11.3. Behavioural interventions for challenging behaviour

Knowledge

- An ability to draw on knowledge that behaviour is defined as 'challenging' when it involves significant risks to the child/young person's physical well-being and/or has a significant impact on their quality of life and their access to ordinary facilities
- An ability to draw on knowledge that challenging behaviours are more common in children/young people with learning disabilities, and in those with an IQ in the normal range but with neurodevelopmental disorders (such as autism spectrum disorder), although the pattern varies depending on the type of behaviour, their age, their social and family context, and:
  - an ability draw on knowledge that because these children/young people's social and communication skills may only partly develop, they may have fewer ways of signalling their needs or having them met; as such challenging behaviour can often be understood as an act of communication
- An ability to draw on knowledge that challenging behaviour is context specific and can be culturally determined (i.e. in relation to cultural or familial expectations of standards and behaviour)
- An ability to draw on knowledge of normal child development and that:
  - most young children display some forms of challenging behaviour early in their lives, and that these usually diminish or disappear as children develop social and communication skills, and also gain more 'executive' control
- An ability to draw on knowledge of different types of challenging behaviour, and the prevalence of those associated with specific syndromes and with learning disabilities
- An ability to draw on knowledge of the uses and limitations of pharmacology in treating some forms of challenging behaviour, and the ability to liaise with relevant members of the team regarding the use and monitoring of medication

Knowledge of behavioural theory

- An ability to draw on knowledge of the range of reinforcement contingencies that shape or maintain behaviour, e.g.:
  - positive reinforcement: the contingent presentation of a reinforcing stimulus when the desired behaviour or act occurs
  - negative reinforcement: the contingent removal of an aversive stimulus
  - positive punishment: the application of a contingent response that is aversive to the individual (e.g. saying 'no' loudly and clearly)
  - negative punishment: the contingent removal of a reinforcing stimulus (e.g. the removal of positive reinforcement for a set time)

- extinction: achieved by the removal of the reinforcing stimulus, or by breaking the contingent association between the behavior and the reinforcer
- automatic/perceptual reinforcement: where the reinforcing stimuli are private or internal to the person (e.g. scratching is reinforced because it relieves the sensation of itching)
- stimulus control: where the probability of a behaviour occurring is made more or less likely by the presence of a particular stimulus

- An ability to draw on knowledge that causal and maintaining factors of behaviour may be complex and controlled by more than one reinforcement contingency
- An ability to draw on knowledge that the reinforcing powers of stimuli are influenced by personal, biological, historical and environmental contexts
- An ability to draw on knowledge that maintaining factors may vary across different forms of challenging behaviour shown by the same child/young person
- An ability to draw on knowledge that maintaining factors vary across contexts, e.g.:
  - bio-behavioural states (e.g. tiredness, hunger, pain)
  - preceding interactions (e.g. cancelled activity, criticism from others)
  - current context (e.g. noise, temperature, interventions made by ward staff)

Assessment

- An ability to shape the initial focus of the intervention by gathering background information about the child/young person, their environment and the behaviour that is challenging to others
- An ability to identify the child/young person's strengths (i.e. their skills, competencies, opportunities and resources)
- An ability to identify the child/young person's needs (including their developmental needs, the impact of their disabilities, gaps in resources (family/carers, services, etc.), and any mental and physical health needs)
- An ability to identify the child/young person's likes and preferences, and how they express them, and:
  - an ability to gather information from family/carers who are familiar with the communications of the child/young person (e.g. facial expressions or physical movements)
  - an ability to draw on awareness that children/young people with learning disabilities may be overly acquiescent, and to hold this in mind when helping them express their preferences
- An ability to gather information about the child/young person's developmental, social, educational and medical history, and their previous use of services
- An ability to assess the carer's (and if relevant, ward staff's) expectations of how the child/young person should behave, and discuss these expectations if they are not congruent with their stage of development and cognitive abilities

Gathering information about the challenging behaviour

- An ability to clearly specify and describe the challenging behaviours in ways that can be measured, and to ensure that all parties to the intervention share a common understanding of the specific problems that are being targeted
- An ability (where possible) to identify the onset of challenging behaviour, and how it was responded to when it first started
- An ability to use a range of methods to gather information about the challenging behaviour (applying knowledge of the strengths and limitations of these methods), including:
  - informant based approaches (semi-structured interviews, questionnaires, self-report accounts of past behaviour)
  - observational methods (direct and indirect, simultaneously or subsequently recorded)
- An ability to undertake behavioural observation[g]

Assessment of physical and mental health

- An ability to know when to involve other professionals to assess physical problems that may contribute to a child/young person's challenging behaviour (e.g. pain due to an ear infection, constipation, etc.)
- An ability to explore any relationships between challenging behaviour and psychiatric illness (e.g. where a challenging behaviour [such as aggression] is a response to hearing voices)

Ability to conduct a functional assessment

- An ability to conduct a comprehensive functional assessment, which includes:
  - the selection and definition of challenging behaviours as potential targets for intervention, considering:
    - their personal and social impact
    - the function of separate forms of challenging behaviour
    - the identification of functionally equivalent behaviours (i.e. behaviours that have the same function as the challenging behaviour, but are socially appropriate)
    - identifying sequences of behaviour that are maintained by an end-point that reinforces the whole sequence
  - a description of relationships between the occurrence of challenging behaviour, environmental events and bio-behavioural states
  - the generation of hypotheses concerning:
    - the contexts or settings in which the challenging behaviours occur
    - the operations which may either activate or abolish the contingencies maintaining the child/young person's challenging behaviour

[g] Competences associated with behavioural observation are in the relevant section of this competence framework.

- the nature of the contingencies maintaining the child/young person's challenging behaviours

- An ability to test hypotheses by monitoring behaviour in the child/young person's everyday environment (e.g. by using ABC Charts)[h]
- An ability to evaluate and refine hypotheses mid-way through the functional assessment, and prior to intervention
- An ability to identify when a hypothesis-driven 'experimental functional analysis' may be relevant (i.e. changing environmental conditions in an experimental fashion to examine the stimulus control of challenging behaviour [e.g. assessing rates of self-injury with and without different types of social interaction, such as praise or disapproval])

Ability to plan a behavioural intervention

- An ability to base the choice of interventions on a comprehensive assessment and on the functional assessment
- An ability to base the choice of interventions on knowledge of:
  - their efficacy (time to take effect and long-term outcomes)
  - complexity of implementation in the child/young person's current context (in terms of cost, time, skills required)
  - their generalisability
  - their acceptability
- An ability to gauge the motivation of the child/young person to make changes to their behaviour

Ability to develop and implement behavioural interventions

- An ability to ensure that intervention plans follow the principle of starting with behavioural interventions that are likely to be effective but are also the least intrusive and most acceptable

- An ability to identify any antecedent factors ('triggers') that are clearly linked to the occurrence of challenging behaviour, and whose removal is easily achieved, acceptable and appropriate
- An ability to identify biobehavioural states that make the challenging behaviour more likely to occur (e.g. tiredness due to a sleep disorders, pain or discomfort due to medical conditions) and to modify these (involving clinical colleagues where appropriate)
- An ability to identify when changing preceding activities will impact on the child/young person's responses to subsequent events (e.g. preceding an intervention by a rest period rather than vigorous activity)
- An ability to implement 'neutralising routines' that aim to eliminate the effects of established operations (e.g. introducing a brief nap to compensate for a poor night's sleep)

[h] Antecedents, Behaviours and Consequences: the use of ABC charts is described in competences on 'Positive behavioural support interventions' (11.4.).

- An ability to change the nature or context of concurrent activities (e.g. reducing an activity associated with challenging behaviour in favour of something less likely to evoke this response, and reintroducing the activity gradually)
- An ability to increase the child/young person's interaction using materials, such as visual stimulation or music, but to do so in a way that does not increase rates of stereotypy and aggression
- An ability to develop a curriculum or routine for the child/young person that is age-appropriate, meaningful, and takes into account their preferences
- An ability to reintroduce potential triggers for challenging behaviour if being in the presence of the 'trigger' will be of benefit to the child/young person (e.g. where the person acting as a trigger is a member of the team), using stimulus fading or embedding:
  - 'stimulus fading': the temporary withdrawal and gradual reintroduction of stimuli linked to challenging behaviour
  - embedding: changing relatively superficial aspects of the context in which the challenging behaviour occurs (e.g. introducing a rewarding activity, to help the child/young person maintain contact with an individual who previously evoked challenging behaviour)
- An ability to decrease challenging behaviour by differentially increasing the rate of other behaviours, e.g.:
  - differential reinforcement of other behaviour (building up other behaviours by reinforcing them, and ceasing reinforcement if the challenging behaviour re-emerges)
  - differential reinforcement of incompatible behaviour (e.g. with a child/young person who is eye-poking, encouraging play with a toy which makes sounds only when manipulated, making use of the toy incompatible with eye-poking)
- An ability to modify the maintaining contingencies of challenging behaviour (in conjunction with sufficient other opportunities for positive reinforcement) using:
  - extinction: removing the contingencies responsible for maintaining challenging behaviour (e.g. by not paying attention to the child/young person if this is reinforcing the behaviour)
    - an ability to ensure that extinction is applied consistently by all those with whom the child/young person comes in contact
    - an ability to manage the usual but temporary increase in the frequency of the behaviour in early stages of extinction process, and to assess any risk attendant on aggressive or self-injurious behaviours

Physical interventions

- An ability draw on knowledge that physical interventions will almost certainly be used on an informal basis within any service supporting children/young people with severely challenging behaviour
- Ability to apply knowledge of national and local policy guidelines on the use of physical interventions, and to ensure that when restrictive physical interventions are employed:

- they are in the best interests of the child/young person
- they are combined with other strategies which encourage the development of behaviours which are non-challenging
- they are individualised as part of a care plan, implemented by appropriately trained staff and subject to regular review
- they employ minimal force and not cause pain

Prevention of abuse

- An ability to identify when interventions are being used that constitute cruel, inhuman or degrading treatment or punishment, and to follow national and local guidance to report colleagues who are using such interventions
- An ability to identify whether challenging behaviour is a response to neglectful or abusive environment or relationships, and where this is the case to intervene to protect the child/young person

Ability to evaluate outcomes

- An ability routinely to evaluate interventions for their effectiveness, considering:
  - the severity, frequency and duration of the target challenging behaviour, repeating baseline measures in order to identify whether change has taken place
  - the child/young person's quality of life and range of opportunities
  - the child/young person's development of positive skills
  - the wellbeing and satisfaction of the child/young person, and those in close contact with them
- An ability to assess whether the intervention conducted in one context has had any impact on behaviour in other contexts

11.4. Positive behavioural support interventions

Knowledge

- An ability to draw on knowledge that positive behavioural support (PBS) is a framework for providing long-term support to individuals who have or may be at risk of developing behaviours that challenge, and that:
  - it is often employed to help people with a learning disability and/or autism, including those with mental health conditions
  - it is based on an assessment of the social and physical context in which the behaviour occurs, and used to construct socially valid interventions that enhance quality of life for the person and their carers
- An ability to draw on knowledge that behaviour support plans can be used to understand and manage behaviour that challenges in order to reduce the behaviour, increase the service user's safety and facilitate a safe discharge

- An ability to draw on knowledge that behaviours that challenge are a form of communication, whose meaning and function need to be understood to help reduce them

- An ability to draw on knowledge that understanding behaviours that challenge requires identification of its antecedents, the behaviour itself, and its consequences (Antecedents, Behaviours and Consequences [ABC] model)
- An ability to draw on knowledge that a PBS plan should incorporate behavioural strategies that fall into one of three key areas:
  - primary proactive strategies, which aim to reduce the likelihood of the behaviour occurring
  - secondary strategies, which manage the behaviour at the early stages of escalation
  - reactive strategies, which manage the behaviour when it reaches crisis and no other strategies have worked
- An ability to draw on knowledge that a PBS intervention plan should support the development of new skills that serve the same function as the behaviour or enable the person to cope more effectively with situations they find hard to manage

- An ability to draw on knowledge that all practitioners in regular contact with a person need to understand and accurately implement the PBS plan for every person being supported

Assessment

- An ability to develop an assessment that includes a clear description of the behaviours of concern (including classes or sequences of behaviour that occur together), based on:
  - collaborative stakeholder involvement (e.g. children/young people [where appropriate], family/carers, multidisciplinary colleagues)

- multiple sources of information (e.g. the service user, feedback from family/carers/staff, clinical notes, clinical assessment)
- multiple methods pf data collection (e.g. structured interviews, using rating scales, direct structured observation)

- An ability to identify events, times, and situations that predict when the behaviour will and will not occur across the person's full range of typical daily routines
- An ability to identify the consequences that maintain the behaviour (i.e. the purposes or functions that the behaviour appears to serve for the person)
- An ability to develop summary statements that describe specific behaviours, the situations in which they occur and the consequences that may maintain them, and:
  - an ability to collect observational data that support the summary statements that have been developed

- An ability to develop a behaviour support plan based on the assessment and formulation
- An ability to specify the primary, secondary, and reactive strategies
- An ability to regularly review and revise the plan to ensure it reflects the service user's current needs, interests, health, and well-being, as well as risks, by:
  - regularly seeking out further assessment information about the behaviour
  - updating and/or reformulating the formulation the behaviour
- An ability to identify any barriers to implementation and ways that these can be managed

Intervention

- An ability to implement primary strategies that aim to help the person predict, understand and control their environment, and prevent the behaviour that challenges from escalating, e.g.:
  - minimising triggers for the behaviour (e.g. scheduling meaningful occupation for much of the time)
  - modifying the environment (e.g. changing rooms to a quiet room)
  - proving opportunities to acquire skills that are functionally equivalent to the behaviour that challenges, or which or help to manage potential triggers
  - helping the person communicate their needs in a more functional way

- An ability to implement secondary strategies to manage the behaviour when it starts to escalate, e.g.:
  - calming approaches aimed at de-escalation (e.g. calming talk, actively listening to the issue)
  - environmental modifications (e.g. reducing sensory load by moving the person away from big groups)
  - coping strategies (e.g. shifting the focus by helping the person engage in meaningful activities)

- An ability to implement reactive strategies as a last resort when the behaviour which challenges has not reduced despite the implementation of primary and secondary strategies, e.g.:
  - non-aversive reactive strategies (e.g. diversion/distraction)
  - crisis management (e.g. implementing restrictive practices such as seclusion or physical restraint)

- An ability to systematically monitor the implementation and effectiveness of the support plan and to review and adapt it in the light of this evaluation

11.5. Managing adverse peer influence (contagion)

Adverse peer influence takes place when an inpatient peer group is engaged in destructive or self-harming strategies, and where these behaviours spread among the group, creating an unhelpful situation that needs to be addressed.[i]

In the field, the word 'contagion' has been used to describe this process, and so is retained here. This term is usually unhelpful, because it risks pathologising the normal process of social influence among young people: being open to strong peer influence is developmentally appropriate, is part of healthy teenage behaviour, and is usually positive. It is only when there are adverse impacts that it becomes a matter for concern.

- An ability to draw on knowledge that (in an inpatient unit) adverse peer influence (contagion) refers to the risk of young people:
  - learning (and adopting) unhelpful behaviours from other young people (such as self-harming)
  - making unhelpful friendships in which they pick up on other young people's difficulties
- An ability to draw on knowledge that young people who may be particularly vulnerable to adverse peer influence include those:
  - who have an eating disorder, usually by making comparisons with others (e.g. competing to be thin)
  - who self-harm

- An ability to draw on knowledge that there is some evidence that the likelihood of adverse peer influence can be reduced by:
  - ensuring that staff are consistently available to, and able to engage and communicate with, young people in the unit
  - detecting and responding to unhelpful behaviours, as part of maintaining a positive therapeutic milieu
  - taking a non-pathologising and non-blaming approach, and:
    - responding to self-harming behaviour in a compassionate, non-judgmental and least restrictive way that is in proportion with the level of risk
  - providing regular, structured activities that the young person chooses to engage in throughout the day and in the evening (acting both as a distraction from troubling thoughts, reducing a sense of isolation and fostering positive relationships with others)
  - staff modelling prosocial interactions with each other and young people to help young people learn how to manage difficult and unhelpful social situations

- An ability to describe and discuss the risks of adverse peer influence with the young person (and when appropriate, parents/carers and community teams)

[i] The social processes described in this section are more commonly observed with adolescents than among younger children.