Position statement on the state of Intensive Support Teams for People with Learning Disabilities in the United Kingdom

J. Shaw, K. Fuchs, S. Daynes, R. Roach, V. Cassutti & V. Laute
on behalf of the National IST Network

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Summary and Overview

This position statement has been written by a subgroup of the National Intensive Support Team (IST) Network which is a group of service leads and senior clinicians working in Intensive or Enhanced Support teams for people with learning disabilities.

The national IST network has found that there is clear consensus on shared aims and shared models of care in ISTs, and a clear model with key ingredients that make ISTs effective. This position paper aims to share these findings.

We highlight the effective elements of ISTs which we have summarised as best practice guidance.

The paper highlights 5 key areas of best practice:

- ISTs should be commissioned as a ringfenced, separate provision that is linked to core learning disabilities services. This means they have capacity to have a quick response to referrals and should have sufficient capacity to provide intensive support as needed.
- IST should work alongside and in partnership with key stakeholders including having service user and carer involvement.
- ISTs should be robust multi-disciplinary, and often multi-agency teams with a mix of skills so that a client's needs in all areas can be considered and a high proportion of senior, skilled staff.
- ISTs should offer Positive Behaviour Support, Trauma Informed Care and systemic interventions. ISTs should offer different levels of support based on need and should support the development of capable environments.
- Access to emergency residential support is essential for ISTs having best possible outcomes.

We also share key challenges to implementing this guidance and offer some recommendations for improving equity of services nationwide. Our recommendations are aimed at commissioning bodies, care and support providers, health and social care services, service users, families and carers and other key stakeholders.

The paper makes several recommendations:

- Where there is no IST commissioned, this should be addressed as a matter of priority. New services should be commissioned in line with the best practice outlined in this paper and with consideration of the known challenges.
- Where ISTs are commissioned, services should be audited against the best practice criteria outlined in this document. This will allow ISTs to move towards a more standardised and equitable offer nationally.
- The provider market needs significant development at both a national and local level to ensure more equity in provision and more good quality services. This includes supported living, outreach care, residential care, respite provision and day services for those whose behaviour most challenges services. Integrated Care Systems should review their strategy for provider development and

consider initiatives such as providing ‘top up’ fees for services supporting people with behaviours of distress. Commissioning of providers should be joined-up or integrated with the wider health and social care system. There are some pockets of innovative practice nationally working to upskill providers and improve the capability of provision available. ISTs are essential stakeholders in this work and it would be helpful to have some of these models written up for dissemination.

- In order to address the challenges outlined in the paper, IST are keen to open a dialogue about how to overcome these challenges to best practice and deliver positive outcomes, for this group of people. We believe this task will involve partnership working between commissioning bodies, care and support providers, health and social care services, service users and carers and other key stakeholders. Working across an integrated care system and moving care from hospital to community care underpin a future-focused NHS (NHSE, 2025).
- This position statement focuses on ISTs for people with learning disabilities. ISTs for autistic people have not been commissioned as extensively as services for people with a learning disability and are often configured differently due to the paucity of core specialist services for autistic people. However, a review of autism ISTs and a position statement on the current state of such services would be a helpful addition to the literature.

Introduction

This position statement has been written by a subgroup of the National Intensive Support Team (IST) Network. The National IST Network is a group of service leads and senior clinicians working in Intensive or Enhanced Support teams for people with learning disabilities. Although these teams have different names over the country, for the purpose of this paper we will refer to them as Intensive Support Teams (ISTs).

ISTs were commissioned in the context of the Transforming Care agenda to support people with a learning disability whose behaviour presents a significant challenge to services, with a particular focus on reducing the need for hospital admissions. The National Service Model (NHS England, 2015a) and Building the Right Support (NHS England, 2015b) documents outline how services should be commissioned for this cohort and what key values and principles should underlie the support offered. Since these publications there has been a huge expansion of ISTs across the country.

Moving care from hospitals to communities is a central focus for modernising the National Health Service (NHS Long term plan, 2025). Furthermore, the reforms to the Mental Health Act (2025) aim to reduce the number of people with learning disabilities and/ or autism in inappropriate settings, encourage stronger community support and place new duties on commissioners to ensure adequate services, and safer community alternatives at point of crisis. ISTs are likely to have a key role in these reforms by supporting admission avoidance, and there is work currently underway by NHS England to review and update the original IST guidance that is now a decade old.

The National IST Network is a virtual professional network within the UK which set out to establish what best practice currently looks like in ISTs. The network acts as a group of experts on this topic and is well placed to review current provision of ISTs and pull together a consensus of what are effective ingredients in delivering positive outcomes. As a network, we have gathered feedback from ISTs across England and Wales, including formal feedback from twenty six ISTs, as well as a group of nine family carers who have used ISTs, about the landscape of current practice including elements of best practice and challenges to implementing this. It is clear from the National IST Network and existing literature (e.g. Hassiotis, et al., 2020) that there is significant variation nationally in how and where ISTs are commissioned, level of investment, size, population and team make up. Although services should be flexible and designed based on local need (NHS England, 2015b), it is important to have some parity of service offered nationally and for services to be evidence based and effective.

Despite this variation, our work has found that there is clear consensus on shared aims and shared models of care, and that there is a clear model and key ingredients that make ISTs effective. This position paper aims to share these findings. We will highlight the effective elements of ISTs and offer some recommendations for improving equity of services nationwide. Our recommendations are aimed at

commissioning bodies, care and support providers, health and social care services, service users, families and carers and other key stakeholders.

The current position statement will focus on ISTs for people with learning disabilities. ISTs for autistic people with no learning disability are not as well established nationally with large variation in how these are configured. Furthermore, although the needs of those with learning disabilities and autistic people are often considered together, we know that there are significant differences between these two cohorts and the support models/ interventions offered. Additionally, the voices of people with learning disabilities, especially those who use ISTs, are sometimes harder to hear and be represented. Therefore, although the IST needs for autistic people without a learning disability are complex and important, they are not the focus of this paper.

Who do ISTs see?

The clients seen by ISTs overlap significantly with the cohort of people on Dynamic Support Registers (DSRs), those open to key working (NHS England, 2019) and those accessing community Care, Education and Treatment Reviews (CeTRs) (NHS England, 2023). This cohort of clients have complex needs; as well as having a learning disability, they often experience other neurodivergent conditions including Attention Deficit Hyperactivity Disorder (ADHD) and Autism. People seen by ISTs often have multiple presenting difficulties (including mental health difficulties, behaviours of distress and physical health issues), significant adverse life experiences and a background of trauma. By the nature of accessing an IST, they can present with high risks to themselves and others and can be vulnerable to abuse from others. They are also usually embedded in complex networks of support, and often have long histories of involvement from services, multiple care provider breakdowns, previous Assessment and Treatment Unit (ATU) admissions and/or frequent use of crisis, emergency services and police or the criminal justice system.

Aims and outcomes of ISTs

The primary aim of ISTs is to prevent avoidable ATU hospital admissions and to support people to remain in the community. However, most services also aim to reduce placement breakdowns, reduce overall risk in the community and support improved clinical outcomes. There is a growing evidence base on IST outcomes from service evaluation. The key outcomes of ISTs in practice, as found in literature and in the survey completed by the IST network are:

- **Reduce hospital admissions** (e.g. *Fuchs & Ravoux, 2019; Dodd, Laute & Daniel, 2022, Durand, Hanna & Mills, 2025*).
- **Reduce out of area placements** particularly for children and young people being placed away from their family in residential educational facilities (*Reid, Sholl & Gore, 2013*).
- **Reduce the use of restraint** (e.g. *Dodd, Laute & Daniel, 2022*)

- **Reduce the frequency, intensity and duration of challenging behaviour** (e.g. *Lines & Crank, 2021; Fuchs & Ravoux, 2019*) with long term change being evidenced (*Hassiotis et al., 2022*).
- **Increase family satisfaction** with the support provided to their relative (e.g. *Reid, Sholl & Gore, 2013; Fuchs & Ravoux, 2019)*
- **Improve quality of life for the individual** (e.g. *Fuchs & Ravoux, 2019; Lines & Crank, 2021; Prakash, Andrews & Porter, 2007*)
- **Generate financial savings** by facilitating hospital discharges and preventing admissions (*e.g. Fuchs and Ravoux, 2019*).
- **Reduction in risk -** on DSR or other risk measures as a result of the outcomes above.

This shows that ISTs are operating in line with the original Building the Right Support Guidance (NHS England, 2015b) in terms of their aims and are clinically effective services. Furthermore, there is growing evidence that ISTs are cost effective as they generate financial savings by avoiding hospital admissions, avoiding expensive out of area placements and by reducing restrictive practices such as high staffing levels. ISTs are successful when they have clear aims and sufficient resources to deliver on this.

Best Practice in ISTs

In this section we will outline current best practice in ISTs according to research, literature, the IST network survey results (with both services and carers) and information gathered from the National IST Network who act as a group of experts on this subject matter.

ISTs have a dedicated purpose to wrap around a person and their network at a time of crisis and support them to remain in the community wherever possible. They work flexibly and innovatively around a person's unique needs and situation. ISTs aim to develop a shared understanding (formulation) of an individual's unique situation and support the coordination of meaning across the network so that there is a shared vision and goals within the system. ISTs help mobilise the network collaboratively and co-develop new and more stabilising and least restrictive responses to crises. The teams work with complex networks and high levels of risk and provide psychological safety for a person and their key networks to manage risk and contain anxiety at a time of crisis (West, 2021).

Best practice is clustered around five key areas for effective service models. We will outline what the effective ingredients of an IST are, that enable them to deliver the above outcomes.

1. Provide intensive, rapid, flexible support

ISTs need to be positioned and provisioned to offer rapid, intensive and flexible support to prevent hospital admission or placement breakdown. This is a key element

of best practice for ISTs and why they are commissioned in addition to core provision for people with learning disabilities (e.g., CLDTs, MHLDs or CAMHS). Offering timely and flexible responses at a time of crisis can offer a window of opportunity for positive change. ISTs should be commissioned as a **ringfenced**, separate provision which means there is capacity to have a quick response to referrals. Further to this, they should have sufficient capacity to provide intensive support as needed.

The majority of ISTs are attached or linked to core community teams (e.g. CLDT or CAMHS). ISTs act as a tier of community support which is higher intensity to the existing offer by the community learning disability team. ISTs can therefore access the wider multi-disciplinary team from the CLDT should this be required e.g. psychiatry. This model of being a distinct team that is linked to, or part of, core provision is recommended as best practice.

The NHSE guidance (2015a & 2015b) and NICE guidance (2018) all propose the need for ISTs to deliver crisis intervention 24/7. However, there is no agreed model of what an out of hours IST looks like, with teams offering different levels of out of hours provision. Furthermore, not all ISTs offer an out of hours service (35% of services surveyed said they only worked within usual office hours, and the majority did not offer 24/7 support). Some areas rely on mainstream crisis provision with mixed effect. However, it is essential that crisis provision is inclusive of people with learning disabilities including those who engage in behaviours of distress, particularly in light of the Mental Health Act reforms. Overall it is felt that it is best practice for ISTs to have some out of hours provision however the best models for this needs further research.

2. Work in partnership with key stakeholders

People with learning disabilities who access ISTs are often embedded in complex and varied networks of support. This often includes families and a range of care providers, as well as a professional system across multiple agencies. One of the core components of effective ISTs is their ability to help navigate complex systems, to mobilise, coordinate and work closely with that wider system, where risk and levels of anxiety in the support network are often high at a time of crisis. ISTs need to be robust teams that are able to create and support psychological safety within a network of support, to develop a coordinated understanding of a person's needs (formulation), embrace diverse perspectives and contexts, and offer a clarity of focus for change. Best practice is that ISTs work alongside and in partnership with key stakeholders.

Due to the nature and intensity of the work, ISTs work very closely with key stakeholders in a person's life. This can include social care colleagues, wider MDT professionals (e.g. from CLDT, MHLD, CAMHS), continuing healthcare, education colleagues, care providers, families and commissioners. This relationship building is a key role of the IST lead and team and can significantly influence the success of the service. Best practice is for ISTs to be multi-agency teams and/or to have close working relationships with other agencies locally.

Working with carers and families is a core approach within ISTs although services fed back that they were keen to build on this further and involve families more in aspects

of service development and delivery. Best practice in ISTs is for service user and carer involvement in IST service design and delivery.

3. Work as multi-disciplinary teams

A consistent finding across literature, surveys with ISTs and carers and within the IST network is the importance of having a robust multi-disciplinary staff team (MDT) available within the IST to offer the input needed at the right time in a coordinated and timely way. It is essential that MDT members work together in a joined up way so that there is a single, shared formulation.

In the context of a crisis, there is a pressure to rapidly do things differently. As such, being able to assess and formulate in a timely manner is essential, while also managing immediate risk. Having an MDT who can develop a holistic understanding of someone's needs is essential at these times. This ensures that effective interventions can then be offered which address the person's needs. Best practice is for ISTs to have a range of professionals with a mix of skills so that a client's needs in all areas can be considered. This includes physical health, sensory needs, communication needs, behavioural presentation, mental health needs, psychological needs, their overall wellbeing and quality of life, amongst others.

IST survey data has shown that the most common disciplines in ISTs are psychology, nursing, unqualified staff (e.g., support workers and assistant psychologists), behavioural support staff, Occupational Therapy (OT) and Speech and Language Therapy (SaLTs). Some ISTs have additional social worker provision within the team.

ISTs see individuals with complex needs and significant behaviours of distress. They also see a high number of service users who have an additional neurodevelopmental condition. As such, in terms of the skill mix of staff, ISTs should be comprised of enough senior specialist staff to conduct specialist assessments, develop clinical formulations, develop intervention plans, and support the implementation of those recommendations. Compassionate leadership is seen as a fundamental aspect of well functioning and effective teams (West, 2021) and this was seen in the ISTs surveyed. Senior staff are also needed to facilitate network meetings and to ensure dissemination of knowledge and resources. This is as well as offering clinical leadership, supervision to more junior staff and service development work e.g. research and audit.

This need for specialist, skilled staff is not unexpected as ISTs are likely to be working with individuals with the most complex presentations at times of crisis. This requires high levels of competence in working with individuals and across systems. However, it is also best practice for ISTs to include some pre-qualified lower banded staff to assist in assessments (e.g. carrying out observations and analysing data) and support the implementation of recommendations developed by clinical experts including modelling approaches and being able to provide regular check ins and practical and emotional support to families and carers.

As such, having a robust MDT with a high proportion of senior skilled specialist staff is good practice in ISTs.

Further to this, having social care within the IST is good practice, or where this is not possible, having a robust joint commitment or model of joint working at a senior level is essential.

Currently, most teams are led by Clinical Psychology, some are led by Nursing and few are led by Allied Health Professionals, and the majority of teams have a mixed multi-disciplinary workforce. MacDonald & Goody (2025) in their development of a model and toolkit for crisis teams in adult mental health highlight how MDTs trained in psychologically informed ways of working along with embedded psychological professionals are key to progressive mental health care. Where nurses are employed, they often offer additional specialist skills around PBS and mental health within IST services.

4. Offer a range of therapeutic approaches

All ISTs should offer Positive Behaviour Support (PBS), Trauma Informed Care (TIC) and Systemic approaches.

It is essential that ISTs are able to assess, formulate and offer suitable interventions at times of crisis when someone is at risk of hospital admission. This includes effective risk assessment and risk management and to work within legal frameworks e.g. the Mental Health Act (1983) and the Mental Capacity Act (2005). ISTs should be able to support those with complex needs including a range of neurodivergent conditions, high levels of trauma and complex physical and mental health needs.

ISTs offer PBS and TIC as a standard key part of the service. Most ISTs also offer specific family therapy informed systemic interventions and approaches. These approaches are in line with systemic psychology and include a specific range of approaches and interventions. Systemic work can be a key part of engaging networks to work together, to harness existing resources at point of crisis and co-develop and implement workable PBS recommendations and strategies and can increase the success of PBS interventions (e.g. Fuchs & Ravoux, 2019). Positive behaviour support includes functional assessments, positive behaviour support plans and training. It is best practice for ISTs to offer PBS, TIC and systemic interventions.

Most ISTs offer a range of ways of working from consultation with the system of concern, to more intensive assessment and intervention, training and helping develop capable environments (McGill et al., 2020). Integral to this is risk assessment and risk management. This input goes beyond individual assessment and recommendations but also supports the integration of best practice and clinical recommendations around the understanding of an individual within the context of their support environment and provision. This model of offering differing levels of intervention based on need is best practice e.g. consultation to prevent escalation or intensive support to those who need rapid, intensive input. ISTs should offer support to develop capable environments.

Best practice is that ISTs should offer bespoke training to support individuals under their care. This is often a core aspect of service delivery. It can also have far reaching benefits for services, in terms of generalising some aspects of the training in order to support other individuals well, in line with capable environment development.

5. Access to emergency residential support is essential

One of the key aims of ISTs is to prevent admission, however, it is acknowledged that sometimes brief admissions are needed. When this is needed, people should have access to a specialist ATU that meets their needs. It is also acknowledged that sometimes families need respite or an emergency alternative to hospital, to allow them to continue to support their loved one. ISTs report that having access to emergency residential care at times of need can prevent further placement breakdown as carers can get access to essential respite. Furthermore, these settings can be ideal for ISTs to conduct further assessments and to gather another view of a situation or difficulty. Crash pads, crisis houses or residential respite options can provide a controlled setting to assess and offer support and intervention. A hospital cannot offer this same environment due to the nature of hospital wards being busy places that are usually not low arousal. Furthermore, the Mental Health Act changes will require adequate alternative community provision for people who engage in behaviours of distress.

ISTs can provide support to such services to ensure they are good quality and capable to meet the needs of the cohort. It is acknowledged that many specialist ATUs nationally are closing in the move to community care, however this will not be adequate for all and many places do not have appropriate emergency residential community support. Best practice is for emergency residential support to be available locally and for ISTs to support these services to provide adequate respite.

Figure 1. Diagram of the effective components of ISTs

Challenges to implementing best practice

It has been highlighted by the National IST Network that although services work to implement the best practice outlined above, they are often reliant on other services, agencies or provision to have positive outcomes. Key challenges to achieving best practice are outlined below, as well as some recommendations to overcoming these challenges.

1. Services **not having the provision to deliver on the areas of best practice** outlined above.

This challenge includes issues with the level of investment in ISTs. There are still areas that do not have access to an IST. Where ISTs are commissioned, as well as significant differences in how services are positioned and commissioned, there are significant differences in the level of investment made in the IST in terms of staffing provision and make-up of the MDT within the team. Some teams do not have access to a full MDT as needed, some report not having sufficient resource for the population covered, not being able to offer out of hours support and some report not having enough senior, skilled clinicians needed as outlined above.

Furthermore, this challenge can include a lack of coherent integrated commissioning of wider services required for this cohort of people e.g. insufficient access to core learning disabilities team prior to crisis escalation, no access to inpatient services/ crisis provision/ respite services, inadequate local provision for a more complex cohort of individuals, limited access to wider social care and MDT (as per The Learning Disability Improvement Standards for NHS Trusts, NHS Improvement, 2018). It is acknowledged that ISTs provide an intensive service to a small number of individuals with complex presentations and high risk (as per the National Service Model [NHS England, 2015a], see Figure 2 below). If core LD services are not adequately resourced, there can be problems with ISTs becoming overwhelmed by taking on other pieces of work as there is a lack of capacity in local LD provision. Furthermore, when specialist LD forensic services are not commissioned, the IST is often faced with pressure to take forensic clients which can exhaust their capacity and the IST may not have the specialist forensic expertise and skill set needed for this client group.

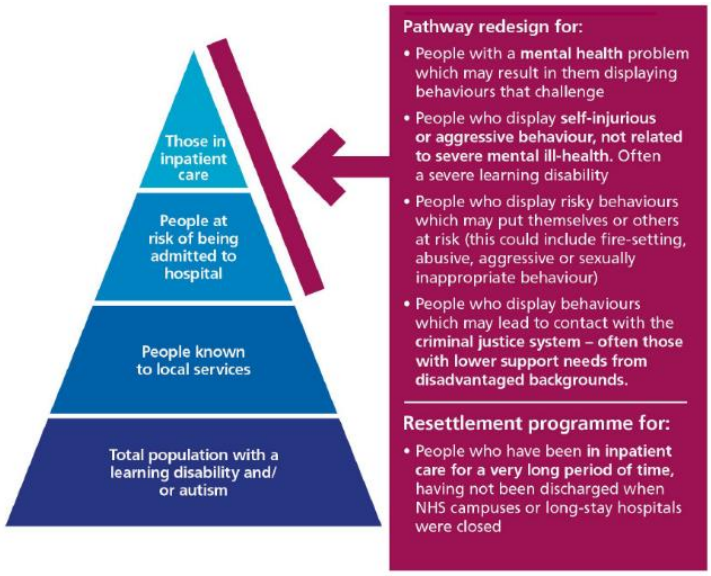

Figure 2. Outline from National Service Model (NHS England, 2015a) of who needs transforming care services

Recommendations:

- ICBs should review locally commissioned services to ensure that there is access to an IST when needed.
- ICBs and Trusts/Local Authorities should review local IST provision to ensure that it is adequately resourced to offer the best practice outlined in this document.
- ICBs and Trusts/Local Authorities should review local out of hours provision including emergency support and emergency residential services available for adults with learning disabilities, alongside mainstream crisis provision.

2. **Difficulties accessing good quality community care provision**

A significant barrier to ISTs being able to implement best practice support and interventions is the lack of good quality community care providers who can provide capable environments to individuals with behaviours of distress and complex needs in the individual's local area. It is acknowledged that although this is a concern felt across the system, ISTs see a cohort of people with complex needs and as such, need a robust and skilled provision.

The lack of placements and providers available can then result in an over burden on good placements to take on more. This then impacts on the quality of the service. Services need to have the basics of care right to be able to use the IST offer effectively otherwise IST support is likely to fail. For example, if a provider has no knowledge of key principles such as PBS, Active Support or communication support, bespoke training on a specific client is likely to be of little impact. Good quality providers should have a basic understanding in each of the areas needed for a capable environment (McGill et al., 2020) for IST support to be effective. Often such services do not exist

locally; services often have high staff turnover, low staffing numbers, or there are significant shortfalls in training and skills to support individuals in their local community. This is the case for residential, supported living and outreach providers.

Commissioners often pay high costs for 'specialist' providers who may have in-house professionals such as behavioural support. However, often these staff cover a large area or a large number of services and the skills and governance around this approach can vary so the input for a specific client can be very limited and of variable quality.

Recommendations:

- The provider market needs significant development at both a national and local level. This includes supported living, outreach care, residential care, respite provision and day services for those whose behaviour most challenges services.
- Integrated Care Systems (ICSs) should review their strategy for provider development and consider initiatives such as providing 'top up' fees for services supporting people with behaviours of distress.
- Commissioning of providers should be joined-up or integrated with the wider health and social care system.
- There are some pockets of innovative practice nationally working to upskill providers and improve the capability of provision available. ISTs are essential stakeholders in this work and it would be helpful to have some of these models written up for dissemination.

3. **Joint working across sectors**

It is acknowledged that ongoing barriers to joint working across agencies and sectors remain, in particular health and social care.

As ISTs see a population who have high levels of Care Act (2014) eligible support needs, getting support right for this group can require skilled staff and often large care packages which can be expensive.

ISTs report that a significant barrier to their work can be waiting for care packages to be implemented or liaising with social care colleagues to arrange or review care packages. Not having a social worker in the IST or a lack of sufficient joint working approaches is highlighted as a significant challenge as social care input into IST work is highly valued. It is felt that social care is integral to some of the outcomes for the individuals seen and that joint working is an essential component to effective support. It is acknowledged that the current context of social care e.g. budget cuts, is a significant challenge across the system.

Further to this, the transition processes for young people moving from child to adult services is often poor. This means that there can be gaps in care or poor joint working or handover for young people with complex needs. Returning to Transforming Care as a national priority agenda could support this joint working.

Recommendations:

- ISTs and commissioners should consider having a social worker within the IST. Where this is the case, it is reported that such barriers are reduced.
- ISTs should work with local authority colleagues to develop shared pathways and processes that support both services in achieving their core outcomes.
- DSRs should be used as a way of identifying those at risk of admission and local DSR meetings and CeTRs should facilitate joined up discussions and identification of need.

Conclusion

ISTs were commissioned in the context of the Transforming Care agenda to support people with a learning disability whose behaviour presents a significant challenge to services. The National Service Model (NHS England, 2015a) and Building the Right Support (NHS England, 2015b) documents detail what and how services should be commissioned for this cohort and what key values and principles should underlie the support offered. Although there has been some research and service evaluation written to review the core elements and key outcomes of ISTs, there remain significant differences in how ISTs are commissioned and provisioned nationally, with some areas still not having any IST.

This paper brings together a model of best practice in ISTs in terms of core elements of ISTs and key outcomes of ISTs. It also outlines key challenges to implementing this best practice. It is of note that ISTs currently outline best practice very much in line with policy and literature. This indicates that ISTs have retained the fidelity of what they were originally commissioned to offer and are successful in achieving the aims originally planned e.g., preventing admissions. It is already recommended by national policy and guidance that all areas should have an IST commissioned, however this evidence further emphasises this as a commissioning priority.

Overall, it is recommended that:

- Where there is no IST commissioned, this should be addressed as a matter of priority. New services should be commissioned in line with the best practice outlined in this paper and with consideration of the known challenges.
- Where ISTs are commissioned, services should be audited against the best practice criteria outlined in this document. This will allow ISTs to move towards a more standardised and equitable offer nationally.
- The National IST Network will work towards collating an IST toolkit to support best practice implementation.
- In order to address the challenges outlined, we are keen to open a dialogue about how to overcome these challenges to best practice and deliver positive outcomes, for this group of people. We believe this task will involve partnership working between commissioning bodies, care and support providers, health and social care services, service users and carers and other key stakeholders. Working across an integrated care system and moving care from hospital to community care underpin a future-focused NHS (NHSE, 2025).

- This position statement focused on ISTs for people with learning disabilities. ISTs for autistic people have not been commissioned as extensively as services for people with a learning disability and are often configured differently due to the paucity of core specialist services for autistic people. However, a review of autism ISTs and a position statement on the current state of such services would be a helpful addition to the literature.

References

Dodd, K., Laute, V. and Daniel, S. (2022). The development and evaluation of an integrated intensive support service. *Advances in Mental Health and Intellectual Disabilities*, *16*(1), pp.1-17.

Durand, M., Hanna, M. & Mills, R. (2025) Characteristics of individuals using an integrated intensive support team within an adult community learning disability team. *Advances in Mental Health and Intellectual Disabilities, 19(1).* https://doi.org/10.1108/AMHID-09-2024-0030

Fuchs, K. and Ravoux, P. (2019). Systemic Ideas and Positive Behaviour Support in a Crisis Service. In V. Jones & M. Haydon-Laurelut (Eds.), *Working with People with Learning Disabilities: Systemic Approaches* (1st ed., pp. 119-131). Bloomsbury Academic.

Hassiotis, A., Kouroupa, A., Hamza, L., Marston, L., Romeo, R., Yaziji, N., Hall, I., Langdon, PE., Courtenay, K., Taggart, L., Morant, N., Crossey., & Lloyd-Evans, B. (2022). Evaluating specialist intensive support teams for adults with intellectual disabilities who display behaviours that challenge: The IST-ID mixed methods study. medRxiv preprint doi: https://doi.org/10.1101/2022.05.16.22275150

Hassiotis, A., Walsh, A., Budgett, J., Harrison, I., Jones, R., Morant, N., Courtenay, K., Crossey, E.V., Hall, I., Romeo, R., Taggart, L.G., Langdon, P.E., Ratti, V. (2020) Intensive support for adults with intellectual disability and behaviours that challenge: a survey of provision and service typologies in England. *BJPsychOpen, 6(2), pp*1-8.

Lines, J., & Crank, S. (2021). An evaluation of an intellectual disabilities intensive support team's interventions–A practice paper. *International Journal of Positive Behavioural Support*, *11*(2), 37-43.

Macdonald, B. & Goody, L. (2025) Developing psychologically informed care in Crisis Resolution and Home Treatment Teams: a model and toolkit. *Psychological Professions Network South East (PPN-SE)*

McGill, P., Bradshaw, J., Smyth, G., Hurman, M. and Roy, A. (2020). Capable environments. *Tizard Learning Disability Review*, *25*(3), pp.109-116.

National Institute for Clinical Excellence (2018) *Learning disabilities and behaviour that challenges: service design and delivery*. NICE guideline [NG93]

NHS England (2015a). *Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition: Service model for commissioners of health and social care services.*

NHS England (2015b). *Building the right support.*

NHS England (2019). *The NHS Long Term Plan.*

NHS England (2023). *Dynamic support register and Care (Education) and Treatment Review - Policy and guidance.*

NHS England (2025). *Fit for Future: 10 Year Health Plan for England.*

NHS Improvement (2018). *The Learning Disability Improvement Standards for NHS Trusts.*

Prakash, J., Andrews, T., & Porter, I. (2007). Service innovation: Assertive outreach teams for adults with learning disability. *Psychiatric Bulletin*, *31*(4), 138-141.

Reid, C., Sholl, C. and Gore, N. (2013). Seeking to prevent residential care for young people with intellectual disabilities and challenging behaviour: examples and early outcomes from the Ealing ITSBS. *Tizard Learning Disability Review*, *18*(4), pp.171-178.

West, M (2021). Compassionate Leadership: Sustaining wisdom, humanity and presence in health and social care. The Swirling Leaf Press.