

Violence Against Social Care Workers Supporting People with Learning Difficulties: A Review

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The Prevalence of Violent Incidents in Care Settings for People With Learning Difficulties

Little is known directly about the actual prevalence of violent incidents in social care settings for people with learning difficulties in the UK. The available information suggests that:

- 70% of social care workers in England who are supporting *either* people with learning difficulties *or* people with mental health problems have experienced a violent incident in the previous 12 months (Pahl, 1999). The most common forms of violent incidents reported were being shouted at/insulted (64% of all respondents), threats of violence (40%) and physical attack (38%);
- 87% of nursing staff working with people with learning difficulties report having experienced feelings of threat or actual physical assault at some point in their career (Reeves, 1994);
- 81% of staff employed in one NHS Trust reported experiencing at least one violent episode during the preceding 12 months, with 20% of respondents reporting experiencing over 15 violent incidents during this period (Kiely & Pankhurst, 1998).

More is known, however, about the prevalence of violence among people with learning difficulties.

- Approximately 7-10% of people with learning difficulties receiving services are reported to engage in violent behaviours (Emerson et al, in press; Harris, 1993).
- Harris (1993) reported that the most prevalent forms of aggression shown in the past month by 168 people with learning difficulties identified in one administratively defined area were: punching, slapping, pushing or pulling (51% of people showing aggression); kicking (24%); pinching (21%); scratching (20%); pulling hair (13%); biting (13%); head-butting (7%); using weapons (7%); choking, throttling (4%). Emerson et al (in press) reported that the most prevalent behaviours shown by 153 people with intellectual difficulties who showed aggression were: hitting others with their hands (75% of people showing aggression); verbal aggression (60%); hitting others with objects (41%); meanness or cruelty (34%); scratching (27%); pulling hair (23%); pinching (20%) and biting (16%).
- Secondary analysis of the data collected by Emerson et al (in press) indicates that, among 120 people with learning difficulties whose aggression was considered to constitute a serious management problem: 25% of assaults were reported to involve sustained attack; 29% involved the use of weapons; 26%

of individuals were reported to show aggressive behaviours on a daily basis and 37% on a weekly basis; the most common victims of attacks were care staff (37% of individuals) and other people with learning difficulties (23%); for 45% of individuals aggressive incidents usually required the physical intervention of at least one member of care staff; 14% of individuals were reported to have caused injuries to care staff which required immediate medical attention; 5% of individuals were reported to have themselves received injuries which required immediate medical attention as a direct result of their aggressive behaviours.

Policy Implications and Research Priorities

Taken together, and when placed in the context of current and emerging patterns of service provision, these data suggest that violence or the threat of violence is likely to be a fairly common occurrence for social care staff supporting people with learning difficulties. While the majority of episodes of violence are likely to be brief and not to involve serious physical risk, a minority of care staff are likely to experience serious violence or the threat of serious violence on a routine basis. These observations clearly indicate the importance of policy initiatives directed towards this area (see below).

The main research tasks in this area are to clearly identify (from the perspective of care workers) the prevalence of specific forms of violence and the extent to which these vary as a function of such issues as user characteristics, casemix, staff characteristics and service organisation.

The Impact of Violence

Again, little is known directly about the actual impact of violent incidents in social care settings for people with learning difficulties in the UK.

- As noted above, secondary analysis of the data collected by Emerson et al (in press) highlights the impact of violent incidents with regards to demands on care staff to physically manage episodes (the usual outcome for 45% of violent individuals) and injuries to staff and people with learning difficulties. In addition, care staff reported that, in response to the aggressive behaviour of the person with learning difficulties, half or more of their colleagues usually experienced such emotions as annoyance (in 57% of cases), despair (41%), sadness (40%), anger (39%), fear (27%), disgust (16%). They also reported that half or more of other people with learning difficulties (e.g., co-tenants, co-workers) experienced annoyance (54%), fear (53%), anger (41%), despair (18%), disgust (18%), sadness (16%).
- In response to violent incidents, nursing staff supporting *either* people with learning difficulties *or* people with mental health problems are reported to show temporarily elevated anxiety levels and generally elevated levels of critical comments directed at the service user (Cottle et al, 1995; see also Kiely & Pankhurst, 1998).

There is, however, a significantly larger literature on the impact of 'challenging behaviours' shown by people with learning difficulties (of which the most common specific form is aggression). This literature suggests that such behaviours may significantly impair the health and/or quality of life of the person themselves, those who care for them and those who live or work in close proximity. Thus, for example, serious aggression may result in significant injury to others as well as to the person themselves as a result of the defensive or restraining action of others (Konarski, Sutton, & Huffman, 1997; Spreat, Lipinski, Hill & Halpin, 1986). However, the combined responses of the community, carers, care staff and service agencies to people who show challenging behaviours may prove significantly more detrimental to their quality of life than the immediate physical consequences of the challenging behaviours themselves. These social responses may include abuse, inappropriate treatment, exclusion, deprivation and systematic neglect.

- *Abuse*: Rusch, Hall and Griffin (1986), in an analysis of documented instances of abuse in a North American institution, identified challenging behaviour as the major predictor of who was likely to be abused.
- *Inappropriate Treatment*: Studies undertaken in the UK suggest that up to one in two people with learning difficulties who show challenging behaviours are prescribed neuroleptic (ant-psychotic) medication (Emerson et al, in press a; Kiernan, Reeves & Alborz, 1995; Oliver, Murphy & Corbett, 1987; Robertson et al, in press). This must be of concern as: (1) there is little evidence that neuroleptics have any specific effect in reducing challenging behaviours (Baumeister, Sevin & King, 1998; Brylewski & Duggan, 1999); (2) such medication has a number of well documented serious side effects (Baumeister et al, 1998; Thompson, Hackenberg & Schaal, 1991); (3) prescription practices for people with intellectual difficulties and a clearly diagnosed psychiatric illness have been judged to be inappropriate in many instances (Davis et al, 1998); and (4) the prevalence of prescribing of neuroleptics has been substantially reduced through peer review processes with no apparent negative effects for the majority of participants (e.g., Ahmed et al, 2000; Davis et al, 1998).
- *Exclusion, Deprivation and Systematic Neglect*: People with challenging behaviours are significantly more likely to be excluded from community-based services and to be admitted, re-admitted to or retained in institutional settings (Borthwick-Duffy, Eyman & White, 1987; Eyman & Call, 1977; Hill & Bruininks, 1984; Intagliata & Willer, 1982; Lakin, Hill, Hauber, Bruininks & Heal, 1983; Schalock, Harper & Genung, 1981). Once admitted to institutional care they are likely to spend most of their time in materially deprived surroundings (cf., Emerson & Hatton, 1994), disengaged from their world and avoided by staff (Emerson, Beasley, Offord & Mansell, 1992; Mansell, 1994, 1995). Most episodes of challenging behaviours occurring in institutions are ignored by staff (Cullen, Burton, Watts & Thomas, 1983; Felce et al, 1987) and the low levels of attention that are provided are likely to be disproportionately negative in character (Grant & Moores, 1977). Within the community, challenging behaviours may serve to limit the development of social relationships (Anderson, Lakin, Hill & Chen, 1992), reduce opportunities to participate in community-based activities (Hill & Bruininks, 1984) and prevent access to health and social services (Jacobsen, Silver & Schwartz, 1984). They are also, of course, a major cause of stress experienced

by carers (Quine & Pahl, 1985, 1991; Qureshi, 1992; Saxby & Morgan, 1993; Sloper, Knussen, Turner & Cunningham, 1991; Stores, Stores, Fellows & Buckley, 1998) and care staff (Bersani & Heifetz, 1985; Hatton, Brown, Caine & Emerson, 1995; Jenkins, Rose & Lovell, 1997).

Policy Implications and Research Priorities

Again, when placed in the context of current and emerging patterns of service provision, these data suggest that the 'costs' of violence or the threat of violence in social care provision for people with learning difficulties are likely to be complex and substantial, an observation which further indicates the importance of policy initiatives directed towards this area (see below).

The main research tasks in this area are to clearly document the economic and social costs of violence in this sector and the extent to which these costs vary as a function of such issues as user characteristics, casemix, staff characteristics and service organisation. Research investigating the efficacy of post-event support, debriefing and counselling with social care staff is urgently required, as research concerning the treatment of post traumatic stress disorder has demonstrated the efficacy of complex cognitive-behavioural interventions but has also demonstrated the lack of efficacy of generic counselling or support groups (Roth & Fonagy, 1996).

Understanding and Responding to Violence

There exists an extensive international literature on the causes and treatment of aggression and other forms of challenging behaviour in people with learning difficulties (e.g., Ball & Bush, 2000; Bouras, 1999; Carr, Robinson, Taylor & Carlson, 1990; Carr et al, 1999; Cataldo, 1991; Cipani & Spooner, 1997; Didden, Duker & Korzilius, 1997; Emerson, in press; Kiernan, 1993; Koegel et al, 1996; Konarski et al, 1992; Lehr & Brown, 1996; Luiselli & Cameron, 1998; Luiselli, Matson & Singh, 1992; Matson et al, 1996; McGill, Clare & Murphy, 1996; Reichle & Wacker, 1993; Repp & Singh, 1990; Schroeder, Rojahn & Oldenquist, 1991; Scotti et al, 1991; Singh, 1997).

There is now strong evidence to support a broad behaviourally based approach to understanding and intervention¹. This approach suggests that, for many people with severe learning difficulties, aggression may be most profitably conceptualised as a way in which people with restricted abilities (especially verbal ability) and restricted power can exercise some control over important aspects of their environment (particularly the behaviour or actions of care staff). This approach does not assume that these behaviours are 'consciously planned'; rather it argues that social environments have, over time, selectively reinforced such ways of acting. It conceptualises aggression as a functional and adaptive response to unusual circumstances. Common examples of such 'controlling' or 'communicative' functions of aggression would include the capacity of aggression to terminate

¹ It is not suggested that such an approach is applicable to *all* situations involving violence to social care staff. Other factors, which may be important in individual cases, include associations in people with learning difficulties between violent acts and epilepsy (Gedye, 1989), mental illness (Emerson, Moss & Kiernan, 1999) and as 'elicited' responses to punishment.

unwanted interactions with care staff, terminate unwanted activities mediated by care staff and to elicit the attention of care staff (Emerson, in press).

This type of behavioural approach to understanding aggression would posit three main questions:

- What function does aggression/violence serve for this person in this context (e.g., to terminate unwanted interactions with care staff)?
- Why is this outcome important for this person (e.g., what is making interactions with care staff aversive in this context)?
- What other alternatives are available for this person in this context to achieve these ends?

These questions suggest a range of approaches to intervention which, taken together, form the basis of the technology of *positive behavioural support* (Carr et al, 1999; Koegel et al, 1996). Specific approaches to intervention would include:

- Providing the person with a more efficient and acceptable alternative to attaining the desired outcome (e.g., by teaching and ensuring that support staff respond to an alternative or gestural request for a break from an unwanted task; e.g., Carr et al, 1994). This would often need to be accompanied by reducing the efficiency of aggression in attaining the desired outcome (e.g., by preventing violence leading to an escape from an unwanted task).
- Reducing the saliency of that specific outcome for that person in a specific context (e.g., reducing the 'aversiveness' of the unwanted task). Such an approach could involve a range of strategies including: preventing exposure to the unwanted task; providing the person with more efficient strategies for coping with undesirable situations; changing the social and material context in which the task was presented; attending to historical or biological factors which may reduce the person's tolerance in coping with undesired tasks (Emerson, in press).

While there exists a strong and growing evidence-base in support of the technology of positive behavioural support, there is also fairly extensive evidence that such approaches are not being implemented in social (or health) care services for people with learning difficulties. Indeed, it is clear that, in the UK at least, the majority of people who show challenging behaviour do not receive effective behavioural support (Emerson et al, in press b; Oliver et al, 1987; Qureshi, 1994). Emerson et al (in press b), for example, investigated treatment and management practices among 265 people with challenging behaviours who were receiving some form of residential support in 1998 from agencies nominated as providing examples of 'better practice'. Only 15% of participants had a written behaviourally oriented treatment programme. Many of these were highly simplistic and were far from being exemplars of positive behavioural support.

A range of factors is likely to underlie the widespread failure of current services to provide appropriate levels of access to behavioural supports. Among these are:

- Organisational inefficiency reflected in lack of commitment, leadership and poor management procedures (Department of Health, 1993; Mansell, 1994; Mansell et al, 1994; McBrien & Candy, 1998);
- Inefficient organisation of the care environment (McGill & Toogood, 1994);
- Conflict between service ideologies, personal beliefs and beliefs about the nature of behavioural practice (Albin, Lucyshyn, Horner & Flannery, 1996; Emerson, Hastings & McGill, 1994; Emerson & McGill, 1989; Hastings, 1995, 1997; Hastings, Reed & Watts, 1997; Hastings & Remington, 1994a,b; Hastings, Remington & Hopper, 1995; McBrien & Candy, 1998; Morgan & Hastings, 1998; Watts, Reed & Hastings, 1997);
- Lack of knowledge about behavioural interventions among service providers, including specialist providers (Anderson, Russo, Dunlap & Albin, 1996; Desrochers et al, 1997; Emerson, Forrest, Cambridge & Mansell, 1996; Hastings & Remington, 1993);
- Insufficient resources, including specialist health care providers (Bailey & Cooper, 1997).

The failure of current services to provide access to technologies with a proven track record may be contrasted with the extent to which people with learning difficulties and challenging behaviour are exposed to risky technologies (e.g., anti-psychotic medication) for which there is little evidence in support of their efficacy. Such a contrast can only be considered professionally and ethically indefensible.

In addition to evaluating the impact of approaches to intervention, a number of studies have addressed aspects of the management of episodes of challenging behaviours including aggression involving people with learning difficulties (e.g., Allen & Tynan, 2000; Harris, 1996; Konarski, Sutton, & Huffman, 1997; Spreat, Lipinski, Hill & Halpin, 1986). This literature suggests that training staff in procedures for preventing, diffusing and managing episodes of violence may be associated with:

- Reduced rates of injuries to care staff and people with learning difficulties (Allen, McDonald, Dunn & Doyle, 1997; Harris, 1996; Spreat, Lipinski, Hill & Halpin, 1986).
- Avoidance of the breakdown of community-based placements (Allen, 1999).
- Increased probability of successfully reducing the levels of anti-psychotic medication prescribed to people with challenging behaviours (Ahmed et al, 2000).
- Reduced rates of the use of restraint and emergency medication (Allen et al, 1997).
- Increased self-reported confidence for working with people with learning difficulties who exhibited violent behaviours (Allen & Tynan, 2000).

Again, however, the available evidence suggests that access to such training or knowledge is often limited (cf., Allen & Hill-Tout, 1999; Harris et al, 1996).

Policy Implications and Research Priorities

As noted above, the failure of current services to provide access to approaches to intervention with a proven track record (when contrasted with the extent to which

people with learning difficulties and challenging behaviour are exposed to risky technologies of dubious efficacy) can only be considered professionally and ethically indefensible. These observations suggest a number of clear policy objectives including:

- Establishing clear expectations that people with learning difficulties who are known to be at risk of showing violent behaviours are given access to positive behavioural support.
- Establishing clear expectations that social care staff working with people with learning difficulties who are known to be at risk of showing violent behaviours receive appropriate training in the prevention, diffusion and management of violent incidents.
- Establishing support systems to help agencies supporting people with learning difficulties who are known to be at risk of showing violent behaviours to increase the proportion of users gaining access to positive behavioural support.
- Establishing support systems to help agencies supporting people with learning difficulties who are known to be at risk of showing violent behaviours to increase the proportion of social care staff who receive appropriate training in the prevention, diffusion and management of violent incidents.
- Monitoring the extent to which users who are known to be at risk of showing violent behaviours have access to positive behavioural support.
- Monitoring the extent to which users who are known to be at risk of showing violent behaviours are prescribed anti-psychotic medication.
- Monitoring the extent to which social care staff working with people with learning difficulties who are known to be at risk of showing violent behaviours receive appropriate training in the prevention, diffusion and management of violent incidents.

The two main research tasks in this area are to:

- Identify those factors within current services that act as barriers to the effective uptake and implementation of positive behavioural support and training in the prevention, diffusion and management of violent incidents.
- Evaluate the costs and systemic impact of different models for increasing the implementation of positive behavioural support and training in the prevention, diffusion and management of violent incidents in UK services

References

- Ahmed, Z., Fraser, W. I., Kerr, M., Kiernan, C., Emerson, E., Robertson, J., Felce, D., Allen, D., Baxter, H., & Thomas, J. (2000). The effects of reducing antipsychotic medication in people with a learning disability. *British Journal of Psychiatry* **176**, 42-46.
- Albin, R.W., Lucyshyn, J.M., Horner, R.H., & Flannery, K.B. (1996). Contextual fit for behavior support plans: A model of Agoodness of fit@. In L.K. Koegel, R.L. Koegel & G. Dunlap (Eds.). *Positive Behavioral Support: Including People With Difficult Behavior in the Community*, 81-98. Baltimore: Paul H Brookes.
- Allen, D., McDonald, L., Dunn, C., & Doyle, T. (1997). Changing care staff approaches to the prevention and management of aggressive behavior in a residential treatment unit for persons with mental retardation and challenging behavior. *Research in Developmental Disabilities* **18**, 101-112.
- Allen, D. (1999). Success and failure in community placements for people with learning disabilities and challenging behaviour: An analysis of key variables. *Journal of Mental Health* **8**, 307-320. This study examines the differences in the individual and service characteristics of 2 groups of people with learning disability and challenging behaviour, one which was successfully maintained in the community and one which experienced placement breakdown. Looks at the differences between the 2 groups in relation to service users and carers. Discusses the implications for future research and clinical practice.
- Allen, D., & Hill-Tout, J. (1999). A day in the life: Day activities for people with intellectual disabilities and challenging behaviour in two English counties. *Journal of Applied Research in Intellectual Disabilities* **12**, 30-45.
- Allen, D., & Tynan, H. (2000). Responding to aggressive behavior: Impact of training on staff members' knowledge and confidence. *Mental Retardation* **38**, 97-104.
- Anderson, D.J., Lakin, K.C., Hill, B.K., & Chen, T.H. (1992). Social integration of older persons with *Mental Retardation* in residential facilities. *American Journal on Mental Retardation* **96**, 488-501.
- Anderson, J.L., Russo, A., Dunlap, G., & Albin, R.W. (1996). A team training model for building the capacity to provide positive behavioral supports in inclusive settings. In L.K. Koegel, R.L. Koegel & G. Dunlap (Eds.). *Positive Behavioral Support: Including People With Difficult Behavior in the Community*, 81-98. Baltimore: Paul H Brookes.
- Bailey, N.M., & Cooper, S.-A. (1997). The current provision of specialist health services to people with learning disabilities in England and Wales. *Journal of Intellectual Disability Research* **41**, 52-59.
- Ball, T., & Bush, A. (in press). *Clinical Practice Guidelines: Psychological Interventions For Severely Challenging Behaviours in People With Learning Disabilities*. Leicester: British Psychological Society.
- Baumeister, A.A., Sevin, J.A., & King, B.H. (1988). Neuroleptic medications. In S. Reiss & M.G. Aman (Eds.). *Psychotropic Medication and Developmental Disabilities: The International Consensus Handbook*, p133-150. Ohio: Nisonger Center, Ohio State University.
- Bersani, H.A., & Heifetz, L.J. (1985). Perceived stress and satisfaction of direct-care staff members in community residences for mentally retarded adults. *American Journal of Mental Deficiency* **90**, 289-295.
- Borthwick-Duffy, S.A., Eyman, R.K., & White, J.F. (1987). Client characteristics and residential placement patterns. *American Journal of Mental Deficiency* **92**, 24-30.
- Bouras, N. (1999). *Psychiatric and Behavioural Disorders in Developmental Disabilities and Mental Retardation*. Cambridge: Cambridge University Press.
- Brylewski, J., & Duggan, L. (1999). Antipsychotic medication for challenging behaviour in people with intellectual disability: A systematic review of randomized controlled trials. *Journal of Intellectual Disability Research* **43**, 360-371.

Carr, E.G., Horner, R.H., Turnbull, A.P., Marquis, J.G., McLaughlin, D.M., McAtee, M.L., Smith, C.E., Ryan, K.A., Ruef, M.B., & Doolabh, A. (1999). *Positive Behavior Support For People with Developmental Disabilities*. Washington, DC: American Association on Mental Retardation.

Carr, E.G., Levin, L., McConnachie, G., Carlson, J.I., Kemp, D.C., & Smith, C.E. (1994). *Communication-Based Intervention for Problem Behavior: A User's Guide for Producing Positive Change*. Baltimore: P.H. Brookes.

Step by step guide to innovative methods for managing problem behaviour in people with learning difficulties, or with mental health problems.

Carr, E.G., Robinson, S., Taylor, J.C., & Carlson, J.I. (1990). *Positive Approaches to the Treatment of Severe Behavior Problems in Persons with Developmental Disabilities*. Seattle: The Association for Persons with Severe Handicaps.

Cataldo, M.F. (1991). The effects of punishment and other behavior reducing procedures on the destructive behaviors of persons with developmental disabilities. In National Institute of Health (Ed.) *Treatment of Destructive Behaviors in Persons with Developmental Disabilities*. Department of Health and Human Services: Washington.

Cipani, E., & Spooner, F. (1997). Treating problem behaviors maintained by negative reinforcement. *Research in Developmental Disabilities* **18**, 329-342.

Cottle, M., Kuipers, L., Murphy, G., & Oakes, P. (1995). Expressed emotion, attributions and coping in staff who have been victims of violent incidents. *Mental Handicap Research* **8**, 168-183.
This study examined how staff felt, after a violent incident, towards the perpetrator of the incident, and the reasons that the care staff gave as to their belief about the cause of the incident.

Cullen, C., Burton, M., Watts, S., & Thomas, M. (1983). A preliminary report on the nature of interactions in a mental handicap institution. *Behaviour Research and Therapy* **21**, 579-583.

Davis, S., Wehmeyer, M.L., Board, J.P., Fox, S., Maher, F., & Roberts, B. (1998). Interdisciplinary teams. In S. Reiss & M.G. Aman (Eds.). *Psychotropic Medication and Developmental Disabilities: The International Consensus Handbook*, p133-150. Ohio: Nisonger Center, Ohio State University.

Department of Health (1993). *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs*. London: HMSO.

Defines the client group involved, looks at their needs and goes on to examine 4 examples of model service provision. Includes a section on guidance for commissioners.

Desrochers, M.N., Hile, M.G., & Williams-Moseley, T.L. (1997). Survey of functional assessment procedures used with individuals who display mental retardation and severe problem behaviors. *American Journal of Mental Retardation* **101**, 535-546.

Didden, R., Duker, P.C., & Korzilius, H. (1997). Meta-analytic study on treatment effectiveness for problem behaviors with individuals who have mental retardation. *American Journal of Mental Retardation* **101**, 387-399.

Emerson, E. (in press). *Challenging Behaviour: Analysis and Intervention for People With Intellectual Disabilities, 2nd Edition*. Cambridge: Cambridge University Press.

Presents an overview of current practice in behavioural approaches to the understanding, assessment and treatment of challenging behaviour by people with learning difficulties. Discusses criticisms of these approaches, and draws attention to recent developments which have implications for future practice. Also covers social contexts and epidemiology, neurobiological models and psychopharmacological approaches to intervention.

Emerson, E., Alborz, A., Reeves, D., Mason, H., Swarbrick, R., Kiernan, C., & Mason, L. (in press a). The prevalence of challenging behavior. *Research in Developmental Disabilities*

Emerson, E., Beasley, F., Offord, G., & Mansell, J. (1992). Specialised housing for people with seriously challenging behaviours. *Journal of Mental Deficiency Research* **36**, 291-307.

Emerson, E., Forrest, J., Cambridge, P., & Mansell, J. (1996). Community support teams for people with learning disabilities and challenging behaviour: Results of a National survey. *Journal of Mental Health* **5**, 395-406.

Examines the results of a survey of community support teams for people with learning disabilities and challenging behaviour in England and Wales. The survey looks at the organisation and cost-effectiveness of community support teams, service aims and the impact of the teams.

Emerson, E., Hastings, R., & McGill, P. (1994). Values, attitudes and service ideology. In E. Emerson, P. McGill & J. Mansell (Eds.) *Severe Learning Disabilities and Challenging Behaviours: Designing High Quality Services*. London: Chapman & Hall.

Emerson, E., & Hatton, C. (1994). *Moving Out: The Effect of the Move from Hospital to Community of the Quality of Life of People with Learning Disabilities*. London: HMSO.

Critical review of 71 research reports which examined the impact of care in the community on the quality of life of people with learning difficulties who had been discharged from residential care. Draws out key implications for the purchasers and providers of health and social care.

Emerson, E., & McGill, P. (1989). Normalisation and applied behaviour analysis: Values and technology in services for people with learning difficulties. *Behavioural Psychotherapy* **17**, 101-117.

Emerson, E., Moss, S., & Kiernan, C. (1999). The relationship between challenging behaviour and psychiatric disorder in people with severe developmental disabilities. In N. Bouras (ed.) *Psychiatric and Behavioural Disorders in Developmental Disabilities and Mental Retardation*. Cambridge: Cambridge University Press.

Emerson, E., Robertson, J., Gregory, N., Hatton, C., Kessissoglou, S., Hallam, A., & Hillery, J. (in press a). The treatment and management of challenging behaviours in residential settings. *Journal of Applied Research in Intellectual Disabilities*

Eyman, R.K., & Call, T. (1977). Maladaptive behavior and community placement of mentally retarded persons. *American Journal of Mental Deficiency* **82**, 137-144.

Felce, D., Saxby, H., de Kock, U., Repp, A., Ager, A., & Blunden, R. (1987). To what behaviors do attending adults respond? A replication. *American Journal of Mental Deficiency* **91**, 496-504.

Grant, G.W. & Moores, B. (1977). Resident characteristics and staff behavior in two hospitals for mentally retarded adults. *American Journal of Mental Deficiency* **82**, 259-265.

Harris, P. (1993). The nature and extent of aggressive behaviour among people with learning difficulties (mental handicap) in a single health district. *Journal of Intellectual Disability Research* **37**, 221-242.

Harris, J. (1996). Physical restraint procedures for managing challenging behaviors presented by mentally retarded adults and children. *Research in Developmental Disabilities* **17**, 99-134.

Harris, J., Allen, D., Cornick, M., Jefferson, A., & Mills, R. (1996). *Physical Interventions: A Policy Framework*. Kidderminster: BILD/NAS.

Hastings, R.P. (1995). Understanding factors that influence staff responses to challenging behaviour. *Mental Handicap Research* **8**, 296-320.

Investigates staff beliefs about challenging behaviours in a systematic semi-structured interview of care staff. Findings and their implications for research and practice are discussed.

Hastings, R.P. (1997). Measuring staff perceptions of challenging behaviour: the Challenging Behaviour Attributions Scale (CHABA). *Journal of Intellectual Disability Research* **41**, 495-501.

Hastings, R.P., Reed, T.R., & Watts, M.J. (1997). Community staff causal attributions about challenging behaviour in people with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities* **10**, 238-249.

This article focuses on a study of community staff attributions as compared with those of inexperienced healthcare workers such as student nurses. Outlines the implications of research in this area for staff training and behavioural intervention and discusses suggestions for future research.

- Hastings, R., & Remington, B. (1993). "Is there anything on Why 'good' behavioural programmes fail?": A brief review. *Clinical Psychology Forum* **55**, 9-11.
- Hastings, R., & Remington, B. (1994a). Rules of engagement: Toward an analysis of staff responses to challenging behaviour. *Research in Developmental Disabilities* **15**, 279-298.
- Hastings, R., & Remington, B. (1994b). Staff behaviour and its implications for people with learning disabilities and challenging behaviour. *British Journal of Clinical Psychology* **33**, 423-438.
Reviews the research literature on the behaviour of staff, especially in relation to interactions with people with challenging behaviours.
- Hastings, R.P., Remington, B., & Hopper, G.M. (1995). Experienced and inexperienced health care workers= beliefs about challenging behaviour. *Journal of Intellectual Disability Research* **39**, 474-483.
- Hatton, C., Brown, R., Caine, A., & Emerson, E. (1995). Stressors, coping strategies and stress-related outcomes among direct care staff in staffed houses for people with learning disabilities. *Mental Handicap Research* **8**, 252-271.
Self-reported stressors, coping strategies and stress related outcomes were explored among direct care staff working in 2 networks of small staffed houses for people with learning disabilities. Reports on the research methods used and the conclusions drawn from the investigation.
- Hill, B.K., & Bruininks, R.H. (1984). Maladaptive behavior of mentally retarded individuals in residential facilities. *American Journal of Mental Deficiency* **88**, 380-387.
- Intagliata, J., & Willer, B. (1982). Reinstitutionalization of mentally retarded persons successfully placed into family care and group homes. *American Journal of Mental Deficiency* **87**, 34-39.
- Jacobsen, J.W., Silver, E.J., & Schwartz, A.A. (1984). Service provision in New York's group homes. *Mental Retardation* **22**, 231- 239.
- Jenkins, R., Rose, J., & Lovell, C. (1997). Psychological well-being of staff working with people who have challenging behaviour. *Journal of Intellectual Disability Research* **41**, 502-511.
- Kiely, J. & Pankhurst, H. (1998). Violence faced by staff in a learning disability service. *Disability and Rehabilitation* **20**, 81-89.
- Kiernan, C. (1993). *Research Into Practice? Implications of Research on the Challenging Behaviour of People with Learning Disabilities*. Kidderminster: British Institute on Learning Disabilities.
Research report. Looks at the epidemiology of self-injury amongst people with severe learning disabilities; assessing the prevalence of aggressive behaviour and the effectiveness of interventions; challenging behaviour, family responses and the impact on families of children with learning difficulties who show challenging behaviour; behaviour modification; supporting people with severe learning difficulties and challenging behaviour in ordinary housing; the special development team; service provision for people with mild learning difficulties; staff training; and future directions for research and service development.
- Kiernan, C., Reeves, D., & Alborz, A. (1995). The use of anti-psychotic drugs with adults with learning disabilities and challenging behaviour. *Journal of Intellectual Disability Research* **39**, 263-274.
- Koegel, L.K., Koegel, R.L., & Dunlap, G. (1996). *Positive Behavioral Support: Including People With Difficult Behavior in the Community*. Baltimore: Paul H Brookes.
- Konariski, E.A., Favell, J.E., & Favell, J.E. (1992). *Manual for the Assessment and Treatment of the Behavior Disorders of People with Mental Retardation*. Morganton, NC: Western Carolina Centre Foundation.
- Konariski, E.A., Sutton, K., & Huffman, A. (1997). Personal characteristics associated with episodes of injury in a residential facility. *American Journal of Mental Retardation* **102**, 37-44.
- Lakin, K.C., Hill, B.K., Hauber, F.A., Bruininks, R.H., & Heal, L.W. (1983). New admissions and readmissions to a national sample of public residential facilities. *American Journal of Mental Deficiency* **88**, 13-20.

- Lehr, D.H., & Brown, F. (1996). *People With Disabilities Who Challenge the System*. Baltimore: Paul H Brookes.
Demonstrates how to build supports to surmount the unique challenges of including people who are deaf-blind, who have severe cognitive disabilities, or have serious behavioural problems, into school, the workplace, and the community. Uses case studies to illustrate ideas.
- Luiselli, J.K., & Cameron, M.J. (1998). *Antecedent Control: Innovative Approaches to Behavioral Support*. Baltimore: Paul H Brookes.
- Luiselli, J.K., Matson, J.L., & Singh, N.N. (1992). *Self-Injurious Behavior: Analysis, Assessment and Treatment*. New York: Springer-Verlag.
- Mansell, J. (1994). Specialized group homes for persons with severe or profound mental retardation and serious behavior problem in England. *Research in Developmental Disabilities* **15**, 371-388.
- Mansell, J. (1995). Staffing and staff performance in services for people with severe or profound learning disability and seriously challenging behaviour. *Journal of Intellectual Disability Research* **39**, 3-14.
- Mansell, J., McGill, P., & Emerson, E. (1994). Conceptualising service provision. In E. Emerson, P. McGill & J. Mansell (Eds.) *Severe Learning Disabilities and Challenging Behaviours: Designing High Quality Services*. London: Chapman & Hall.
Draws together information from over the last 10 years on caring for people with severe learning difficulties and challenging behaviour in the community. Considers kinds of services and support needed and describes and evaluates some innovative advances in residential, day and support services.
- Matson, J.L., Benavidez, D.A., Compton, L.S., Paclawskyj, T., & Baglio, C. (1996). Behavioral treatment of autistic persons: A review of research from 1980 to the present. *Research in Developmental Disabilities* **17**, 433-465.
- McBrien, J. & Candy, S. (1998). Working with organisations, or: why won't they follow my advice? In E. Emerson, C. Hatton, J. Bromley & A. Caine (eds) *Clinical Psychology and People With Intellectual Disabilities*. Chichester: Wiley.
- McGill, P., Clare, I., & Murphy, G. (1996). Understanding and responding to challenging behaviour: From theory to practice. *Tizard Learning Disability Review* **1**, 9-17.
- McGill, P., & Toogood, S.. (1994). Organising community placements. In E. Emerson, P. McGill & J. Mansell (Eds.) *Severe Learning Disabilities and Challenging Behaviours: Designing High Quality Services*, 119-156. London: Chapman and Hall.
- Morgan, G.M., & Hastings, R.P. (1998). Special educators= understanding of challenging behaviour in children with learning disabilities: Sensitivity to information about behavioural function. *Behavioural and Cognitive Psychotherapy* **26**, 43-52.
- Oliver, C., Murphy, G.H., & Corbett, J.A. (1987). Self-injurious behaviour in people with mental handicap: A total population survey. *Journal of Mental Deficiency Research* **31**, 147-162.
- Pahl, J. (1999). Coping with physical violence and abuse. In S. Balloch, J. McLean & M. Fisher (Eds.) *Social Services: Working Under Pressure*. Bristol: Policy Press.
- Quine, L., & Pahl, J. (1985). Examining the causes of stress in families with mentally handicapped children. *British Journal of Social Work* **15**, 501-517.
Levels of stress were measured using the Malaise Inventory. Results suggested that highest levels of stress were associated with the pressure of a child with behaviour disorders or with multiple impairments, with stress aggravated by levels of adversity. Concludes with recommendations for service provision.
- Quine, L., & Pahl, J. (1991). Stress and coping in mothers caring for a child with severe learning difficulties: A test of Lazarus=s transactional model of coping. *Journal of Community and Applied Psychology* **1**, 57-70.
Report of a study of 166 mothers, which investigated both the factors associated with maternal stress, and those which might mediate or buffer the effects, taking into account those elements of family functioning which make families vulnerable or

resistant to stress. Concludes that there is a need for a comprehensive method of assessing child and family in order to identify needs and target resources accurately.

Qureshi, H. (1992). Young adults with learning difficulties and challenging behavior: Parents' views of services in the community. *Social Work and Social Services Review* **3**, 104-123.

Reports on a study of services received: day care, short term residential care, social work and community nursing and analyses parents' evaluation of services.

Qureshi, H. (1994). The size of the problem. In E. Emerson, P. McGill & J. Mansell (Eds.) *Severe Learning Disabilities and Challenging Behaviours: Designing High Quality Services*. London: Chapman & Hall.

Reeves, S. (1994). Violent clients: How do care staff cope? *Nursing Times* **90**, 12.

Reichle, J., & Wacker, D.P. (1993). *Communicative Alternatives to Challenging Behavior*. Baltimore: Paul H. Brookes.

Repp, A.C., & Singh, N.N. (1990). *Perspectives on the Use of Nonaversive and Aversive Interventions for Persons with Developmental Disabilities*. Sycamore, IL: Sycamore Publishing Company.

Robertson, J., Emerson, E., Gregory, N., Hatton, C., & Kessissoglou, S. (in press a). Receipt of psychotropic medication by people with intellectual disabilities in residential settings. *Journal of Intellectual Disability Research*

Roth, A. & Fonagy, P. (1996). *What Works For Whom? A critical review of psychotherapy research*. New York: The Guilford Press.

Rusch, R.G., Hall, J.C., & Griffin, H.C. (1986). Abuse provoking characteristics of institutionalized mentally retarded individuals. *American Journal of Mental Deficiency* **90**, 618-624.

Saxby, H., & Morgan, H. (1993). Behaviour problems in children with learning disabilities: To what extent do they exist and are they a problem. *Child: Care, Health & Development* **19**, 149-157.

Schalock, R.L., Harper, R.S., & Genung, T. (1981). Community integration of mentally retarded adults: Community placement and program success. *American Journal of Mental Deficiency* **85**, 478-488.

Schroeder, S.R., Rojahn, J., & Oldenquist, A. (1991). Treatment of destructive behaviors among people with mental retardation and developmental disabilities: Overview of the problem. In National Institute of Health (Ed.) *Treatment of Destructive Behaviors in Persons with Developmental Disabilities*. Washington, DC: US Department of Health and Human Services.

Scotti, J.R., Evans, I.M., Meyer, L.H., & Walker, P. (1991b). A meta-analysis of behavioral research with problem behavior: Treatment validity and standards of practice. *American Journal of Mental Retardation* **93**, 233-256.

Singh, N.N. (1997) (Ed.) *Prevention and Treatment of Severe Behavior Problems: Models and Methods in Developmental Disabilities*. Baltimore: Paul H Brookes.

Sloper, P., Knussen, C., Turner, S. & Cunningham, C. (1991). Factors relating to stress and satisfaction with life in families of children with Down=s syndrome. *Journal of Child Psychology and Psychiatry* **32**, 655-676.

Spreat, S., Lipinski, D., Hill, J., & Halpin, M.E. (1986). Safety indices associated with the use of contingent restraint procedures. *Applied Research in Mental Retardation* **7**, 475-481.

Stores, R., Stores, G., Fellows, B., & Buckley, S. (1998). Daytime behaviour problems and maternal stress in children with Down=s syndrome, their siblings, and non-intellectually disabled and other intellectually disabled peers. *Journal of Intellectual Disability Research* **42**, 228-237.

Thompson, T., Hackenberg, T., & Schaal, D. (1991). Pharmacological treatments for behavior problems in developmental disabilities. In U.S. Department of Health and Human Services (Ed.) *Treatment of Destructive Behaviors in Persons with Developmental Disabilities*, 343-445. Bethesda, MD: National Institutes of Health.

Watts, M.J., Reed, T.R., & Hastings, R.P.(1997). Staff strategies and explanations for intervening with challenging behaviour: A replication in a community sample. *Journal of Intellectual Disability Research* **41**, 258-263.