Why do you think he/she is doing this?', 'Why is this happening?', 'What are you/we doing in response to this?')
- communication assessments and interventions
- person-centred approaches
- assessment, formulation/diagnosis, intervention
- psychotherapeutic interventions
- risk assessment
- multidisciplinary and inter-agency collaboration.

For any particular individual, the balance of skills that are required must be titrated according to need, and this will be always changing over time.

The drivers behind service development will be pushing towards a greater degree of competence and capacity in the environment, with more skills being delivered through type A interventions; currently we find low competence/capacity environments with maximum reliance on highly specialised services. This aim can be expressed in a reconstruction of Fig. 3, see Fig. 4 where capability parallels need.

It is important to note that this does not express an intent to reduce the numbers of professionals with specialist skills. On the contrary, in order for there to be greater competence and capacity within services and agencies, it is essential that there is a highly skilled specialist workforce to deliver advice, support, training and supervision in addition to specific interventions and therapeutic work with individuals, carers and families. In this model, the role of specialist practitioners should be more focused, validated and strengthened.

PROMOTING CREATIVE SOLUTIONS

Capacity and competence in the person's environment are essential, but the nature of the concept of challenging behaviour begs a further quality – that of creativity. In the original sense of the term, the challenge of a particular behaviour was aimed at those around the person, carers, professionals and services to find alternative ways of responding to the behaviour. It is, therefore, clear that the greater the challenge then the more likely that people will need to

- find more creative responses and solutions
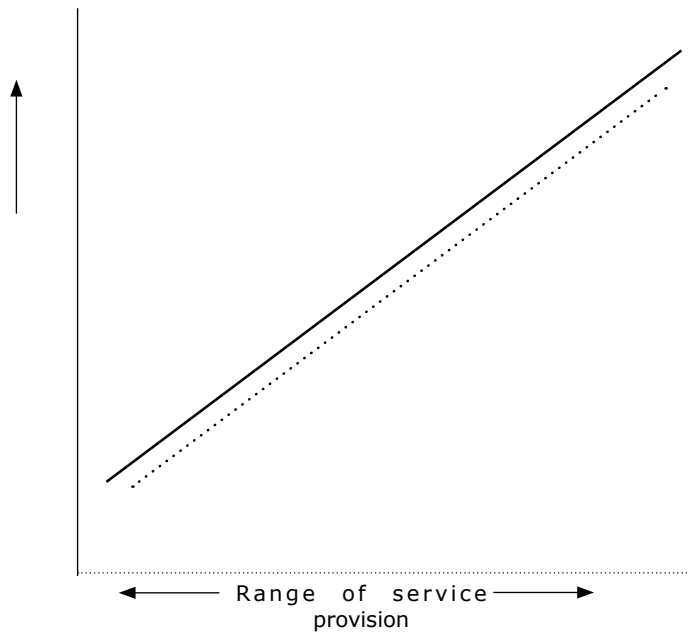- overturn traditional or longstanding responses

Fig. 4   Aim for capability to parallel need. ——— , capability of service to respond; ·············· , individual demand on service.

- adopt counter-intuitive ideas
- question the necessity for the established reputation and practice around the individual
- take managed risks
- adopt a greater flexibility of roles and responsibilities
- establish creative and unconventional working partnerships between individuals, community supports, voluntary and statutory agencies, professionals.

Many emergency placements are made at times when it is not easy to enlist the assistance of people who might be able to find and provide more creative responses. Faced with a breakdown of an individual's support and with limited resources, time and clear paths of access to a range of options, clinicians and managers often have to adopt restrictive or custodial solutions of admission to hospital, assessment and treatment units or out-of-area placements. More creative and person-centred solutions cannot be rapidly conjured up at short notice; services and living environments therefore need to be in a state of 'creative preparedness'. Day-to-day operation should be based on principles and practice that expands the range of

- activities
- community links and participation
- networks of friends and supporters
- links between statutory and non-statutory services
- people able to provide support both in the short and long term.

Potential solutions to a placement breakdown might include, for example

- deployment of support workers to engage the individual in activities outside the home until the crisis has abated or to enable less time to be spent in the home on a daily basis

- deployment of support workers or extra skilled staff into the individual's home to work through a crisis
- extra skilled leadership or support for staff to help in 'getting back on track'
- a weekend hotel break for the individual (or for family)
- staying with tolerant or skilled friends
- borrowing a caravan or flat for a holiday break
- using a local flat or house before it is permanently occupied
- using a designated respite care home.

To support such an approach, services need to adopt new ways and principles of working. These should allow for example

- flexibility in recruitment and deployment of a range of skilled staff
- a focus on enriching the capabilities of the immediate environment rather than a reliance on specialist services
- planning realistic futures with individuals rather than leading a life of surprises
- building spare capacity into service growth and individual care plans
- working in an integrated manner with a range of service provision for an individual who crosses the conventional statutory and non-statutory sector boundaries
- clear 'rules' about not taking an individual's home away while they are in assessment/treatment or respite facilities
- Proactive risk management plans for predictable crises.

PERSON-CENTREDNESS

When thinking about the skills of carers and professionals, service structures and provision, it becomes easy to overlook the individual at the heart of all this activity. Experience would suggest that individuals who present severe challenges are less likely to have supports that are tailored to individual preferences and choices. Of course, it can also be argued that it is the failure to deliver such individualised supports that may lead to the occurrence of challenging behaviour.

It is essential that those planning and delivering support and packages of care should consider what a 'good enough' service would feel like to the service user. We assume that such a service would be constructed firmly around the individual's

- likes, dislikes, aspirations
- preferred social activities
- valued activities
- communication style
- friendships and other social relationships
- integration and participation in community activities, relationships and supports
- validating and non-aversive, non-punitive support from others
- physical, psychological and spiritual well-being
- sense of 'home'.

Focus on care practices

The service community (the people commissioning and planning services, providing them, working in them and using them) needs to recognise that challenging behaviour is relatively common in services for people with learning disabilities and that it is unlikely to disappear as the result of short-term treatment. The implication is that the present model, in which support is almost entirely provided by unqualified and unskilled staff, relying on a small amount of specialist services to help them or deal directly with the most challenging individuals, needs to be replaced.

The pervasive ideology of treatment, moving people around in the belief that they can be 'fixed' somewhere else, is inappropriate. What is required is that a much greater proportion of staff are sufficiently skilled so that they can support people to live well in the community, even if they present challenges in terms of their behaviour.

Although this might seem a radical departure from a well-entrenched model, it is in fact one expression of a general shift that is required in social care services. Across all client groups, the populations now using community services have many more disabilities than those who were using them 20 or 30 years ago and they have complex needs which demand considerable skill as well as common sense and humanity in the staff who work in these services.

If the goal is to support the individual in achieving as good a quality of life as possible in spite of their problems, this has implications for the kind of support provided by staff, and their training, management and organisation. It requires individually tailored placements, which may involve living with two or three other people, but which are not 'challenging behaviour homes'. Whether these are people's own homes (e.g. through the 'supported living' movement) or small group homes they should provide a homely, comfortable and individualised environment.

The quality of staff support provided should be focused on enabling the individual to engage in meaningful activity and relationships at home and in the community, and staff should be skilled and well-organised to deliver what is called active support (Mansell *et al*, 1987, 1994*a,* 2005; Jones *et al*, 1996; Mansell, 1998).

Within this context of good preventative practice, through providing skilled active support, placements will need to address challenging behaviour through methods of positive behavioural support (Koegel *et al*, 1996). This involves developing individual skills, especially communication skills, and rendering them differentially effective over challenging behaviour through contingent reinforcement (McGill, 1993; British Psychological Society, 2004).

This implies changes in the training and status of staff in order to achieve and retain the expertise required. Whereas current training policy is focused only on achieving the most basic level of training (Department of Health, 2002), services that can support people with a wider range of needs require staff with more advanced training who can follow a career providing skilled support to people with learning disabilities. It also implies changes in regulatory practice to focus on the quality of support offered to people (Commission for Social Care Inspection, 2004) and to detect the early signs of decay in care practices which lead to placement breakdown (Mansell *et al*, 1994*a, b*).

Creative commissioning

MATCHING PURCHASING STRATEGY TO NEED

The requirements for good support for individuals give commissioners a clear basis on which to develop and select competent providers. Most directly, the requirement for more skilled support could be reflected in service specifications and monitored through contract compliance arrangements. Given evidence of the very limited developmental role now played by local authority social services in respect of learning disability services (Cambridge *et al*, 2005), an alternative route to developing the market may be through personal budgets and independent brokerage (Department of Health, 2005).

However needs are specified there are not enough services that can provide the level of skilled support required in each local area. Commissioners therefore have an important role in developing the new kinds of services that will be required. This might include direct facilitation through recognition, help and financial reward to bring new service providers into the local market, or to shape up existing service providers to be able to provide the level of support needed. There are documented examples of this approach (Mansell *et al*, 2001) and recently the 'In Control' project set out to build individualised support arrangements around individuals, including people with complex needs, in the context of personal budgets (Duffy *et al*, 2004). Developing sufficient skilled support locally will also require commissioners to manage the incentives for provider competence, so that services which really do provide more skilled support are treated differently from those that do not.

Recognising the fragmented nature of service provision, it is also important to encourage provider cooperation and mutual support. For example, if a particular service enters a difficult period in which several staff are injured, it is important that they can call on other staff of comparable levels of skill to help get through the difficulties. At present, services tend to work in isolation and even if staff could be borrowed from other local providers, they would be unlikely to have the knowledge and skill required in the more specialised service. Small-scale services have to work together if they are to be sustainable.

RE-FASHION 'CHALLENGING BEHAVIOUR' SERVICES

Instead of functioning as a route for taking over service provision to individuals in crisis, challenging behaviour services need to use their specialist skills to help managers in the provider network lead their staff in

the provision of effective local services. This requires closer coordination between the people paying for services, the managers providing services and the professional specialists advising on the support people need, to ensure that advice is both practical and is acted upon.

This might be achieved in at least three ways

- there could be closer integration between care managers, care standards inspectors and members of community learning disability teams or more specialised challenging behaviour teams. These different external sources of advice, help and control could work together (in the way that they do, for example, in adult protection investigations) so that advice to service providers is clear, consistent and authoritative
- many of the skills and the expertise to carry out assessments, interventions and proactive risk management plans exist within the clinical staff employed within the NHS. Staff training and support to local services in different sectors should be a core role of specialist health professionals
- the extension of personal budgets could allow individuals (or individual trusts, or other representatives) to decide for themselves whether the specialist advice they pay for is useful and whether the support staff they employ follow it. Present proposals for the extension of direct payments and personal budgets (Department of Health, 2005) do not include health services but this would be a logical development of present policy.

When placements enter crisis, people whose behaviour is challenging are likely to be excluded, often to specialised challenging behaviour assessment and treatment units. These units serve multiple functions, including assessment, treatment, respite for the individual or others and a 'holding area' while new placements are sought. Part of the strategy should therefore be to replace the 'one-stop shop' of challenging behaviour units with a wide range of tailored options to meet these multiple needs. In particular, help will be required to find or create new options for housing and support locally. For as long as sufficiently skilled services are scarce, the expertise of challenging behaviour support teams is likely to be needed to help in this task.

Instead of regarding challenging behaviour as a clinical problem located within a minority of individuals, commissioners should recognise that challenging behaviour is relatively widespread and persistent. Services need to be configured in order to support people in spite of potential or actual challenging behaviour and this means that commissioners need to choose services in which staff have the expertise to do so.

Commissioners also need to manage the market they have created in order to sustain the capacity of local services to meet the needs of everyone with learning disabilities. This involves encouraging service providers to cooperate, underpinning service competence through training and service development and reshaping specialised challenging behaviour services to support effective local placements.

Whether commissioning can meet this challenge remains to be seen. Cambridge (1999) suggests that commissioning in learning disability services has failed to realise its potential. Increasing enthusiasm among policymakers for direct payments and personal budgets may reflect a view that commissioning by local authorities is unlikely to meet the needs of disabled people. However, although increased personalisation may reduce the need for some aspects of service selection and design at the individual

level, it will not remove the need for the population-level work of developing and coordinating sufficient services in each locality.

Future commissioning arrangements

In 2005 new funding arrangements for the NHS were introduced, which are likely to impact on the commissioning and provision of specialist psychological and psychiatric services for people who present behavioural challenges.

At the time of writing, it is intended that services provided by the NHS will be subject to a national tariff. Each provider will then have to match their services against this benchmark cost, and services that are significantly over the base tariff will presumably have to either cut costs or justify them. These tariffs are not yet available for services for people with learning disabilities whose behaviour is challenging and an alternative method of costing may be developed.

Whatever form of costing is decided upon, however, services will be more accountable in terms of their cost and their outcomes. Funding is likely to be on a contracted basis, and sourced through primary care trusts (PCTs) and practice-based commissioning. The financial imperatives may drive commissioning to the cheapest provider (and the NHS will face competition from voluntary and private sector providers). Services therefore will need to be able to demonstrate both value for money and effectiveness. They will need to promote high standards demonstrating high-quality evidence-based interventions, effective outcomes and at a cost that appears to be broadly in line with other services.

Providers of psychological and psychiatric services to people whose behaviour is challenging will therefore need to demonstrate that they are achieving good outcomes. This is difficult to achieve in work which usually requires input and support from a range of other individuals and organisations. They will also need to gain contracts from commissioners, as purchasing of services will no longer automatically go to the local NHS provider. Those services which either do not deliver good outcomes or fail to meet other contractual requirements may lose their funding, while those services which do achieve good outcomes, at a reasonable cost, are more likely to grow and expand.

Clarity over outcomes and clearly defined service provision should increase the quality of services available to people presenting challenging behaviour. However, difficulties may occur if one provider has a contract via the NHS arrangement, but circumstances arise where it can not be properly delivered. This is not an infrequent occurrence in delivering services to this client group and specialist services have usually retained the right to withdraw their services if the advised treatment is not being implemented. This may be more difficult to do in the new contracting arrangements, or it may be that the intervention will take longer (and therefore cost more) with consequent impact on overall contract activity. Commissioners will, therefore, need to be aware of

- best practice in intervention
- the outcomes achieved by the intervention (and these may be broader than behavioural change)
- the difficulties in predicting how long an intervention will take, as it depends on many others to implement.

Future directions

Compared with most other areas of work with people who have learning disabilities, there is an extensive evidence-base to guide professionals who support people whose behaviour is seen as challenging. However, there are significant issues around implementation of best practice, as is evidenced by the number of people who have to be referred to out-of-area placements when their local services are unable to support them. The purpose of this section is to identify some of the areas of practice that have not been fully addressed within this document, or where future research is required in order to create a context for successful professional practice.

AREAS NOT ADDRESSED IN THIS DOCUMENT

The main focus of this document has been on adults who have limited capacity or ability to exercise choice over their interactions with the environment. This has therefore excluded children and many people who may fall within the forensic services. Much of this document may be of relevance to professionals who work with children or offenders, however their needs should be fully considered in a future report. In addition, functional assessment and functional analysis are approaches that are applicable to many different client groups, not just to people with learning disabilities.

In particular, it is recognised that there needs to be an emphasis on early intervention and preventative work. There is an evidence-base that suggests that once patterns of behaviour have developed, and environmental responses have become entrenched, it is difficult to bring about lasting change without extensive interventions. Challenging behaviour may be a lifelong problem and there needs to be a greater emphasis on lifelong planning across services. Within services for adults, there is a recognition that by the time of transition into adult services, many children have unnecessarily been moved into large scale, out-of area residential care, and that interventions are too rarely based upon the principles of positive behavioural support. Many adults are also in out-of-area placements, and services are actively seeking to bring them back. This document could be useful in assisting in the transition process and in the quality monitoring of both existing and planned placements, as well as in developing new services.

This report has been written by professionals, primarily for professionals. Although there has been consultation with both service users and carers in its development, it has not been our intention to address the content specifically to them. Instead, our aim is to work with service user and family carer groups in the near future to prepare a charter that outlines

'what should you expect your local services to look like if they are meeting the standards set out in this report?'

IMPLEMENTATION

By itself, this document is unlikely to bring about significant improvements in services for people who present behavioural challenges. Locally tailored multidisciplinary implementation plans are required in order to develop these guidelines into local care pathways. It is neither possible nor appropriate to dictate the details of such pathways, as they will be determined by existing local service strengths and gaps. However, the good practice standards (see Appendix 1) should provide a framework for local teams to review themselves and agree their own pattern of service delivery. This process should include all local stakeholders, including carers, service users, providers, commissioners, professionals, regulatory bodies etc. Local teams should ensure that they have in place a service delivery plan that includes all the elements addressed within this report.

Currently, most residential accommodation support to people is provided through systems that are regulated in England by the Commission for Social Care Inspection (CSCI), the Care Standards Inspectorate for Wales (CSIW), and the Care Commission in Scotland. Generally psychiatrists and psychologists do not directly influence these bodies. A policy paper, 'Best Practice Guidance on the Operation and Management of Registered Care Homes for People with Learning Disability Who Present Significant Challenges' was written by the National Care Standards Commission (NCSC) (2003), the forerunner to CSCI. It is important that there is consistency between our groups. It may be possible for clinicians to work with colleagues in the various inspection bodies to develop a process for challenging behaviour accreditation.

Other specific areas of work that could potentially influence the implementation of 'best practice' include

- collaboration with service users and family carers. Partnership models such as the family partnership approach (Davis *et al*, 2002) offer ideas for implementing change in collaboration with a range of carers, paid and unpaid. Albin *et al* (2002) have highlighted some of the difficulties of transferring interventions based on positive behavioural support from the clinic or research environment into people's natural environments. This requires further specific work
- NICE guidance development. There is currently a lack of NICE guidance relating directly to people with learning disabilities though, unless specifically excluded, all NICE guidance should be considered to be applicable across the range of intellectual ability. The development of guidance on psychological and physical treatments or management strategies for behaviours that are challenging could prove useful though, in a field of great heterogeneity of individual characteristics, aetiologies etc., such guidance should aim to facilitate a range of approaches rather than be narrowly restrictive
- training of support/care staff. There is a need for new support workers to be able to 'hit the ground running' when they start to work with people who challenge. In an area of high staff turn over, there is a need for a rolling programme of competency-based training, including responding to potentially violent situations. The

current LDAF and NVQ models of staff training do not place sufficient emphasis on training staff, from their first day of employment, in methods that will enable them to fully support people who challenge. It is to be hoped that the new learning disability qualifications training models that are being developed by the Valuing People support team and skills for care will address this.

Professionals using this document will have a significant role in teaching and training others. Carers and support staff will have a major role in delivering the interventions described, and we will need to provide ongoing training and support to both develop and maintain services that can meet the complex needs described in this document. Allen *et al* (2005) draw attention to some of the reasons for positive behavioural support not being used more widely. These include the limited training opportunities and commissioners' reluctance to specify that staff have such training.

- Core skills and training for professional staff. Professional training for psychologists, psychiatrists, speech and language therapists and other members of the multidisciplinary team, at all levels, including ongoing professional development should be developing a strong and clear focus on core skills and demonstrable competences in working with people who present behavioural challenges. Current changes in professional training regulation and monitoring provides opportunities for building new training approaches and methods of evaluation.

- New commissioning/purchasing models. The growth of individualised budgets can be viewed as a means of introducing greater individuality, flexibility and creativity of service purchasing and delivery. Where people can have control of who they purchase to support them, there may be concerns about the nature and standards of training, supervision and support that those individuals might have in supporting people with behavioural challenges.

- 'Payment by results'. It is difficult to envisage how this will work in learning disability services as a whole, in the absence of examples of its operation or piloting elsewhere. In the model of defining and responding to challenging behaviour as laid out in this document it is not immediately apparent how one might conceptualise activity, case-mix and healthcare resource groups. It is essential that clinicians engage with this process at an early stage in order to assist in finding meaningful parameters to describe and quantify healthcare activity and to avoid a regression to the use of challenging behaviour as a diagnostic term.

FURTHER JOINT WORK BETWEEN PROFESSIONS

It is hoped that the production of this report represents the early steps in a developing programme of joint professional working at both national and local levels that should include

- further development of guidance on the appropriate and specific uses of psychotropic medication
- the development and description of integrated models of diagnosis and formulation, for example bio-behavioural or bio-psychosocial models. Effort should be made to bring together models that may, at times, appear to be in opposition to one another

- the description and demonstration of the characteristics of effective multidisciplinary working
- acknowledging that providing input to social care settings should be a core role for clinicians, we need to be clearer on how we work with and influence services that are not delivered within the NHS (for example how do clinicians influence training plans, philosophy, values, therapeutic approaches etc. in residential care homes within the independent sector?)
- addressing workforce issues including implementation of 'New Ways of Working' and 'New Types of Workers' initiatives
- the further development of psychotherapeutic approaches, extending the potential benefit to families, carers and those with greater degrees of intellectual impairment, for whom these may not be currently the prime intervention of choice
- addressing issues of abuse perpetrated against, rather than by people with learning disabilities who present severe behavioural challenges; considering how we should investigate and protect against abuse in such vulnerable people.

RESEARCH, EVALUATION AND AUDIT

More collaborative and inter-disciplinary activity is needed in research evaluation and audit to look at

- the development of a set of outcome measures for interventions in the assessment and management of the behavioural challenges of people with learning disabilities. Particular focus should be placed on measuring the outcomes of interventions with carers, staff teams and other systems
- the establishment of a current evidence-base around effective interventions, based on good single case methodology and generally building up a research evidence base from clinical practice
- the prevention of unnecessary out-of-area placements, including how best to provide effective supports to families and local care systems. This may include a cost-benefit analysis of preventing unnecessary out-of-area placements that addresses outcomes for people, financial cost of placing people away from their communities, and the lost opportunities for investing locally in services that might support other people who present challenges.

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Appendix

Good practice standards for service responses to challenging behaviour— self assessment checklist

This framework is designed to be used by senior professionals (clinicians, social workers, managers, commissioners and those responsible for inspection and review) who have responsibility within a defined area or population for the provision of services to people with learning disabilities whose behaviour severely challenges services. It is a self-assessment checklist that should be used to establish the extent to which local processes and practices reflect 'best practice' as described in more detail elsewhere in this document.

The standards should be reviewed against the current position and practices that are followed by services. Users, advocates and carers should also be involved in the review process. The standards apply to people living in family homes, and health and social care provision (within the statutory and independent sectors). They also apply when out-of-area placements have been purchased by the relevant authorities.

The checklist should be reviewed in a multidisciplinary/multi-agency setting with the aim of achieving a consensus view about how local services compare with good practice standards. The team that carries out the review of standards should ensure that they have the appropriate membership to achieve a broad view of services. Different teams may be required to review different subsets of standards as outlined in the table following the checklist. A joint action plan should be developed to address any areas of need or to build on current good practice.

Table 1 Standards for service provision

| Standard | Current position | | |
	Green	Amber	Red
1. Assessments and interventions are delivered within the current legal framework, by taking full account of the care programme approach, Mental Capacity Act, Mental Health Act, Bournewood ruling, Health and Safety at Work Act, CSCI guidance etc.	There are clear written processes in place to ensure that all practices meet current legal requirements. These will include: ■ people who require assessment or treatment under the MHA have access to appropriate local facilities ■ clear health and social care pathways incorporate assessment of capacity, in line with the Mental Capacity Act ■ a local advisory group with clear terms of reference, to consider issues of best interest for people who lack capacity ■ explicit multidisciplinary processes using standard national policies (e.g. care programme approach) is used ■ there is a published local adult protection policy that service users, clinicians, carers can access ■ Where people have out-of-area placements purchased for them, the purchasing authority regularly checks that the provider also achieves these standards.	Progress has been made to fully achieve 4–6 of these criteria.	Only 1–3 of these criteria have been achieved.

Table 1 *Continued*

Standard	Current position		
	Green	**Amber**	**Red**
2. A detailed risk assessment is carried out with individuals who present severely challenging behaviour to ensure that interventions are appropriately and systematically targeted.	There is an agreed written process for carrying out individualised risk assessments. It includes at least the following criteria: ■ a multidisciplinary process. ■ a statement of philosophy that addresses 'the least restrictive alternative'. ■ clarity about what triggers an assessment. ■ risk assessment informs a written management plan that identifies: □ individuals' level of risk and risk factors □ clarity about individual professionals' responsibilities and actions □ a clear process for reviewing plans. ■ where people move between services, up-to-date risk assessments are shared between purchasers and providers.	Systematic risk assessments and management plans are in place, with 3–5 of the criteria being met.	There are no formal processes in place to ensure a systematic approach to risk management.
3. For each person who presents severely challenging behaviour, there is a written assessment that takes account of relevant factors about the person, their environment and the behaviour.	There is an agreed multidisciplinary assessment care pathway in place for all people whose behaviour presents severe challenges. It will include sufficient information to: 1. exclude/treat biological factors that contribute to the person's behaviour 2. lead to a coherent formulation and, where appropriate, a psychiatric diagnosis 3. lead to an intervention plan which fits the person and their environment 4. provide a baseline so that the effectiveness of any intervention can be subsequently measured.	Multidisciplinary assessments are in place for most people, but there are no agreed care pathways or standards in place to ensure that these are systematically carried out.	There is a limited multidisciplinary approach to assessments, with most assessments being uni-professional.

Table 1 *Continued*

Standard	Current position		
	Green	**Amber**	**Red**
4. There is a multifaceted written formulation that takes account of possible diagnosis, psychological and relationship factors. This formulation has been developed from the assessment, and leads to an appropriate intervention.	For each person who presents severe challenges, there is an agreed written multidisciplinary formulation that includes each of the following components: ■ hypotheses about how/why the behaviour has developed ■ rationale for any psychiatric diagnosis ■ psychological and relationship factors ■ integration of behavioural, biological, communication and environmental factors ■ hypotheses about how the behaviour is being maintained ■ clear links between the formulation and intervention.	For some people who present severe challenges the written formulation meets these standards, but this is not the norm for all people.	Generally, professionals who assess an individual will develop their own uni-professional assessments, formulations or diagnoses, and this will not be coordinated into an agreed multidisciplinary formulation.
5. There is clear evidence that the intervention has person-centred approaches at its core.	In addition to any pharmacological, psychological, and/or behavioural interventions, each person has a written person-centred plan that describes how the person will be supported in ways that address their rights, inclusion, choice and independence. It will address the factors that contribute to the person's challenging behaviour. There is evidence that the plans are implemented by support teams.	Most people have a person-centred plan in addition to any 'treatment' but evidence of implementation is limited.	There is little evidence of a person-centred plan at the core of the person's care.

Table 1 *Continued*

Standard	Current position		
	Green	**Amber**	**Red**
6. Interventions are written down, are derived from the formulation and include: ■ primary preventative strategies, and ■ early crisis intervention strategies.	Each person has a written multidisciplinary care plan that details strategies that include: ■ clarity about how the interventions are derived from the formulation ■ ways to enhance the person's quality of life ■ promotion of the 'least restrictive alternative' ■ appropriate 'talking treatments' can be accessed when so indicated by the formulation ■ potential triggers for the behaviour are identified and addressed ■ clarity about how staff/carers should respond to the target behaviour ■ a clear rationale for any psychoactive medication, and the circumstances under which p.r.n. medication is to be used ■ evidence of a skills-based, psychoeducational or other positive strategy aimed to help the person to manage their own behaviour ■ clarity about how any physical intervention or restrictive practice should be used how and when they will be reviewed ■ clarity that the interventions are informed by the evidence-base of effectiveness.	Many intervention plans meet this standard but there is not a systematic approach to the development of multidisciplinary written care plans that address preventative and crisis intervention strategies.	There is no process to ensure that all intervention plans meet this standard, and few do.

Table 1 *Continued*

Standard	Current position		
	Green	**Amber**	**Red**
7. There is clarity about how 'crises' will be managed, with clear links to mental health and other services when required.	There are clear written protocols for managing crises, including those that might occur 'out-of-hours' in the person's usual place of residence or work. Theses include: ■ processes for providing additional support to carers in the person's usual place of residence ■ access to a responsive emergency and out-of-hours on-call assessment service ■ access to mental health services, including in-patient beds, if admission is required ■ register or database of people most at risk of requiring out-of-hours support ■ written risk management plans (possibly as part of care programme approach process), identifying proactive actions to be taken to support people identified as being at significant risk of crises ■ a process to ensure effective communication of crisis management plan to all appropriate people.	Generally staff/carers can access some out-of-hours crisis service, but responses are not comprehensive, and there are few clear protocols across different services.	Responses to out-of-hours crises are patchy, with regular disagreements between services about issues of responsibility.
8. Each person whose behaviour challenges services will have their care coordinated within a clear system.	There is a clear inter-agency care coordination system that ensures that all people who present severe challenges have: ■ a named care coordinator ■ a written multidisciplinary care plan ■ a system that ensures regular care reviews ■ care programme approach process in place for those with additional mental health needs. Where out-of-area placements are purchased, the purchasing authority ensures that multidisciplinary care is coordinated in the placement, and that there is a named person in the purchasing authority who is responsible for ensuring the quality of the care received	Elements of a multidisciplinary care coordination process are in place, but it is not systematically available to everyone who presents severe challenges.	Care planning is generally uni-professional, with few multidisciplinary coordinated pro-cesses.

Table 1 *Continued*

Standard	Current position		
	Green	**Amber**	**Red**
9. Effective processes will be used to ensure that everyone supporting the person has the necessary skills and knowledge to carry out the intervention.	Within an authority there is a multi-agency training strategy that provides systematic competency-based training for care staff. This is based on a clear value-base that promotes positive strategies and ensures that care staff who are required to implement any physical interventions or restrictive practices are appropriately trained. There are processes to ensure that staff have the required skills.	Individual service providers have their own challenging behaviour training plans, but these are not systematic in the way they are delivered or evaluated.	Training for care staff is generally uncoordinated, with many untrained staff supporting people who present severe challenges.
10. The interventions will be fully evaluated in terms of the behaviour and the impact of the behaviour on the person's quality of life and on others.	There are processes in place to ensure that care plans for people who present severe challenges are systematically evaluated across the authority by managers or appropriate professionals. This will include monitoring of: ■ the impact of the intervention on the targeted behaviour ■ the impact on the person's quality of life ■ the use of physical interventions, restrictive practices and psychotropic medications.	Most service providers systematically evaluate the quality and effectiveness of their interventions, but this is not a universal process within the authority.	There are no systematic evaluation processes across the authority. Less than half of the service providers evaluate the quality or effectiveness of their interventions, and even these are generally unsystematic.
11. There is a system in place across an authority for auditing the standards for service provision that are described in these guidelines.	The partnership/management board has a clear process across the authority that it has responsibility for commissioning or purchasing, to ensure that all these standards are being met.	There are processes to ensure that at least some of these standards are being met across all services in an authority.	There is no mechanism within an authority to ensure the service standards are being met.

Table 1 *Continued*

Standard	Current position		
	Green	**Amber**	**Red**
Availability of long-term supports			
12. People who present severely challenging behaviour have equality of access to a comprehensive range of local social and health service provision.	People presenting challenges have access to: ■ housing ■ support at home ■ meaningful day-time activity, education or work ■ advocacy ■ generic and specialist healthcare.	Some people presenting challenges have all these service elements in place but others do not	Arrangements typically exclude at least one of these elements
13. The full range of service options is available locally to everyone, including those who present challenges.	All levels of support are available to people challenging services within different housing and service configurations, for example family home, direct payments or personalised budgets as well as residential homes.	Some people have high levels of support while living in their own home, but this is not available to everyone.	There is only token availability of high levels of support to people living in their own home.
14. The competence of local services within the statutory, private and voluntary sectors, matches the needs of the people being supported.	Commissioners purchase local support and housing in which staff support is sufficiently skilled to (a) provide activity and personal growth and development for the individual and (b) prevent or minimise challenging behaviour. This is for people: ■ with minimal, latent or emerging challenging behaviour ■ presenting moderate levels of challenge ■ with the most complex or enduring problems.	Up to 10% of housing and support placements for people fail each year because of problems responding to challenging behaviour.	More than 10% of housing and support placements for people fail each year because of problems responding to challenging behaviour.
15. Mechanisms are in place to ensure that out-of-area placements reflect individual choices.	People placed out-of-area (or their advocates, where appropriate) can choose to move back to local services which are at least as good as the ones they are coming from.	Some people placed out-of-area (or their advocates, where appropriate) can choose to move back to local services but others cannot (whether due to cost or quality).	People placed out-of-area (or their advocates, where appropriate) have no choice whether to move back to their local area or not.

Table 1 *Continued*

Standard	Current position		
	Green	**Amber**	**Red**
16. Services are commissioned that ensure that family carers are supported locally.	Local services are available to all families that support members who present challenges (including the most serious challenges) such as ■ respite ■ day activity, work or education.	Local services exclude people who present challenges but fund alternatives out-of-area.	Local services exclude people who present challenges without alternatives.
Access to specialist help			
17. Specialised multidisciplinary professional advice is readily available locally for everyone presenting a challenge.	Every person presenting a challenge has access to a specialist assessment of their situation and their behaviour which is multidisciplinary and which: ■ checks for psychiatric or other biomedical causes ■ identifies possible functions of learned behaviour ■ takes account of weaknesses or problems in placement organisation ■ provides initial assessment within X weeks and completed within Y weeks.	More than 25% of assessments are incomplete or late.	More than 50% of assessments are incomplete or late.
18. Highly specialised professional advice is available for people who present the most complex challenges.	People presenting the most complex challenges have access to assessment by highly specialised experts in challenging behaviour (e.g. special behaviour support teams), within a multidisciplinary team.	Highly specialised advice available but only by purchase from out-of-area, or uni-professionally.	No highly specialised professional advice available locally.

Table 1 *Continued*

Standard	Current position			
	Green	Amber	Red	
19. Assessment and treatment units are used appropriately.	Assessment and treatment units are only used for this purpose. They use contracts that specify the specific purpose of the stay, its maximum length, a binding undertaking that the referring agency will provide local services at the end of this period and a specification of how the gains made in the unit will be transferred to and maintained in the local placement.	More than 10% of residents in assessment and treatment units have completed treatment (such as crisis management or emergency placement) but have not returned to the community.	More than 25% of residents in assessment and treatment units have completed treatment, or are there for other reasons (such as crisis management or emergency placement), but have not returned to the community.	
20. Mental health services are available to all.	Local mental health services have taken the lead in reviewing their provision to people with learning disabilities, using the NIMHE greenlight toolkit. Local mental health services are readily available to people with learning disabilities who have mental health problems. Psychiatric care of people with learning disabilities is an integrated part of local mental health services.	Local mental health services only serve some people with learning disabilities who have mental health problems. Psychiatric care of people with learning disabilities has some links with local mental health services.	Local mental health services routinely exclude people with learning disabilities who have mental health problems. Psychiatric care of people with learning disabilities is separate from local mental health services.	
Individualisation				
21. People presenting challenges have person-centred plans.	Each person presenting challenges has an effective person-centred plan including a 'circle of support' beyond service personnel.	Only people presenting moderate levels of challenge have an effective person-centred plan including a circle of support'beyond service personnel.	Only people presenting the most complex challenges have an effective person-centred plan including a circle of support beyond service personnel.	

Table 1 *Continued*

Standard	Current position		
	Green	**Amber**	**Red**
22. Commissioners and professionals have effective systems to review everyone who is out-of-area or is likely to be at risk of their local service breaking down.	There is a process agreed between commissioners and professionals that ensures: ■ knowledge about the needs of, and plans for, everyone who is placed out-of-area ■ review system for the ongoing appropriateness of out-of-area placements for each person ■ knowledge about people who live locally but are most at risk of placement breaking down ■ contingency plans available for those most at risk of local placement breaking down.	There is some knowledge about the ongoing appropriateness of out-of-area placements, and some planning to address inadequacies of placements. Local 'placement breakdown' planning is in place for a few people.	There is only limited knowledge about people who are placed out-of-area, and few active systems are in place to prevent local service breakdown.
23. There is an agreed Partnership Board (or other commissioning body) strategy to promote local services for people who present severe challenges.	Partnership Board has an agreed strategy that addresses all the standards outlined in this document.	Multi-agency strategies are in place to meet most standards outlined in this document. There is an agreed process to address the others.	Agreement has been reached on how to achieve some of these standards.

Who will be involved in reviewing the standards?

The purpose of the chart illustrated in Table 2 is to offer suggestions as to the possible composition of teams that will be involved in reviewing local standards. Different review teams may be required to audit different subsets of standards. The completed table is not intended to be prescriptive, and local circumstances will dictate who should be involved (the last column can be used as a local checklist).

Table 2 Team members who might be involved in reviewing different standards

Standard	Specialist challenging behaviour team	Prac-titioners in CLDTs	Specialist residential providers	Hospitals including ATUs	Social services care managers	Commissioners	Inspection teams	Users/carers	Other
1. Legal framework	✓	✓	✓	✓	✓	✓	✓	✓	
2. Risk assessment	✓	✓	✓	✓	✓	✓	✓	✓	
3. Written assessment	✓	✓	✓	✓	✓	?	✓	✓	
4. Written formulation	✓	✓	✓	✓	✓	?	✓	✓	
5. Person-centred approaches	✓	✓	✓	✓	✓	?	✓	✓	
6. Written intervention plan	✓	✓	✓	✓	✓	?	✓	✓	
7. Crisis management	✓	✓	✓	✓	✓	✓	✓	✓	
8. Care coordination	✓	✓	✓	✓	✓	✓	✓	✓	
9. Trained support staff	✓	✓	✓	✓	✓	✓	✓	✓	
10. Evaluate outcomes	✓	✓	✓	✓	✓	✓	✓	✓	
11. Auditing of standards	✓	✓	✓	✓	✓	✓	✓	✓	
12. Equality of access to local provision	×	×	✓	×	✓	✓	×	✓	
13. Full range of services	×	×	✓	×	✓	✓	×	✓	
14. Competence of services matches people's need	×	×	✓	×	✓	✓	×	✓	

Table 2 Team members who might be involved in reviewing different standards

Standard	Specialist challenging behaviour team	Prac-titioners in CLDTs	Specialist residential providers	Hospitals including ATUs	Social services care managers	Commissioners	Inspection teams	Users/carers	Other
15. Out-of-area placements reflect individual choice	✗	✗	✗	✗	✓	✓	✓	✓	
16. Commissioned services support people locally	✓	✓	✓	✓	✓	✓	✓	✓	
17. Access to local MD specialised advice	✓	✓	✓	✓	✓	✓		✓	
18. Access to highly specialised advice	✓	✓	✓	✓	✓	✓		✓	
19. Appropriate use of ATUs	✓	✗	✗	✓	✓	✓	✓	✓	
20. Availability of mental health services	✓	✓	✗	✓	✓	✓	✓	✓	
21. Person-centred plans	✓	✓	✓	✓	✓	✓	✓	✓	
22. Review of people out-of-area	✓	✗	✗	✗	✗	✓	✓	✓	
23. Agreed commissioning strategy	✓	✓	✓	✓	✓	✓	✓	✓	

Composition of team reviewing standards ....
Standards to be reviewed ....
Coordinator responsible for carrying out review...