Improving the lives of people who exhibit challenging behaviours is an important part of the learning disability nurse’s role (Department of Health (DH) 2006, 2009, Sturmey 2009) and, to this end, many experts in the field advocate the application of positive behavioural support (PBS) (Carr et al 1999, Allen et al 2005, McLean et al 2007, Royal College of Psychiatrists (RCP) 2007). For PBS interventions to succeed, the participation of carers and nurses is essential (Carr et al 2002) but some services are reluctant to adopt the model (RCP 2007, Allen 2009).

This article discusses a development project undertaken at an assessment and treatment inpatient service for adults with learning disabilities who present with challenging behaviours. In this service, interventions to deal with problematic behaviours are guided by the standards set out in the report Challenging behaviour: a unified approach (RCP 2007) and delivered according to a framework devised by Carr et al (2002). The multiprofessional team understand challenging behaviours as a product of the interaction between individuals and their environments (Harris et al 2008), but a problem remains in translating the recommended interventions to front line staff.

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In highlighting this problem in other services, Baker and Shepard (2005) refer to the apparent reluctance of services to embrace the PBS model of care, the primary goal of which is improving the quality of life of people with learning disabilities rather than reducing the incidence of their problematic behaviours (Carr et al 2002). Staff who adopt this model are expected to develop proactive strategies, which are intended to produce changes over time to prevent problematic behaviours – such as environmental changes and the individual’s skills development – from occurring (LaVigna and Willis 2005), and reactive strategies to manage such behaviours when they occur.

To explore the reluctance of front line staff to implement PBS intervention plans, the author interviewed the staff during informal discussions and team meetings. The three main objections to intervention plans identified were:

- Time constraints, which limit the opportunities of staff to consult individual’s intervention plans.
- The greater importance of other clinical tasks, such as risk assessments.
- Former intervention plan was too lengthy which made it difficult to recall all its content.

As a result of these discussions, the author drew up a behaviour intervention plan in which these objections were taken into account. The multiprofessional team understand challenging behaviours as a product of the interaction between individuals and their environments (Harris et al 2008), but a problem remains in translating the recommended interventions to front line staff.

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Figure 1 Traffic light system for proactive strategies to reduce incidence and duration of challenging behaviours

‘Maintain’

**Signs**
Client is smiling, laughing, looking relaxed, talking to others and taking part in activities.

**Proactive strategies**
Staff should ensure the structure of client’s day is maintained. Implement service plans, teach client coping skills. Review earlier events.

‘Rumbling’

**Possible stressors**
Environmental triggers can include open-ended questions, unfamiliar people or environments, and unexpected or unmet demands. Personal triggers can include discomfort, misunderstanding, boredom and uncertainty about friendships.

**Signs**
Agitation, swearing, staring, pacing, moving away from other people or objects, reporting signs or symptoms of injury or illness.

**Proactive strategies**
Staff should remove environmental stressors, speak to the client calmly, encourage client to use coping skills such as deep breathing, and introduce diversions such as sports or games. If the ‘rumbling’ period continues, staff should ask the client to spend time in his or her bedroom, and alert staff and ensure environment is safe.

‘Rage’

**Early signs**
Intensified agitation, shouting, banging on furniture, intruding on personal boundaries, ruminating on bad experiences, throwing objects aimlessly.

**Later signs**
Physical aggression, use of objects as weapons.

**Reactive strategies**
If rage occurs staff should tell the client to go to a safe, non-communal area. Staff should use restraint as a last resort and only after assessing what physical interventions are safe for the client. They should de-escalate the interventions as soon as it is safe to do so.

‘Recovery’

**Signs**
No facial expression, client appears ‘numb’. These signs may last for hours or even days.

**Proactive strategies**
Give client space and time to calm down.
each of which is described in terms already familiar to service staff: ‘maintain’, ‘rumbling’, ‘rage’ and ‘recovery’. A simplified and generalised version of the cover page is shown in Figure 1.

Before the PBS intervention was introduced, service staff tended to adopt reactive strategies, such as the use of restraint or administration of medications, in the management of service users to reduce the risk of harm to clients and staff, rather than proactive strategies that can prevent the onset of challenging behaviours in the first place. This need to reduce risk is emphasised by the mandatory prevention and management of violence and aggression training programmes undertaken by all staff who must respond to potential restraint situations. The tendency to administer medications when challenging behaviours are exhibited was surprising given that the Healthcare Commission (2007) has raised concerns about such use of medications, and Brylewski and Duggan (1999) have highlighted the lack of evidence in the efficacy of psychotropic medication.

To try to overcome these problems, the author devised a ‘traffic light’ system, in which ‘maintain’ is indicated by green, ‘rumbling’ and ‘recovery’ by amber, and ‘rage’ by red. This helps staff to distinguish between reactive strategies, adopted only during the ‘rage’ phase, and proactive strategies adopted at other times. Thus, proactive strategies should be the first step of all PBS interventions.

Finally, individual daily activity planners were drawn up to illustrate the importance of ‘personalising’ each service user’s environment in accordance with the service user’s choice and needs.

**Results**

While the project focused on helping front line staff to implement the recommended interventions, the effectiveness of the interventions in improving the quality of service users’ lives was an important consideration. Audits of service user’s participation in preferred recreational activities were undertaken and the results expressed in graphic form. The graphs in Figure 2, below, and Figure 3, page 34, show patient A’s and patient C’s participation in activities increased slightly when the intervention was introduced at the beginning of the audit.

Audits of the frequency of challenging behaviours were also undertaken, and the graphs in Figure 4, page 34 and Figure 5, page 35, show that patient A and patient C tended to exhibit such behaviours less after the intervention had been introduced.

Measures of social engagement represent only one aspect of an individual’s quality of life, however and assessments should also take into account, for example, social relationships, community integration, and the extent of self-determination and satisfactions. Using measures devised by Ager (1990), and Marshall and Willoughby-Booth (2007), staff can make more holistic assessments.

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**Figure 2** Patient A’s engagement in recreational activities between August 2010 and January 2011

![Graph showing Patient A's engagement in recreational activities between August 2010 and January 2011](image-url)
Further evaluation of the intervention is needed to explore whether it improves service users’ quality of life and reduces the incidence of challenging behaviours. Furthermore, a quality assurance system is required to ensure staff are capable of complying with the support plan at all times.

Such management system may include competency-based training and the monitoring of a consistent implementation (LaVigna et al 2005). It is evident, meanwhile, that proactive approaches can be written as separate, accessible steps.

**Conclusion**

The success of PBS interventions, like other behavioural approaches, depends on how it is incorporated into a natural context, where other environmental variables can come into play (Carr et al 2002). To determine the effect of the proposed support plan on an individual's quality of life, therefore, independent variables must be isolated and confounding variables controlled, and these processes could in turn have the effect of removing the service users concerned from their natural contexts. No one lives in an experimental vacuum or can be free of their social environments, and it would be unethical to isolate these variables simply to measure the experimental effectiveness of the current support plan.

The project discussed in this article involved front line staff undertaking PBS interventions for the first time. They had never associated challenging behaviour interventions with enhancing a client’s quality of life before, and it is hoped that their experiences with the project will lead them to alter their expectations of service users.

It is also hoped that service staff will acknowledge the role of psychologically informed practices and proactive strategies in the learning disability nursing field, to enhance clients’ treatment outcomes.
This project has indicated the importance of assessing client's quality of life but further measures are needed to ensure the proposed support plan meets all its aims, including analysis of staff uptake of proactive approaches.

However, the current support plan emphasises the responsibilities of frontline staff and the support they can offer to individuals and show that the support plan can be developed into a socially valid intervention.

References


