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Evaluating an assertive outreach team for supporting clients who present behaviour that challenges.

Accessible Summary

- Some people with a learning disability have behaviours that are hard for services to cope with.
- This paper looked at a team that tried to help these people to stay in their own homes instead of having to move to a different area.
- The paper looked at the good things about the team and things that could be better.
- We found that the team helped the services to support people in a different way so that there were less behaviours which were hard to manage.

Keywords: *challenging behaviour, learning disability, community care*

Summary

This paper evaluates an Assertive Outreach Team (AOT) which aimed to help support people with a learning disability who displayed challenging behaviour, in their own environment. The service was evaluated using Maxwell's Multi-dimensional Quality Evaluation Model (Maxwell, 1984), which recognises that different stakeholders in a service are likely to focus on different indices of quality including: effectiveness, efficiency, economy, equity, access to services, appropriateness and social acceptability. The main strengths of the team were staff skills and professionalism, whereas the most frequently cited weaknesses centred around issues of liaison, communication and the role and remit of the team.

Introduction

Providing good quality support for clients who challenge presents a dilemma for many services. The preferred option is to support clients in their local community, yet presenting with challenging behaviour increases the possibility of being moved to an out of area service (Mansell, 2007, RCPsych, BPS & RCSLT, 2007, Mansell et al., 2006, Mackenzie-Davies & Mansell, 2007). One of the most frequently cited reasons for this is the lack of suitable local placements which would adequately meet the needs of this client group (Brown & Paterson, 2008, Beadle-Brown et al., 2006).

While specialist units offer one means of responding to placement breakdown and offer an effective service for some clients (Rowland & Treece, 2000) they are often expensive (Hassiotis et al. 2006), and may not always offer an effective long term solution. For example, interventions devised and implemented in a specialist environment may not successfully generalise to a community setting, resulting in difficulty discharging clients back to their local areas. Mackenzie-Davies & Mansell, (2007) cite figures from the Healthcare Commission (2006) which indicate that 25% of individuals with a learning disability remained in specialist units despite their treatment having been completed.

As many out of area services specialize in meeting the needs of particular client groups, in this case those who challenge, the severity of the behaviour may actual increase in some cases, through clients copying the behaviour of others or through a chain reaction of one client triggering the behaviour of another (La Vigna & Donnellan, 1995). In

addition, the relocation from one service to another can, in itself, result in emotional and behavioural upset for the individual (Van Minnen & Hoogduin, 1998).

Despite these disadvantages, specialist service provision continues to grow. Research in Scotland suggests that there may be as many as 500 individuals with a learning disability in out of area placements (Brown & Paterson, 2008). Many authors argue that this development reflects a failure on the part of local services to develop a broad and comprehensive range of local services which can adequately meet the needs of all clients (Beadle-Brown et al., 2006). In addition, it is argued that a more systematic approach to the commissioning of services for people with a learning disability is required to ensure good value and effective service provision (Campbell, 2008; Mackenzie-Davies & Mansell, 2008).

A number of barriers to the development of local services for individuals with behaviours which challenge have been proposed. While behavioural interventions have been shown to be effective (Lindsay, 2001), research has indicated that other approaches such as medication and restraint are more likely to be used, due to factors such as staff knowledge, with many staff lacking knowledge about behaviours which challenge (Emerson et al., 2000) and feeling ill-prepared for their job (Edwards, 1999).

Challenging behaviour services also frequently face high rates of staff turn-over which can lead to inconsistency and failure in applying behavioural approaches (Allen & Warzak, 2000). As behaviours can re-emerge if consistency is not maintained there is a

need to monitor the effectiveness of interventions over time and to intervene quickly if the situation deteriorates (Ball et al., 2004). This is difficult in services with high staff turn-over.

Services need to respond to any challenging behaviour by developing a range of 'capable environments' (RCPsych, BPS & RCSLT, 2007) where carers and professionals have the relevant knowledge and skills and are able to work collaboratively to respond to challenges in a positive, person centred way. For any local service to be successful it must, therefore, have the following: a responsive staff team with the skills, knowledge and time to develop and provide skilled assessments and interventions; provision of support and training to local services to enable change to be maintained in the long term and provision of evaluation and monitoring over time, in order to intervene quickly if required (Allen et al., 2006). The current study outlines a one year evaluation of an Assertive Outreach Team (AOT) and the extent to which it was able to meet these requirements.

Background to the service

The service was based in a predominantly rural area of Scotland, which has a population of approximately 100000 people. There had never been a large institution for people with a learning disability in the area. The only inpatient resource which was exclusively for this client group had been a small five-bedded assessment and treatment unit for those who presented with severe challenging behaviour. This unit was staffed by a mix of qualified and unqualified nursing staff and had input from the community learning

disability team. In 2001, there was a service plan to reduce the use of in-patient beds (while retaining actual bed numbers), allowing the staff to carry out more assessment and treatment in the clients' environment. This model was piloted for one year and the subsequent evaluation (Powell et al., 2003) found that the outreach model enabled an increase in the number of people accessing the service, reduced the average period of delayed discharge by a number of months and led to improvement in 70% of those seen (the remaining 30% showed no change). Despite, these positive outcomes, the pilot project was suspended following the admission to the unit of a person who required very high staff support. The AOT was subsequently established a number of years later, when the NHS in-patient unit was finally closed.

The service was named an Assertive Outreach Team to reflect similarities with mental health teams which provided intensive input to individuals with severe, long-term difficulties. The remit of the AOT was to provide assessment and support to individuals who were in danger of their community placement breaking down because of severely challenging behaviour. In addition, the team aimed to prevent delayed discharge for individuals who had to be admitted to out of area in-patient facilities. The AOT was co-located with the community learning disability team (CLDT) and referrals to the AOT were made via the CLDT. When the service was initially set up it was staffed entirely by nursing staff who had previously worked within the in-patient unit.

Method

The evaluation was structured using Maxwell's Multi-dimensional Quality Evaluation Model (Maxwell, 1984), which recognises that different stakeholders in a service are likely to focus on different indices of quality. This model has been used previously to successfully evaluate a learning disability service (McKenzie et al., 1999) and comprises of seven dimensions against which the quality of any given service can be measured. These are: effectiveness, efficiency, economy, equity, access to services, appropriateness and social acceptability. Table 1 provides a definition of each dimension, an outline of the indicators relating to each dimension and the method used for measurement. A number of factors may contribute to more than one dimension, for example, providing staff training may impact on both the effectiveness of a service, by promoting greater adherence to guidelines and efficiency, by reducing the amount of time required to teach staff basic principles.

Ethics

Ethical advice was sought from the local ethics committee. Ethical approval for the project was not required as it was deemed to be a service evaluation.

Participants

The participants were AOT staff and service managers (6), members of the community learning disability team (11) and staff from support services who had received input from the team (7).

Measures

The majority of the information for the evaluation was obtained from the existing AOT data, which was routinely collected and collated by the service. In addition, two questionnaires were designed for the evaluation, one for AOT staff and the other for referrers and for services which had received input from the AOT.   Both questionnaires asked the following (all ratings were on a 5 point likert scale):

- Whether joint work had taken place in relation to an AOT referral and if so how useful this was (1= useless and 5= very useful)
- Whether liaison had taken place in relation to an AOT referral and if so how good this had been (1= very poor liaison and 5 = very good liaison).
- To rate the usefulness of the input in relation the challenging behaviour (1=useless, 5= very useful).

Referrers and support service staff were also asked to rate how quickly the AOT had responded to the referral (1=very slowly and 5=very quickly), how satisfied they were with the input from the AOT (1=not at all satisfied, 5 =very satisfied) and to describe their understanding of the AOT referral route. AOT staff were also asked to rate their job satisfaction (1= very dissatisfied and 5= very satisfied).

Procedure

Following discussion at a learning disability service meeting, where the nature of the evaluation was explained, the questionnaires were put in the mail slots of the AOT staff and CLDT referrers. Participants were asked to return these to the mail slot of the first author. All responses were anonymous and confidential. Questionnaires and a covering

letter, explaining the purpose of the evaluation were sent by post to key workers who supported clients who had received input from the AOT. Participants were asked to return the questionnaires to the first author. A total of 47 questionnaires were distributed and 24 were returned, giving a response rate of 51%. Mean ratings were calculated for each of the questions which were measured on a likert scale. Responses to questions relating to the strengths and weaknesses of the AOT were categorized according to broad themes (see Tables 2 and 3 for examples) and the number and percentage of respondents who referred to each of the themes was calculated.

Results

Clinical effectiveness

a. Appropriateness of referrals

At the time of the evaluation, the service had received 30 referrals (mean per month = 2.1) all of which were considered to be appropriate by the AOT staff. Many individuals displayed more than one behaviour which challenged, with the most common reason for referral being for verbal or physical aggression (18), followed by self-injurious behaviour (6), anti-social behaviour (5) and sexually inappropriate behaviour (1). The average period of input from the team was 7.9 months per client (range = less than 1 month to 26 months).

b. Outcome of referrals

Fifteen cases had been closed at the time of the evaluation and all of these were judged by the AOT staff to have had a significant reduction/elimination of challenging behaviour

at the time of discharge. Of the 7 respondents who supported clients who had received input from the team, 5 considered that it had resulted in a reduction in the challenging behaviour, while 2 felt it had not. The mean rating for the usefulness of the input was 3.4.

c. Delayed discharge

There had been no delayed discharges since the establishment of the AOT.

d. Joint working and skill mix

The AOT originally comprised of 1.8 Charge nurses and 5.8 Staff nurses. At the time of the assessment five (17%) of the AOT cases also had involvement from at least one other member of the wider community learning disability service.

e. AOT staff training

All of the AOT staff had received some form of training on the assessment and treatment of challenging behaviour during their nurse training. In addition, the service had a rolling programme such that staff had the opportunity to complete diploma level training relevant to their work. The team interventions comprise of positive practice approaches based initially on the work of LaVigna and Donellan (1995).

f. Providing education and training

The time spent by the AOT in providing staff training was an average of 1.5 days per month, comprising of 40 training sessions to a total of 67 staff.

Efficiency

a. Multi-professional Working

Thirteen respondents indicated that they had worked jointly with the AOT and the mean rating relating to the usefulness of this joint approach was 3.5. Five of the AOT members had worked jointly with other professionals in relation to clients and their mean rating of the usefulness of this joint approach was 4.8. In relation to liaison with other members of the learning disability services, the mean rating from non-AOT members was 2.8. This compared with a mean rating of 3.7 by AOT members.

b. Staff satisfaction, turn-over and sickness

In a one year period, one staff member left the service and there were 330 hours of staff sickness, all of which was short-term. The average rating of staff satisfaction with their job was 3.2.

Equity

Of the 30 clients referred to the AOT, 21 were males and 9 females. The average age was 36 years (range 22 - 65). Referrals were received from all geographical areas of the health board area. Over half of the referrals (16) were received from community nursing, with the remainder being received from a mixture of other health professionals (10) and social workers (4).

Access

The average AOT waiting time was 2.6 days (range = 0-19 days). The mean rating by referrers of how quickly they felt the AOT had responded to their referral was 3.6. Three respondents were unsure about the referral route into the service.

Appropriateness

The mean satisfaction rating from referrers was 3.5. There were no complaints received about the AOT. A number of strengths and weaknesses of the AOT were identified by respondents and are shown in Table 2.

Table 2: **Strengths and weaknesses of the AOT identified by respondents**

Strengths	No.	Example	Weaknesses	No.	Example
Accessibility	4	'Accessible' 'On-site' 'Availability to engage' 'ability to respond quickly to crisis'	Poor communication	7	'Lack of communication with others in LDS' 'Lack of representation at meetings' 'not a lot of communication given unless asked for' 'little or no attempt made to gather my views or to feedback on their involvement' 'Need to improve communication'
Prevent admission	1	'reduce patient admission to hospital'	Response Time	2	'Lengthy process of acceptance of cases'
Expertise/ approach to work	7	'level of skills/knowledge beneficial to completing pieces of work' 'Objectivity in ongoing situations which are challenging' 'The AOT is professional and willing to help' 'great enthusiasm to work with others'	Clarity/ Expectations of role and remit	8	'Clarity of role.' 'Not sure what my role was when AOT involved.' 'I'm still not clear about all the areas that AOT work in.' 'Need more coordination and clarity of roles' 'Gave some advice but no practical involvement.' 'Need to review type of work accepted and prioritisation process' 'Used inappropriately e.g. to replace service providers' 'As purely a nursing team has limited access to AHPs,

					so perhaps focused too narrowly' 'Lacking leadership'
Intensive input	3	The ability to provide more intensive assessments/observations	Relationship with wider LD service and team	7	'Still very separate from LDS' 'I feel we should have one large community nursing team' 'Feels like a stand alone team' 'Other CLDT members should be more involved' 'Could the AOT be merged with our other nurses to make work more integrated?'
			Variable service	3	'My experience of AOT has been variable ranging from very good to lack of input which was said would be available'

Social acceptability

Table 3 illustrates the strengths and weakness of the service as assessed by the AOT staff.

Table 3: The strengths and weakness of the service as assessed by the AOT staff

Strengths of AOT			Weaknesses of AOT		
Theme	**No**	**Example**	**Theme**	**No**	**Example**
Team work/liaison	3	'Ability/time to work alongside carers' 'Working alongside support agencies' 'Working collaboratively with all parties involved'	Limited liaison time with other team members	3	'often don't see much of each other' Time to support S/N 'Initially not felt to be part of the wider picture, although this is now not the case. 'Lack of dedicated input from other disciplines e.g. psychology'
Time for more in-depth work	3	'Ability to look at wider issues affecting behaviour' 'Ability and time to look at the wider picture of CB.' 'Having the time to spend completing process and research involved'	Limited knowledge/skill of staff	1	'Lack of staff knowledge and skill'

Working in evidence based/methodical way	2	'Working from a methodical approach' 'Evidence based info gathering'	Unrealistic expectations re: role of team	3	'Other people's expectations of outreach role-frequently requested/used to 'plug gaps' in services' 'LD team expectations of outreach role-used to plug gaps' 'Value given in our role' 'Too much time spent shoring up one other service and crippling the AOT' 'Management focus drawn away from main purpose of AOT' 'Lack of self-promotion: informing other disciplines/services of AOT purpose'
Distinct from Learning Disability team	1	'Separate team within wider learning disability team'			

Discussion

The AOT was developed in response to a need for local service provision for clients who presented with severe challenging behaviour and the main aims were to prevent out of area placements and delayed discharge if individuals were admitted to hospital. The clinical effectiveness of a service indicates the extent to which it achieves what it sets out to and this dimension is arguably of most relevance to clinicians. A number of factors impact on the potential clinical effectiveness of a service. These include the extent to which the referrals which are received are appropriate, to what extent the interventions are successful, how well relevant professionals work together and whether the staff have the appropriate skills and training required for the job.

Clinical effectiveness

The evaluation found that the service had received and dealt with 30 appropriate referrals since it was established, mostly in relation to aggression, and that the pattern of referrals was consistent with that of other learning disability services (McKenzie et al., 1999). The

service was considered by the AOT staff to be effective at significantly reducing or elimination challenging behaviour. Referrer ratings of the effectiveness of the service varied, but in general the input was rated as being ‘quite useful’ and was reported as having led to a reduction in challenging behaviour in 71% of clients.

Since the development of the AOT, there had been no delayed discharges (i.e. the period during which the client remains in hospital once the assessment or treatment episode is complete due to the unavailability of a place to move to). This compares with the last available figures prior to the establishment of the AOT of an average of 3.17 months (Powell et al., 2003). This suggests that the service is having some success at providing an effective local service provision which prevents delayed discharge.

In order to be both effective and efficient, any service needs to have the skill mix required to meet the needs of the job and the individual staff need to have the appropriate knowledge and skills. The composition of the AOT was constrained by the need to re-provide for the staff from the de-commissioned in-patient unit and therefore comprised solely of nursing staff. As such, it was not based on a needs analysis or in relation to the evidence base. Research suggests that the most effective and efficient interventions for behaviours which challenge are multi-professional (RCPsych, BPS & RCSLT, 2007). The team, did however, have an undertaking to review the composition as staff turnover freed up resources and some input from clinical psychology, speech and language therapy and occupational therapy was subsequently funded. A small number of clients also had

involvement from members of the community learning disability team, however, at the time of the evaluation, the AOT could not be viewed as a multi-disciplinary service.

The provision of staff training can also be an indicator of the efficiency of a service, although the relationship is not always straightforward. Research has indicated that staff training can increase knowledge and confidence and improve practice in relation to managing challenging behaviour (Murray et al., 1999; McKenzie et al., 2000) and that this is an important element of the effective management of challenging behaviour. The AOT staff had spent an average of 1.5 days per month training others since the service was set up. The impact of this training had not been formally evaluated at the time of writing, however, and this was highlighted as a goal for the service.

Efficiency

Efficiency refers to the relationship between the resources allocated and the work done and is often of most interest to service planners and commissioners. The AOT service was working within budget at the time of the evaluation although a number of factors were highlighted as being likely to impact on funding in the future. These included staff maternity leave and the need for intensive input from a number of AOT staff to maintain one particular service. Factors such as skill mix and staff training, as outlined above, are also indicative of efficiency.

It is possible for a uni-professional service to work effectively and efficiently with other team members if good communication systems and joint working procedures are in place.

Joint working took place with 13 staff members in relation to 5 clients. In addition, AOT staff attended the learning disability team meetings and had developed a clear pathway for involving CLDT members. This joint working was seen as useful overall, however AOT staff rated the contact more highly than other respondents. A similar pattern was seen in relation to liaison with other members of the learning disability services, although the ratings were lower overall, indicating room for improvement on this dimension.

Staff working with people who present severe challenging behaviour are more likely to experience stress (Sharp et al., 2002) and high levels of staff turnover and burnout (Attwood and Joachim, 1994). These in turn impact on service efficiency, effectiveness and quality. In a one year period, the AOT service experienced 330 hours of short-term staff sickness. This compares with an average figure of 422.5 hours per month for the de-commissioned in-patient unit (Murray et al., 1999a). Only one staff member had left the service and the average rating of staff satisfaction indicated that the staff were, on the whole, reasonably satisfied with their work. This suggests that the AOT is a less stressful and more satisfying working environment for the staff compared to the in-patient unit.

Equity

Equity reflects the extent to which a service is available to all who fall within its remit. More males than females were referred to the AOT, however this is likely to reflect the finding that the presentation of challenging behaviour is more common in males (Emerson et al., 2001). Referrals were received from throughout the health board region, although 2/3rds were from the areas with the largest population centres, as might be

expected. A range of professionals from the community learning disability team had made referrals to the AOT, indicating a good awareness of the service. In general, the equity indicators suggest that clients across the age range and from all the main geographical areas can access the service.

Access is also commonly measured by waiting times. The AOT had a short average waiting time and there was only one occasion when the service has been unable to provide an immediate response to a referral due to capacity issues. There were no clients on the waiting list at the time of the evaluation and the referrer ratings indicated that the majority felt the response time to referrals was acceptable.

Knowledge about the service and referral routes can also be a useful indicator of access. If people don't know a service exists or how to make a referral they are unlikely to access it. Feedback from the survey indicated that all respondents were aware of the AOT and all but one knew the type of service it provided. There was some uncertainty around referral routes from respondents out-with the community learning disability team, suggesting that further work needed to be done by the AOT to address this.

Appropriateness and social appropriateness

Appropriateness reflects the ability of a service to meet the needs of a given population, while social appropriateness reflects the extent to which the service users and the wider society find the service morally valid. Both are often measured by referrer satisfaction and complaints. Overall referrers were satisfied with the AOT, although two respondents

noted that the input had been variable and that they had been satisfied with the input of some staff and very dissatisfied with the input of others. In terms of the strengths of the AOT, nearly half of the respondents referred to the expertise and approach to work. The AOT staff were seen as professional, objective and keen to help, as well as having the skills and knowledge required. The service was also viewed as accessible and able to provide intensive input. Recent practice guidelines have emphasized the importance of staff skills and knowledge in creating 'capable environments' for those who challenge (RCPsych, BPS & RCSLT, 2007). Referrer ratings suggest that AOT staff are viewed as having these skills, although some of the weaknesses reported by AOT staff related to unrealistic expectations that others had of them and a concern about their own levels of skill and knowledge.

The most common area of dissatisfaction was in relation to a lack of clarity about the role and remit of the AOT, the relationship with the wider learning disability service and communication issues. These constituted 81% of all responses in relation to negative aspects of the team. These concerns were also shared by AOT staff. As the ability to work collaboratively is also seen as a key component of successful approaches to challenging behaviour (RCPsych, BPS & RCSLT, 2007, this suggests key areas where the AOT needs to improve.

Limitations of the study

There were a number of limitations of the evaluation, the most obvious being the lack of input from individuals with a learning disability about the AOT. An earlier evaluation of

the community learning disability service was based on the views of service users (Murray et al., 1998), however the intellectual and communication difficulties of the majority of individuals referred to the AOT, meant that a similar approach could not be used in the current study. While the views of carers were sought, these were all paid support staff, rather than family members. The evaluation would have been greatly improved by service user involvement and this is an area that needs to be addressed in future evaluations. A second limitation was that the effectiveness of the service was evaluated purely in terms of a reduction in challenging behaviour. A future evaluation could consider assessing whether successful intervention in relation to challenging behaviour also result in improvements in other areas, such as an increase in meaningful activities for the individual (RCPsych, BPS & RCSLT, 2007). Thirdly, while the evaluation had an acceptable response rate (Harrison & Cock, 2004), the numbers involved in the evaluation were relatively small, raising questions about the extent to which the results can be generalized.

Despite these limitations, the evaluation highlighted a number of areas of strengths of the service, as well as areas for future development. The results indicated that the AOT provided a locally based service that was generally effective, efficient, accessible, equitable and appropriate. There was a clear need for improved clarity about the role and remit of the team and to strengthen communication with the wider learning disability service. In addition, the AOT needs to continue to move towards becoming truly multi-disciplinary, in line with the evidence base that multidisciplinary approaches are more effective for challenging behaviour (RCPsych, BPS & RCSLT, 2007).

Table 1: definition of each dimension in Maxwell's Multi-dimensional Quality Evaluation Model (Maxwell, 1984), an outline of the indicators relating to each dimension and the method used for measurement.

Dimension	Definition	Indicators	Method
Effectiveness	The extent to which a service achieves what it sets out to	The extent to which input is successful i.e. reducing/eliminating challenging behaviour	AOT staff ratings Referrer/ support staff ratings
		Reducing/preventing delayed discharge	Comparison with delayed discharge figures from previous in-patient service
		The extent to which the staff have the appropriate skills and knowledge for the job	Existing AOT skill mix Staff training and qualifications
		Provision of training and education to others	Information from AOT records
Efficiency	The relationship between the resources allocated and the work done	The extent to which the staff have the appropriate skills and knowledge for the job	As above
		The extent of multi-professional working	Information from AOT records AOT staff and referrer/support staff ratings
		Staff satisfaction	AOT staff satisfaction rating
		Staff turn-over and sickness	Information from AOT records
Economy	The relationship between the resources which have been allocated and the needs to be addressed	The investment in funding for the population served	Information not available
Equity	The extent to which a service is available to all who fall within its remit.	The extent to which referrals are representative of the population in terms of gender, age and geographical location	Information from AOT records
		The extent to which referrals are received from all those who are eligible to make them	Information from AOT records
Access	The ease with which clients can utilise a service.	Waiting times	Information from AOT records
		The extent to which others are aware of the service and how to refer	Information from referrer /support staff
Appropriateness	The ability of a service to meet the needs of a given population	Referrer/support staff satisfaction	Information from referrer/support staff ratings of satisfaction
		Complaints	Information from AOT records
Social Acceptability	The extent to which the service users and the wider society find the service morally valid.	Referrer satisfaction, complaints, staff satisfaction, sickness and turnover	As above
		AOT staff rating of the service	Information from AOT staff questionnaire

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