Challenging behaviours: Back to the basics.

I have spent over 20 years of my working life supporting individuals who challenge services. As a clinical psychologist I have always been acutely aware that there has been a growing move towards a mechanistic approach to managing these difficulties. It also took me a considerable period of time to realise that professionals can be part of the problem. They often make complex solutions to difficulties that do not require these as such. I will write this short article from the essential premise that we need to concentrate on what was colloquially described as 'the basics'.

In the mid 1980's I was a newly qualified clinical psychologist, trained in behaviour analysis; I even possessed a briefcase for a short period of time (I should stress that this was a necessary part of the unofficial uniform at the time). To complete my rite of passage I wrote an article on functional analysis! This was a very cerebral piece of work which I believe very few people took the trouble to read. But, my first real lesson in 'the basics' came within the first year. I was working in a house for a number of people who had been resettled into the community from a local institution. It is no surprise that many of these individuals were labelled as very challenging. Years of control by often well intentioned carers had led to a situation that the few pleasures in their life (food and drink) were restricted. Given their extremely traumatic histories it was not surprising that food and drink were a major issue. I remember when one staff member complained that every time she 'unlocked' the kitchen door service users would almost charge past her. One young man even accessed a freezer and attempted to eat frozen meat.

I realised very early on that the staff wanted me to 'sort these problems'. Was it all about ABC charts and functional assessment? Or should I attempt to understand the person by thinking carefully about the person's life? The latter started to make more sense to me. Somebody with an intellectual disability who lived in a large communal setting probably would have become obsessed with food. I then started to ask myself a basic question. *What would it be like to be this person?* The first basic rule was to spend time 'being' with the person and try to 'walk in their shoes'. I did not reject all aspects of behaviour analysis; I merely placed it in a compartment. Since this time I have met many gifted behaviour analysts who apply Positive Behaviour Supports in a systematic and rather mechanistic manner. I think that there can be too much analysis at a distance and not enough time spent directly with individuals developing a basic understanding of their world.

My second basic rule evolved very early on in my career. It became more apparent to me that the people I was supposed to support tended to be placed in 'analytic goldfish bowls'. Carers often were a cause of many episodes of challenging behaviour (mostly inadvertently). Most of my information came from these people. Often the most negatively vocal individuals had poor relationships with the service user in question. In many cases these people had real difficulties in taking the service user's perspective. So my second basic rule was '*view staff as sometimes part of the problem'*. This could be reframed very easily in a positive manner; if carers can be part of the problem they can also be part of the solution.

The third learning experience for me was that communal care is not for everyone. So many times I would be asked to fix behavioural difficulties and tried to ignore the fact that these individuals lived with individuals with similar difficulties. As an analogy, if you have a

problem with your weight, will you learn to control your weight living with other people with similar problems? Putting it more bluntly do distressed people improve by living with others who are similarly distressed? I still witnessed traumatised individuals herded together with other people with issues. My third rule involves understanding that crowded environments do not lead to individual supports. *People who have their own supported areas and ideally their own front door have fewer difficulties.*

The use of drugs to control behaviour is still at epidemic levels, even though the evidence for their use is very scant indeed. One of my basics rules is that we cannot support people who challenge and ignore the over medication of this population. For me the rule is clear cut, drugs administered to individuals are often requested by stressed carers. So let us teach these individuals to make fewer of these requests. Even if I became angry or agitated on a weekly basis; I would not find it acceptable to be placed on medication. *So let us make medication the exception rather than the rule.*

In the last 10 years I have worked with many individuals who are supported by large staff teams. In the bad old days of the institutions these were referred to as 'specials'. I always respect the view that people need to be kept safe, but, I do feel very strongly that this approach to safety does not empower service users. In addition, these types of schemes actually reduce staff confidence and to some extent reduces their ability to take risks. That is, they feel that they need this level of support to take risks. My last golden rule involves the development of risk taking cultures. The mantra *'take a risk every day'* is my repetitive advice. We learn through experience. A good term from cognitive psychology is 'crystal ball gazing'. Staff teams will sometimes develop a culture where they resist risk taking. When a new activity is suggested it is usually followed by armchair predictions from staff. That is 'I think that would not work' or 'bad things will happen if we try 'X' or 'Y'.

Cultures that support people in a person centred way develop a positive attitude to crisis management. There is an acceptance that crises will happen from time to time. Understanding the reasons for these crises is part of the learning process. Despite what we think, things do not happen completely 'out of the blue'. Even if we understand why the individual behaves in the way he or she does we may not be able to prevent all incidents of challenging behaviours. In these circumstances people need to *'Ride out the storm'.* This can be scary for people and practical support is often required. But, the storm analogy is clear. We cannot change bad weather but we can learn to adapt to it.

Even when we ride out storms it is useful remember that the people we support often have histories of abuse and trauma. My colleague David Pitonyak provides useful insights into trauma. It is important to understand that *if we view someone as traumatised it should influence how we manage support them.*

Throughout my career I have been involved in the development of a low arousal approach. This involves a low key response from carers to manage challenging behaviours. In essence it can be reduced to one very basic idea. *Be tolerant and respectful of the person and avoid punitive responses.* This is an easy principle to state but, very difficult to apply in practice. I am often reminded of the old saying 'you can take a horse to water, but, you cannot make it drink'. I believe passionately that our job is to support and empower people and this involves self reflection, understanding and tolerance. It is not about 'us' it is about 'them'.

Recap of the basic rules

What would it be like to be this person?

View staff as sometimes part of the problem and the solution

Let us make medication the exception rather than the rule.

People who have their own supported areas and ideally their own front door have fewer difficulties

Take a risk every day

Ride out storms

if we view someone as traumatised, it should influence how we manage support them.

Be tolerant and respectful of the person and avoid punitive responses.

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