Review of Services to People Whose Behaviour Challenges Services in the NW Region

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Summary

In the NW Region we do now have a good understanding of what is needed to enable most people with learning difficulties, whose behaviour challenges services, to live in the community. There is still much to be done, however, in implementing that understanding. Nearly all districts have made a start in developing special provision. Staff training is well established. Special short term care provision is not essential as a variety of ordinary means are widely found to be effective. The special teams are providing valuable expertise but should not be expected to be a substitute for the continued development of comprehensive local services. Organisational issues are emerging as central to the effectiveness of teams: the disjunction between their recommendations on service design and the authority to implement them; conflict between special teams and other service workers. Joint management offers resolution of these organisational difficulties. Unified services may prove even more effective. Work remains to be done on designing services for people with moderate learning difficulties including those with mental health problems and offenders. Change agents are seen as essential to prompt and guide service development locally.

Introduction

In 1989 a decision was made to invest £2.1m in developing local competence in coping with people whose behaviour challenged the ordinary life approach. At its December 1990 meeting the Strategy Steering Group asked the North Western Development Team to review progress in local service developments.

The review, carried out by Chris Gathercole, NWDT member, during 1991, was based on:

discussions with specialist challenging behaviour staff in each of the 19 districts, and staff of the Medium Secure Unit at Calderstones

- review of operational policies and other documentation from each district

- participation in information exchange days involving specialist challenging behaviour staff from each district, now formed into the North West Challenging Behaviour Interest Group

- discussions with research staff at Hester Adrian Research Centre, University of Manchester
- discussions with tutors and organisers of courses: *Insight into Challenges* and *Behavioural Approaches for Staff Working with People with Learning Disabilities*
- review of Regional policy and Learning Disability Advisory Group guidance documents
- in depth reviews of challenging behaviour services in two districts including discussions with users and family members.

Outcomes for Users

Considerable improvements in quality of life have occurred for a number of people. The programme of resettlement from hospitals and hostels has enabled a number of people who previously had bad reputations to live in ordinary houses, supported by staff, almost unrecognisable from their pre-discharge hospital casenote descriptions. The behaviour of a number of people has made distinct progress, some through placements, some through meeting needs in more appropriate ways and some through training. However, some people continue to be maintained in segregated settings: day centres, hostels and school. For others whilst their behaviour has not necessarily improved it has at least been contained without them having to be sent to long stay hospital. Calderstones Medium Secure Unit continues to be needed for a small number of people. Some people continue at home causing severe stress to their carers.

Many, if not most people with learning difficulties have few relationships outside the world of handicap, peopled by family, service workers and other clients. Physical integration gets people closer to better opportunities for getting to know, and be known, by people outside the world of handicap. However, taking advantage of these opportunities needs facilitating and services have so far generally been slow to provide this bridge into community. For people with challenging behaviour the difficulty is even greater. They are often very isolated from contact with people outside family, service workers and clients. There needs to be greater awareness of the importance of broadening social contacts and how to do it. There is growing experience,

research and literature which needs to be more widely known in the NW (e.g. see 1,2).

Local Services

Of the 19 districts in Greater Manchester and Lancashire, 16 have opted for special teams and three have not. In 12 districts services are now well established. The other seven are still embryonic. Although the full funding allocations have been available to all districts in this financial year, from April 1991, several districts have experienced delays in getting posts advertised.

Three districts started their challenging behaviour services in the mid 1980's (1985, 86 and 87). Several others have served people with challenging behaviour since that time, including resettling people so labelled from long stay hospitals. The others mostly came on stream during 1989, 90 and 91.

Most districts had arrived at overall policies for comprehensive local services in previous years, jointly agreed by health and local authorities. These overall policies built on the framework of *A Model District Service* and show a strong commitment to its underlying aim: to see people with learning disabilities included fully within the life of the community. Plans for challenging behaviour services, therefore, had emerged from a sound base after careful and wide ranging discussion.

However, several districts did not have written, jointly agreed policies for learning disability services. One local authority appeared to have a tradition of questioning the value of written policies. Where policies existed there was not always an agreed strategy for implementation.

It is highly desirable that all concerned in each district come together to agree written overall policies as well as operational policies and plan implementation. Whilst the best documentation does not guarantee high quality services, the process of debate and clarification is an essential prerequisite.

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1 Mount, B., Beeman, P., and Ducharme, G., 1988 *What Are We Learning About Circles of Support? A Collection of Tools, Ideas, and Reflections on Building and Facilitating Circles of Support* Communitas: Manchester, Connecticut.

2 Mount, B., Beeman, P., and Ducharme, G., *What Are We Learning About Bridge Building? A Summary of a Dialogue Between People Seeking to Build Community for People With Disabilities* Communitas: Manchester, Connecticut.

Only nine districts had operational policies for challenging behaviour services.

The pattern of management varies. Some are managed within health, others within social services and several are jointly managed.

Clientele

All teams work with adults having severe learning disabilities, but several excluded children in their operational policies, although they recognised that they would need to be involved with school leavers in the transition to adult services. Some acknowledged that they would be flexible in their response to requests for help from children's services. Most teams do little work with children even though roughly a quarter of people with severe challenging behaviour are aged 5-19 years (3). However, since 1982, Lancashire Education Authority has had a special team of teachers, now numbering six. This team is probably unique in Britain. They work with schools for children with severe learning difficulties, assisting teachers to cope with difficult behaviour but they do not work with families in the child's own home. Lancashire LEA currently has seconded to them the NW Regional Development Officer of the National Autism Society for a year to review educational provision for autistic children and make recommendations. A number of people with challenging behaviour carry the label of autism and there is a parent lobby for them to be educated separately as a group.

Educational psychologists help in the management of children with challenging behaviour in schools but do relatively little work with families. Some parent guidance work is done by community mental handicap nurses and clinical psychologists.

There is an impression that prevalence of severe challenging behaviour has reduced among primary age children in recent years. This is not researched but if true it may be related to the improved support for families and reduction in institutional living for children during the 1980's.

Many education authorities do not have close working contact with health and social services so that services are often inadequately co-ordinated, most noticeably at the transition between children's and adult services. Legislation places a duty on services to liaise. The Disabled Persons Act requires joint planning for school leavers and the Children Act requires joint planning to identify and meet the

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3 Qureshi, H. and Alborz, A., 1990 *Epidemiology of Challenging Behaviour*. HARC.

needs of children. This legal framework is intended to ensure that services come together in the interests of children.

There is evidence that challenging behaviour in children can be very persistent (4). Work with children, therefore, is vital as a contribution to reducing prevalence in adulthood. However, children with learning disabilities are served within child services and it does appear that those with challenging behaviour and their families throughout the Region are generally inadequately served and services to children often do not have the expertise they need available to them. Services to children therefore will need either to develop their own specialist workers for work with parents as well as in schools or take guidance from specialists who mainly work with adults.

Several teams do not serve people with moderate learning disability. This includes those who have offended or are at risk of offending against the law. Offenders who come to the attention of teams tend to be people with moderate learning difficulties. Community mental handicap teams mostly focus on people with severe learning disabilities and so are generally not experienced with this group. Additional support teams are still gathering the experience needed to work effectively with offenders. The Medium Secure Unit at Calderstones provides a reservoir of experience with offenders on which teams are drawing. Three districts have ruled out work with offenders by learning disability services. They recognise that such service is needed but have decided to focus on serving people with severe learning disability and leave services for those with moderate disability to others such as the probation service. The gap in provision by these three districts may have implications for future use of Calderstones Medium Secure Unit.

There is still a question in nearly all districts of what are the most appropriate services for people with moderate learning disability and mental health problems. Most general adult psychiatrists do not accept such referrals and most mental handicap psychiatrists feel they do not have the resources to provide a service to them.

There is some pressure for teams to get involved with adults with brain injury and posing challenges to community living, but whose development in childhood was not delayed. Psychiatric services often claim they are not equipped to serve these people.

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4 Fleming, I., and Stenfert Kroese, B., 1990 *The Prevalence and Persistency of Challenging Behaviour Amongst a Population of Children with Severe Learning Difficulties.* Unpublished.

Short Term Care

When the £2.1m was originally allocated it was partly intended to improve short term care provision to ease the stress experienced by parents. A number of districts have acquired, or plan to acquire, property specifically for use by people with challenging behaviour for short term care. However, several districts have found that they can serve this purpose without having to have a house solely for people with challenging behaviour.

Some districts are well provided with an adequate range of short term care so that they have so far had no need of any special short term care accommodation for people with challenging behaviour. One district can bring staff together in an emergency, to staff a bungalow available for this purpose, for up to two or three weeks. Another district has an option to use a place in a voluntary agency's short term care provision but has not so far had to use it. In one district, which doesn't have short term care specially for people with challenging behaviour, community nurses take people with challenging behaviour on adventure holidays in Wales to give families a break. In another, which also plans not to have special short term care provision, the specialist team say they would use holiday accommodation, such as a caravan, if there was an emergency need for short term care. One has had a house, with four places which serves 13 families, in operation for six years. It is regarded as having been an invaluable part of their challenging behaviour service. Two districts have still to plan their short term care provision for challenging behaviour.

Two districts are using adult placements for short term care for people with challenging behaviour. The motto in one was, 'We don't make a crisis out of a tragedy.' This is a highly desirable development. Adult placements should form a major part of regular provision but development across the Region is very patchy with a few districts putting a lot of effort and resources into it whilst one or two have hardly started. Even where adult placement services exist people with challenging behaviour are often excluded on the assumption that ordinary people could not be asked to cope with challenging behaviour. Where this assumption is challenged there have been some valuable placements.

It would appear that no special short term care house reserved for people with challenging behaviour is needed where there is enough short term care provision available for all who need it, including adult placements and sitting. In such a situation there is enough flexibility to respond to the individual needs of all users in the most cost effective way. The extra expense of staffing a short term care

house for people with challenging behaviour is therefore saved and put to better use.

Staffing

The three districts which do not have teams have used their allocations mainly to appoint support workers. These workers can be a valuable resource if properly used. There is a danger however, that they can come to be used to contain a few people without adequate assessment and intervention design. If this happens there is little prospect of improvement and the extra support workers are tied up indefinitely, not being available for flexible work with other people.

There is a view in some quarters that specialists in challenging behaviour are not needed. This is based on the observation that the behaviour of many people improves greatly when their circumstances are improved: moving from segregated hostel or hospital to ordinary housing or moving from a day centre to supported employment.

There is a need for, at the very least, one specialist in challenging behaviour, in every district. Such specialists should have a brief to keep up to date with current research and good practice, with access to current literature, attendance on courses and conferences, visits and study tours. They would be available for consultation with staff and managers in all agencies, as well as contributing to policy making and service development.

There is agreement that services need both direct care practitioners who can be there when needed, working flexible hours and readily available, as well as specialists in the assessment and analysis of challenging behaviour who can design interventions, advise managers on resource allocation and supervise direct care workers.

Teams are known by various names: Additional Support Team, Outreach Team, Extra Support Team. Nearly all have mental handicap nurses. Some have clinical psychologists. Some have other professionals: teacher, social worker, speech therapist. Several have support workers who work to the supervision of qualified team members.

Nurses are recognised as having the practical experience of day to day working with challenging behaviour. This background gives the confidence to cope with situations which others often find difficult to tolerate.

The appointment of speech and language therapists gives recognition to the importance of communication for a large proportion of people with challenging behaviour, especially those labelled as having severe learning disability.

The appointment of teachers gives recognition to the importance of educational opportunities, especially for the 16-25 year olds who form a significant proportion of those with challenging behaviour.

An understanding of principles of learning, relationship formation, and other aspects of psychology are acknowledged to be basic to good quality challenging behaviour services. It is not the only relevant subject of course, but it is central. It is essential that psychological knowledge, skill and expertise are available to challenging behaviour services.

Most practitioners in health and social services have received some psychology in their basic professional training. Some RNMH nurses may have had a sound grounding in learning principles and their applications in learning disability. However, there has been a misguided backlash against behaviour analysis from the social role valorisation movement. It seems that some schools of nursing are not providing the thorough grounding which the syllabus allows. It cannot be assumed therefore, that RNMH nurses have the technical knowledge and expertise needed. Post qualification courses which cover aspects of this technical knowledge are widely available and many staff are benefiting from these (see 5).

Where clinical psychologists are available to challenging behaviour services they can act as a resource: disseminating psychological knowledge through teaching, designing assessment and intervention strategies, influencing service organisation and provision, supervising practitioners, designing service monitoring and evaluation. There is however, a shortage of qualified clinical psychologists, largely because of the training bottle neck. Although there are many vacant posts and many applicants for training courses there have not been enough places on training courses for throughput to fill the vacant posts for qualified psychologists. It would be highly desirable for there to be an increase in the number of places on the two training courses in the NW and funds available for vacant posts to be used for trainees.

Of the 19 districts, three had no clinical psychologists available for challenging behaviour services and five had a psychologist in post

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5 NWDT 1991 *Guidelines for Good Practice in Challenging Behaviour Services*

working full time in challenging behaviour. Ten had part time psychologists, four of these being service managers whose responsibilities included challenging behaviour services. One district had a psychologist as a leader of a challenging behaviour team.

The View from the Teams

There is agreement across each of the teams:

- that the ordinary life approach is right
- that special buildings for congregating people with behaviour which challenges services are not needed
- that we do know enough to meet most people's needs in the community
- that aversive methods are to be avoided
- that the role of special teams is to provide support to enable generic and regular learning disability services to meet the needs of those who challenge the ordinary life approach. They recognise that there is great pressure to pass the buck to them but all claim that this is being consistently resisted. The role is not to take over ownership by the special teams. Nor is it to assist segregated services, such as day centres or hostels, to contain people in inappropriate provision
- that a very small number of people, of the order of 5-10 in each district, are likely to require considerable staff resources, possibly long term
- that much challenging behaviour is a direct result of lack of regular services or inadequate regular services and redesigning services around individual needs is already leading to substantial reductions in challenging behaviour
- that emergencies arising as a result of challenging behaviour are rare in a well established team which has identified all the people in the district whose behaviour is likely to challenge services. Where teams have got to know such people and provide regular support, the likelihood of difficult situations arising can usually be anticipated and headed off. Where emergencies do arise staff are quickly available to respond without the need for institutional provision.

- that as teams get established there will be negligible referrals for people with severe learning disabilities to the Medium Secure Unit or other institutional or out of district placements, provided progress on the topics listed below is maintained and the service deficiencies, also listed, are remedied.

Constraints on Good Practice

Guidelines for good practice were published in November 1991, based on discussions with users, family members, practitioners, managers, researchers and course tutors in Greater Manchester and Lancashire with a wide measure of agreement.(6)

Naturally practice varies across the Region. Partly, this is because services have come on stream at differing times and some are still getting established. In addition, there are constraints on good practice which need to be identified and addressed.

The major constraint is in the degree of progress towards local and comprehensive services. The thinking underlying *A Model District Service* was that if high quality, comprehensive services could be developed locally then in time, the proportion of people who challenged local services would gradually diminish. Considerable and gratifying progress towards comprehensive local services has been made throughout the North Western Region. However, much remains to be done.

The work of additional support teams is made more productive where the service context is most positive. Some districts have gone a considerable way towards developing local and comprehensive services, including:

- a sound, overall, written policy statement derived from widespread discussion involving all with an interest, including parents

- good co-operative relationships between people and agencies at all levels, leading to joint management arrangements, clear accountability and good co-ordination of different service components

6 NWDT 1991 *Guidelines for Good Practice in Challenging Behaviour Services*

- a spread across the various service components of people committed to the ordinary life approach, with a sound grasp of the principles and taking responsibility to work out their practical implications

- extensive arrangements for training for all service workers in a variety of aspects, for the new dispersed, flexible and individualised services

- established procedures for individual planning in all service components

- authority to allocate resources flexibly as needed.

Where one or more of these features is missing the work of an additional support team is made so much harder.

All teams agreed that their role is largely to fill gaps in existing services and that as existing services improve, the need for special teams reduces. Service deficiencies identified included for example:

- lack of local, dispersed supported accommodation for people living with families especially where there was only one elderly, frail parent. This puts severe stress on carers and is a direct consequence of reducing admissions to long stay hospitals without the development of local alternatives.

- lack of identified responsibility and accountability for provision and quality of local services

- lack of individual planning

- limited parent guidance in child rearing

- inclusion in mainstream schools has hardly begun in most areas

- although there are extensive opportunities in further education, these are mostly in segregated provision

- the majority of adults remain in segregated day centres although a growing number are finding jobs through the newly developing employment finding and coaching services

- there is a widespread shortage of non-institutional short term provision for children and adults

- limited service co-ordination
- health care received by young adults with physical and learning disabilities often rapidly declines after they leave paediatric services.
- lack of relevant training for direct contact staff including induction, and subsequent in-service training
- high turnover of care staff, sometimes associated with casual contracts, part-time working, lack of training and supervision
- even where turnover of staff is low, they may be moved around a lot
- Some social services staff in day centres and hostels object to serving people with challenging behaviour. In days gone by such clients would often have gone to long stay hospitals. Now that they are placed in local provision some staff are finding it difficult to adjust. This is a continuing management task to ensure that all staff understand how the service is developing and ensure commitment to shared objectives.

Specialist challenging behaviour services can only supplement regular services. They should not be expected to be a substitute for poor quality provision.

We are in a period of transition in service provision. Many people whose behaviour currently challenges services are victims of inadequate or inappropriate services. Many will undoubtedly improve when they receive more suitable services. The lesson here is that the steady, continued, long term effort to develop good quality, local and comprehensive services has to be continued as part of the aim to prevent challenging behaviour in future and to ameliorate existing such behaviour. This task falls mainly to mainstream learning disability services as well as generic services rather than to special services.

The more that service deficiencies coalesce the more are additional support teams expected to take problems away from hard pressed regular services. Challenging behaviour can generate fear, anger and frustration among carers and staff. In less developed services this leads to victim blaming. Users are blamed by workers, direct contact workers and their managers are blamed as being incompetent and additional support teams expected to work

miracles when the real culprits are inadequate policies, service design, management and staff training.

In such a situation, an additional support team can act as a force for change, bringing in thinking and ways of working which can in time, improve the wider policy making, service design and staff training. However, too much should not be expected too quickly. Along the way there are likely to be conflicts and casualties.

Organisational Problems

Several teams have insufficient influence over authority to implement their recommendations which require redesigning a person's environment such as:

- individualising their day activities so as not to rely on a day centre which cannot cope
- enabling a person to move out of the family home long term to more appropriate domestic scale accommodation.

Organisational arrangements can facilitate working relationships of teams or hinder them. There are examples of teams with very constructive working relationships and also examples of conflict, described on occasion even as warfare. A team which belongs to health for example, may have difficulty working with social services staff. A community mental handicap team may feel that an additional support team is intruding on its territory. Conflict can be at practitioner level or managerial level or both. Some of these conflicts are entrenched and long standing. Local authorities in a number of districts are in process of reorganisation and/or financial crisis which puts severe constraints on joint working. There is considerable pressure to address these problems as local authorities prepare their care in the community plans.

There is a strong move towards joint management of both additional support teams as well as wider learning disability services. Joint management was a major recommendation in *A Model District Service* (7) and the subsequent *Implementing and Staffing a Model District Service* (8). This is an idea, it seems, whose time has now come. Services which have managed to achieve genuine joint management appear to be much more effective in delivering the provisions recommended by additional support teams. Accountability and co-ordination are greatly

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7 NWRHA 1983 *A Model District Service* NWRHA: Manchester

8 Mental Handicap Advisory Group 1985 *Implementing and Staffing a Model District Service* NWRHA: Manchester

enhanced. As far as can be judged, the effectiveness of these teams in reducing challenging behaviour is so much greater.

Movement towards unified services is likely to accelerate. This would probably be even more effective than joint management in improving co-ordination of provision to meet the needs of those whose behaviour challenges services.

Good joint working creates the conditions in which challenging behaviour can be addressed more effectively. It is not a panacea but it is an essential ingredient for success. It also creates opportunities for the most cost effective use of resources as the service can access several budgets. For example, if adult placements and employment services are developed resources can be released from hostels and day services. In a joint service these savings can be used for people with challenging behaviour whose support often costs much more than average. If challenging behaviour services are the responsibility of health then savings from improved social services are unlikely to be transferred from local to health authority.

Patterns of joint working vary. One district, recognising that something had to be done about the frequent bickering, set up a working party on joint working in 1984. By 1988 this district had adopted joint management with a single manager for all health and social services learning disability services. Another district has set up a Joint Placement Group to ensure that health and social services resources are used according to agreed priorities.

Resources

Tightened budgets are causing difficulties in all services: the Cost Improvement Programme in health and cuts to avoid capping in local authorities. It is rare now for social services to be able to provide a place to live for people who never left home, unless there is a family crisis. Many families whose sons or daughters never went in to hospital feel very aggrieved at the development of two tiers of services: one for people resettled from hospital with their dowries and a second class, impoverished service for the rest. Many of those families who have the stress of coping with challenging behaviour at home are angry at what they see as their abandonment. In one district such parents have formed an action group with the help of an MP. Understandably, pressure for segregated provision grows among disaffected parents.

Education services are cutting back on further and adult education so that more adults are experiencing a lack of adequate day

activities. Social services are even planning to cut posts in day centres.

These resource constraints reduce flexibility in services which in turn reduces responsiveness to individual need in a time of transition in service provision.

Apart from people in long stay hospitals in the NW, every district has a small number of people with challenging behaviour (probably not more than about 10 in any one district and mainly less than 5) in out of area placements. These may be funded by health, social services or education and can be very costly, even over £1000 per week. Some districts have reviewed these placements and know exact numbers and associated costs. In other districts this information is not available.

It is highly desirable that every district should survey its out of area placements, identify costs and begin planning to bring people back to the district. In almost all districts there are severe bureaucratic impediments however. It usually requires an item to committee to reallocate costs to be used locally.

Medication Review

Major tranquillisers are widely but inappropriately used to suppress challenging behaviour. Russell (9) states

> '.....the use of such drugs on a long term basis for the treatment of mentally handicapped people with chronic social and behavioural disorders is based upon remarkably little evidence.....these drugs may actually lead to a worsening in the behaviour and performance of some mentally handicapped people.'

They are often used in the absence of other constructive approaches. Often users are put on repeat prescriptions without review for long periods. Many examples are available from the NW where medication has been substantially reduced or eliminated through work on challenging behaviour. One district has undertaken a systematic review of medication of all people with challenging behaviour in order to begin reducing the use of major tranquillisers. Such a programme would be valuable in all districts.

Agents of Change

The new pattern of services in which people with challenging behaviour are served locally requires substantial changes: in provision, in attitudes, in skills, in understanding. The management of change on the scale required is a very demanding task which requires expertise, skill, and time to do well. Wherever marked

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9 Russell, O., 1985 *Mental Handicap* Churchill Livingstone.

progress is being made there is always an agent of change to be found: a product champion, someone who has taken the responsibility to initiate and guide the changes. In the NW there are a number of examples: the principal health liaison officers of Lancashire Social Service Divisions, clinical psychologists, social workers, community nurses, managers (health, social services and joint provision).

The need is for at least one person in each district who has the time to identify needs for development and find ways of bringing about the changes needed. This requires:

- an understanding of the needs and situations of service users (keeping close to the user)
- a vision of how things could be (keeping in touch with what is best in the world)
- understanding of and commitment to the principles of social role valorisation
- an understanding of how to bring about change.

The person needs to be at an appropriate level in the organisation to have the authority to pursue these activities but not so senior that they are distracted by other responsibilities. Managers who are swamped by their day to day work often have little time to initiate and pursue longer term developments, Some find ways to delegate in order to create the time needed for change leadership.

The change agent has to:

- find out what is the present pattern of users' lives and of service provision
- strengthen whatever supports the changes needed
- recruit support for the vision of alternatives
- seek opportunities to move towards the vision.

Priorities for attention are:

- to develop a broad policy statement (if none exists) in discussion with all who have an interest

- then to develop a strategic plan (if none exists) also in discussion with all who have an interest
- to find ways of redirecting existing resources
- to identify sources of finance
- to write proposals for the creation of new posts
- to identify staff training needs and develop a training strategy
- to prepare operational policies for new services.

Training

There has been considerable investment in training, now widely available, using the £2.1m budget allocations. Two training initiatives within the Region are making major contributions. The ENB/CCETSW validated course *Behavioural Approaches for Staff Working with People with Learning Disability* run jointly by the Hester Adrian Research Centre at the University of Manchester and the E. Lancs School of Nursing is now in its third year. This one year, full time course is highly regarded by team leaders who have students from the course on placement or who have appointed graduates from the course. Allocations from the £2.1m have funded the salary for the course tutor, fees for several students from the Region and salaries for replacement staff at Calderstones. It is worthy of note that all 13 students this year are nurses, nine of whom are from the NW Region.

The other major training initiative is the *Insight into Challenges* course developed by the Regional Training Team. This has been devised for local in-service training and is also highly regarded. It has been used for training staff of additional support teams as well as regular staff in health, local authority and voluntary services. Each course lasts six months and is based on modules with practical work in between. More than six courses have now been run in the Region.

Allocations from the £2.1m budget have been used for a variety of other short courses. There are a number of national and local short courses on challenging behaviour now, including gentle teaching, counselling etc.

A network of specialist workers in challenging behaviour in the Region began in 1991, meeting three times a year, which provides a forum for discussion, learning from each other, valuable contacts and circulation of information.

Challenging behaviour specialists often do a substantial amount of training with regular staff. A major focus of this training is in helping staff to understand the origins of challenging behaviour. Often challenging behaviour appears to occur for no reason and unpredictably. Taking the mystery out of it can help regular staff to cope better and feel that they can take responsibility for serving a person they would otherwise want to get rid of. *Insight into Challenges* has been a particularly useful vehicle for this training and is being used in many districts.

All but three districts in the Region have joint training groups which have contributed significantly to the development of local competence in regular services to meet the needs of people with challenging behaviour better. Establishing joint training groups in the remaining districts could help them improve their challenging behaviour services substantially.

Many courses include a mix of people with different backgrounds and from different agencies. However, education has remained almost totally isolated from these events.

Although some parents have had opportunities to take part in courses and events relating to challenging behaviour more opportunities are needed. One parent who took part in *Insight into Challenges* described it as a lifeline.

Skills of behavioural analysis are well established: observation, description, recording and measurement of behaviour and its determinants; design and implementation of interventions; monitoring and evaluation of change.

Courses on control and restraint are becoming popular. The argument in their favour is that there is less danger of damage to user and others where staff know how to restrain somebody safely. There is a danger, however, of attendance on such a course being seen as a licence to use violence on users. Before control and restraint training is contemplated it is essential to have a violence

limitation strategy which includes a risk management policy(10). Safeguards are therefore essential (11) including:

- recording of the use of restraint with regular review of records by managers
- a review meeting to be held after each incident where restraint is used
- training in restraint only to be given in the context of programming which includes teaching of acceptable behaviour and recording of data to monitor its effects.

Important as training is, it should not be expected to crack all problems. Training has to be planned within an overall context in which organisation, management, service design and development and resource issues are all attended to.

Training is rarely evaluated in terms of its contribution to improving service quality over the long term. Joint training teams could give greater priority to this issue in order to identify the variables associated with successful implementation of what has been gained in training. This might draw attention for example to the widespread lack of adequate staff supervision.

Epidemiology and Evaluation

The Hester Adrian Research Centre has produced valuable reports on prevalence of challenging behaviour in the NW (12). A major finding was that prevalence of severe challenging behaviour in Salford and N. Manchester is almost twice that in Chorley. Other work suggests an even higher rate in Central Manchester (13).

Further research to unravel this variation could be important for both practice and equitable funding. Qureshi suggests that the difference relates to differential population growth and decline. Chorley is described as a growth area, Salford and N. Manchester, as declining areas. The implication is that overall prevalence of learning disability is likely to be higher in a declining area than in a

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10 See Coldwell, J. B., 1992, *Towards a Strategy for Reducing Workplace Violence,* Calderstones.

11 NWDT 1991 *Guidelines for Good Practice in Challenging Behaviour Provision.*

12 Qureshi, H. and Alborz, A., 1990 *Epidemiology of Challenging Behaviour.* HARC.

13 Burton, M., 1991 Personal Communication.

growth area due to differential mobility and the difference in challenging behaviour rates merely reflects differences in the overall rates. Another possibility is that higher rates of challenging behaviour in inner city areas are understandable in terms of the stress of deprivation, poverty, high unemployment, and all the other indices of social breakdown: crime, drug abuse, homelessness and so forth. In addition to investigating this question, it would be valuable to have independent research to investigate whether improved services throughout the Region are leading to a decline in prevalence of challenging behaviour in children and in adults.

A further research question concerns prevalence in rural areas such as the Ribble Valley. Qureshi and Alborz(10) did not include data from a rural area in their reports.

It would be helpful for challenging behaviour services to standardise their data collection and definitions so that valid comparisons across time and districts can be made.

There is a need to develop measures of change which can be used for audit (14). The new culture of purchaser/provider will require attention to quality assurance including standards setting and specifying outcomes. This is not easy because of the variety of challenging behaviour, the factors that influence it and its consequences.

One district has adopted the Quality Assessment approach developed within the Region (15).

One Health Authority requires throughout its services annual satisfaction surveys of colleagues, users, families and referring agents. This will be part of the challenging behaviour service which is managed by health.

Four districts have invited external evaluations, three by the North Western Development Team and one over a two year period by the Hester Adrian Research Centre.

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14 NWDT 1991 *Guidelines for Good Practice in Challenging Behaviour Services*

15 Mental Handicap Advisory Group, 1989 *Quality Assessment*, NWRHA: Manchester.

Future Role of Hospital Resources

The Medium Secure Unit at Calderstones and Lathom House and Tomlinson Ward at Royal Albert serve people with challenging behaviour including offenders.

The Medium Secure Unit has three nurses, a social worker and a clinical psychologist who are available to local services for:

- advice, direct care, staff or parent training, reassurance to local staff, and guidance on wider organisational arrangements to prevent admission
- planning for admissions, arranging contracts for joint working between the Unit and local services
- making arrangements for discharge and follow-up support.

Other MSU staff work under the guidance of these advisers when needed.

This outreach work has assisted in the dissemination of skills and expertise in the management of challenging behaviour and in the planning and development of local provision. It is highly regarded by local services.

It is envisaged that as district services develop there will be less pressure to admit people to hospital. The impression is that local services are indeed coping better with people labelled as having challenging behaviour and severe learning difficulties and that in future there is likely to be a continuing decline in referrals to hospital for them. However, it appears that referrals of offenders (mainly with moderate learning disabilities) to hospitals may be increasing. People who previously may have gone to prison or been dealt with by probation services appear more likely in future to be referred to hospital, local services have relatively little experience of serving these people. Indeed several districts exclude them from learning disability services. It will be some time before district services develop the relevant expertise to serve them locally(16).

As Royal Albert is scheduled to close in 1996 it will be necessary to stop admissions there so that Calderstones Medium Secure Unit will remain, as it was intended, as a Regional resource for 1990's.

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16 Mental Handicap Advisory Group, 1989 *Caught in the Competence Trap* NWRHA: Manchester.

The longer term need for the Medium Secure Unit cannot be predicted yet. It will not become clear for several years how far the capacity of districts to serve people locally will develop. It is likely that a relatively small number of people will continue to need the services of the Medium Secure Unit but the scale will only emerge with time.

In the meantime it is vital that the people considered by the Medium Secure Unit as ready for return to their districts are enabled to leave Calderstones as soon as possible. There are currently about 50 such people for whom their continued detention in hospital is a grave infringement of civil liberties.