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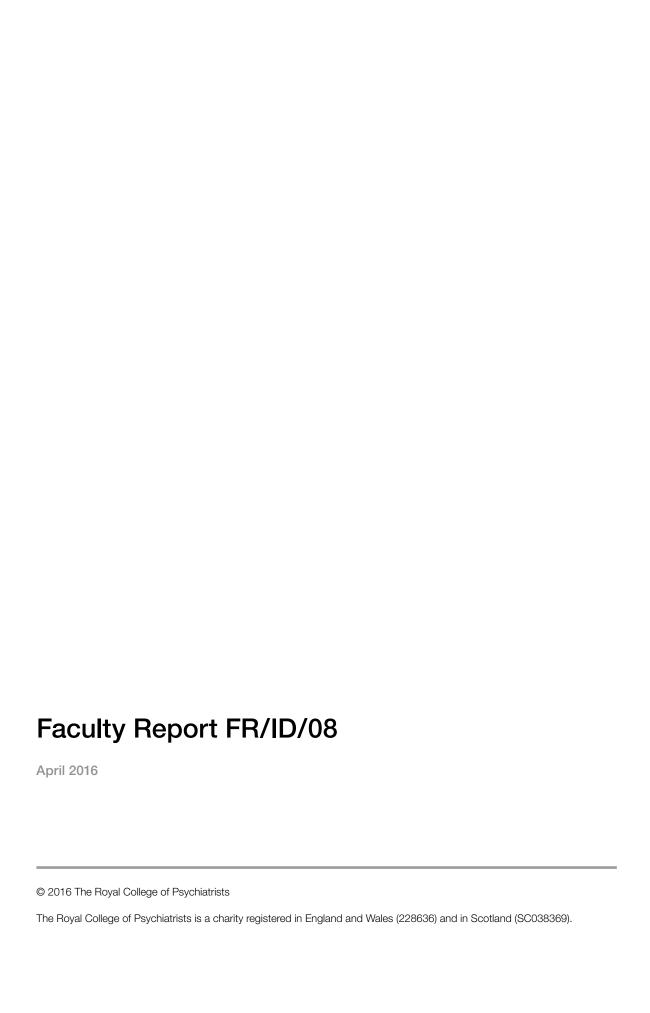
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Challenging behaviour: a unified approach – update

Clinical and service guidelines for supporting children, young people and adults with intellectual disabilities who are at risk of receiving abusive or restrictive practices

Report from the Faculties of Intellectual Disability of the Royal College of Psychiatrists and the British Psychological Society on behalf of the Learning Disabilities Professional Senate

FACULTY REPORT

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Contents

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Foreword

Challenging Behaviour: A Unified Approach – Update is a revised and updated clinical and service guideline for supporting children, young people and adults with learning disabilities who are at risk of receiving abusive or restrictive practice. This guideline is jointly produced by the intellectual disability faculties of the Royal College of Psychiatrists and the British Psychological Society on behalf of the Learning Disabilities Professional Senate.

Services for this group of people vary in the quality of the support they deliver. Although there are numerous examples of high-quality local services that are person-centred and support people in achieving a good quality of life, at the other end of the spectrum there have been shocking examples of abusive practice, such as at Winterbourne View. We feel that what is needed now is not another weighty report on challenging behaviour but rapid action, such as that proposed in the Transforming Care programme. This is a view strongly supported by people with intellectual disabilities and their families, who feel let down at the perceived lack of progress and have become cynical about the reports that have appeared at regular intervals since the original College Report.

We have therefore decided not to rewrite *Challenging Behaviour: A Unified Approach,* instead we have produced a brief, user-friendly 'how to' guide that is easy to use and has an up-to-date reference list for additional resources. The original document remains a useful reference source and the NICE guidelines are also now available for use. In addition, the Learning Disabilities Professional Senate has provided guidance on the role and function of community teams and there is reference to guidance for commissioners.

We hope that, armed with this information, we will be able to develop high-quality, consistent, local, person-centred services for a group of citizens who may have justifiably felt let down at times in the past.

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Executive summary

It is our belief that people who present behavioural challenges can and should be supported in living close to home, integrated within the community, engaged in activities that promote optimum quality of life and with support that ensures protection of their human rights. They should not be subject to inappropriate, punitive or harmful restrictions, ineffective treatments or unjustified and excessive use of medication.

- 'Challenging behaviour' is a socially determined construct. Reiteration of this construct and its accepted definition is necessary to focus assessment, formulation and interventions on the relationship between the individual and their environment, rather than on the elimination of behaviours.

- Effective and safe support of people who present significant behavioural challenges can, and does, occur in integrated community settings.

- Professionals should work with the individual, families, providers and other community resources to deliver interventions and support.

- Hospitals and large-scale residential settings are not acceptable alternatives to providing integrated and comprehensive care that is close to home.

- Interventions delivered as part of care and treatment plans must be based on a clear, comprehensive and agreed formulation and diagnosis.

- Priority outcome measures for interventions should focus on quality of life and the protection of human rights.

- Clinical services should prioritise early intervention and a lifelong, seamless approach that delivers proactive and effective planning for periods of transition.

- Effective responses to behavioural challenges will involve clinicians collectively taking and managing risk, adopting new, creative and flexible ways of working, and drawing on a wide range of potential therapeutic interventions to ensure that people receive the right support, in the right place, at the right time.

- The majority of individuals who present behavioural challenges are well known to services. The focus of the work of community intellectual disability teams must therefore be on planned, proactive and responsive risk management, ongoing positive-behaviour support for these individuals and the reduction of restrictive interventions.

- Clinicians have a responsibility to work in partnership in a responsive, mutually supportive and facilitative manner with the individual, families, social services and commissioners and colleagues across all sectors.

- The teaching, development and appraisal of clinical skills, competences and practice need to reflect clinical evidence, particularly that published in NICE and other professional guidance.

- It is essential to work closely with families. Clinicians need to understand that families can be vital partners in enabling better understanding and support of an individual who presents behavioural challenges. Families can also be traumatised, distressed, angry and at times dysfunctional. Clinicians must have and continually develop the skills to be able to engage families (and other non-familial systems) in working on and resolving these issues.

- Clinicians have a significant role in enabling and empowering individuals with intellectual disabilities and their families. This must be an integral part of any care and treatment plan.

- Clinicians should be prepared to take the lead in ensuring continuity of care coordination, care and treatment plans, and discharge planning for individuals admitted to hospitals or other institutions away from their local area.

- Clinicians should be very aware of when perverse financial incentives are shaping and driving decisions about appropriate care and treatment. They should not engage with this and should be prepared to challenge it.

- Clinicians should be open to challenges of their opinions and treatment plans and should work constructively in response to such challenges to empower people with intellectual disabilities, their families, experts by experience, and others (through such processes as Care and Treatment Reviews) to be able to work in real partnership to commonly agreed goals.

- Clinicians should advise and support commissioners in avoiding models of care that are not consistent with the principles of care, treatment and professional practice laid out in this document.

Background and purpose

This brief update builds on, and should be read together with, the College Report known as CR144 – *Challenging Behaviour: A Unified Approach* (Royal College of Psychiatrists *et al*, 2007). Both have the following aims:

- to deliver an authoritative consensus of clinical opinion, experience and evidence-based practice;
- to provide a unified framework for best practice in multidisciplinary clinical and social interventions and support;
- to encourage and guide the provision of creative, flexible and effective responses to individuals who present behavioural challenges;
- to reduce inappropriately restrictive or inflexible service responses (e.g. long-term admission to hospital, restraint, routine and long-term seclusion, excessive or inappropriate use of psychotropic medication);
- to support national initiatives to reduce the number of people with intellectual disabilities in hospital settings;
- to promote partnership working across the healthcare, social-care and third sectors (in particular between service developers and commissioners), as well as with individuals and their families;
- to promote comprehensive and effective local support and services and to reduce the number of individuals who are failed by current service provision.

The underlying aim of these reports is to improve the quality of life of people who present behavioural challenges to families and services. The continuing emergence of evidence of poor-quality care and abuse in settings such as Winterbourne View (Department of Health, 2012) and the subsequent scrutiny of service provision and performance demonstrate, however, that these and other widely available and referenced policy documents, such as the Mansell Report (Department of Health,

2007) in themselves have not improved support for people who present behavioural challenges.

This guide, therefore, aims to tie in closely with and support wider initiatives from national policy and practice with which it shares a common vision. It provides professional guidance to those whose role is to support people with intellectual disabilities. It addresses the competences and working practices required to enable people to live within their local communities in ways that enhance their reputations and quality of life, ensuring that they are provided with effective support that minimises the likelihood of restrictive, harmful or punitive interventions.

This report should be read alongside a number of other documents that aim to bring about a fundamental change in the organisation and delivery of services. These include:

- *Statement of Ethics for Professionals who Work in Learning Disability Services Post Winterbourne View* (Learning Disability Professional Senate, 2014);
- *Guidance for Commissioners of Mental Health Services for People with Learning Disabilities.* (Joint Commissioning Panel for Mental Health, 2013);
- *The Challenging Behaviour Charter* (Challenging Behaviour National Strategy Group, 2009);
- *Delivering Effective Specialist Community Learning Disabilities Health Team Support to People with Learning Disabilities and their Families or Carers* (Learning Disability Professional Senate, 2015);
- *Positive and Proactive Care, Reducing the need for restrictive interventions* (Social Care, Local Government and Care Partnership Directorate, 2014);
- *Winterbourne View – Time for Change: Transforming the Commissioning of Services for People with Learning Disabilities*

and/or Autism (Transforming Care and Commissioning Steering Group, 2014);

● *Challenging Behaviour and Learning Disabilities: Prevention and Interventions for People with Learning Disabilities whose Behaviour Challenges* (NICE, 2015);

● *Out of Sight: Stopping the Neglect and Abuse of People with a Learning Disability* (MENCAP and Challenging Behaviour Foundation, 2012);

● *Building the Right Support* (NHS England, *et al*, 2015);

● The imminent NICE guidelines for mental health in learning disabilities (due to be published in 2016).

According to the *National Audit Office* (2015), in September 2014, 2600 people with an intellectual disability were in-patients in mental health hospitals in England, and 920 of these did not have a discharge date. In 691 cases, this lack of a discharge date was a clinical decision. The average length of continuous in-patient stay in a sample of four hospitals was 6 years and 9 months; if admissions and readmissions are considered together, the average length of stay was 17 years and 4 months. Just over a third of in-patients were placed more than 50 km (31 m) from their home.

These findings add to information previously obtained by the Count Me In census surveys of people with intellectual disabilities in assessment and treatment units in England carried out by the Improving Health and Lives Learning Disabilities Observatory (Glover & Olson, 2012). It found that the use of assessment and treatment units varies considerably across the country, as does the placement of people outside their home area. In addition, there were concerning rates of hands-on restraint and assault, and these were more common in independent-sector provision than in the NHS. Emerging evidence from Care and Treatment Reviews initiated by NHS England (2015) and studies of the use of medication in the intellectual disability population (Sheehan *et al*, 2015) show high rates of prescribing of psychotropic medication and a lack of clearly articulated formulation and diagnosis underlying treatment plans.

The Scottish government and NHS boards completed their first *Mental Health and Learning Disability Inpatient Bed Census* in October 2014 (The Scottish Government, 2015). The census indicated:

● 181 individuals were in intellectual-disability-specific wards across Scotland: 79 individuals aged 18–39 years; 92 individuals aged 40–64 years; and 10 individuals aged at least 65 years.

● The average time since admission for adult patients with an intellectual disability or autism was 2 years and 9 months, significantly longer than for other adult (mental health and addictions) patients, for whom the average time since admission was around 5 months.

There are currently no Scottish Intercollegiate Guidelines Network (SIGN) guidelines or other Scotland key policies on challenging behaviours.

Values and definitions

Challenging behaviour

Many of the key recommendations from CR144 (Royal College of Psychiatrists *et al*, 2007), *Challenging Behaviour: A Unified Approach*, are as relevant today as they were when the report was first published.

The introduction of the term 'challenging behaviour' aimed to bring about a shift in perception and practice that would emphasise severely problematic or socially unacceptable behaviours as posing a challenge to carers, professionals and services. Rather than focusing on behaviour as a problem located solely within the individual (as a manifestation of psychopathological processes), services should promote positive behavioural development, reduce the frequency of circumstances in which damaging behaviour can occur, and maintain a good quality of life for the person despite continuing behavioural difficulties. These principles are at the core of the model of positive behaviour support.

Despite almost three decades of the term challenging behaviour being in widespread use, its purpose is still not properly understood, and there is a tendency to use it as a diagnostic label, locating the problem solely within the individual. There needs to be a firm and repeated affirmation of the term in its original context and a shift of emphasis back to the responsibility for change being with the systems around the individual.

Challenging behaviour is a socially constructed concept. For an individual's behaviour to be viewed as challenging, a judgement is being 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, have to be incorporated in the application and understanding of the term challenging behaviour.

The definition proposed in the original report (Royal College of Psychiatrists *et al*, 2007) is still appropriate:

> '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 quality of life, physical safety and human rights of the individual and those around them are fundamental to this definition. It stresses the response of individuals and services, rather than the qualitative aspects of the behaviour of the person, and it therefore follows that the actual nature of the behaviours should be described separately; for example, self-injury, assault, socially inappropriate behaviour. However, we maintain that behaviour should also be regarded as challenging when responses that are neglectful, socially and morally unacceptable, abusive or restrictive are being used to manage or contain it, particularly when basic human rights are being contravened.

The prevalence of challenging behaviour, therefore, can be understood within a range of parameters:

- 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 as a result of behavioural challenges;
- the number of children in 52-week residential schooling placements (often as a result of behavioural challenges);
- service responses involving:
  - seclusion
  - restraint
  - locked doors
  - abuse;

- clinical responses involving:
  - inappropriate prescription of drug treatments
  - punitive and aversive behavioural interventions
  - risk avoidance rather than risk management.

The label 'challenging behaviour' becomes less appropriate once consequences and the responses of others change to be non-punitive, non-restrictive and socially enabling. The nature and even the severity and frequency of the behaviour may remain unchanged and yet be seen as less challenging when carers, professionals and services are able to maintain a capable environment and respond in positive, inclusive and enabling ways.

Capable environment

Challenging behaviour can be encountered in all settings, including in the family home, small-scale community settings or in-patient settings. It has been shown that people who present behavioural challenges can be effectively supported in ordinary housing in the community (Mansell *et al*, 2001). When an individual's living situation breaks down, it is generally not the behaviour but rather the service response that is the critical determinant.

Challenging behaviour is more likely to occur in environments that are poorly organised and unable to respond well to the needs of the person. There is often a mismatch between the needs of people with intellectual disabilities and the range of available, individualised packages of support that can respond to 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 clinicians and those of staff providing direct support to individuals in community settings. The care staff say that professionals do not understand the constraints under which they work and give 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 these people to remain in their own homes and communities, the creation and support of capable environments is necessary. Capable environments are characterised by positive social interactions, support for meaningful activity, opportunities for choice, encouragement of greater independence, support to establish and maintain relationships, and mindful and skilled family/carers and paid support/care staff (NHS England *et al*, 2015). Competency-based training and professional support is required for all carers to enable effective joint working in seeking and implementing creative solutions to the challenges faced.

Services and staff should work within the model of 'active support', which focuses on enabling the individual to engage in meaningful activity and relationships at home and in the community. As a consequence of this, they gain greater control over their lives, become more independent and become more included as a valued member of their community. The provision of active support has a demonstrable impact on the quality of life of people with learning disabilities (Mansell & Beadle-Brown, 2012). Staff should have the organisational and other skills necessary to deliver active support and there should be values-based recruitment processes in place.

Roles, skills and responsibilities

Challenging Behaviour and Learning Disabilities: Prevention and Interventions for People with Learning Disabilities Whose Behaviour Challenges (NICE, 2015) sets out guidance for how adult and child health and social-care teams should work together to provide assessment and services to people with intellectual disabilities and challenging behaviour. It includes a number of recommendations:

- effective ways of working with individuals, their families and carers;
- support and interventions for family members and carers;
- early identification;
- assessment of challenging behaviour, including:
  - what should be considered within the assessment process
  - risk assessment
  - functional assessment of behaviour;
- psychological and environmental interventions;
- medication.

The recommendations for psychological and environmental interventions, in particular, highlight the need for personalised interventions that are based on behavioural principles and a functional assessment of behaviour, tailored to the range of settings in which they spend time. They should consist of:

- clear, targeted behaviours with agreed outcomes;
- assessment and modification of environmental factors that could trigger or maintain the behaviour (e.g. altering task demands for avoidant behaviours);
- addressing staff, family member and carer responses to challenging behaviour;
- a clear schedule of reinforcement of desired behaviour and the capacity to offer reinforcement promptly;
- a specified timescale to meet intervention goals (and modification of intervention strategies that do not lead to change within a specified time);

There are also recommendations for the use of medication (NICE, 2015; Public Health England, 2015). Antipsychotic medication to manage challenging behaviour should only be offered in combination with psychological or other interventions, and even then should only be considered if:

- psychological or other interventions alone do not produce change within an agreed time;
- treatment for any coexisting mental or physical health problem has not led to a reduction in the behaviour; or
- the risk to the person or others is very severe (e.g. because of violence, aggression or self-injury).

Professionals who assess and support individuals and provide advice to carers should adopt practices that focus on the individual. They should operate within interdisciplinary teams to provide expert assessment, formulation and interventions, either directly or through others.

Providing effective responses to challenging behaviour will inevitably challenge established, traditional (and comfortable) ways of working. Clinicians bring essential skills and experience to the process of understanding and responding to the individual and their circumstances. On occasion, they will be expected to take the lead in providing an authoritative appraisal, direction and coordination of the person's care and treatment. It is essential that clinicians take a collaborative and collective approach to managing risk and that they are prepared to adapt their practice to more flexible and creative ways of working – one in which a broad range of options for therapeutic interventions and models of support can be drawn on to develop a coherent package of care.

When professionals fail to work in close collaboration with families, providers and other community resources to deliver interventions and support that enable people with intellectual disabilities to live in their family homes or in community settings close to their home, they fail to meet their responsibilities. Coordinated and collaborative support should be provided from as early in life as possible – there is evidence that early intervention can lessen challenging behaviours and reduce the need for long-term residential care. However, as many challenging behaviours can persist throughout life, early intervention should be provided in the context of a lifelong, seamless and responsive approach that is able to predict and plan for periods of transition (e.g. going to school, puberty, leaving school, moving from child to adult services, forming relationships, seeking employment, ageing).

Most adults with intellectual disabilities who present behavioural challenges are already in receipt of health and social-care and are well known to services. The focus of community intellectual disability teams, in close liaison with primary care and hospital-based services where required, should be on providing proactive and responsive risk management and on enabling those caring for the person to deliver ongoing positive-behaviour support. Care and Treatment Review policy (NHS England *et al*, 2015) specifies that the commissioner, through local providers who are involved in supporting people in the community, will identify those individuals who are at risk of admission. (As stated in *Winterbourne View Review: Concordat: A Programme of Action* (Department of Health, 2012), 'all Primary Care Trusts develop registers of all people with learning disabilities or autism who have mental health conditions or behaviour that challenges in NHS-funded care as soon as possible'.)

It is expected that such registers will enable a better understanding of the needs of the local population and assist commissioners in tracking individuals, identifying gaps in current service provision and design and, in partnership with relevant stakeholders, in their ability to consider the types of resource required to provide more robust community-based alternatives. Clinicians are key to the gathering of this information and should work openly and proactively with commissioners.

Multidisciplinary working

Positive-behaviour support should guide the delivery of an evidence-based range of interventions that place the person at the centre. This support should be underpinned by thorough, multidisciplinary assessment, formulation and diagnosis and produce a coherent plan of intervention with clear evaluation of outcomes for the individual, family and carers. The formulation should explicitly address the potential contribution of aetiological and contributory factors, particularly:

- how the person communicates with others and how others can best communicate with them;
- acute and chronic physical health disorders (especially those resulting in discomfort or pain);
- mental health problems;
- the effects of medication;
- pervasive developmental disorders;
- behavioural phenotypes;
- the effects of trauma and abuse (both acute and long-term).

It is essential that health and social-care professionals work closely with families. Too often, families are ignored, marginalised or actively excluded from involvement in the planning and delivery of care for people with intellectual disabilities who present behavioural challenges. Families are a vital asset in better understanding and supporting such individuals. Continuity and completeness of knowledge of an individual's developmental and family history is often lost or corrupted when they are moved between services, and information crucial for a comprehensive and accurate formulation might not be taken into account unless the family are consulted.

Families of people with intellectual disabilities might be traumatised, distressed, angry and, at times, dysfunctional. Rather than ignoring them, or adopting an attitude of blame, clinicians should seek to continually develop the skills to engage families

(and other, non-familial, systems) in working on and resolving these issues as part of the overall plan of care.

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

Professionals should ensure that they take a multifaceted approach to manage crises effectively through:

- proactive crisis prevention;
- reactive crisis management and immediate resource deployment;
- proactive strategic planning and service development (informed by the two previous points).

Community intellectual disability teams must identify and work with individuals who present with or are at risk of challenging behaviours, as well as everyone supporting them, to plan for when things might be difficult (see the section on risk of admission registers, p. 11). They should work proactively to stop crises from happening, and there should be contingency plans in place for situations where a crisis might occur. If a crisis does happen, they should make sure that the right sort of help is at hand to rapidly defuse and stabilise the situation.

When people are experiencing a serious problem or crisis, it is essential that the service can respond to their needs with appropriate and effective advice and support 7 days a week and outside office hours. Access to 24 h emergency on-call, community crisis centre or in-patient outreach resources is essential, including access to psychiatric cover as part of the agreed local crisis response system.

This is likely to include access to short-term crisis access beds and intensive in-reach/outreach, assertive outreach and home support teams. Improving service accessibility and responsiveness directly reduces the number of out-of-area placements, high-cost care packages and inappropriate admissions to in-patient units (Learning Disability Professional Senate, 2015).

Professionals have an essential role in developing and maintaining the skills and competences of the workforce across all sectors of health and social care. Quality intellectual disability services take an approach based on providing strong community support that is planned around people in the environment that they are in, focusing on individualised, person-centred care. This approach should be applied to all, including people with very complex support needs. Services must be committed to achieving the outcomes of 'rights, inclusion, independence and choice' (Department of Health, 2001), and to sticking with individuals in spite of the difficulties experienced in meeting their needs. Community intellectual disability community health services should:

- promote safe, person-centred support and evidence-based practice;
- demonstrate positive outcomes, particularly reductions in restrictive practices and health inequalities;
- support mainstream practice and directly serve those with the most complex support needs;
- direct people away from institutional responses to crisis and put support around people in community settings;
- integrate planning and development work that promotes local services;
- have staff who offer advice and support to other professionals or services and those who provide day-to-day care and direct interventions with people with intellectual disabilities and families;
- enable and train others to have the skills to provide specific and responsive care in all settings for people with intellectual disabilities and their families/carers;

- enable swift access to medical, nursing and therapy professionals;
- invest in training and development for specialist professionals, families and front-line support staff;
- support a robust community infrastructure that takes a broad, early-intervention view on addressing health needs and the factors associated with social exclusion and health inequalities to secure better and more inclusive service outcomes;
- fulfil all legal requirements and ensure the voices of individuals and families are heard, including giving access to appropriate advocacy and representation.

Clinicians and other professionals have essential roles in providing strong leadership, assurance and accountability, particularly around reducing the use of restrictive interventions. They are also required to work in collaboration with the NHS and social-care bodies on reducing unnecessary admissions, discharging individuals from hospital, taking the lead on continuity-of-care coordination and care and discharge planning.

Care and Treatment Reviews implemented by NHS England in response to the number of individuals remaining in hospital care without identified discharge dates have highlighted some important issues for professional practice (NHS England, 2015).

- Responsible clinicians must ensure that clear formulation, diagnosis and treatment plans are developed and adopted.
- Clear outcomes for interventions should be defined, with appropriate outcome measures.
- Professionals should work closely with experts by experience (people with intellectual disabilities or family carers) in service review, development and evaluation.
- Clinicians and their professional bodies should strive for a culture in which challenge to clinical decisions should be not only accepted, but regarded as a healthy, effective way to achieve the best treatment, planning and commissioning outcomes.

Working with commissioners

The Learning Disability Professional Senate (2015) suggests a number of ways in which health professionals can become engaged with the wider picture of service provision, planning and commissioning.

- Supporting local commissioners through taking an active operational or micro-commissioning role in strategic planning, care-package contract oversight and policy development.
- Providing commissioners with their knowledge and critical evaluation of service providers.
- Contributing to the design, creation, and monitoring of provider support arrangements for individuals, particularly those requiring extensive support from family and community and a range of agencies.
- Supporting delivery of the Transforming Care agenda (NHS England *et al*, 2015) through the development of appropriate and adequate local policies, procedures, support and care arrangements for people with complex needs who are at risk of hospital admissions and placements away from their home communities.
- Supporting the work of local learning disability partnership boards and forums (and now Transforming Care partnerships), providing leadership in the related Better Health sub-groups, and coordinating and demonstrating action in line with the National Joint Health and Social Care Learning Disability Self-Assessment Framework (NHS England, 2015).

Commissioners should have a clear basis on which to develop and select competent providers.

Commissioners need to manage the market they have created to sustain the capacity of local services to meet the needs of everyone with intellectual disabilities. This involves encouraging service providers to cooperate, underpinning service competence through training and service development and reshaping specialised services for people with challenging behaviour 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 services that are required. Alternative routes to market development should be pursued, for example through the establishment of personal budgets and independent brokerage.

In addition, commissioners and clinicians should work together in refashioning services and enabling closer integration between care managers, care-standards inspectors and members of community intellectual 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 present with behaviour that challenges services.

Commissioners need to be aware of best practice in intervention, the outcomes achieved by interventions (and these might 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.

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