Policy & Guidelines on Provision of Positive Behaviour Support

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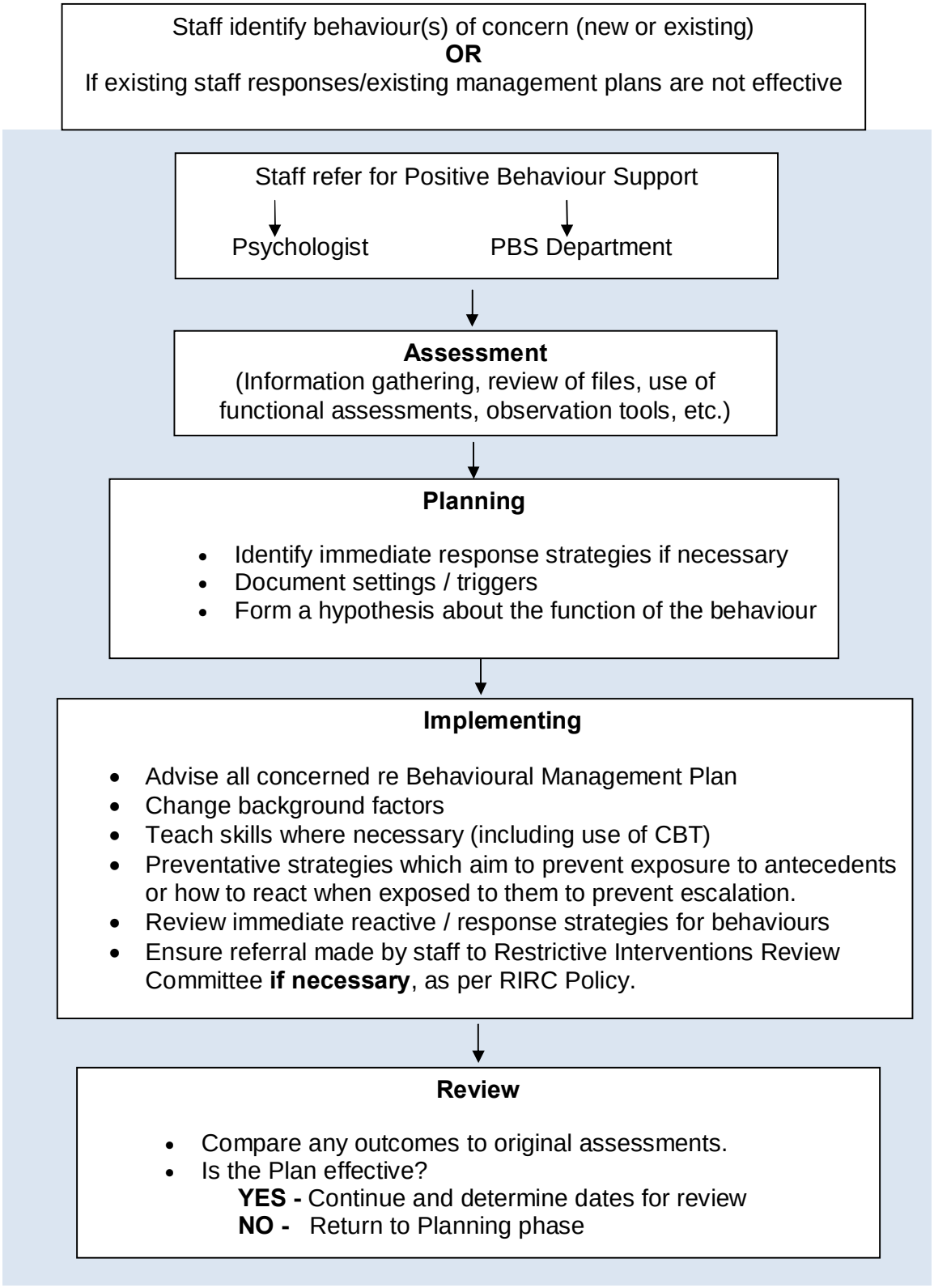
FLOWCHART FOR PROVISION POSITIVE BEHAVIOUR SUPPORT



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Introduction

It is acknowledged that people with Intellectual Disability/Autism may occasionally present with behaviours that pose a risk to themselves or others. Such behaviours described as ó*challenging'* (or ó*of concern')* may impact on the quality of life of the person engaging in the behaviour and on the quality of life of others.

Therefore, the use of the term *challenging* should be understood primarily in terms of the social context in which the behaviour occurs, rather than necessarily a symptom of individual pathology (Emerson & Bromley, 1995). It should not be interpreted automatically as an expression of deviance or abnormality inherent in the person, but viewed rather with reference to much wider social contextual factors.

PART 1: POLICY

1.1 Policy Statement

Consistent with legislative requirements and evidence based best practice, COPE Foundation will endeavour to provide appropriate positive behavioural support to the person accessing our services, who engages in behaviours described as *challenging (*or *of concern),* and to their family, peers and friends.

1.2 Policy Purposes

The purposes of this Policy are:

- To outline the requirements in providing a behaviour support service to adults, children or young people with an intellectual disability and/or autism;
- To provide guidance to staff on the provision of positive behavioural support.

1.3 Policy Scope

- This Policy is applicable to all COPE Foundation employees in any setting where care, support, education and/or training is provided.

1.4 Related Policies/Standards

- *Policy for the Prevention of/Use of Restrictive Interventions* (COPE Foundation 2014);
- *Guidelines for the Prevention of/Use of Restrictive Interventions* (COPE Foundation 2014);
- *Trust in Care (HSE 2005)* ï Policy for Health Service Employers on Upholding the Dignity and Welfare of Patient/Service Users and the Procedure for Managing Allegations of Abuse against Staff Members;
- *National Standards for Residential Services for Children and Adults with Disabilities* (Health Information & Quality Authority, January 2013).

PART 2: Roles & Responsibilities

2.1 Line Manager

- Ensure that this Policy is available to all staff, and that they are aware and supported in the implementation of its guidelines;
- Ensure that people we support who present with behaviours of concern are referred for assessment;
- Ensure that all relevant information is shared between staff, family and the person we support, as appropriate;
- Ensure that staff members receive appropriate training and education, including Crisis Prevention Institute training programmes such as *non-violent crisis intervention (NCI)* and *management of actual or potential aggression (MAPA).*

2.2 Staff Members

- Be aware of the content of this Policy and its Guidelines;
- Adhere to positive pro-active strategies as much as is possible;
- Employ *restrictive* strategies only as a last resort, and as directed by the personôs Behaviour Support Plan;
- Ensure that *reactive* strategies are only used as a last resort (in accordance with COPE Foundationôs *Policy for the Prevention of /Use of Restrictive Interventions* & *Guidelines for the Prevention of /Use of Restrictive Interventions);*
- Adhere to the content of training, such as *Crisis Prevention Institute (CPI)* training programmes;
- Advise line manager of training support needs;
- Adhere to staff self-preparation guidelines (Appendix 3);
- Adhere to local protocols and guidelines concerning use of panic alarm systems.

2.3 Positive Behaviour Support Department/ Psychology Department

- Provide staff with support and training to understand, prevent and manage behavioural incidences;
- Ensure staff understand the presentation and possible meanings of challenging behaviour, the nature and rationale for possible interventions;

- Ensure that any person referred, who presents with behaviours of concern, will have a written Behaviour Support Plan;
- Ensure staff understand all aspects of the Behaviour Support Plan;
- Each department to liaise, and decide on the appropriate provider of the intervention;
- Refer to other members of the multidisciplinary team, if other specific needs are identified.

PART 3: Behaviours of Concern

3.1 Behaviours of Concern: Possible Causes?

- Genetic, cognitive, phenotypic, medical, sensory, psychiatric, historical, cultural, or other factors;
- Mismatches between existing supports and individual need;
- Attempts to communicate positive or negative emotions, release stress, obtain, escape, avoid or reject objects or events;
- Biological (pain, medication, the need for sensory stimulation);
- Social (boredom, seeking social interaction, the need for an element of control, lack of knowledge of community norms, insensitivity of staff and services to the person's wishes and needs);
- Environmental (physical aspects such as noise and lighting, or gaining access to preferred objects or activities);
- Psychological (feeling excluded, lonely, devalued, labelled, disempowered, living up to people's negative expectations);
- Use as a means of communication;

PART 4: Provision of Positive Behaviour Support

4.1 Referral for Positive Behaviour Support

Staff may refer a person for behaviour support to either the *Psychology Department* or *Positive Behaviour Support Team*, dependent on the need and specific nature of the support required. Where the Psychology Department are already supporting a person/area, referrals to the Positive Behaviour Support Team should only be made in consultation with the Psychology Department.

A behaviour support service may be appropriate where staff believe:

- There are reasonable concerns over risk of harm or serious injury to the person or to others;
- Existing strategies have not been effective in managing the behaviour of the person;
- There are concerns over the use of existing strategies for other reasons, including limiting opportunities for the person;
- The personôs behaviour of concern appears to prevent other significant needs being met;
- The capacity of the support system is under significant stress.

4.2 Behaviour Assessment & Analysis

- *Behaviour Assessment* is the process of systematically gathering information which will clearly define the behaviours/ issues that have been identified as *challenging* or *of concern,* within the context of the total life of the person (see Appendix 2);
- Staff play an integral part in any assessment and are encouraged to record/document behaviours of concern, such as the conditions and frequency under which the behaviour occurs or does not occur, even prior to any referral for behavioural support;
- *Analysis* is the process of using the information gathered from the assessment to understand the *function* of the behaviour, and the complexities of the personôs support needs;
- Assessment and analysis should lead to the development of appropriate interventions aimed at improving the personôs quality of life, enhancing their skills/coping strategies, reducing the severity of issues associated with the

identified behaviour(s), supporting staff and peers, while minimising any potential risk.

4.3 Positive Behaviour Support Plan

4.3.1 Purposes of the Plan

- To adapt the environment to suit the person;
- To bring about a reduction in the behaviour;
- To assist the person to replace the challenging behaviour with alternative behaviours;
- To react to the behaviour safely, sensitively, and with dignity.

4.3.2 Development of the Plan

The development of a plan based on the information gathered from the *Behaviour Assessment & Analysis* is a collaborative process:

- With those who know the person well;
- With those who provide support in the setting in which the strategies are to be used;
- With those familiar with the technical aspects of any specialised supports that may be involved.

The Behaviour Support Practitioner (Psychology/PBS) will assume a lead role in the planning process, but is also dependent on the knowledge and relationship that staff have with the person to underpin it.

4.3.3 The Plan

The plan should give clear instructions to guide carers in how they should:

- Intervene at an early stage to prevent further progress of the behaviour;
- Implement the agreed strategies, in response to an episode or incident, and thus restore order or calm as quickly and as safely as possible.

4.3.4 Activation of the Plan

All steps in the provision of behaviour support require collaboration with a range of parties, including (but not limited to):

- The person who requires positive behaviour support;
- Parent/s, siblings, extended family members, carers, guardian, advocate, friends and significant others;
- COPE Foundation staff;
- Practitioners, external services and disciplines who are involved in providing a service to the person.

4.3.5 Review of the Plan

- The aim of the review is to ascertain the effectiveness of the various strategies that are being used to address the behaviours of concern;
- The review should prompt change to the plan where evidence suggests that it is warranted;
- Once it is established that the plan or strategy is being implemented consistently, and that no significant alteration is needed, the review period may be lengthened.

4.3.6 Time Factor

- The imperative for timely action may often limit the *Behaviour Support Practitioner* to immediate consideration of such issues as quality of life, and the inherent risk of harm. In some cases, where risk of harm is immediate, or if there are existing plans in place which are deemed ineffective:
- Another plan may be devised;
- Attention should be paid to known triggers, or setting events, and the plan should give direction on minimising their effects;
- It should give clear instructions which aim to *prevent* incidents wherever possible.

PART 5: Restrictive Practices

5.1 Restrictive Practices

- Should be based on the principle of the *least restrictive alternative;*
- Should be proportionate to the risk;
- Should be used only as a last resort;
- Should be used when the individual is a risk to themselves and/or others;
- Should be used when the preventative strategies have been unsuccessful;
- Should not be more restrictive or intrusive than is necessary to prevent foreseeable harm;
- Should be applied for no longer than is necessary to contain or address the risk.

Restrictive Practices must meet consent and approval requirements in accordance with COPE Foundation Policies:

- *Policy for the Prevention of / Use of Restrictive Interventions;*
- *Guidelines for the Prevention of / Use of Restrictive Interventions.*

Appendix 1

TERMS & DEFINITIONS

Intellectual Disability

Intellectual Disability means a significantly reduced ability to understand new or complex information and to learn and apply new skills (impaired intelligence). This results in a reduced ability to cope independently (impaired social functioning) and begins before adulthood, with a lasting effect on development. (www.euro.who.int).

Autism Spectrum Disorder

A category characterised by having symptoms within three areasé qualitative impairment in social interaction; qualitative impairments in communication and restricted, repetitive, and stereotyped patterns of behaviours, interests, and activities. (Gerland, 2013, p. 186*).*

Under the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) criteria, individuals with Autism Spectrum Disorder (ASD) must show symptoms from early childhood, even if those symptoms are not recognized until later. (DSM-5, 2013)

Challenging Behaviour / Behaviours of Concern

Behaviouré of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion. (Banks et. al, 2007).

Mental Illness

Mental illness is a substantial disturbance of thoughts or mood, that significantly impairs judgement, behaviour, and capacity to recognise reality or to cope with the ordinary demands of life. (Rawlins et al 1993).

Dual Diagnosis

When people with intellectual disabilities (ID) experience a mental health problem, they are sometimes referred to as having a dual diagnosis. People with ID are more susceptible to mental health problems than many other groups within society (Emerson et al 2001), yet their problems often remain undetected. This is because

the symptoms may be obscured amongst the various other behaviours which they may exhibit. It is thus essential to be as aware as possible of potential mental health problems, and have the person assessed and treated without delay.

Positive Behaviour Support

ó..characterised by educational, proactive, reactive and respectful interventions to problem behaviours and by changing problematic environments. It blends best practices in behavioural technology, educational methods, and ecological systems change, with person-centred values, in order to achieve outcomes that are meaningful to the individual and to his or her familyô(Bambara et al., 2004).

Positive Behaviour Support Plan

Proactive and reactive strategies based on goals which endeavour to:

- Adapt the environment to suit the person;
- Bring about a reduction in the behaviour;
- Assist the person to replace the challenging behaviour with alternative behaviours;
- React to the behaviour safely, sensitively and with dignity.

Risk Assessment

Determining as well as possible, the likely benefits and harms, which will arise in determining a course of action. A behavioural risk assessment may categorise behaviour(s) of concern as a low, medium or high risk dependent on likelihood of its occurrence and the severity of outcome.

Functional Assessment

- *Direct Functional Assessment*

An observational assessment which gathers broad and specific information but looking at triggers to and/or consequences of behaviour in order to have a clearer understanding of the reasons for a personôs behaviours.

- *Indirect Functional Assessment*

ôStructured interviews, checklists, rating scales, or questionnaires to obtain informationé to identify possible conditions or events in the natural environment that correlate with the problem behaviourô (Cooper, Heron & Heward, 2007).

Functional Analysis

Antecedents and consequences, representing those in the personôs natural environment, are arranged so that their separate effects on problem behaviour can be observed and measured (Cooper, Heron & Heward (2007).

Proactive Strategies / Preventative Strategies

These are strategies which are used with the aim of avoiding triggers to behaviours of concern, or preventing them from escalating when they do occur (La Vigna & Wiillis, 2005

Reactive Strategies / Response Strategies

Interventions which focus on containing (managing) behaviour which presents a risk of harm or injury to the person or to others (La Vigna & Wiillis, 2005)

Cognitive Behaviour Therapy (CBT)

Cognitive therapy is based on the fact that peopleôs mood is influenced by the way in which they view and structure their experiences. Beliefs, expectancies, plans and values are seen as having a large contribution to the maintenance of abnormal behaviour, so changing them can have a beneficial effect. The application of cognitive therapy in individuals with learning disabilities is relatively new, but there are some promising findings. A wide range of therapies, such as cognitive behaviour therapy and psychotherapy, are now increasingly being offered to people with learning disabilities, all of which are compatible with the use of PBS (Hayes 2007).

Crisis Prevention Institute (CPI)

The *Crisis Prevention Institute* is a worldwide organisation that promotes and trains in safe management of disruptive and assaultive behaviour. (www.crisisprevention.com)

CPI: Nonviolent Crisis Intervention (NCI) Training Programme

NCI training is a safe, non-harmful behaviour management system designed to aid staff in maintaining the best possible *care, welfare, safety and security* for individuals who engage in challenging behaviour. The cornerstone of CPI is the *Nonviolent Crisis Intervention*® programme, which is considered the worldwide standard for

crisis prevention and intervention training. With a core philosophy of providing for the *Care, Welfare, Safety, and Security*SM of everyone involved in a crisis situation, the programôs proven strategies give service providers and educators, the skills to safely and effectively respond to anxious, hostile, or violent behaviour, while balancing the responsibilities of care.

Management of Actual or Potential Aggression (MAPA®)

CPIôs MAPA curriculum began in 1996 with its origins in health care, social care, and special education. It includes a suite of disengagement techniques designed to enhance personal safety. The ultimate focus of MAPA is to ensure that staff acquire the essential knowledge, skills and confidence to prevent and de-escalate crisis situations. MAPA® Physical Interventions are independently risk assessed and accredited by the British Institute of Learning Disabilities (BILD). It is now being taught in COPE Foundation.

Restrictive Interventions

Restrictive Interventions refers to the application of any physical, mechanical, environmental, psychological or pharmacological means of restraint, that is used for the purpose, or intent, or restricting the free movement, or decision making abilities of another person. (Nursing Board of Western Australia, 2009, (www.nbwa.org.au).

Restraint

Any action, word or deed that is used for the purpose or intent of restricting the free movement, or decision making abilities of another person. (Nursing Board of Western Australia, 2009, (www.nbwa.org.au).

Appendix 2

Assessment: Areas of Focus

A comprehensive assessment of a personôs individual support needs must include due consideration of the impact of a range of contextual variables on the personôs life. Each of following contextual variables may be considered as interlinked for purposes of the assessment:

- Personôs quality of life;
- Inherent risks of harm;
- Support system: its characteristics and overall resilience;
- Relevant diagnoses, genetic, developmental and cognitive factors;
- Medical and dental factors;
- Mental health factors;
- Communication system, including:

(a) Expressive and receptive communication skills of person;

(b) Expressive and receptive communication skills of carers and significant others;

- Presence of characteristics associated with Autism Spectrum Disorder;
- Mobility and sensory factors;
- The many environments in which the person interacts with others;
- Family context and family expectations of service provision;
- Cultural and linguistic factors;
- The wider social network of the person;
- Life skills, experiences and preferences;
- Previous contact with support services (history and outcomes).

It should be remembered that the intensity or depth of consideration given to these *areas* during assessment will vary, depending on the nature of the presenting variables and other factors such as the prevailing environment, etc. Some of the assessments can only be carried out by members of the Psychology Dept., such as assessing a personôs degree of intellectual disability, etc.

APPENDIX 3

Staff Self-Preparation

- Staff who support people with actual or potential aggression / violence must consider their self-preparation, so that attire and personal affects worn do not pose a safety risk in a crisis situation.
- Some areas may have specific guidelines relating to appropriate clothing, but in general, attention must be given to the following:
- **Hair**: Long hair must be tied up to limit/ reduce the risk of hair pulls.
- **Jewellery:** All staff are advised to remove all jewellery prior to reporting for duty. This includes both visible and concealed jewellery, such as body piercings, tongue bars, etc.
- **Clothing:** Staff at all times should dress appropriately, to reduce the risk of the people we support grabbing clothing and causing injury. Clothing worn by staff must not pose a trip hazard, or be restrictive to spontaneous movement.
- **Nails:** All finger nails must be short and clean. False nails are not permitted when supporting people in COPE Foundation.
- **Footwear:** Appropriate footwear must be worn at all times, including: Full shoe with laced or Velcro fastenings; Flat non-wedged/ non-slip sole surface.

References/Bibliography

- American Psychiatric Association (2014) Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5).

- Banks, R., Bush, A., Baker, P., Bradshaw, J., Carpenter, P., Deb, S., Joyce, T., Mansell, J. and Xenitidis, K. (2007). *Challenging Behaviour- A unified approach: Clinical and service guidelines for supporting peoples with learning disabilities who are at risk of receiving abusive or restrictive practices.* College Report CR144. Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists.

- Crisis Prevention Institute www.crisisprevention.com

- Cooper J.O., Heron T.E. & Heward W.L. (2007) *Applied Behavior Analysis* (2nd Ed.) Pearson. Upper Saddle River.

- Emerson E & Bromley J. (1995) *The form and function of challenging behaviours.* Journal of Intellectual Disability Research 39(5), 388-398.

- Emerson E., Hatton C, Felce D et al (2001). *Learning disabilities: the fundamental facts.* The Mental Health Foundation, London.

- Gerland, G. (2013). *Secrets to Success for professionals in the Autism Field: An Insider's Guide to understanding the Autism Spectrum, the Environment and Your Role.* Jessica Kingsley Publishers: London and Philadelphia.

- Heyes S. (2007) *Cognitive behavior therapy for people with ID who are victims of crime – can it be accessed and does it work.* Paper presented at the 5th World Congress of Cognitive and Behavioral Therapies, Barcelona, 11-14 July 2007.

- *National Standards for Residential Services for Children and Adults with Disabilities.* (Health Information & Quality Authority, January 2013).

- Nursing Board of Western Australia, 2009. *Guidelines for the use of restraint in Western Australia.* (www.nbwa.org.au)

- La Vigna, G.W. & Willis, T.J. (2005) *Episodic Severity: an overlooked dependent variable in the application of behavior analysis to challenging behavior.* Journal of Positive Behavior Interventions **7**: 47-54.

- *Policy for the Prevention of / Use of Restrictive Interventions (COPE Foundation 2014).*

- *Guidelines for the Prevention of/ Use of Restrictive Interventions (COPE Foundation 2014).*

- Rawlins, R., Williams, S., Kelly Beck, C. (1993). *Mental Health – Psychiatric Nursing. A Holistic Life-Cycle Approach.* 3rd Ed. Mosby-Year Book Inc.

- *Trust in Care: Policy for Health Service Employers on Upholding the Dignity and Welfare of Patient/Service Users and the Procedure for Managing Allegations of Abuse against Staff Members.* (HSE, 2005).

- World Health Organisation (2014) www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/news/news/2010/15/childrens-right-to-family-life/definition-intellectual-disability