

College of Occupational Therapists



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Dear Dr Bush and Dr Banks,

Re: Challenging Behaviour: A Unified Approach.

Further to the joint response which we issued with the RCN on 19/12/07 we would like to provide you with a more detailed response to the document from the College of Occupational Therapists (COT) and its members. COT represents over 28 000 occupational therapists (OTs) and support workers who are working or studying across the United Kingdom. Occupational therapists are employed in the NHS, local authority social services and housing departments, schools, primary care settings, private health and social care providers.

In general we feel this document would have been improved with the inclusion of OTs in its creation and consultation. OT members were disappointed not to have been included as it seeks to be a consensus position statement on best practice, incorporating multiple theoretical perspectives. We agree that effort will need to be made to bring together different models of practice. The COT has fully supported New Ways of Working and suggest this may be a banner under which to embrace more collaborative working in the future. As the document intends to provoke debate, review and response, we have collated the views of OTs in conjunction with the COT Specialist Section –People with Learning Disabilities.

We agree that different views on this topic exist and to balance the purely behavioural paradigm presented in the document, we would like to present some additional views. It is hoped that with improved understanding we will be better able to negotiate and deal with the complexity of working in this area.

Human occupation refers to engaging in work, play or activities of daily living within a temporal, physical and socio-cultural context. Occupational performance covers four key areas: volition (what motivates and interests the person), habituation (their daily roles and routines), performance (motor and process skills for successful task outcome) and the environment. These four areas are used to provide the basis of OT assessment and intervention.

In many services people with a learning disability spend large amounts of time in impoverished environments doing nothing and are thus occupationally deprived. Engaging in meaningful activity can have a significant impact in reducing levels of behaviour that appear challenging. When an individual is identified as being occupationally deprived, with behaviours associated with boredom and a lack of stimulation, interventions will include maintenance and development of skills, engagement in meaningful activities and support to carers to provide more stimulating, richer daily routines and environments.

Although occupational therapy is mentioned, the document makes very little mention of the benefit of highly specialised occupational therapy interventions or of sensory integration. Sensory processing is the ability to organise sensory information for use. It enables individuals to perform functions of daily living, adapt to changes and challenges within the environment and to remain calm and alert despite challenges. Effective sensory processing can reduce the duration of challenging behaviours, improve functional behaviour and lead to enhanced task outcomes.

The list of underlying causes and individual factors in considering challenging behaviour does not include lack of meaningful occupational engagement, sensory processing dysfunction or sensory hypersensitivity. Much work has been done by OTs in the area of autism successfully using the Intensive Interaction approach which seeks to use a clinician's own body language to facilitate communication, shared activity and emotional engagement. This normally leads to a reduction in behaviours seen as challenging. Assessment should therefore not just involve medical, psychological and psychiatric factors but also occupational and sensory processing factors. Occupational therapy interventions are also part of proactive strategies to work with individuals with challenging behaviour.

The document asserts that challenging behaviour is a social construct. However, no mention is made of the social model of disability. We therefore feel that more attention is required within the document to deal with assessment of and interventions targeted at the socio-cultural environment. Although we support the recognition of stigma as a major disabler for people, the document is too focused on the individual with 19 pages devoted to changing the individual and only 10 for changing the environment. Thus, although the document states that the attribution of responsibility for behaviours has gravitated towards the individual, the document seems to perpetuate this

As a social construct, alternative definitions of 'challenging behaviour' can be considered. The definition used in the document excludes the person and solely talks about their behaviour. The term 'challenging behaviour' can unfortunately result in adversarial staff reactions which then reinforce unhelpful 'them' and 'us' attitudes refocusing attention on coping with the behaviour rather than the underlying causes. Some clinicians working with those with autism prefer the term 'distressed behaviour' which draws attention to the sensory distress and overload with which they are struggling to cope.

The document describes individual risk factors as communication difficulties or a history of abuse but these are also social risk factors. In addition risk assessment should include identification of when and where the behaviours do not occur of which there is no mention.

Communication interventions frequently focus on 'functional communication' and overlook the second component of interaction; monitoring how the other person in conversation feels and developing emotional engagement through the use of body language. When using imitation the capacity to respond socially increases which can in turn decrease distressed and challenging behaviours. Communication passports should be compiled and used of which there is no mention.

We suggest that all individuals exist wholly within and surrounded by their environment and not as your diagram portrays. Many OT models show exactly this relationship and also highlight different aspects of environment such as economic and political influences. In addition, LaVigna and Willis have a multi-elemental model which considers a person's behaviour within the environment and is an excellent basis from which different professionals can cooperate.

OTs are experts at recognising the problems that occur in 'poor fit' of environment and person and agree that poor environmental fit can cause difficulty for individuals. Analysis of why this occurs is obviously a key part of understanding the people we work with, for example through an analysis of environmental demands, stressors, staff expectations, institutional practices and the individual's skill level.

It should be acknowledged that stress can be the result of boredom, inactivity and under stimulation as much as over stimulation and that individuals are sometimes trying to increase arousal. People with autism are often trying to maintain coherence in what they perceive as a chaotic sensory environment. We support the idea of increasing the capacity of people's environments in order to facilitate appropriate interaction with individuals but believe that this will usually require additional resources. We also agree that the term 'challenging behaviour' should not be used as diagnostic term in payment by results and that more outcome measures need to be developed in this area.

We support the assertion that people sometimes feel powerless in their environment and that advocacy is required to change this. Changing systems can feel much harder than trying to change the individual yet it should be a vital part of multi-disciplinary work. If we are concerned with system change, introducing interventions one at a time may be counter-productive as resistance can build in one part of the system thus preventing change in another. Thus clinicians sometimes abdicate their responsibility to young adults in particular by waiting for the rest of the family to be ready for change, rather than moving towards the service user's goals.

The document successfully highlights that although a range of services are needed, this does not exist, leaving service users, families and clinicians in a difficult situation. We therefore welcome the section about creative commissioning of services and the problems of operating with market systems where expert staff may cost more. It will thus be important for all members of the multidisciplinary team to be able to provide evidence of outcomes.

It should be noted that the term 'functional assessment' has a different meaning to that used in the document for occupation therapists who carry out functional assessment of occupational performance. In addition the word 'formulation' is specific to medical and psychological perspectives. Thus the language of the document could have been more inclusive to all members of the multidisciplinary team.

The section about assessment of physical and psychological disorders makes no reference to reproductive, menstrual or sexual difficulties. Consideration of pharmacological interventions should include possible side effects of medications and the impact they will have on the individual's occupation performance. Positive programming is centrally concerned with engaging people in meaningful activity and activity planning which are main elements of OT interventions, as are expanding ranges of valued activity, community links and preferred social participation.

We are pleased to see that having a good quality of life is acknowledged as a valid aim of services as this receives insufficient attention and will lead to consideration of how people are meaningfully occupied. However, planning realistic futures when considering quality of life should not be at the expense of creativity or hope. We do not agree that challenging behaviour is necessarily a life long problem and clinicians working with Intensive Interaction feel that even older individuals have the capacity to change.

We are concerned that the document describes support staff as being unable to carry out interventions due to lack of training yet have made no acknowledgment of the valuable work they do provide and of the additional problems they face such as low numbers of staff, work load, conflict of duties, low levels of pay, morale and recognition. Unqualified does not necessarily mean unskilled and expertise can be developed through experience rather than only through professional qualification.

We support the provision for more training for support staff but feel that qualified staff too can benefit from additional learning rather than being the sole holders of knowledge which they pass onto others. Under the Mental Capacity Act, all staff need to be able to assess capacity, not just clinicians and all staff should be trained under the 'Promoting safer and therapeutic services' framework.

The use of the analogy with insulin-dependent diabetes as a way of explaining life long interventions seems unusual and unnecessarily medical in a document which attempts to consider the social construction of behaviour. It also represents coping via restrictions to diet and life style while the document aims to move away from overtly restrictive environments.

We agree that much work involves strengthening family relationships and providing parents with enough support and information through periods of exhaustion and fear. However, there are times where some family relationships hinder development or are at worse, abusive. The clinician's responsibility is to take an advocacy role and attend to the legal systems that exist for vulnerable adults to gain declaratory relief via the courts. At times, services and parents are over protective and this prevents people moving onto age appropriate opportunities in the company of peers. Thus infantilisation inhibits transition from childhood to adulthood. As people with learning disabilities need to be treated in age appropriate manner, guidelines therefore need to be tailored using a life span perspective, rather than simply applying one set of principles to all service users.

We hope our comments can contribute to on-going multidisciplinary work in this area and hope that we will be invited to join future work in this area.

Yours sincerely,

A handwritten signature in black ink, appearing to be 'Genevieve Smyth', with a long horizontal line extending to the right.

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COT would like to acknowledge the valuable input to this response from:

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