APPENDIX D

TWO EXAMPLES OF POSITIVE BEHAVIOURAL SUPPORT REPORTS

These independent reports by a certified behaviour analyst / positive behavioural support expert were requested by a commissioning care manager within the CBF's personalisation project

The aim was to advise the care manager as to

- whether the commissioned services are delivering the sought outcomes
- whether the services can be helped to deliver improved outcomes

The aim of sharing the reports is to demonstrate how detailed such independent reports can be and how they can be useful to a commissioning care manager

It can be seen that the reports

- highlight which aspects of a service are working well/not working well for the person
- provide constructive information to enable improvement
- would be very useful in commissioning a new service

REPORT 1: BEHAVIOUR SUPPORT FOR MR ANDREW SMITH (PSEUDONYM)

Based on one visit to his care home and t/c discussion with his care manager

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1. Assessment methods

- Interview with Support Worker 1
- Interview with support worker 2 when working with A
- Brief interview with Support worker 3
- Brief interview with Co-keyworker
- Joint interview with Home Manager and Psychologist
- Interaction and observation of A for 90mins whilst eating his lunch and in his room
- Review of Care home records

2. General observations

Support staff were very friendly and helpful and A came across as well liked. There was some discontentment expressed about A's support plan and potential strategies that staff thought would work well with A. In particular some staff have tried things or made suggestions which have been rejected by other staff or management.

Examples are:
- Having access to certain preferred objects
- Paying for his own items in shops
- Putting things up in his bedroom

Despite having made formal arrangements to visit the care home, the manager did not meet or greet me and did not introduce herself despite me entering her office twice. She was with the in-house psychologist until I asked to see her mid-afternoon.

When we did meet she said there was “nothing she would change” about A's support strategies and therefore I surmise she will not find my input useful. The manager and psychologist said they think their care home is not the right place for A. They suggested a smaller unit that specialises in Autistic Spectrum Conditions or a placement where they have a safe room.

The manager said she thought I would be there to specifically give them strategies regarding A's biting of others. I discussed the need to understand the function of behaviour (I.e. why A presents with certain behaviours) and the need to include proactive strategies (supporting someone so they do not need to present the behaviour).

3. All about A

A has a learning disability, Autism Spectrum Condition and reported seizure activity but no diagnosis. He presents as bent over and has an unsteady gait. No exercises or aids or adaptations were utilised to assist with this, although the psychologist reported his GP is aware of his back. During the assessment, A reported a sore toe and was reluctant to walk on it.

A is reported to be possessive over items. He was witnessed taking DVDs from a store cupboard but agreed to return them with support using a light-hearted approach and distraction.

The assessment and intervention suggestions are detailed in the following format
- Defining the behaviour: a description, its triggers, course and function
- Proactive strategies (including physical, interpersonal and programmatic strategies)
- Reactive strategies

4. Defining The Behaviour

According to A's file and the support staff, A presents with the following behaviour challenges

Self-injurious behaviour
- Biting self on arm – can be through skin
- Hitting self
- Head butting windows and walls and the ground including concrete
- Crying

Property Destruction
- Ripping his own clothing
- Refusing to give back items that do not belong to him

Aggression
- Verbal aggression towards others
- Kicking others
- Throwing items at others
- Spitting at others

The psychologist was particularly concerned about A biting staff and the risk this behaviour poses. I did not recall reading any reports of this in his records held at the care home but had discussed one incident with the care manager where this happened when A was at a theme park. This appeared to have a clear trigger (the preferred activity coming to an end) and the staff member reflected independently on what could have been done differently.

The psychologist said that A is not someone she typically works with as her area of expertise is risk management and direct 1-1 working with verbal clients. She therefore does not get involved in A’s care planning. Her lack of relevant expertise for doing so was borne out by her discussion of A in terms which were not pertinent to his history nor needs and a lack of understanding about the function of challenging behaviour in a person with A’s range of needs.

4a) Triggers

The support staff seemed aware of the triggers to A's behaviours. These included:

- Not being understood
- Poor interpersonal match and/or lack of interaction with staff. This included reports that staff were using mobile phone or IPods when with A
- Another client going into his bedroom
- His clothes being messy e.g. saliva on them
- Possible sexual frustration

Despite this I did not observe any evidence of or read in his file about actions to mitigate these triggers such as communication aids or adaptations in the home; a training plan for how to interact/develop a rapport with A; strategies to prevent other clients entering his bedroom; investigation of sexual needs.

4b) Course of behaviour
A's behaviour frequently includes coming out of bedroom and behaving aggressively to the support staff in the hallway. They may then withdraw and direct A outside to the bench in the garden. A will walk down stairs hitting his head on the way on the walls and windows. When at the bench A may take off his clothes and hit his head on the ground or concrete driveway.

There are between 3-5 critical incidents per month where Accident & Injury forms are completed.

4c) Function of behaviour
The Aide to Functional Analysis assessment has previously been filled out and indicates that A displays challenging behaviours to initiate social contact. This appears to be the primary reason and could be understood as reliable way of getting staff support when situations are devoid of appropriate interaction. See Antecedent, Behaviour, Consequence contingency below:

A: Lack of appropriate staff support (e.g. staff remaining in the corridor/poor rapport with A)
B: Challenging behaviour
C: Well skilled/confident/familiar members of staff being called upon to provide intensive support
At times A also appears to display challenging behaviour in order to obtain an activity/object/event (access to tangibles). This occurs when he has been refused an item e.g. staff denying him an additional can of coke, staff preventing him putting pictures on his wall and staff informing him the theme park activity was over. The access to such items may be more reinforcing than they ought to be due to a lack of freely available activities and events (see Proactive strategies section below).

A: Lack of reinforcing activities/objects/events available; staff deny request or terminate access to activity/object/event
B: Challenging behaviour
C: Staff 'give in' and activity/object/event is provided. There is inconsistency in staff response in these situations.

5. Proactive Strategies (Ensuring a Good Quality Of Life)

5a) Physical environment strategies

A has a lovely large bright room which is a great match for him as he likes having space. He needs however to go up two set of stairs which he appeared a little unsteady on which may cause him anxiety. These may also prove dangerous when he is descending them during an incident. There is a lounge and a couple of small kitchenettes. A makes himself tea in one of the kitchenettes. This activity could be expanded to include simple cooking and baking. The house is in lovely grounds with grass and trees. A concrete road runs around the grass and there is a bench in the middle of the grass. The concrete road presents a very serious hazard to A as he will bang his head on it during an incident.
A's bedroom has huge windows overlooking the front and side garden. It is relatively sparsely furnished, with a radio and ball pool. Other items are locked away (clothes

in a box that staff have key to), pictures very high on the walls; no curtains; no play objects. This is reported to occur because he can't cope with choice. Any toys he had are reported by the manager to be stored downstairs as A uses them as weapons during behaviour challenges. It is my suggestion that regular opportunities to interact with these should be included in a structured timetable. The use of them should come with clear behavioural contracts explaining that they are not A's to keep.

A lives with approximately 12 other residents. They appear to have very varied needs, including personality disorder and no apparent learning disability, mental health problems and Asperger's. There is also a wide age range from approximately 19 years to 50+. I suggest this makes it difficult for staff to build up expertise in working with A especially in regard to his autism.

5b) Interpersonal environment strategies

A receives 1:1 staffing in the home for 14 hours per day, although when he is in his bedroom staff often are in the hallway. This may be because he asks them to leave. This appears to occur with particular staff who do not have a good rapport with A. This then appears to establish itself as a setting event or trigger for challenging behaviour when there is a lack of social engagement. I suggest the development of a training plan/induction for staff on how to interact/develop a rapport with A. A profile of the kind of staff who works well with A should be created to try to establish a good match.

Some staff appear to enjoy spending time with A and use a laid back, humorous approach that appears to work well. He appeared playful, enjoying toddler-type games, such as pretending objects were a telephone, pretending he is a dog and using games to shock, e.g. pretending to pee on the files for a reaction. The staff seemed relaxed and confident but with him but the psychologist suggests that they are cajoling him and appeasing him because they are scared. The appropriateness of the dog game should be questioned as it involves biting objects – I suggest staff reinforce other safer games and pay less attention to this game (differential reinforcement).

5c) Programmatic environment strategies

A's file contained lots of information about things he liked to do but these are only infrequently part of his programme. Examples include swimming, visiting the trains, collecting eggs, horse riding and going to the park. Support staff interviewed said they didn't know he enjoyed these things and therefore never offer them to him. The manager reported A chooses not to engage in activities and wants to spend all his time in his bedroom. This is his own choice.

I suggested to the manager that A may need strategies in place to help him engage in varied activities. This includes 1) understanding what is being offered (e.g. using visual aids), 2) making a choice (e.g. giving limited choices); 3) feeling confident doing it (e.g. with staff that he has a good rapport with). There are various behavioural strategies that could be employed such as 'behaviour momentum'[1]. No visual aids, timetables, PEC's etc were observed to be used with A. Since poor

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[1] presenting instructions that occasion compliance at a high rate and then taking advantage of the resulting 'momentum' to present a task related instruction that typically does not occasion compliance but rather occasions challenging behaviour.

interaction and lack of understanding of A are significant triggers it is suggested that these are explored.

A is funded for 2:1 to access the community however staff interviewed reported he may not always go out, at times due to staffing shortages. The manager disputed this and said there are 10 staff per shift but the rota seemed to show there are 7-8 on shift, with 4 clients requiring 1-1 support due to sickness and shortages. I suggest this is checked.

6. Reactive Strategies (To Use When Challenging Behaviour Occurs)

Studio 3 provides the methodology behind the reactive strategies and it appears useful that staff are not using physical interventions with A. Instead staff withdraw and move away from A and encourage A to go outside away from others. However going outside makes A vulnerable, due to his mobility (going down the stairs) and his engagement in head hitting of the walls and windows. Further being outside brings him into contact with the concrete ground which he bangs his head on. It is therefore suggested to review and risk assess these strategies to consider if they can be amended. This may include moving the bench, him having a downstairs room etc. One staff member also reported that there are sometimes too many people involved. This needs reviewing.

A is then supported to put on new clothes. Previously this has involved staff having to go up to his bedroom to collect some. Recently a support manager proposed the use of a “grab bag” to take out during the incident which contains clothes. This was reported to have been agreed but staff are not implementing the strategy. I suggest this should be put in place and monitored.

REPORT 2 : BEHAVIOUR SUPPORT FOR MR BRENDAN FOSTER (PSEUDONYM)

Based on one training day at his care home and t/c discussion with his care manager

Mr BF lives in a care home for four individuals. He is moving to his own supported living house soon and will eventually have his own dedicated support team. Until then his current staff are providing the support.

I carried out the functional behaviour assessment (FBI) to understand what his challenging behaviours look like, the rates and severity of occurrence and antecedents and consequences in order to gain a consensus on the function of them.

Mr BF displays excessive fluid intake, requesting and drinking large quantities of tea and water - to the extent that he has been hospitalised after an apparent seizure caused by low sodium levels - as well as self-injurious behaviour and the grabbing of staff. We established that all his behaviours appear to be a reliable way of gaining staff attention in the form of social interaction.

With support I helped the team identify strategies that would prevent Mr BF from displaying challenging behaviour based on what we had established the behaviour to mean.

This included proactive strategies in the form of environmental strategies and skills teaching strategies. Of particular use were the physical environmental strategies as these can be implemented immediately in his new home. These included strategies such as not having the kettle, tea and coffee on display and not having his chair in the lounge facing the kitchen door. Mr BF appeared to see the sight of such objects as prompts for excessive fluid intake behaviour.

Recognised the lack of social interaction can be a trigger for challenging behaviour, in other words it can be the withdrawal of an environmental event as well as the presentation of an environmental event that acts as a trigger.

We identified the replacement skill of learning to use another method to attract staff attention and increasing his independence skills, through greater staff engagement with Mr BF in his home. On this note we discussed the role of active support and the manager has asked for some more information about this.

Finally we also re-worked their reactive strategies. The staff team were unknowingly responding frequently with high levels of attention to these behaviours so we considered ways we can reduce this and provide the attention when engaged in positive activities. Staff found this area particularly helpful and it helped explain why it is so important to also have proactive strategies.

Nine staff attended the assessment half of the training and seven staff attended the intervention development. All staff reported finding the day very useful as it provided them with ways of working that they had not thought of before. They wrote up their own strategies and have agreed to type this up to form a behaviour support plan.

This was a really good session, working in partnership with a team to use their knowledge and expertise of a person to develop a positive behaviour support plan.

Environmental strategies

- Kettle, tea etc to be put away after use so not visual prompt.
- Begin introducing de-caffeinated tea.
- Staff not to have tea in between his times.
- Staff to move out of the kitchen area and engage him in other areas of the home.
- Use of visual schedules for AM and PM (implement the one he has at his day service).
- Support during transition times, such as handovers.
- More social interactions when engaged in positive behaviours.
- Use new house new rules to implement new behaviour strategies.
- Benefits from laid back male staff -consider when recruiting.

Skills teaching

Learning to use another method to attract staff attention (achieved through differential reinforcement.

Increasing his independence skills, using task analysis to break down tasks for him to participate in. This will provide greater staff engagement with Mr BF in his home. On this note we discussed the role of 'active support'[2] and the manager has asked for some more information about this.

Reactive strategies

- Low key response to challenging behaviour:
- Stop providing attention for the behaviour (even in the form of negative attention e.g. social disapproval).
- Walking away.
- Turning off the tap and gesturing for him to move away, no verbal interaction.
- Use of distraction such as singing.

NB These reactive strategies will only be effective if Mr BF has the chance to receive social attention through other means i.e. through the display of pro-social and positive behaviours.

Both of the names of the people above are fictitious but the reports are real reports which were prepared as part of the personalisation project .

[2]http://www.kent.ac.uk/tizard/staff/documents/Mansell%202002%20RDD%20Engagement%20and%20active%20support%20preprint.pdf