western Care association

Policy / Procedure Details	Title:	**Listening and Responding to People**
	Type:	**Essential Procedure**
	Related Personal Outcome Measure:	**I feel Safe**
	Code:	**1.14**
Original Version Details	Previous Title: *(If applicable)*	**SP 21.1 Policy Guidelines on Positive Approaches** **SP21.2 Guidelines on the use of Physical Restraint**
	Date Released:	**SP 21.1 10/04/2002** **SP 21.2 20/03/2002**
Previous Version(s) Details	Previous Title:	**SP21.1 and SP21.2 - 21 / 11 / 2003** **Title Changed from: Listening and Responding to People who Challenge and the use of Restrictive Practices on 20.01.2017**
	Date(s) Released:	**31/10/2013**	**01/01/2017**	
Current Version Details	Written By:	**BSS Team** **Training and Development Manager** **Quality and Risk Manager**
	Reviewed By:	**Procedural Review Committee**
	Approved By:	**Procedural Review Committee**
	Date Released:	**20 / 01 / 2020**
	Monitoring Process:	**Procedural Review Process**
	Date Due for Review:	**20 / 01 / 2023**

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1. Introduction / Policy Statement

Purpose: This policy describes Western Care's approach to listening and responding to people who engage in behaviours of concern and whom the service finds a challenge. It promotes the importance of supporting people in a safe, positive, respectful, empathic and non-judgemental way.
It also defines practices that are viewed as prohibitive and which must never be used and practices that are considered restrictive which may be used in supporting a person from time to time.

Western Care Association is committed to ensuring that adults and children who engage in behaviours of concern are entitled to the same rights and safeguards as any other adult or child in society and that they are supported in environments that are safe, positive, empathic, respectful and inclusive.

The purpose of a Policy around how we support people who challenge us is to make sure that the practices, strategies, plans and interventions that we use to work with people are of the highest standards.

a) All people within the organization are not the subject of dehumanizing practices.
b) Procedures that limit or restrict personal freedoms are only carried out in accordance with the national and international laws governing such actions.
c) To ensure a collaborative and consistent approach to supporting people who may engage in behaviours of concern.

Promoting positive behaviour and preventing and managing behaviours of concern in a safe non-aversive way is vital for the safety of those we support and for their supporters.

2. Values Informing Practice

Respect the Rights of the Person Served
The human rights, safety, and well-being of the individual are paramount. Each individual is treated with the same degree of respect and dignity that would be accorded to any citizen. In particular, the dignity, feelings, values, personal and lifestyle choices of the individual must be respected and safeguarded. The person's culture, ethnic background, heritage, religious and spiritual beliefs, must also be respected.

Positive Focus on the Interests and Quality of Life of the Person Served
Service users and staff are people first; all people are valuable and have strength and abilities Support must focus on benefits for the individual through increased quality of life and independence. It should support the growth and learning of the individual as a whole person, within a positive environment. It must be appropriate to the age, maturity and understanding of the individual involved.

Limit Use of Restrictive Practices
Restrictive practices may only be used within an individual's Personal Risk Management Plan (PRMP) or in an emergency. Restrictive practices are only included in the PRMP when circumstances are serious enough to justify them, and there must be a clear plan in place to address them. The principle of "there is no alternative" should apply to any intervention that places limits or restrictions on an individual.
The decision rule to follow for when restrictive practices (as defined in this Guide) are used is that the least intrusive responses must be used for de-escalating the behaviour while providing safety for the individual and others. (See Restrictive Policy for further information)

Prohibited Practices are never to be used
Prohibited practices are never to be used. Use of any prohibited practices constitutes abuse and staff and service providers must report it immediately, as outlined in the Association's Protection and Welfare policy.

It is prohibited to use any practice whose purpose is to demonstrate power, enforce compliance, inflict pain, harm, to punish or discipline an individual.

Examples of practices which would be considered prohibitive are:

a) Restrict food, drink, clothes, choice, and information for the sole purpose of trying to encourage 'good behaviour' i.e. obedience
b) Shout at service users, swear at them or strike them.
c) Deny or restrict the basic rights of everyday life such as food or drink
d) Talk about them as if they were not present
e) Treat someone as if their feelings do not matter.
f) Withdraw the things that people value, own or are entitled to, as a punishment for bad 'behaviour'.
g) Any instance where fear is deliberately induced in an individual.

3. From Challenging Behaviour to Behaviours of Concern

The term ***behaviour that challenges the service*** began to be adopted in the field of intellectual disability in the 1980's. At that time it was considered a progressive development, as it was a move away from stigmatising individuals who may at times be compelled to display severe behaviours because in some-way their needs were not being met.

Internationally there is now a move away from the term challenging behaviour to 'behaviours of concern', this is an endeavour to ensure that an individual will not have the stigmatising and devaluing label challenging behaviour attached to them as a person.

When considering a person's behaviour of concern we always need to consider who the behaviour is a problem for? Is it a problem for the person, a problem for those supporting the person, a problem for those living with the person or for those who come into contact with the person in the community?

For the context of this document behaviour of concern is defined as: "*behaviour of such intensity, frequency and duration that the physical safety of the person or others is placed or is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit the use of, or result in the person being denied access to ordinary community facilities, services and experiences".* (Emerson 1995).

Some people have developed 'behaviours' over many years and may be part of the person's coping mechanism or a means of escaping from situations that they found stressful or fearful. These behaviours serve a purpose for the person and whilst we should always 'listen deeply' and seek to understand what the person is trying to communicate via their behaviour, we must always be extremely cautious about interfering in a person's life and seeking to change their behaviour just because it does not fit with what we believe to be 'normal behaviour'. A real danger in trying to extinguish behaviour without fully understanding it from the person's perspective is that it can be replaced by more extreme and more dangerous behaviours.

People may engage for instance in behaviours on an episodic basis e.g. loud vocalisations, these may be long-standing and they require those supporting the person to be patient, tolerant, empathic, supportive and resilient. Other people living with the person during those times also will need additional support including the opportunity to spend quality time away from the person who is experiencing difficult times.

When a person engages in behaviours of concern we support them by trying to understand the reason for these behaviours. We develop a plan that is appropriate to the particular behaviours of concern. We track how the plan is working through the use of evidence such as data gathered for that specific purpose. For directly provided centre based services we also use the Associations Incident reporting system to provide data to flag concerns and track whether our plans help to reduce the frequency or severity of incidents are working.

This Policy sets out the various approaches that are used to address behaviours of concern as they escalate. It provides some background on the approaches used and some detail regarding specific elements of these approaches. All approaches are based in the same set of Person/Family Centred values.

4. Positive Behaviour Support

Positive behaviour support (PBS) comes from the perspective that there is not a simple answer to the complex reasons why people show behaviours of concern. PBS has emerged from three main sources; the movement towards inclusion, applied behaviour analysis and person centred approaches which has as a primary goal the enhancement of the quality of life of the person with a disability.

Carr describes PBS in the following manner:
"Positive Behaviour Support is less a process of selecting an intervention, and more the construction of a comprehensive set of procedures that include change of the environment to make the problem behaviour irrelevant, inefficient and ineffective, and helping the person to achieve his or her goals in a socially acceptable manner". Carr et al (2002).

Western Care Association embraces a non-aversive multi-element Positive Behaviour Support (PBS) approach to understanding the function of behaviour in the context of a person's life.
The PBS approach is a framework within which we, the person's supporters (paid and unpaid), try to understand what the person is communication via his/her behaviour(s) of concern.
PBS is an evidence based approach which includes the systematic gathering of relevant information, conducting a functional assessment, designing support plans, implementation and on-going evaluation.
PBS approach is in line with WCA's individual planning process, and this should be referred to in the first instance.
First and foremost people are kept safe. People's behaviour of concern, their associated risk and response strategies are identified in their *Personal Risk Management Plan*
The PBS approach places a strong emphasis on proactive and reactive strategies to behaviour(s) of concern. At times these strategies may not be available or effective and in these situations crisis management strategies may be required, see section 'The Components of a Multi Element Positive Behaviour Support Plan'
PBS also takes into account the behaviour and wellbeing of the person's supporters (paid and unpaid).
This approach emphasises the person and their supporter's participation to ensure that assessments, interventions and outcomes are meaningful. PBS is 'done with' the person.

This approach places an emphasis on the need for responsiveness to a person's feelings and needs and has the following defining features:

- Valuing the person, deliberately building a sense of self-worth, acknowledging all attempts at positive interaction
- Creating situations that enable the person, regardless of the behaviours of concern that they show, to be seen in a positive light
- Acknowledging and trying to interpret what the person is communicating via their behaviour rather than just stopping the behaviour
- Analysing the function(s) (meaning) of the behaviour(s)
- Teaching the person other ways to meet their need or communicate their feelings
- Creating a supportive and person centred environment and service that meets the persons needs and recognised their individual differences.
- Gently supporting and leading the person to a calmer state
- Providing encouragement and praise to the person about any person successes they may achieved and any difficult situations they may have handled well.

5. Listening to the Person with Behaviours of Concern

People who engage in behaviour(s) of concern always do so for a reason and the challenge for those supporting them is to listen deeply and continue to seek to understand why the person is engaging in the behaviour.

The way we behave around other people and the relationships we establish are a critical factor in determining and achieving our goals, hopes and dreams. People with behaviours that others find difficult to understand often find that their relationships are difficult to maintain and their goals, hopes and dreams can be difficult to ascertain or achieve.

It is important to consider the environmental factors that can exist in any given situation around a person. This can include the physical environment that the person experiences, the range of activities available to the person, the predictability of the person's day and the person's communication system. It can also include the rules, routines and restrictions present in the environment. Also the relationship that exists between the person and other people that may share the environment needs to be considered.

An important consideration is the quality of the relationship between the person and their supports both paid and freely given. Is there consistency in the people providing supports or is there a lot of turnover which provides staff coverage but does not foster continuity, security or strong relationships. Good practice would always place a high priority to achieving a 'good match' between the person and his or her supporters and on sustaining this relationship.

Supporters who want to 'walk a mile' in the person's shoes and try to understand the chaos the person is experiencing, and who are prepared to give the person ' a break' in terms of their behaviour, are the ideal people to be around the individual. Empathy, positivity, optimism and resilience are vital characteristics in those supporting a person who is in crisis.

6. A Step by Step Guide in responding to Behaviours of Concern

a) <u>Role of Direct Support Staff:</u> When someone's behaviour changes, we need to pay attention to what might be causing them to act like this. We also need to acknowledge that we support people in the Association who engage in particular behaviours either on an on-going basis or periodically. These behaviours may be long-standing and in may take a long time to change. Those supporting the person will need to be tolerant, empathic, supportive and resilient. Special consideration must be given to those who share the same environment with the person and they may need to spend quality time away from that location to reduce their stress and any distress that they may be experiencing as this may be their home and they may not have had a choice with whom they live with.

b) Look at any changes that may have taken place in their lives recently. What is different in their life now and how are we going to manage this?

c) Consider their health and what might be causing them to feel differently – *(see Best Possible Health policy).*

d) Review their IP and use the principles set out by O'Brien and Lyle O'Brien below when considering their overall life circumstances. Develop an Action Plan to comprehensively address what is happening for person.

e) If the situation persists and the behaviour continues or escalates, all those who are closest to the person (Circle of Support) should come together and review how life is for the person using the IP process and try to develop solutions.

f) The strength of this approach is it assumes capacity in the local team and Support Network to address situations based on their knowledge of and relationship with the person, their experience and training and their ability to respond rapidly as a staff team who see the person on a daily basis. Ownership and implementation of solutions closest to the source of occurrence is an empowering model for the person's supporters. It also represents a more targeted use of resources so that referrals to more specialised functions occur only when local efforts require additional support.

g) If the situation is not resolving and the behaviour continues and/or escalates staff will need to consider onward referral to another source. At this point a referral form is completed using Western Care Association referral form (internal). This form is then forwarded to the Regional Service Manager/Senior Service Manager who will sign it and make a decision as to who might best respond to the referral at this time. The referral pathway may be directed towards support internally within Western Care from BSS, Psychology, SLT or may be directed externally towards specialist support. The RSM will keeping the frontline manager briefed on progress in addressing the referral and ensure safe practice is maintained while additional support is secured. Once an external support is engaged, the RSM/Service Manager is responsible to ensure there is full relevant guidance on file. On completion of this engagement, should internal BSS support be required to follow up, a separate referral to BSS should be completed, see below.

Note: Consent for the referral is required and must be obtained by the person making the referral.

CHANGE IN BEHAVIOUR NOTICED; BEHAVIOUR OF CONCERN APPEARS	Those closest to the person should consider why and pay close attention to: • Changes in their life • Health	Develop Action Plan to address what is happening.
IF THE BEHAVIOUR OF CONCERN CONTINUES	Overall review of I.P. and what is happening in the person's life	Develop plans to address priorities.
IF THE BEHAVIOUR OF CONCERN CONTINUES AND ESCALATES	Forward referral to R.S.M. For Adult Community Services outside the RSM structures, the social worker should liaise with their line manager to determine the most suitable referral pathway, see (h) above	

Using the framework above as a reference guide, select the appropriate level of review, planning or intervention based on the nature of the concerns. For behaviour(s) of concern, the response hierarchy might look as follows, beginning with the most straightforward response and moving to more complex ones if the behaviour of concern continues or escalates:

- Review the person's overall life circumstances through the IP; Staff Team/Support Network
- Apply a Low Arousal Approach as appropriate to the circumstances; Staff Team/Support Network
- Develop or update the person's Personal Risk Management Plan and additional documents e.g. Intimate Care Plan, How I like to be supported to ensure people's safety if this is a concern; Staff Team/Support Network
- Staff Team/Support Network may seek support of BSS in developing a PRMP
- Onward referral to support:
    - Complete a formal Functional Assessment
    - Develop a more comprehensive Behaviour Support Plan, BSS / Psychology
    - Seek additional or bespoke training; BSS / Psychology / SLT / ETD
    - Develop an alternative support arrangement; Management/Social work.

If the behaviour of concern continues or escalates or is of such intensity from the outset, the point of action may be elevated directly to one of the more comprehensive responses. In Children's Services, particularly services provided to families, the issues may present differently given the different dynamics and the approach needs to be adapted accordingly.

7. BSS Method of Engagement – Adults Services

Where the service user and/or their support network is requesting Behaviour Support Service (BSS), they can consider two pathways BSS or BSS Quick Access Forum (QAF), which can be identified on the referral form (internal) by writing either "BSS" or "BSS QAF" under the heading 'service required'

When the R.S.M. signs the referral form (internal) they can specify which pathway is being requested by ensuring either BSS or BSS QAF is written on the referral form (internal) under the heading 'service required'

A BSS QAF referral is considered to be a brief engagement with BSS e.g. one or two interactions for advice or support. A BSS QAF may include brief behaviour assessment or screening and related recommendations and/or positive behaviour strategies, reviewing Personal risk management plan (PRMP) sections relating to behaviours of concern, reviewing existing protocols for physical or chemical restraint, reviewing existing behaviour support plans. BSS QAF may also include short debriefing and/or bespoke training sessions if required and/or appropriate onward referral to another source. The strength of engaging with BSS QAF is that it may offset the need for full "direct intervention" referral, and be supportive to people who engage in low severity and high frequency behaviours of concern.

Where a need for BSS QAF is identified within the framework of an Individual plan and the referral form (internal) is signed by the R.S.M. the R.S.M. will forward the referral form (internal) to the Western Care Association Psychology/BSS department administration support.

Once the behavioural support team receives the referral form (internal) requesting BSS QAF the referrer will be contacted by a member of the BSS team to arranged a BSS QAF meeting.

A BSS referral is considered to be a request for full "direct intervention" resulting in more than two or three interactions with BSS. Direct intervention may include BSS completing comprehensive functional assessment, writing an individualised Positive Behavioural Support Plan (BSP) based on functional assessment, writing a Stress Reduction Plan as part of a positive BSP, writing PRMP sections related to BoC and/or physical or chemical restraint protocols along with the manager of the service, providing learning support for service user and/or staff, which may include bespoke training, coaching and/or specialist projects e.g. Mindfulness Based Stress Reduction (MBSR), Dementia, Autism, low arousal etc. that promote positive behavioural support throughout the service user's support network. Direct intervention may also include ongoing debriefing, attending formal meeting e.g. circle of support, appointments etc. as required and/or appropriate onward referral to another source

BSS engagement will be designed for individual service users and their support network to equip people with information and skills required understanding and dealing with situations before they escalate, and as they arise.

Where a need for BSS is identified within the framework of an Individual plan and the referral form (internal) is signed by the R.S.M., the R.S.M. will forward the referral form (internal) to the Senior Psychologist/BSS Manager who will determine the appropriateness of the referral and allocate it to a member of the Behaviour Support Team. At this point the referrer may be asked for additional information via a phone call or questionnaire (prioritisation form and/or responding to new referral form). This information will shape the initial focus and will be the first step in the information gathering process.

Once the referral is allocated to a member of the Behaviour Support Team the referrer will be contacted and an appointment will be offered to explore the referral in greater detail which will also inform information gathering, screening and assessment.

A referral to **BSS** may be appropriate where:

- An existing behaviours of concern has increased in frequency, intensity and/or duration
- There is a presentation of a new behaviour of concern
- Existing proactive or reactive strategies prove not to be effective in managing the behaviour of concern
- There are reasonable concerns over risk of harm or serious injury to the Service User or to others
- The behaviour of concern appears to prevent other significant needs being met;
- Existing proactive or reactive strategies appear to prevent significant needs being met;
- The capacity of the support network is under significant stress as determined by the staff team in conjunction with the Regional Service Manager.
- The Service User is in jeopardy of being excluded e.g. from home, services, employment, community facilities etc.
- On-going debriefing is required
- A comprehensive functional assessment is required
- A comprehensive positive behavioural support plan is required

A referral to **BSS QAF** may be appropriate where

- An existing Behaviour Support Plan, existing Protocol for physical or chemical restraint, PRMP section relating to BoC need to be reviewed
- Problem solving with identified persons surrounding the behaviour of concern and the wider systems is required
- Review of previous and current strategies, and their effectiveness is required
- Refocusing on current priorities to address BoC is required
- Reflecting with team and advise where appropriate
- One off debriefing is required
- Onward referral can be completed with staff in the BSS QAF appointment. If this occurs, an email will be sent to the RSM and Person in Charge of this action. An onward referral can be to:
    - Senior Psychologist/BSS Manager for BSS 'direct intervention
- Other onward referrals may be recommended and the team will be supported to compete referral form (internal) and referral process will be followed
    - Education and Training Department for bespoke training, e.g. Bespoke Studio III, Dementia Training, Autistic Spectrum Disorder Training etc.
    - Other disciplines e.g. Speech and language, Social Work, psychology etc.

8. BSS Method of Engagement –Children's Services

Western Care's BSS service provides support to all WCA School Age service and has a remit to the Mayo Early Intervention Service (MEIS). The Children's' RSM receives and manages all referrals for Behaviour Support Service (BSS) across Children's Services. A specific BSS referral form is used to help prioritise responses to referrals. Any staff working in Children's services can complete this referral form and forward it to the RSM on completion. It is good practice to include parents in completing this form.

Each referral is reviewed at a BSS referral forum chaired by the Children's' RSM and involving the BSS staff that work in Children's Services. This forum meets on a monthly basis. Following each meeting, the RSM informs the referee of the outcome of the referral and where relevant indicates a likely timeframe for response.

For staff working in MEIS, staff members can make a referral direct to the RSM using the referral form for children with behaviours of concern who are already engaged with the service.

For new referrals to MEIS, a BSS referral should be made once the initial visit has been conducted by the MEIS team members. In such cases, it is often effective to arrange for a resource worker trained in Autism Friendly Approaches can put in place basic behavioural strategies. If this initial step is not successful, a referral for specific BSS involvement should then be made using the BSS referral form. It will in turn be responded to through the BSS referral form as above.

9. Responses are informed by a Low Arousal Approach

What is a Low Arousal Approach?
Low Arousal is a way of managing your own behaviour in order to diffuse a potentially challenging situation; it is a style of interacting with a person who is highly anxious/stressed and not in control of their behaviour at that time

a) Low Arousal is a non-confrontational way of managing situations which challenge us
b) A philosophy of care which is based on valuing people
c) An approach that specifically attempts to avoid aversive interventions
d) An approach that requires staff/carers to focus on their own responses and behaviour and not just locate the problem in the person with the label
e) A collection of strategies specific to the person supported that are designed to rapidly reduce aggression.

A Low Arousal Approach identifies a number of specific practices that support a calming and low key way of interacting with a person who may be in a heightened state of arousal or stress. These include managing your own body language, eye contact, physical proximity/distance, tone of voice, communication, distraction, etc.

However, there has been some confusion and mixed messages around what is meant by Low Arousal. *Do not misinterpret Low Arousal to mean No Arousal.*

Low arousal is not:
A low arousal approach does not mean *NO* rules/guidance, *NO* structure/demands or *NO* boundaries.

It is clear that rules and demands that arise from service related routines are often the source of conflict.
For many people who are going through a difficult and stressful time it is really important we should be aware that they need to have fewer demands on them during times like this.
However, some people, particularly those on the autism spectrum require structure and boundaries in their life. Implement the degree of routine and structure that is required based on your knowledge of what helps the person.

For example – John appears stressed in the morning and horse riding is on the schedule. Staff believes he shouldn't go / doesn't want to go or can't go because of how he is, and yet completing the routine of the day is necessary for John because predictability of routine is as necessary to the person with autism as 'air is for breathing'.

Supporting John in an autism-informed manner tells us that:
a) We shouldn't assume he doesn't want to go horse riding
b) If he doesn't go horse riding he needs to do another meaningful predictable activity
c) Doing a Physical activity will help John when he is in a stressed state and is necessary to help him work off the levels of cortisol that are in his system.

10. Development of a Personal Risk Management Plan

Personal Risk Management Plans are informed by the principles of a Low Arousal Approach. Personal Risk Management Plan (PRMP) is a tool to help people pursue their preferences and choices safely (See Risk Management Policy). *It is not limited to addressing behaviours of concern.* However, when a person engages in behaviours of concern that includes the risk of harm to themselves or others, then it is important that the nature of the risk is determined and managed in a proportionate way. The purpose of the *Personal Risk Management Plan* in this context is to respond to a situation where people are unsafe as a result of their behaviour.

The strength of a PRMP is it can be used by the direct support team and it is focussed on managing situations where safety is a concern.
Activities are planned based on the priorities and preferences as defined by the person using the services. Whether risk arises from the pursuit of a personal goal or from the places and activities the person participates in their day to day routines and environments, the nature of the potential risk needs to be considered. The Personal Risk Management Plan (PRMP) should be completed by the Frontline Manager to manage a situation of risk that has arisen in the course of providing support to Individual using services.

The *Personal Risk Management Plan* will identify the specific harm that could occur and how likely it is that this will occur. The PRMP contains proactive strategies that reduce the probability of the harm occurring and reactive strategies that specify how in the *least restrictive way* the risk of harm can be managed if it does occur.If physical restraint is specified as part of the reactive strategies, then the physical restraint protocol (see Restrictive Practice Policy) must be completed and attached to the PRMP.

The *Personal Risk Management Plan* must be developed in close collaboration with those closest to the person and where possible with the person themselves. The person's Circle of Support should be included in the development of the *Personal Risk Management Plan* in line with their agreed way of working. Each member of the Circle should agree to and sign the plan.

The *Personal Risk Management Plan* will contain details of any Rights Restrictions imposed on the person including instances where physical restraint may have to be used to protect the person or others in a potentially dangerous situation. Details of psychotropic medications and the use of PRN where it is prescribed must also be included except where they are prescribed by psychiatry to address a mental health condition e.g. depression. *A Personal Risk Management Plan* that contains restrictive practices must be highlighted on the rights checklist for each person and forwarded to the Rights Review Committee.

See also Risk Management for Individuals Using Service

11. Developing a Behavioural Support Plan

When a person has been referred to BSS/Psychology because of their behaviour(s) of concern, those supporting the person may be asked for additional information via a questionnaire (responding to referral form), phone conversation or initial meeting. This information will shape the initial focus and will be the first step in the information gathering process.
Information gathering is necessary for the development of a behaviour support plan where this is deemed necessary.

Functional Assessment
"It is not a matter of what causes self-injury or what causes aggression or what causes stereotyped or repetitive movements but for each of these forms of difficult behaviour, what does it do for the individual, what purpose does it serve for them in life?" Brown and Brown (1994).

Behaviours of concern usually occur for a reason and it is our collective role as people's supporters to try to understand the meaning behind these behaviours. PBS functional assessment is in line with WCA Incident Reporting Procedure and this should be engaged with in the first incidence. Behaviour(s) of concern may not always be explained by a single factor or cause. The same behaviour of concern may serve one function or many functions for a person. A functional assessment seeks to clearly determine what function(s) the behaviour(s) of concern is serving for the person.

The Functional Assessment aims to define the behaviour of concern and identify specific events that predict (antecedents) and/or maintain the behaviour of concern. In other words, what happens before and what happens after the behaviour of concern occurred. It also takes into account the person's motivation to engage in the behaviour of concern by looking at the broader context of the person's life and at other things which might affect the person. Examples of these may be:

- Physical health including; (dental, ears, nose and throat, constipation and gastric issues and the endocrine system)
- Mental Health conditions
- Medications including side-effects
- Communication
- The person preferences e.g. likes and dislikes
- Relationships and sexuality issues
- What are the current stressors in the person's life?
- Are the person's needs been met
- The importance of syndrome specific detailed characteristics eg. Fragile X syndrome, Rett's syndrome, Angelman syndrome, Autism, etc.
- Impact of trauma, e.g. people feeling excluded and different, people that have experienced abuse or the loss of a close family member, etc.
- Impact of attachment, e.g. adults who experienced serious medical conditions in early life and were kept in hospital often show high levels of anxiety. People who have lost one parent may be extremely anxious about the health of the remaining parent.
- Ability to express emotions
- Seeking control in their lives

Function assessment methods used to gather the information may vary across circumstances, but typically include:

- Review of existing records and information e.g. the person's IP and main file, incident injury reports etc.,
- Interviews with people who know the person well and represent a range of environments the person uses
- Direct observation. The assessment may range from highly precise and systematic to relatively informal. Particular tools and strategies used will be based on the circumstances, individuals involved, and goals of the intervention. Regardless of which methods are used, the aim of the assessment is to answer certain questions:

1. Under what circumstances is the behaviour most/least likely to occur (e.g., when, where, with whom)?
2. What outcomes does the behaviour produce for the person (i.e. what does the person get or avoid through his or her behaviour)? Another way to say this is what is the person trying to communicate?

The information gathered is then used to develop a reasonable proposition (hypothesis) based on evidence of the function or purpose the behaviour is serving for the person. Some common functions that behaviours of concern can serve for people are:

- To escape from undesired or feared situations
- To gain/access something tangible e.g. food, drink, preferred items
- To gain social attention/interactions, positive or negative
- For non-social reasons e.g. nothing else to do, repetitive behaviour, enjoys it, sensory stimulation
- For physical reasons e.g. in pain or discomfort
- To reduce their stress and anxiety.
- In response to their individual experience e.g. sensory processing (sight, sound, smell, touch, taste, proprioception: sense of own body regarding its position, motion, and equilibrium.)

When a hypothesis as to the function(s) of the behaviour(s) of concern has been determined, then strategies for enabling the person to more effectively achieve the same function without engaging in the behaviour can be identified.
In summary a functional assessment is a broad term referring to the information gathering and hypothesis development process around the behaviour(s) of concern.

Resulting from this process a support plan is designed, in line with the components of a Multi Element Positive Behaviour Support Plan, to effectively address various aspects of the behaviour of concern and provides an alternative way of achieving the same thing for the person.

The support plan will be centred around meeting the person's needs by building on the person's strengths. It will contain relevant information gathered during the assessment process. The plans will have proactive strategies that are designed to lessen the possibility of behaviours of concern occurring and may also contain reactive strategies. Crisis management strategies specify the least restrictive way that person and others can be kept safe during a crisis situation. Any useful strategies already in place should be added to the support plan.

The most effective plans are those that are developed in consultation with the person and the person's supporters. The responsibility for implementing the plan rests with those directly working with the person, but with support from members of the Behaviour Support Service. The member of the Behaviour Support Service (BSS) will offer practical 'on the ground' support in implementing the plan, modelling and coaching will be important components of that practical support.

Plans, where appropriate, should be written in accessible person-centred language devoid of jargon and should be easily understood by the person and their supporters. A multi-element plan will look at a person's life in a holistic manner and will identify different areas of their lives where they require support.

Note: Permission should always be sought from parents in the case of a child and where possible, the person themselves or their advocate when it's an adult before any assessment work is undertaken. The primary aim of assessment is to identify what the behaviour means for the person. Behaviour may be the person's sole way of communicating physical, mental or emotional illness and/or stress.

The Components of a Multi Element Positive Behaviour Support Plan

Behaviours of concern that are complex and severe may need to be addressed in a comprehensive and systematic manner and may require multidisciplinary input. When responding to such behaviours of concern, Western Care Association embraces a non-aversive multi-element Positive Behaviour Support (PBS) approach *to understanding the function of behaviour in the context of a person's life*. The multi-element approach considers the life of a person under the following important areas:

<u>Proactive strategies</u>

Environmental strategies. Note: Environment refers to the person's immediate surroundings which includes the place and the people and things in it.

- Personal factors e.g. health, medication and side effects, hunger, sensory issues and communication difficulties, etc.
- Predictable environments and consistent approaches and routines
- Opportunities to sample new activities
- Improve interactions, and realistic expectations
- Improve relationships
- Increase opportunities to exercise choice
- Know the person's likes dislikes and motivations.

Teaching Skills

- General life skills
- Communication skills
- Self-managing, coping and tolerance skills including managing stressful situations
- Functionally equivalent skills.

Preventative strategies

- Avoiding situations or environments that can trigger behaviours of concern
- Dos and don’ts when supporting an individual
- Increase the reinforcement value of desired/alternative behaviour for the person
- Work out what the person is communicating
- Increase access to what the person wants/needs

Reactive Strategies

Secondary preventative strategies

- Practice low arousal. This includes managing your own behaviour so you appear calm in order to manage the situation and support the person
- Respond to early indications of the behaviour
- Prompt coping skills, communication etc.
- Change environment
- Removing things or others that may be causing concern

Reactive Strategies

- Practice low arousal with the person
- Endeavour to de-escalate the situation
  - Give the person what they want
  - Redirection / Distraction,
  - Offer an alternative

Crisis management

If the behaviour of concern escalates, more restrictive measures may be warranted including:

- Administration of PRN-Psychotropic if prescribed. The PRN protocol should be followed that will clearly specify when the administration will take place
- Use of physical restraint but only if the person or others are in immediate danger and there is no alternative. If physical restraint is specified as part of the reactive strategies, then the physical restraint protocol must be completed.
- Provide a recovery strategies and debriefing for all involved

These elements of a comprehensive Multi Element Behavioural Assessment may be used to match the particular circumstances. Each component does not require to be used for each person. The framework provides a set of options that should inform enquiry for solutions.

All of the above strategies must be located in the person’s Relational Environment as the wider context for understanding the person, their needs and why they behave the way they do. Consider who are the people in the person’s life, how strong is their support network, do they have many/any positive relationships, are there positive relationships with family and/or unpaid supporters and peers, do they feel safe around the people they spend time with, are they suffering through loss or bereavement, have they continuity and stability in their relationships, do they have positive relationships and strong champions in their staff supports, are they a valued part of a their community, do they see enough of the people they love to see?

11. Supporting the Supporters

A key part of any behaviour support plan should be clear strategies that enable the person's supporters be they paid or freely given to keep the person safe in a crisis and for them to stay safe also.

Supporters who are valued and treated in the most respectful way or more likely to also treat those they support in a comparable manner. In the words of the educator Jean Clarke *"People's needs are best met by those whose own needs are met"*.

De-Briefing
Right Relationships is the foundation of any supporting relationship such as that between staff and person supported.

Staying positive all the time is not easy. We all have ups and downs. Whenever you are working with people your tolerances may well be challenged. The way other people do things, the choices they make, their preferences, may well be different to what you would do. We are all influenced by the emotions these situations generate.
This is especially evident in our decision making. How often have you made a bad decision in a bad mood? Or a good decision in a good mood?

Debriefing is a term used to describe talking about how you feel so that the emotion you feel towards person following an event is processed.

An incident is usually "an emotional event" and we need to be able to talk about how we feel following its occurrence to ensure our relationship with the person is not maintained and we repaired where necessary.

To find effective solutions for how to manage situations, strategies have to be discovered that deal not only with the event but also the emotions that these events generate.

These emotions need to be aired in a constructive way so that our decisions or judgements are not clouded by fear, guilt, anger or doubt.
There will be some times when you feel that something needs to be done about a person because of the way that they behave. The best way to resolve this issue is to:

a) Find a way to resolve your emotions
b) Find a positive approach to the situation after reviewing all the facts.

For debriefing to occur successfully there are some conditions for success that must be paid attention to:

- Confidentiality - It is understood that this is a space whereby the emotions person has around what has occurred are spoken about freely; confidentiality is respected unless there is a disclosure made that person is obliged to report under organisation protection and welfare guidelines where there is potential for harm to self or others.
- Trust - Person who is debriefing must trust person they are debriefing to
- Comfort and free from distraction - occur in a comfortable setting where neither party is likely to be disturbed
- No judgement

- Solutions to the incident are not considered at this stage
- Opportunity to share how you feel about what occurred
- A space is provided for the persons concerned to heal.
- Debriefing is part of a Risk Management Strategy.

Debriefing has to occur respecting confidentiality as it's your time to talk. It's best done with someone you feel comfortable with and this does not have to be your line manager. The purpose is to share and process your emotions and to come to a further understanding and possible resolution.

Debriefing can occur in the following ways:

- Talking to a trusted colleague
- Talking to line manager
- Talking to relevant others within organisation e.g.: BSS, Social Work, Psychology
- Talking to EAP (Employee Assistance Programme).

The organisation recognises the necessity of debriefing for staff and has established systems of support to enable it to happen. It is an activity that all staff recognises as important and is critical to maintaining our wellbeing in our day to day lives. If someone is debriefing to you then remember:

- Don't judge, just listen
- Don't try and find solutions, just listen
- Don't try and fix, just listen
- Give feedback that shows you are listening.

There are also advantages to debriefing before your meetings where problem solving and creativity are required. Both the emotional and creative aspects of the mind use the same side of the brain to process the information. It can be hard to focus on the task at hand if you have unresolved emotional issues relating to an individual you support.

Working Alone

A number of people using the services of Western Care Association have informed us that living and spending time with other people with a disability is not what they want. Consequently, individual support arrangements have been designed around specific individuals. In many of these situations, the people supported find it stressful to have more than one staff member supporting them at a time. This necessitates staff members working in 'lone situations'. Staff members working in such arrangements need to have effective systems in place for calling for support when there is a crisis. In order to work well they need to feel they are not alone and have someone they can call on in the event of crisis.

See also Lone Working Policy

BIBLIOGRAPHY AND REFERENCES

Legislation and related Policies and Procedures

- UN Convention on Rights of Persons with Disabilities (2006)
- Health Information & Quality Standards (HIQA)
- Towards a Restraint Free Environment in Nursing Homes –DOH publication
- AOTI submission regarding Restraint Free Environment in Nursing homes
- AOTI submission -Clinical guidance regarding side rails
- CQL Quality Measures (2005)
- Data Protection Act (1999)
- Health Act (2007)
- Care and Support of Residents in Designated centres for Persons(Children and Adults) with Disabilities (Regulations 2013)
- Linking Service and Safety: Strategy for Managing Work Related Aggression within the Irish Health Service (2009)
- Emerson, Eric 1995 Analysis and interventions with people with severe learning disabilities. Cambridge University Press. 2004 P.3.
- 2A.1 Child Protection Procedure and 2A.2 Adult Safeguarding Policy – (Western Care Association Policies and Procedures)
- 1.6 Enabling People to enjoy Best Possible Health - (Western Care Association Policies and Procedures)
- 1.10 Incident Reporting Procedure - (Western Care Association Policies and Procedures)
- 1.7 Medication Procedure- (Western Care Association Policies and Procedures)
- 1.8 Risk Management (Personal Risk Management Plan) - (Western Care Association Policies and Procedures)
- 3A.25 Lone Workers Procedure (Western Care Association Policies and Procedures)
- Behaviours that Challenge-(Saint John of God Community Services Limited 2009)
- David Pitonyak: Discovery 2012
- Studio III references
- Responding to Adults and Children who display Behaviour that Challenges- (Brothers of Charity Clare, 2012)
- Positive behaviour support-getting it right from the start; Facilitators reference manual 2009.
- Challenging Behaviour: A unified approach policy for providing positive services and supports –(Brothers of Charity Galway, 2008)
- Procedural guidelines for Assessment and Intervention Approaches when working with service users who present with Behaviours that Challenge Service Delivery – (Brothers of Charity Galway, 2008)
- Challenging Behaviour: A unified approach (Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists, 2007