NHS Education for Scotland

Positive Behavioural Support:

a learning resource

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Welcome to Positive Behavioural Support: a learning resource

The learning resource is based on a pilot training programme developed for NHS Education for Scotland (NES) by Edinburgh Napier University, The Learning Disability Managed Care Network and The Forensic Network School of Forensic Mental Health.

The learning resource aims to equip participants with knowledge in positive behaviour support (PBS) and to help participants begin to identify how they could use PBS in their practice, to support positive behavioural change to improve the lives of people with a learning disability. Recognising the invaluable role staff play in supporting people with a learning disability and challenging behaviour and the serious consequences that may arise for people with a learning disability and challenging behaviour including risk of placement breakdown, neglect, abuse and social deprivation (Emerson et al. 1994, Lowe et al. 2007).

NHS Education for Scotland

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Hazel Powell,	Lecturer and Teaching Fellow, Edinburgh Napier University
Colin MacPherson,	Lecturer/Practitioner, Edinburgh Napier University/NHS Lothian
Elaine Kwiatek,	Project Manager, Learning Disability Managed Care Network
Dr Keith Bowden,	Consultant Clinical Psychologist, NHS Forth Valley
Dr Sharon Horne-Jenkins,	Consultant Clinical Psychologist, NHS Fife
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Module 1: An Overview

Module 1: An Overview

The first module consists of three units which are designed to enable you to consolidate existing knowledge and understanding around a number of concepts that relate to the positive behavioural support model, in preparation for the contact days. It is recognised that many of you will already have extensive knowledge and understanding of these concepts and you are advised to assess your own learning needs, familiarise yourselves with the content of each unit and then decide how much time to spend on each unit.

Unit 1: Definitions, Prevalence & Causation

By the end of this unit you will be able to:

- Critically examine the definition of 'challenging behaviour' and problems associated with it.
- Demonstrate understanding of the prevalence rates for challenging behaviour and problems associated with identifying prevalence rates.
- Explore the complex range of causes of challenging behaviour.

Introduction

This unit is an introduction to what is a broad and contentious area. It is not intended to be an exhaustive review, but will provide links to further resources for those who are interested in finding out more and will be a brief update for those of you who have studied this topic previously. To place the concept of challenging behaviour in context, we will look at some definitions of 'challenging behaviour', with a brief introduction to the lack of clarity that can still surround the concept. This unit will then explore prevalence rates for challenging behaviour and some of the difficulties in accurately identifying prevalence before examining the different causes challenging behaviour.

Background

Both 'learning disability' and 'challenging behaviour' are social constructions (a social construct is an idea or notion that appears to be natural and obvious to people who accept it but may or may not represent reality, so it remains largely an invention or artifice of a given society), the name and definition of which have changed over the years. These changes partly depended on the way services were provided in relation to what the perceived needs were at the time. Learning disability is currently defined by three main criteria:

1. Significantly sub-average intellectual functioning, with an IQ of approximately 70 or less.
2. Concurrent deficits or impairments in present adaptive functioning in at least 2 of the following: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety.
3. Onset before adulthood.

(DSM IV, American Psychiatric Association, 1995; AAMR, 1992)

This definition carries with it four assumptions:

1. That the assessment of both intellectual and social functioning is valid i.e. it accounts for factors such as cultural and linguistic diversity.
2. That deficits in adaptive skills functioning are assessed as occurring within the context of community environments, which are typical of those, experienced by the individuals' peers.
3. That the individual may have personal strengths and capabilities, which co-exist with the limitations, associated with the learning disability.
4. That the individual requires the appropriate life supports over a sustained period to ensure that their level of functioning is maintained.

(AAMR, 1992)

Both the term 'learning disability' and 'challenging behaviour' have a number of synonyms. For example learning disabilities can also be described as learning difficulties, intellectual disability, mental handicap, mental retardation to name but a few!

Activity 1.1.1: Terms

List here all the terms you can think of to describe behaviour perceived as challenging – spend about 10 minutes on this activity.

You may have come up with some of the following:

- Interactional challenges
- Behaviour perceived as challenging
- Problem behaviour
- Aberrant behaviour
- Behavioural difficulties
- Maladaptive behaviour
- Abnormal behaviour
- Dysfunctional behaviour
- Disturbed behaviour
- Disordered behaviour

For clarity throughout these materials we will use the term ‘challenging behaviour’.

Defining Behaviour Perceived as Challenging

Activity 1.1.2: Defining Challenging Behaviour

How would you define challenging behaviour? – spend about 10 minutes on this activity.

Module 1: An Overview

In everyday language the term ‘behaviour’ is often used to refer to ‘good’ or ‘bad’ behaviour as if our behaviour is only part of what we do. In terms of behavioural theory, the term behaviour refers to everything we say or do

- A person is behaving all of the time.
- Activity is often thought to be the same as behaviour.
- A person is behaving even when they are doing nothing.

The phrase “challenging behaviour” has become part of the everyday language in the field of learning disability. The term ‘challenging behaviour’ was first introduced in Britain by Blunden and Allen in 1987 and was an attempt to place the emphasis on the service to meet the needs of the client, rather than suggesting that the difficulty was intrinsic to the person with a learning disability.

‘We have decided to adopt the term challenging behaviour rather than problem behaviour or severe problem behaviour since it emphasises that such behaviours represent challenges to services rather than problems which individuals with learning difficulties in some way carry round with them’

(Blunden & Allen, 1987 p.14)

Emerson et al, (1988) defined ‘severe challenging behaviour’ as:

‘Severely challenging behaviour is behaviour of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour which is likely to seriously limit or deny access to the use of ordinary community facilities.’

(Emerson, 2001, p. 3)

Emerson (2001) outlined three additional points to take into account when defining challenging behaviour:

- Challenging behaviours are defined by their impact and, as a result, their causes and topography will vary
- Challenging behaviour is a social construction, i.e. what is defined as challenging may vary between settings and cultures
- Challenging behaviours have wide-ranging personal and social consequences. This may be for the client, family, staff, carers and others

Prevalence Rates Challenging Behaviour
As a result of the definitional issues discussed above, the reported prevalence rates for

challenging behaviour can be quite varied and can include behaviours ranging from non-compliance, teeth grinding and scratching to theft, inappropriate sexual behaviour and aggression. Many studies of the prevalence of challenging behaviour tend to focus on a particular topography or restrict the study to a particular population e.g. those living in hospital. Such studies have found that aggression towards self, others or property tends to be the most commonly reported form of challenging behaviour

(Emerson, 1998; McKenzie et al. 2000).

Emerson et al. (2001) carried out a total population survey of people with a learning disability and challenging behaviour. This attempted to account for the fact that an individual may have multiple forms of challenging behaviour within and across different categories. They defined challenging behaviour as:

Less demanding challenging behaviour

Behaviour constitutes a serious management problem or would do were it not for specific controlling measures undertaken in the person's current setting

More demanding challenging behaviour

Behaviour meets at least one of the four criteria:

- Occurs at least once a day
- Usually prevents person from taking part in programmes or activities appropriate to their level of ability
- Usually requires the physical intervention by one or more members of staff
- Usually led to a major injury i.e. requiring hospital treatment to person or others

This study found that challenging behaviour was shown by 10-15% of people with a learning disability. The most common specific type was aggression and around a third of participants had at least two general forms of challenging behaviour.

A meta-analysis of research into challenging behaviour was carried out by McLintock et al. (2003). They found that the main risk markers were being male, having a severe or profound learning disability, having autism and having

receptive and expressive communication deficits.

There are, however, a number of problems with defining challenging behaviour, which makes establishing exact prevalence figures difficult. Some of these issues are discussed below.

Problems with Defining Challenging Behaviour

Despite the desire to move from the idea that the problem lies with the person with a learning disability, research suggests that staff are still likely to see challenging behaviour in terms of a particular behavioural topography e.g. self-injury, aggression and stereotypy (Hastings et al.1997; McKenzie et al.1999). The term challenging behaviour can often be misinterpreted or misapplied, being seen as referring to behaviour that is deliberately awkward and defiant. The beliefs held by others regarding the nature of learning disability and challenging behaviour have a significant impact on the understanding and accurate assessment, implementation and support of people with a learning disability and challenging behaviour.

Gates (1996) argues that the term 'challenging behaviour' is too broad and is used in two distinct ways:

1. A term to identify a collection of behaviours and a state of being that challenge service providers i.e. people with a learning disabilities and additional disabilities, who may or may not display behavioural difficulties.
2. A term for those people with a learning disability who predominantly demonstrate behavioural difficulties.

He suggests that this can cause difficulties for service providers and purchasers. For instance, service providers may be expert in supporting clients with severe learning disability and associated physical needs, but purchasers may think they are buying services for people who self-injure and are aggressive. Gates (1996) argues that the term 'challenging behaviour' is so inclusive that it is very difficult to identify the prevalence of distinct groups. This in turn effects research and service provision. He proposes that, because of these problems with definition there is a need to replace the term challenging behaviour to aid clarity, operational definition and empirical study.

Other problems with defining challenging behaviour include the different social rules, what constitutes appropriate behaviour in that particular setting and how this can vary between

settings, the capacity of a setting to manage any disruption caused by a person's behaviour and the ability of the person to give a plausible account for their behaviour.

However challenging behaviour is defined it can have a negative impact for clients and those who support them. Apart from those outcomes, which are defining of challenging behaviour e.g. harm to self and others, limited access to community facilities, there are a number of additional negative outcomes. A study by Emerson et al. (2000; p197) quotes the following:

'Physical injury to the person, other people with intellectual disabilities and care staff; social exclusion, isolation and neglect; abuse from caregivers; exposure to restrictive treatment and management practices; increased stress and strain among caregivers and increased cost of service provision.'

The impact of challenging behaviour can be significant:

- Physical injury to self or others
- Exclusion/placed out-of-home
- Increased risk of abuse
- Neglect/avoidance by carers
- Inappropriate intervention (e.g. restraint, seclusion, drug treatments)
- Caregiver stress

Causes of Challenging Behaviour

Activity 1.1.3: Causes of Challenging Behaviour

Write down all the causes you can identify for challenging behaviour. Spend about 15 minutes on this activity.

Module 1: An Overview

Causation of challenging behaviour is as complex as defining the term and is often an amalgamation of several of the following factors: behavioural, cognitive, biological, environmental and psychological.

Psychological Causes
There are a number of psychological theories on the causation of challenging behaviour:

Psychoanalytical theories – suggest that people are motivated by a search for satisfaction and avoidance of distress and that aggression will result if the search for satisfaction fails. If people are continually frustrated they will respond with aggression.

Behavioural theories – Based on operant learning theory, which suggests behaviours that are reinforced following their presentation will be repeated, whereas behaviours that do not receive reinforcement will become extinct. If behaviours are rewarded in any way even covertly they may be maintained. Here behaviour perceived as challenging is seen as being maintained by the consequences for the individual. As a result it is seen as functional for the person with a learning disability i.e. it serves a purpose. The consequences may be external to the individual, for example, to gain staff attention or internal, for example, self-stimulation to relieve feelings of boredom. Behavioural models emphasise that other people's responses can increase, maintain or reduce the challenging behaviour. Positive Behavioural Support has its roots in behavioural theory.

Cognitive theories – Suggest that in early life individuals develop behaviours to solve problems that are rehearsed and coded and some of these may be challenging. When the person encounters the same or a similar situation the response from the previous situation is retrieved. Cognitive theories have been proposed to explain aggression in people with a learning disability. These argue that fundamental cognitive processes differentiate people who are prone to aggression from those who are not. Novaco and Welsh (1989) identify five cognitive biases, which may play mediating roles in anger and aggression:

- Attributional bias i.e. the individual attributes the behaviour of others to personal characteristics rather than situational factors.
- Perceptual matching i.e. aggressive individuals are more likely to perceive aggression in ambiguous situations than non-aggressive individuals
- Anchoring effect i.e. the reduced ability

of aggressive individuals to make use of mitigating information.

- False consensus i.e. a tendency to assume that a larger proportion of others' behaviour, values and opinions are the same as your own than is the case.
- Attention cueing i.e. the vigilance of aggressive individuals for aggressive cues in the environment.

Components of cognitive theories can be used with behavioural approaches, to develop treatment approaches for people with a learning disability e.g. self-monitoring and instruction, impulse control and relaxation training.

W.W.W.

Web Link

Ray Novaco is one of the leading researchers into cognitive theories of aggression. He has worked in the UK with Dr Laura Black to extend his work to people with a learning disability. To find out more visit: **http://www.seweb.uci.edu/faculty/novaco/**

Developmental Factors

Organic brain injury may be considered a causative factor for challenging behaviour. People who have profound or severe learning disabilities display the highest degree of self-injurious behaviour (SIB). It is suggested that up to 90% of people who injure themselves will belong to this group (Kiernan and Moss, 1990). People with severe and profound learning disability are those with most diverse organic brain dysfunction.

In addition, challenging behaviours are part of the developmental process. For example, children typically engage in repetitive movements at transition points in motor development (e.g. rocking on hands and knees prior to crawling), 20% of children aged 5-17 months display headbanging, 'tantrums', or aggression, and property destruction is common in young children (Berkson, & Tupa, 2000; Thelan, 1981). Thus, individuals with delayed or arrested development might be prone to presenting with behaviours that are significant for that developmental period.

Neurobiological Factors

Research has studied the role of neurobiological factors in challenging behaviour, particularly self-injury (Schroeder et al. 1995) and aggression

(Schroeder and Tessel, 1994). This identifies the involvement of the opiodergic, dopaminergic and serotonergic systems. The research has looked at the effect of blocking opiod receptors using drugs. Symons et al. (2004) carried out a meta-analysis of research in this area. They concluded that the self-injurious behaviour (SIB) was improved in 80% of participants when they were taking naltrexone, and that SIB was reduced by 50% or more in nearly half of the participants.

There are also specific conditions that can predispose an individual to display challenging behaviour (behavioural phenotypes)

- biological syndromes, such as Prader-Willi and Lesch-Nyhan syndromes, are strongly linked to challenging behaviour;
- Other conditions associated with challenging behaviour include Fragile X, Williams syndrome, Rhombencephalosynapsys, Cornelia de Lang and Rett syndrome. It is not always clear why these conditions lead to an increased likelihood of challenging behaviour occurring. It may be that the neuro dysfunctions associated with the condition are interpreted as challenging behaviour.

It is important to understand that conditions strongly linked to challenging behaviour are very rare, and that most others can be treated or managed.

Other Risk Factors

Challenging behaviour has also been found to be associated with factors such as: physical illness, epilepsy and in particular mental illness. In terms of general health there are a number of health conditions that can cause challenging behaviour, for example:

- hypo/hyperglycaemic episodes in diabetes;
- urinary tract infections;
- uncontrolled pain (people with a learning disability are often unable to express their pain and will display challenging behaviour to draw attention to it);
- dementia; and
- hypothyroidism (particularly in Down's syndrome).
- constipation

Hormonal imbalance has also been suggested as a causative factor for challenging behaviour with studies suggesting serum progesterone deficiency suggestive of premenstrual tension was more likely to be present in women displaying challenging behaviour. It has also been suggested that aggressive males in the general population have raised testosterone levels.

The prevalence of epilepsy is significantly higher in people with a learning disability compared to the general population and epilepsy can be linked to challenging behaviour. Challenging behaviour is associated with pre and post seizure activity and complex partial seizures in particular. Behaviours can include extreme altered activities to aggression which they have little or no control over.

Lastly, for some people with a learning disability and co-morbid mental illness challenging behaviour will exist, for instance dementia, bi-polar, psychoses and depression can all lead to the presentation of challenging behaviour. Aggression, particularly, has been found to be more common in people with learning disabilities and associated mental illness.

W.W.W.

Web Link

To see how mental illness can impact on people with a learning disability and their families visit: **http://www.learningdisabilities.org.uk/page.cfm?pagecode=PIINCOPYMO**

Therefore:

- Most challenging behaviour is not attributable to organic causation;
- It may result from non/misdiagnosis of manageable and/or treatable conditions;
- Professionals should thoroughly assess people with challenging behaviour to ascertain if there is an organic causation, and offer treatment where appropriate;
- If there is no ascertainable organic causation, then it must be the result of other (often unconsidered) causes, which will now be discussed

Environmental Factors

Although in the past two decades there has been a huge shift away from institutional models of care, there remains a legacy of institutionalisation and some people with a learning disability still display challenging behaviour developed as a consequence of institutional regimes. Even without the large learning disability hospitals of the past we can still see examples of 'mini institutions' within some of the modern day service models. The effects of institutionalisation are well recognised and the following are characteristics of it:

- disempowerment
- learned dependency
- homogenised care
- dominance of the medical model of care
- conditions that contribute, maintain and tolerate behaviour perceived as challenging
- impersonal care
- reliance on medication and physical interventions to control behaviour; and
- social isolation

Bicknell and Conboy-Hill (1992) discussed the problem caused by carers, professionals and society in general having poor expectations for people with learning disabilities. Using a model known as the deviancy cycle, they explained that such poor expectations lead to inadequate services (and other treatment) which, in turn, impacts adversely on the individual. For some people within this cycle, challenging behaviour may, erroneously, be perceived, to be an expected part of their personality and an inevitable consequence of their disability.

Causes of Challenging Behaviour

Activity 1.1.3: Challenging Behaviour

Identify the last time you behaved in a way that could have been perceived as challenging - for example banging the door after a row at home, refusing to empty the dish washer, shouting at another driver when driving home, describe your situation briefly - spend about 30 mins on this activity

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Continues on next page

Activity 1.1.3: Challenging Behaviour

Try to identify the cause for this?

What might have made you feel better in this situation?

Activity 1.1.3: Challenging Behaviour

What might have made you feel worse in this situation?

Module 1: An Overview

Key Messages

- Aggression, self-injury and destructive behaviour are the most common forms challenging behaviour
- The impact of challenging behaviour can be significant: physical injury to self or others; exclusion/placed out-of-home; increased risk of abuse; neglect/avoidance by carers; inappropriate intervention (e.g. restraint, seclusion, drug treatments); caregiver stress.
- Causes of challenging behaviour are as complex as defining the term and is often an amalgamation of several of the following factors: behavioural, cognitive, biological, environmental and psychological.

Conclusion

In this unit you have explored some of the complexities around defining and identifying the prevalence of challenging behaviour. It is likely that the information presented has been revision for most of you however we hope you recognise the benefits of providing an overview and setting the context for Positive Behavioural Support: person focused training.

Module 1: An Overview

Unit 2: Positive Behavioural Support: an introduction

By the end of this unit you will be able to:

- Demonstrate an understanding of the definitions, principles, and values of behavioural models, especially Positive Behaviour Support
- Describe the benefits and limitations of PBS according to the evidence base
- Utilise a framework for collating data, which understands challenging behaviour in the context of the person's social, personal, and environmental context.
- Detail how to intervene and evaluate the effectiveness of a behavioural support plan.

Introduction

This unit introduces the key principles, features, and the process associated with the development of a Positive Behaviour Support (PBS) plan. Specifically, the typical methods used in the assessment of behaviours that are perceived as challenging will be introduced and the techniques of data gathering and interpretation in leading to a working hypothesis will be explored. In addition, time will be spent detailing the components of multi-element behavioural support plans and reviewing the approaches that can be utilised in evaluating the intervention delivered.

Historical Perspective - The Development of Models of Behaviour

We all have our own ideas or 'theories' about what behaviour is and the reasons why people behave the way they do. Some people have looked for reasons outside the person and others believe the reason lies inside.

Activity 1.2.1: Models of Behaviour

Glen is a 30 year old man, who frequently punches the staff supporting him.

Below you will find some written statements concerning possible reasons for a client's behaviour:

1. *"I put it down to his epilepsy".*
2. *"He's just got no self-control".*
3. *"He's bound to behave like that because every time he hits someone he gets away with it".*
4. *"I think he is bored".*
5. *"He wouldn't be like this if he was living in the community".*
6. *"He's only like this when his medication is changed".*
7. *"He's just a nasty piece of work".*
8. *"He's simply copying the others patients".*

Activity 1.2.1: Models of Behaviour

Consider each of the comments and try to decide:

1. *What kind of model of behaviour is each member of staff describing? Put an 'I' after those you think represent the point of view that something is inside Glen that causes him to act this way. 'E' after those that suggest it is something outside himself or external. Spend about 20 minutes on this activity.*
2. *Which model (i.e. an internal model or an external model of behaviour) is typically adopted in your working environment?*
3. *Reflect upon how the model adopted influences your practice.*

Make notes in the space provided opposite.

Activity 1.2.1: Models of Behaviour

Activity 1.2.1: Answers

I (internal) = Statements 1, 2, & 7.
E (external) = Statements 3, 4, 5, 6, & 8.

Learning principles have been applied to the study of behaviour since the early 1900s. The crucial assumption of early behavioural approaches was that all behaviour is learned. **Behaviourism** emphasises the importance of the environment in making people do the things they do. That is, anything outside of the person (including other people).

This type of learning was primarily introduced by Edward Thorndike in the 1890s. Thorndike formulated what was to become known as **the law of effect** - behaviour that is followed by consequences that are satisfying will be repeated, and behaviour that is followed by noxious or unpleasant consequences will be discouraged. Thus, consequences serve to encourage or discourage the repetition of behaviour.

The dominant behavioural model views challenging behaviour as an **operant** behaviour. It is called operant because the behaviour operates on the environment. That is, the challenging behaviour is a way the person exercises control over his/her world.

In the 1950s, Burrhus Frederick Skinner began applying the law of effect to many different aspects of human behaviour. They were interested in discovering the relationships between events. He renamed the law of effect the principle of **reinforcement**. Skinner argued freedom of choice is a myth, and instead, he proposed that all behaviour is determined by positive and negative reinforcers in the environment. Thus, behaviour analysts never make any assumptions about what events or stimuli are likely to be reinforcing for a person in a particular context.

W.W.W.

Web Link

Burrhus Frederick Skinner is commonly known as the person who introduced the concept of reinforcers. To find out more about his work and operant learning visit the website below:
http://www.simplypsychology.pwp.blueyonder.co.uk/operant-conditioning.html

Module 1: An Overview

A **reinforcer** is something which strengthens the behaviour to which it is applied. Reinforcers are not always pleasant things. For example, some people who self-injure have been shown to be reinforced by the subsequent restraint imposed upon them, however unpleasant this may appear to others. Similarly, being shouted at may not seem very pleasant to most of us but if your behaviour is ignored you will increase the behaviour that gets a response, even if it is being shouted at.

There are 2 types of reinforcement:

Positive reinforcement refers to an increase in the rate of behaviour as a result of the presentation of a preferred event or stimulus.

Negative reinforcement refers to an increase in the rate of a behaviour as a result of the withdrawal (or prevention of occurrence) of a non-preferred stimulus or event.

Distinguishing 'positive' from 'negative' is largely a matter of emphasis. For example, in a very warm room, a current of external air serving as reinforcement may be positive because it is relatively cool, but negative because it removes the uncomfortably hot air. Additionally, some reinforcement can simultaneously be both positive and negative. For example, a drug addict may take drugs for the added euphoria and to get rid of withdrawal symptoms. Another example is eating. Eating adds pleasurable flavours while removing feelings of hunger.

The opposite of reinforcement is punishment. Punishment is described in terms of its effects rather than its characteristics. In other words, something can only be described as punishment if, when administered, it reduces the frequency of the behaviour to which it applies.

There are 2 types of punishment:

Positive punishment refers to a decrease in the rate of behaviour as a result of the presentation of a non-preferred event or stimulus.

Negative punishment refers to a decrease in the rate of a behaviour as a result of the withdrawal (or prevention of occurrence) of preferred stimulus or event.

Of course, some behaviour is maintained by internal or private consequences (e.g. masturbation that leads to an orgasm). In these cases, the behaviour is maintained by a process of automatic reinforcement, in which the reinforcing stimuli are private or internal to

the person *(Lovaas, Newson, & Hickman, 1987; Vollmer, 1994).*

The principles of reinforcement and punishment were utilised to develop treatment plans for challenging behaviour. These treatment plans (see Matson & Taras, 1989 for a review) predominately focused on the elimination of problems by using **aversive** techniques. For example, receiving a bank charge for having insufficient funds in your bank account is an aversive event any of us could encounter and learn from. This was despite behaviour analysts promoting the use of non-aversive and aversive interventions in supporting people with a learning disability. Challenging behaviour was seen as something to be removed, regardless of how it first occurred, developed or was maintained. Aversive techniques used an unpleasant event in order to reduce behaviour, and resulted in escape or avoidance responses. The types of aversive interventions utilised included the removal of preferred activities, the use of unpleasant odours, and even electric shock treatment.

In the late 1980s and early 1990s, debates begun around how behaviour analysis was being used. This resulted in the development of a person-centred and values led approach to behavioural change – **positive behaviour support**. Horner and colleagues (1990) first described the characteristics of this model. LaVigna and colleagues are also closely associated with this model and have strongly advocated its use from the mid 1980s. They continue to attempt to advance the use of non-aversive and person-centred behavioural procedures through their work in the Institute for Applied Behaviour Analysis (IABA).

W.W.W.

Web Link

Gary W. LaVigna and Dr. Thomas J. Willis developed the Institute for Applied Behaviour Analysis (IABA). To find out more about this work visit the website below: **http://www.iaba.com/**

Further information on PBS can also be found on the Association for Behavioural Support website: **http://www.apbs.org/index.html**

Positive Behaviour Support (PBS) attempts to remedy the approach adopted by behaviour analysts. PBS is not a specific technique or skill, but a way of viewing the objectives of

a behavioural intervention. In other words, it gives an emphasis to the understanding of the behaviour from the person's point of view and their lifestyle, and developing an intervention based upon this interpretation. It is research based intervention used to increase the quality of life and decrease problem behaviour by teaching new skills and making changes to a person's environment.

As highlighted (Allen et al., 2005), PBS promotes:

- A person-centred and value led approach.
- Behaviour as having meaning.
- The understanding of behaviour in leading to change.
- Predicting behaviour in reducing its likelihood.
- Focusing on the elimination of problems by helping to establish new behaviours or skills; or by re-establishing those which have been lost or distorted.
- Improvements to quality of life.

Activity 1.2.2: Introducing Positive Behaviour Support (PBS)

Go to appendix 1 and read the following article:

Allen, D. James, W. Evans, J. Hawkins, S. Jenkins, R. (2005), ***Positive Behavioural Support: definition, current status and future directions.*** *Tizard Learning Disability Review. 10(2), pp. 4-11.*

Take your time reading the article and feel free to make notes, underline or highlight key points. Then without referring to the article, answer the following questions to test your recall and understanding. You may want to read the article one day and try and answer the questions the next to really test you recall! Finally compare your answers with those in appendix 2.

1. *What did Emerson & McGill suggest was a weakness in Applied Behaviour Analysis (ABA)?*

2. *Which 2 approaches added together created the beginnings of the PBS model?*

Activity 1.2.2: Introducing Positive Behaviour Support (PBS)

3. *Rather than simply behavioural change in isolation the goal of PBS is to.....*

4. *The use of functional assessment within PBS helps us understand....?*

5. *What is suggested as the central intervention in PBS?*

6. *What is used as both an intervention and an outcome measure?*

Activity 1.2.2: Introducing Positive Behaviour Support (PBS)

7. *What is meant by the term multi-component focus?*

8. *What do Bambara et al (2004) describe PBS as being a blend of?*

9. *This paper identifies 6 PBS intervention tools - what are they?*

10. *How does Emerson (2001) describe socially valid interventions?*

Activity 1.2.2: Introducing Positive Behaviour Support (PBS)

11. *What % of people do UK studies suggest receive any kind of behavioural support?*

12. *What do the authors suggest are the reasons for the low use of PBS?*

Core Features of Positive Behavioural Support

Application of behavioural science
Positive behavioural support combines behavioural, cognitive, biophysical, social, developmental and environmental psychology. Positive behavioural support focuses on the design of environments that promote desired behaviours and minimises the development of 'problem behaviours' (Sailor et al. 2009).

Applied behaviour analysis is the conceptual basis for these empirically proven interventions. Applied behaviour analysis is the science of understanding behaviour and assumes that human behaviour can change.

Positive behavioural support emphasises the use of functional analysis to increase the match between need and support, the prevention of behaviours perceived as challenging through environment redesign, instruction of positive behaviours and consequences that promote desired behaviours.

Practical, multicomponent interventions
Positive behavioural support focuses on supports that can be delivered in everyday settings by families, teachers and typical support personnel. The emphasis is on behaviour change that spans the full spectrum of contexts.

Lifestyle outcomes
Positive behavioural support is committed to lifestyle change that is durable. The quality of life a person experiences determines the success of the support.

Systems change
Positive behavioural support also places an emphasis on system and organisational change.

With a focus on person centred approaches to care, such as values based practice, person centred planning, advocacy and partnership working.

Recommended Reading

Take the link below to the NHS Evidence - Learning Disabilities website where you can access

Osgood, T. (2004). *"Doing it for attention"*: *Non-Physical Reactive Strategies*. Kent: Tizard Centre.

http://www.paradigm-uk.org/Resources/h/n/l/doing_it_for_attention.pdf

Positive Behaviour Support: Benefits and Limitations

Activity 1.1.3: Challenging Behaviour

In your experience or from what you have learned about PBS in unit 2, what might be some of the benefits and limitations of adopting a model of PBS in supporting people with a learning disability whose behaviour is perceived as challenging? Spend about 20 minutes on this activity.

Make notes in the space below.

Activity 1.1.3: Challenging Behaviour

Follow the link below to access the following article.

Johnston et al. (2006) Positive Behaviour Support and Applied Behaviour Analysis. **Behaviour Analysis**, *29(1), 51-74.*

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2223172/

Take your time reading the article and feel free to make notes, underline or highlight key points. This article provides some reflections upon the usage of PBS. Compare your answers with the standpoints offered in the article.

Key Messages

- A person-centred approach
- Behaviour is learned, thus, can be unlearned
- Behaviour has meaning
- Behaviour is likely to occur again if it has led to reinforcing consequences in the past
- Understanding behaviour can lead to change
- A constructional approach, which focuses on the elimination of problems by helping to establish new behaviours or by re-establishing those which have been lost or distorted

Conclusion

Unit 2 has given you a brief overview of the positive behavioural support which combines the science of applied behaviour analysis with a strong value base of respecting individuals, working with person centred approaches and avoiding or significantly minimising responses that could be considered punitive. The training days and later units will include further exploration of the components of the positive behavioural model to give you the knowledge, understanding and skills to deliver positive behavioural support in practice and support and educate others to deliver positive behavioural support.

Module 1: An Overview

Unit 3: Values Based Care

By the end of this unit you will be able to:

- Reflect on your values in practice and how these can affect your approaches to people with a learning disability and challenging behaviour.
- Demonstrate an understanding of attribution theory and how this can affect staff responses to challenging behaviour.
- Critically reflect on staff behaviours, including your own and the effect these may have on people with a learning disability whose behaviour is perceived as challenging.

Introduction

Staff are easily the most important resource when supporting people with a learning disability and challenging behaviour. The importance of support and training is well recognised however as important is the understanding of how staff values, perceptions and attitudes can influence responses to challenging behaviour. Unit 3 focuses on the importance of values, perceptions and attitudes in practice, how they can affect your decision making and your approach to care.

Values Based Care

Positive behavioural support emerged from gradual shifts in expectations of practice over the last 30 years. With the 1980s came significant advancements in conceptualising how services for people with a learning disability should be organised resulting in the closure of long stay hospitals and the widespread adoption of the principles of normalisation and social role valorisation (LaVigna & Donnellan, 1986; O'Brien & Lyle, 1988; Wolfensberger, 1972). Approaches to challenging behaviour, that focused on aversive techniques became increasingly unacceptable. These changes have brought a welcome and significant emphasis on human rights, values and attitudes.

'Values based care' and associated terms are now common place in health and social care. The term values can mean different things to different people, what is important to one person may not be to another. Understanding the important role of values within your practice, how values relate, interact and impact on experiences, actions and relationships is vital to working in a respectful, person centred manner with a wide range of people, all of whom will have different values and perspectives

Woodbridge and Fulford, (2004) explain that the complexity of values is because, **values**

come in many varieties, for instance they can be associated with ethics, rights and virtues and also include wishes, desires and aesthetic values, for example beauty. **Values vary with time and place**; they are your perspective, fluid and changeable. **Values also vary from person to person**. In essence it could be said that values tend to be the things in your life that **you consider important**.

Activity 1.3.1: Values

Think about your values at work write down what are important values to you? Spend about 10 minutes on the first part of this activity

Activity 1.3.1: Values

Ask your supervisor or a work colleague to carry out a similar exercise and then compare answers - how many values do you share and how many are different?

The underlying assumption in values based practice is that if decisions are made with respect for values as well as evidence, following a process in which values have been explored, clarified and balanced, such decisions are more owned and more likely to be acted on. Values based practice is about working constructively with differences and diversity of values. This means having insight and understanding of how our values may impact and working with positive

frameworks and processes rather than telling people what values they should have.

Values based practice:

- Places an emphasis on the importance of the diversity of individual values, including the values of clinicians, researchers and managers as well as those of service users and carers.
- Recognises that values whether explicit or implicit guide all decisions.
- Recognises the importance of values and evidence and clinical expertise working together for optimum outcomes for people accessing health or social care.
- Is more than a theoretical stance it has a focus on processes and building skills sets to enable practitioners to work sensitively with different values and perspectives.

Staff Behaviour

A number of studies have tried to understand staff behaviour and responses to challenging behaviour. According to Bruininks, Hill, and Morreau (1988) staffs usual response to challenging behaviour is more likely to be a verbal reprimand or physical restraint. Studies have also shown that staff typically spend little time with clients, tending to fill their time with administrative duties or housework (Felce et al., 1987; Hile & Walbran, 1991). In addition, research has demonstrated that people with the greatest levels of challenging behaviour generally receive more staff attention (although this is not necessarily positive attention) (Duker et al., 1989).

If the full potential of carers as agents of behavioural change is to be realised, then it appears that a far more systemic perspective on functional analysis is required. We need to begin to apply behavioural principles at an organisational-systems level (Frederiksen & Johnson, 1981; Maher, 1984; Holburn. 1997).

McKenzie et al (2005) found that even when staff were supporting people with challenging behaviour where behavioural guidelines where present two thirds of staff had difficult applying these in practice. Staff inconsistency, limited team meetings to discuss the guidelines, limited staff knowledge and skills, attributions and the accessibility of the guidelines are the factors that appear to affect applying the guidelines in practice. McKenzie et al (2005) go on to suggest that where guidelines are in place staff training targeting both knowledge and attributions should run alongside. Furthermore there is a requirement for ongoing contact from the clinical team and management systems such as

periodic service review and regular meetings to resolve any issues.

Activity 1.3.2: Staff Behaviour

Reflect on your own practice and organisation. Spend about 30 minutes on this activity.

How many of the people you support have behavioural guidelines?

Are you conversant with these guidelines?

Are they carried out consistently in practice?

If yes what contributes to this?

If no why do you think this is?

Attribution Theory

'Challenging behaviour by definition poses staff with difficult emotional and professional challenges.'

(McKenzie et al, 2004 p16)

Staff perceptions of behaviours are recognised to impact on their response to them. Attributions are the underlying assumptions that staff make about the cause of the behaviour perceived as challenging. Hastings et al (1997) suggested that a large proportion of staff see a person's behaviour as intentional and this is more likely to increase inappropriate responses. Raising awareness in relation to attributions could help build the essential knowledge and skills central to effective behavioural management.

Activity 1.3.2: Staff Behaviour

Paul an experienced learning disability nurse is finding it increasingly difficult to work with John, a 24 year old man with autistic spectrum disorder and a severe learning disability. John can become distressed and agitated if his programme of activity and routines are disrupted. At these points John will run across to usually smaller or female members of staff, or other clients who do not usually protect themselves or respond aggressively. John will then grap and hit the person, this has resulted in serious injury to others. Recently John seriously hurt Marion a member of staff who is a close friend of Pauls'.

Paul believes that John is targeting those more vulnerable than him and therefore 'knows what he is doing'. As a result of this Paul is avoiding spending time with John and is being less pleasant to John. You are Paul's manager and the last time John was aggressive to Marion you noticed Paul being 'a little rough' with John when he intervened.

Can you can see how the assumptions Paul is making about Johns' behaviour are affecting his response towards John.

Can you think of a time where your assumptions, beliefs and/or values have influenced your work with someone with a learning disability whose behaviour was perceived as challenging? Spend about 20 minutes on this activity.

Activity 1.3.2: Staff Behaviour

Reflect on this situation in particular -
Do you think your assumptions were correct?

How did they impact on your approach?

Would you do things differently if you were in the same situation again? If no why and if yes what would you do differently?

Module 1: An Overview

Key Messages

- Values whether explicit or implicit guide all decisions
- Past reinforcement affects behaviour in similar future situations
- Staff behaviour may be dictated by psychological variables such as coping style, attribution style, and emotional responses

Conclusion

Unit 3 has briefly explored values, staff behaviour and assumptions and the impact these can have in practice and you have reflected on your own practice. This training programme will continue to explore the importance of staff in effectively supporting people with a learning disability and challenging behaviour, as these aspects are relevant both in terms of your own practice and in influencing and supporting others to deliver positive behavioural support.

1 Well done - you have now completed Module 1: An Overview

You may find it helpful to note any particular issues you would like to note below:

Similarly, there may be areas covered in this module that you will find helpful to discuss further with your supervisor. You may find it helpful to list them below:

Further Reading and Resources

Allen, D., James, W., Evans, J., Hawkins, S., Jenkins, R. (2005), Positive Behavioural Support, definitions, current status and future directions. *Tizard Learning Disability Review.* 10(2), 4-11.

Donnellen, A.M., LaVigna, G.W. (1986) *Alternatives to punishment: Solving behaviour problems with non-aversive strategies.* New York: Guildford Press.

Donnellan, A.M., LaVigna, G.W., Negri-Shoultz, N. and Fassbender, L.L. (1988) *Progress without punishment: Effective approaches for learners with behaviour problems.* New York, Teachers College Press.

Emerson, E. (1995) *Challenging Behaviour: Analysis and Intervention in People with Learning Difficulties*. Cambridge: Cambridge University Press.

Emerson, E. (1998). Working with people with challenging behaviour. In E. Emerson, E. Hatton, C. Bromley, J. Caine, A. (Eds), *Clinical Psychology and People with Intellectual Disabilities.* Chichester: John Wiley and Sons.

Emerson, E. (2001) *Challenging behaviour; analysis and intervention in people with severe intellectual disabilities.* 2n ed. Cambridge: Cambridge University Press.

Koegel, L.K., Koegel, R.L. and Dunlap, G. (1996) *Positive Behavioral Support: Including People with Difficult Behavior in the Community.* Baltimore: Paul H Brookes Publishing Company.

Lovaas, O.L., Newson, C., & Hickman, C. (1987) Self-stimulatory behaviour and perceptual reinforcement. *Journal of Applied Behaviour Analysis*, 20, 45-68.

Sailor, W., Dunlap, G., Sugai, G., Horner, R. (2009). *Handbook of Positive Behavior Support.* New York: Springer.

Vollmer T.R. (1994) The concept of automatic reinforcement: Implications for behavioural research in developmental disabilities. *Research in Developmental Disabilities*, 15, 187-207.

Willis, T.J., LaVigna, G.W., & Donellan, A. (1987) *The Behaviour Assessment Guide*. Los Angeles, California: Institute of Applied Behaviour Analysis.

Tizard Centre, web link: **www.kent.ac.uk/tizard**

Organisation that provides research and development in community care, especially for people with a learning disability and challenging behaviour

Challenging Behaviour Foundation, web link: **www.thecbf.org.uk**

Provides guidance and information on supporting people with challenging behaviour, including fact sheets.

Module 1: An Overview

Glossary

Antecedent – something that precedes the challenging behaviour and invites the inference of causation (i.e. appears to cause it).

Aversive – a negative reaction towards something.

Baseline – a record of behaviour frequency taken before an intervention. This can be used to measure the effectiveness of an intervention.

Behaviour – any action the person does that can be seen and is measureable.

Behaviourism – an approach that argues that the only relevant subject matter for psychological investigation is observable, measurable behaviour.

Consequence – an event that occurs following behaviour.

Contingency – an event is said to be contingent upon another if there is a demonstrable relationship (i.e. one event leads to the occurrence of the other).

Environment – the term environment refers to anything that occurs in the presence of or around the person.

Crisis – a sudden interruption in the normal course of events or behaviours.

Cycle – a recurring series of events or pattern to behaviour.

Duration – the passage of time.

Ecological Analysis – a focus on the interaction between behaviour and the environment and the people/individuals in it.

Frequency – refers to the rate at which behaviour occurs.

Latency – the time between the onset of a stimulus and the occurrence of a response/behaviour.

Motivation – an energiser of behaviour.

Operant – any behaviour that can be characterised in terms of its effect upon the environment.

Outcomes – a change in the person as a result of changes in the environment OR a change in the environment as a result of changes in the person.

Perpetuating Factors – events or situations that maintain the challenging behaviour.

Punishment – the delivery of an aversive stimulus following the presentation of a particular behaviour. Reinforcer – something that occurs after a behaviour, which increases or maintains the frequency of the behaviour.

Reinforcement – the operation of strengthening something OR an event that strengths or supports something.

Module 1: An Overview

Setting – all aspects of the environment in which the challenging behaviour usually occurs.

Severity – how serious behaviour is for person or others.

Stimulus – is anything that occurs in the environmental surroundings of the person.

Target behaviour – refers to a specific and observable behaviour amongst other behaviours that has been selected for change. The change can be to increase or decrease behaviour.

Time sampling – a recording of behaviour during specified time periods. For example, behaviour could be observed every minute for 30 minutes. Thus, a sample of the behaviour is taken.

Topography - a full characterisation of the components of behaviour.

Trigger - aspects of the environment and the situation that seem to spark off the challenging behaviour.

Module 1: An Overview

Appendix 1:

Allen, D. James, W. Evans, J. Hawkins, S. Jenkins, R. (2005), Positive Behavioural Support: definition, current status and future directions. Tizard Learning Disability Review. 10(2), pp. 4-11

Appendix 2:

Activity 1.2.1: Answers

Go to appendix 2 and read the following article:

Allen, D. James, W. Evans, J. Hawkins, S. Jenkins, R. (2005), ***Positive Behavioural Support: definition, current status and future directions.*** *Tizard learning Disability Review. 10(2), pp. 4-11.*

Take your time reading the article and feel free to make notes, underline or highlight key points. Then without referring to the article answer the following questions to test your recall and understanding. You may want to read the article one day and try and answer the questions the next to really test you recall!

1. *What did Emerson & McGill suggest was a weakness in Applied Behaviour Analysis (ABA)?*

ABA is a technology for intervention devoid of a values base governing how it should be used therefore could easily be abused

2. *Which 2 approaches added together created the beginnings of the PBS model?*

Applied Behavioural Analysis and Social Role Valorisation

3. *Rather than simply behavioural change in isolation the goal of PBS is to.....*

Achieve enhanced community presence, choice, personal competence, respect & community participation

4. *The use of functional assessment within PBS helps us understand....?*

Why, when & how behaviours happen and what purpose they serve

5. *What is suggested as the central intervention in PBS?*

Skills teaching

6. *What is used as both an intervention and an outcome measure?*

Changes in quality of life

7. *What is meant by the term multi-component focus?*

Challenging behaviours are often multiply determined and users typically display multiple forms

Activity 1.2.1: Answers

8. *What do Bambara et al (2004) describe PBS as being a blend of?*

Best practices in behavioural technology, educational methods, ecological systems change and person centred values

9. *This paper identifies 6 PBS intervention tools - what are they?*

- **Altering known conditions that increase the probability of challenging behaviour occurring**
- **Changing specific triggers e.g. reducing demands**
- **Teaching new competencies**
- **Differential and non-contingent reinforcement**
- **Specifying changes in carer behaviour**
- **Reactive strategies e.g. low level such as distraction**

10. *How does Emerson (2001) describe socially valid interventions?*

Interventions that address a socially significant problem, have clear evidence for their effectiveness and use the least intrusive means acceptable to all involved

11. *What % of people do UK studies suggest receive any kind of behavioural support?*

2-20%

12. *What do the authors suggest are the reasons for the low use of PBS?*

- **Too few staff trained in using PBS**
- **PBS interventions can be labour intensive compared to alternatives e.g. medication**
- **Lack of clear service policy**
- **Resistance to planned structured approaches**

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

Module 2 consists of three units which focus on the needs of people with a learning disability who have offended or are displaying offending behaviour. This module is included within this learning resource in recognition of the importance of using values based approaches in all settings and with a wide range of complex needs.

Unit 1: Values and Qualities

By the end of this unit you will be able to:

- Explore the importance of values based practice when working with people with a learning disability who have offended
- Considered a range of relevant policy and legislation supporting values based practice

Introduction

This learning resource specifically includes consideration of people with a learning disability who have offended (or are displaying offending behaviour) for two reasons. Firstly in recognition that many learning disability professionals will be working in both assessment and treatment, long stay and community settings with people with a learning disability who have offended or are displaying offending behaviour and secondly because the particular needs of this client group highlight a number of challenges in using a positive behavioural support model that are applicable in all settings. If you are interested in learning more about working with people with forensic needs you can access the School of Forensic Mental Health website at the link below.

W.W.W.

Web Link

http://www.forensicnetwork.scot.nhs.uk/SoFMH/N2F.html

Values

Staff working with people with forensic needs must be aware of their attitudes towards these individuals, especially when certain offences are being dealt with. It is essential to be able to assess, treat and care for all people, and to have a good understanding of their offending behaviour, without any punitive stance being taken. Such a stance would interfere with any therapeutic relationship, reduce the chances of successful rehabilitation and potentially increase the risk of further offending by failing to engage effectively.

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

Staff should develop the following key attitudes:

- An understanding of their role and how it relates to care—this should be developed within the service, reinforced by guidance and supervision from a line manager and a cohesive team.
- An understanding of when and where boundaries need to exist between the person with forensic needs and the member of staff, again reinforced by the guidance and supervision of a line manager and a cohesive team.

The development of a good relationship with people with forensic needs is essential if rehabilitation is to be achieved. Staff working with people with forensic needs often spend long periods of time developing these relationships, most of which are positive and beneficial to both parties. However, sometimes relationships develop which are not helpful and which on rare occasions can result in significant difficulties for the person, the staff member(s) and the organisation.

Examples of inappropriate attitudes towards people with forensic needs include:

- Intense relationships with the person, similar to being a close friend
- Focussing attention on one person to the detriment of others
- Bringing the person gifts
- Creating opportunities to spend more time with the person
- Believing that there is a mutual attraction between the person and the member of staff
- Persistent teasing of the person in the belief that it is “fun” and failing to understand the power imbalance between the staff/service user role
- Intimate relationships

Shared values between multi-disciplinary/agency staff are important when working with people who have forensic needs. All staff must strive to promote pro-social behaviours and attitudes. This requires each individual to consider and reflect upon their own attitudes, values and behaviours. When caring for people with forensic needs there should be a zero tolerance attitude towards even “lower level” antisocial behaviours, for example the use of bad language. Team members should always be aware of their very important place as positive role models and their ability to influence the behaviour of people, through being polite, friendly and demonstrating appropriate social skills. As such team members should not display or condone rudeness, hostile behaviours, sexist, racist or sectarian comments or behaviours. Many people with forensic

needs will not have had good parental role models and will therefore not always be aware of what constitutes appropriate and pro-social behaviours. Likewise, many people with forensic needs may not have a reliable or consistent male role model in their life before. It is important for patients to see staff of different gender (and race) interacting appropriately together.

Activity 2.1.1: Staff Qualities

Consider what some of the required qualities are for working with people with forensic needs? Spend about 10 minutes on this activity.

(Appendix 1 contains a list of suggested qualities)

In psychology, an attributional bias is a cognitive bias that affects the way we determine who or what was responsible for an event or action (attribution). An awareness of the potential for such bias helps team members to reflect on why we sometimes treat some people differently from others.

Activity 2.1.2: Gerry

Two different vignettes based around the same person, but 20 year time difference - will hopefully demonstrate attributional bias. Explore the different responses to the vignettes, particularly your "first impressions" and "gut feelings"/emotional responses. Consider how your emotional responses might shape your view of this person and influence your subsequent engagement and treatment approach. Spend about 30 minutes on this activity.

"Gerry"

Case vignette a)
Gerry is a 20 year old man with a mild learning disability. He has been referred to your community LD team after being charged with very serious sexual offences against young boys (there is apparently compelling forensic evidence to support this). He had been referred to you 2 years earlier because of concerns about minor incidents of inappropriate sexual behaviour, but

Activity 2.1.2: Gerry

it had not been possible to engage with him for a variety of reasons, not least the hostility and unhelpfulness of his family (who are known as being very difficult).

When Gerry was 12 years old he had been placed on the child protection register in a different part of the country; at that time his maternal Uncle, a known paedophile, had been living in the family home and there was concern that Gerry had become very withdrawn in his behaviour and had stopped attending school. Unfortunately the family then moved house to your region and it seems there was no follow up.

When you see Gerry he presents as a quiet and shy young man who it is difficult to engage. He does seem to be quite "street wise". You note that he has scars on both forearms from what you believe is likely to be self harm. He is dressed in old, cheap clothes which are apparently "hand me downs". He denies any wrong doing and claims that he would never do anything to young children; he discloses that he had been sexually and physically abused as a child and knows the damage this could cause.

Consider:
1) What are your first thoughts and feelings about Gerry?

2) What are your initial thoughts about his management?

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

Activity 2.1.2: Gerry

"Gerry"

Case vignette b)

Gerry is a 42 year old man with a mild learning disability. He was admitted to the State Hospital at age 20 years after being convicted of very serious sexual offences against young boys. He spent 10 years in high secure care, then 8 years in his local hospital. In hospital he always refused to discuss his offences and never showed any remorse. He was regarded as being "manipulative" and "a loner". He was not well liked. He often self harmed which staff felt he did for attention or to distract them from his other issues. He moved to a 24 hour community placement 4 years ago and is felt by staff to still show an interest in young boys.

When you meet Gerry he presents as a sullen/ surly man, who avoids eye contact and is difficult to engage in conversation. You make note of the numerous scars on his arms, some of which look quite recent. He is dressed in old clothes and has not attended to his personal hygiene. He tells you that if you mention his past he will ask you to leave his house.

Consider:

1) What are your first thoughts and feelings about Gerry?

2) What are your initial thoughts about his management?

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

The Rights of People with a Learning Disability

"The same as you?" (Scottish Government, 2000) represented a significant and wide ranging review of the needs of people with a learning disability in Scotland. The review process involved consultation with all of the key stakeholders in Scotland including service users and their families and carers, statutory organisations and the voluntary and private sector. The following themes came out of the review and are a key part of the Scottish Government's policy for people with a learning disability:

- People with a learning disability should be valued. They should be asked and encouraged to contribute to the community they live in. They should not be picked on or treated differently from others
- People with a learning disability are individual people
- People with a learning disability should be asked about the services they need and be involved in making choices about what they want
- People with a learning disability should be helped and supported to do everything they are able to
- People with a learning disability should be able to use the same local services as everyone else, wherever possible
- People with a learning disability should benefit from specialist social, health and educational services
- People with a learning disability should have services which take account of their age, abilities and other needs

W.W.W.

Web Link

You can access 'The Same as You' by following this web link:
http://www.scotland.gov.uk/Resource/Doc/1095/0001661.pdf

Historically people with a learning disability often had their rights ignored and decisions were frequently made on their behalf by others, even when the person themselves was fully capable of making their own decisions.

The introduction of the Adults with Incapacity (Scotland) Act 2000 made it clear that decisions should only be made on behalf of a person with a learning disability when that person has been assessed as being incapable of making that decision and someone has been given legal powers under the Act to allow them to make such a decision.

W.W.W.

Web Link

Follow the link below for more information about Adults with Incapacity: **www.scotland.gov.uk/Topics/Justice/law/awi**

Changes in attitude towards the rights of people with a learning disability can be seen in the publication of the UK Parliament report by the Joint Committee on Human Rights "A Life Like Any Other? Human Rights of Adults with Learning Disabilities".

W.W.W.

Web Link

You can find the report by following the link below: **www.publications.parliament.uk/pa/jt200708/jtselect/jtrights/40/4002.htm**

The report highlights the following rights as being fundamental:

- You have the right to life
- You have the right not to be treated badly or punished in a cruel way
- You have the right to freedom
- You have the right to a fair trial in court if the police think you have broken the law
- You have the right to respect for your own private life
- People should respect your family life

Under the Disability Discrimination Act (1995) all public services have a legal responsibility not to discriminate against disabled people, or to provide a poorer quality of service because of their disability. The revised DDA (2005) came into force in December 2006. It places new statutory duties on public bodies to eliminate discrimination and harassment of disabled people. It also promotes greater equality of opportunity for disabled people. This therefore applies to the NHS, Local Authorities, Police, Prosecutors, Courts and Prison Service who are required to pay 'due regard' to the promotion of equality for disabled people in every area of their work.

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

The Equality Act 2010 replaces the existing anti-discrimination laws (including the DDA) with a much easier and consistent single Act. People with a 'protected characteristic' (which includes a learning disability) now have specific rights. These rights also apply to people who 'associate with' someone who has a learning disability, such as their family or friends or to someone who is thought to have a learning disability even though they don't. Public bodies, including the NHS, Local Authorities, Police, Prosecutors, Courts and Prison Service (and other organisations that provide services to the public on behalf of these bodies) must:

- Advance equality of opportunity between disabled persons and others
- Eliminate discrimination that is unlawful under the Act
- Eliminate harassment of disabled persons that is related to their disabilities
- Eliminate victimisation where a disabled person is trying to obtain their rights
- Foster good relations between disabled persons and others
- Take positive action to overcome or minimise disadvantage for disabled people, even where that involves treating them more favourably than others

W.W.W.

Web Link

More information can be found at:
http://www.equalityhumanrights.com/legal-and-policy/equality-act/

People with learning disability are often supported to obtain their rights through the support of advocacy services. This can be by self-advocacy groups where individuals are supported to represent their own, and the groups views. Other options include citizen advocacy or professional advocacy where the person will be given individual support to express their views, or where unable to do so, the advocate will represent the person's views.

Advocacy services can be very supportive to individuals with a learning disability who are involved in forensic services and will help them to speak up for their rights in that context.

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

W.W.W.

Web Link

More information can be found at:
www.siaa.org.uk/content/view/14/27/

Key Messages

- Staff need to develop reflective skills to develop insight into their attitudes, values and behaviours and how these may impact on care
- There is a range of legislation and policy that supports the rights of people with a learning disability

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

Unit 2: Risk Assessment and Management

By the end of this unit you will be able to:

- Reflect on your knowledge and understanding of risk management
- Demonstrate understanding of the importance of positive engagement in risk management

Offending Behaviour and Risk Management
This unit is about people with a learning disability who offend, but it is important to remember that people with a learning disability are more likely to be victims of crime rather than offenders. People with a learning disability are no more likely to offend than the general population and there is no evidence that they commit specific types of offences (contrary to some historical myths).

People with a learning disability are likely to offend as a result of numerous factors, some specific to their learning disability, but some in common with offenders of normal intelligence:

- More limited ability to identify risky situations
- Lack of understanding of the motivation of others
- Communication difficulties
- Poor social understanding
- Vulnerability to being tricked, deceived or exploited by others
- More likely to be apprehended by police
- Less likely to be able to "talk themselves out" of trouble
- Being more likely to live in high crime neighbourhoods
- Being unemployed
- Having pro-criminal peers or family
- Misuse of alcohol and drugs

It is important to recognise that people with learning disability are very often able to take responsibility for their actions. Prosecution and conviction can help some people with learning disability to understand the consequences of their actions and discourage them from committing more offences.

For this to work effectively the various stages of the criminal justice system need to be able to meet the support needs of the person in question, to ensure that they receive fair and equal treatment and have the same opportunities as other people accused of crimes.

For some people with learning disability the criminal justice system is not a fair or appropriate

option. If a person's condition means that they cannot cope with the demands of the criminal justice system then they should be assessed and diverted to a more appropriate setting that can address both their care needs and their offending behaviour. This issue is recognised in legislation and in practice.

Maintaining the safety of the person, staff and members of the public is crucial in delivering services to people with a learning disability who have forensic needs. The prevention and management of violent and aggressive behaviour requires a cohesive approach, including a range of policies and procedures designed to:

- assess and reduce risk, particularly the risk of violence
- have a range of graded interventions, including prevention of violence through early recognition, de-escalation, physical interventions and seclusion
- ensure regular staff training and refresher courses in the management and prevention of violence and aggression
- establish audit mechanisms to review episodes of violence and aggression

The Principles of Risk Assessment

"Gordon" Case vignette d)

Gordon is a 37 year old man with a mild learning disability who lives in a remote part of Scotland. His childhood and upbringing was chaotic and in adulthood he has no contact with family members. He has a history of inappropriate sexual behaviour dating back to his early teenage years. He committed a very serious sexual offence when he was 20 years old, but only received a 1 year probation order (which was meant to involve a fortnightly meeting with his probation officer for "a chat"—he failed to attend and no action was taken). At age 23 years he was diagnosed as suffering from a bipolar affective disorder; he has only ever been in the local mental health ward for a couple of brief admissions and his behaviour tended to be disruptive. He has lived in his current house for 20 years and been cared for by the same provider organisation for over 10 years. He generally gets on well with support staff, but at times pushes limits, can be verbally hostile and sometimes is "frisky" with female staff. He has a "girlfriend" who is much less able than he is which a matter of concern. He often "wanders" around his local town and there have been occasional complaints about his behaviour towards younger girls; one such case is currently

sitting on his file with the Procurator Fiscal. He has for many years made sexually inappropriate calls to a variety of different places. He is eventually arrested by police after several complaints about sexually explicit calls. He is aggressive towards the police when detained.

His attitude is that he can do what he wants, but he does value his house and does not want to end up in a locked or custodial setting. Unfortunately criminal proceedings are progressing very slowly and it is still not known if he will end up appearing in court; the Procurator Fiscal has discussed the case with the Consultant Psychiatrist and initially took the view that there was no point in prosecuting Gordon.

Activity 2.2.3 Assessing Risk

Spend about 30 minutes on this activity.

a) Consider what the major areas of risk might be in this case

b) Consider how you would go about completing your risk assessment

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

Risk assessment involves identifying the risk factors that are associated with future violent or sexual offending. A range of assessment tools are available; the HCR-20 which assesses risk of future violent offending is well evidenced and provides a useful structure for risk management planning. The HCR-20 incorporates both static (relatively fixed/unchanging things) and dynamic (changeable things) risk items. Training is required to use most risk assessment tools and it is important to stress that there are no "short cuts" when it comes to gathering data and completing any assessment. The risk factors in the HCR-20 are:

Historical (H) Scale
10 items that are relatively fixed and are the best predictors of future violence:

1. Previous violence
2. Young age at first violence (under 20)
3. Relationship instability
4. Employment problems
5. Substance use problems
6. Major mental illness
7. Psychopathy
8. Early maladjustment
9. Personality disorder
10. Prior supervision failure

Clinical (C) Scale
Based on current/recent functioning; may help to identify imminent risk of violence:

1. Lack of insight
2. Negative attitudes
3. Active symptoms of mental illness
4. Impulsivity
5. Unresponsiveness to treatment

Risk Management (R) Scale
This involves planning treatment, monitoring and supervision:

1. Plans lack feasibility
2. Exposure to destabilisers
3. Lack of personal support
4. Non-compliance with remediation attempts
5. Stress

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

Activity 2.2.4 Formal Risk Assessment

Reconsider and reflect on your original answers for "Gordon's" risk assessment (Case vignette d). Spend about 30 minutes on this activity.

Discussion about this and how we would go about constructing his formal risk assessment.

Key Messages

- Risk assessment should be part of assessment of challenging behaviour
- Risk management interventions should have the outcome of maintaining or increasing positive quality of life outcomes as well as protecting the person and others

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

Unit 3: Positive Engagement

By the end of this unit you will be able to:

- Reflect on the importance of positive engagement
- Critically reflect on the particular challenges associated with working with people with forensic needs within a positive behavioural support model

The Principles of Risk Management and the Importance of Positive Engagement

Risk management involves identifying strategies to manage or reduce the risk posed. The 5 "R" items from the HCR-20 are always important to consider when putting together your risk management plan. However, just as important is how you engage with the person and attempt to "sell" your management plan. A plan that is put together with a degree of collaboration is more likely to be successful (and therefore more likely to reduce risk) than a plan that is imposed on someone. Positive engagement is therefore an integral part of the risk management process. Within teams there is a need for this awareness and it is helpful for the team to have a shared philosophy of care to relate to, e.g. The Good Lives Model (see Appendix 2).

To work collaboratively with people with forensic needs it is necessary to be open and honest about items that are "non-negotiables", e.g. substance use and be very clear about limits and boundaries from the outset. Developing an individual's skills and playing on their strengths is crucial, particularly with regard to improving their self confidence and esteem. Focussing on and achieving small steps allows individuals (and team members) to feel that they are making genuine progress. Encouragement of realistic and achievable future goals should be regarded as being a priority, focussing on an individual's "pathway to progress". **Use should be made of "easy read" materials and pictorial aids to ensure that the patient understands the interventions and their aims**. The involvement of family members, carers and advocacy workers should be seen as being the norm, recognising the value of working in partnership with others who can positively influence the person.

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

Activity 2.3.1 Care Planning

"Gordon" Re-read Case vignette d)
Design Care and Treatment Plan for "Gordon" using template below:
(a model care plan for "Gordon" is contained in appendix 3) Spend about 45 minutes on this activity.

Problems, needs and violence risk factors identified

1.

2.

3.

4.

5.

6.

7.

Strengths

1.

2.

3.

4.

5.

6.

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

Activity 2.3.1 Care Planning

Treatment Plan Objectives

Objective	*Interventions*
1. Improve mental health	
2. Improve physical health and address health promotion	
3. Address any cultural, spiritual or diversity issues	
4. Provide appropriate treatment and management strategies to reduce risk of violence.	

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

Activity 2.3.1 Care Planning

Treatment Plan Objectives

Objective	*Interventions*
5. Address any family or other relationship issues	
6. Address daily living functions	
7. Address any financial incapacity or other social welfare issues	
8. Provide appropriate structured activity	

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

Activity 2.3.1 Care Planning

Treatment Plan Objectives

Objective	*Interventions*
9. Tailor security levels and rehabilitation plan to level of risk	
10. Address Social Care and/or housing needs	
11. Address legal and statutory matters	
12. Develop / review future plans	

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

Key Messages

- Positive engagement is crucial to successful support of people with a learning disability and challenging behaviour
- Support plans should consider the range of elements in a multi-element support plan and aim to improve quality of life and build new skills rather than merely reduce challenging behaviours

2 Well done - you have now completed Module 2: Positive Behaviour Support with people with a Learning Disability who have Offended (or are displaying offending behaviour).

You may find it helpful to note any particular issues you would like to note below:

Similarly, there may be areas covered in this module that you will find helpful to discuss further with your supervisor. You may find it helpful to list them below:

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

Appendix 1: Qualities for staff working with people with forensic needs

- Good interpersonal skills
- Insight into their own motivation for doing the job
- Social and cultural awareness
- Responsibility
- Equality and diversity awareness
- Personal integrity
- Good team working behaviours
- Observant
- Tolerance of difficult and demanding behaviours
- Attention to detail
- Natural curiosity about unusual behaviour
- Ability to remain calm in difficult circumstances
- Willingness to see emergencies at short notice

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

Appendix 2: The Good Lives Model

Ward, Mann & Gannon (2007) The good lives model of offender rehabilitation: Clinical implications. *Aggression and Violent Behaviour,* 12, 67-107.

Key Argument

- Human behaviour is directed towards goal of achieving fundamental needs or 'primary human goods'.
- Difficulties in achieving primary goods in socially appropriate ways will possibly lead to anti-social or offending behaviour.
- Strengthening the ability of offenders to achieve primary human goods in socially appropriate ways will reduce their offending behaviour

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

Appendix 3: Gordon – model care plan

Problems, needs and violence risk factors identified

1. mild learning disability
2. bipolar affective disorder
3. lengthy history of inappropriate sexual beaviour/sexual offending
4. social skills deficits
5. impaired social understanding
6. occasional verbal hostility
7. risk of being victim of community hostility
8. lack of insight into his need for support
9. unrealistic plans for the future, particularly with regard to his desire to form a sexual relationship with a woman

Strengths

1. subject to both compulsion order and guardianship, both providing statutory underpinning of care plans
2. understanding of consequences of breaching compulsion order
3. stable support team who know Gordon well
4. good relationships with support team and wider health/ local authority team
5. can be friendly and display warmth/good sense of humour
6. usually compliant with prescribed medications
7. lives in appropriate tenancy in good neighbourhood

Treatment Plan Objectives

Objective	*Interventions*
1. Improve mental health	Regular review by RMO, CLDN, Psychology, MHO and social care team. Ensure opportunities to talk about feelings, concerns and relationships
2. Improve physical health and address health promotion	Encourage to attend GP for health checks as required promote healthy lifestyle and diet monitor weight 6 monthly dental check up 2 yearly optician and audiology appointments

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

Treatment Plan Objectives

Objective	*Interventions*
3. Address any cultural, spiritual or diversity issues	Care plan developed recognising the need for information which is tailored to intellectual ability, gender and sexuality, and where appropriate, religious and cultural needs built around interventions
4. Provide appropriate treatment and management strategies to reduce risk of violence.	Ongoing psychology input with regard to developing better social skills and social understanding reinforce positive and prosocial behaviours promote good lives model work to improve self esteem and self confidence counsel re inappropriate behaviours maintain good information exchange re any risky behaviours, particularly police officers from offender management unit
5. Address any family or other relationship issues	Attempt to increase his social network in order that he can develop appropriate relationships
6. Address daily living functions	Encourage high standard of personal care encourage to attend to all activities of daily living
7. Address any financial incapacity or other social welfare issues	Promote opportunities for the development of budget skills and community presence, use of different resources and ways of paying

Module 2: Positive Behavioural Support with People with a Learning Disability who have Offended (or are displaying offending behaviour)

Treatment Plan Objectives

Objective	*Interventions*
8. Provide appropriate structured activity	promote structured activities and develop weekly timetable continues to attend and work on the croft
9. Tailor security levels and rehabilitation plan to level of risk	n/a
10. Address Social Care and/or housing needs	current housing appropriate—alarm system in place and staff core house nearby has appropriate level of support from care provider support team
11. Address legal and statutory matters	currently meets criteria for remaining on community based compulsion order
12. Develop / review future plans	ongoing multi-disciplinary/agency work to reduce risk of reoffending attempt to improve client's autonomy

Module 3: Supporting Communication

Module 3: Supporting Communication

Module 3 consists of two units considering the links between communication and challenging behaviour and the role of communication within a positive behavioural support model.

Unit 1: Communication and Behavior

By the end of this unit you will be able to

- Reflect on your understanding of the communication process
- Demonstrate understanding of the links between communication difficulty and challenging behavior

Communication
Communication is a two-way process involving at least two people sending and receiving a message. It involves:

"sharing information with others by speaking, writing, moving your body or using other signals"

(Cambridge Advanced Learner's Dictionary).

In order to be able to communicate effectively an individual has to be able to:

- Express ideas and information
- Understand ideas and information expressed by others
- Remember information

Communication difficulty impacts on all aspects of daily life. It is fundamental to learning new skills, making choices, forming and maintaining relationships and controlling our lives.

When thinking about communication impairment it is important to think of it in terms of the effect it has on the individual. Difficulties in communication reduce opportunities for social interaction, the ability to control the person's own environment, development of language, the initiation of communication, development of life skills and participation in education/employment. All of this can lead to a lack of identity, depression, passivity, isolation and challenging behaviour. Lacey and Ouvry (1998) describe this best when they say:

"Communication is the rock upon which all social activities rest and if this fails other things go awry."

People with learning disabilities are very likely to have problems with all aspects of communication; understanding language, expressing themselves and with interaction and social communication skills.

Figures regarding the number of people with a learning disability who present with communication difficulty vary: "The Same

as You? A review of services for people with learning disabilities" (Scottish Executive, 2000), reports that at least 50% of people with learning disabilities have significant communication problems with up to 80% having some communication difficulties.

Additionally, about 80% of those with severe learning disabilities do not acquire effective speech (Foundation for People with Learning Disabilities, 2000).

Activity 3.1.1: Communication & Behaviour

Reflect on the communication abilities of the people you support, can you think of any ways in which people's communication abilities has an impact on their behaviour? Spend about 15 minutes on this activity.

Module 3: Supporting Communication

Autistic Spectrum Disorder

The National Autistic Society suggest that in Scotland there are 46, 064 people with Autism Spectrum Disorder (ASD). Of this number, Potter and Whittaker (2001) estimate that as many as 50% will not develop functional communication. Those with ASD present with a number of symptoms, all of which increase the likelihood of challenging behaviour. Included in this list are:

- Increased anxiety - particularly about what is happening to and around them
- Sensory difficulties
- Tendency to focus on detail, therefore missing the "gist" of what is happening.
- Difficulty in understanding the consequences of their actions.

People with ASD are described as presenting with a triad of impairments all of which involve communication. These are, difficulty with:

- social communication
- social interaction
- social imagination

The communication of people who have ASD varies greatly. They are likely to have difficulty with verbal and non-verbal communication. They may have no speech or they may have good verbal language. Sometimes they may repeat what others have said (echolalia) or they may say words and phrases repeatedly (repetitive speech). Their intonation, stress, rhythm and pitch may be odd for example monotonous in tone or very loud or high pitched. People with ASD often find it difficult to initiate and sustain a conversation. Verbal interaction may primarily consist of question and answer routines. They tend to have a narrow range of conversation topics. Sometimes making verbal choices is difficult. They may have problems understanding language and can often be very literal in their understanding. They therefore often have difficulty understanding jokes, sarcasm or common phrases or sayings such as "spend a penny" or "that's cool". Sometimes it takes them longer to process verbal information. They may have difficulty with personal pronouns "I" and "you" referring to themselves and others by name instead. Expressing emotions is particularly difficult or people with ASD.

People with ASD have difficulty with the social rules of communication. They often have difficulty understanding and using non-verbal communication; maintaining eye contact can be difficult, they not respond to non-verbal cues such as pauses, nods and smiles and may use non-verbal communication inappropriately for example, smiling at bad news. They sometimes have no interest in others except as a means of

satisfying their own needs. People with ASD may find it difficult to develop relationships.

Social imagination is about being able to anticipate what the other person is likely to do next or what behaviour is expected of you. It enables you to keep yourself safe by enabling you to identify potential risks. People who lack this skill can be very vulnerable.

Hearing Impairment
Hearing loss is relatively common in the learning disability population. Prevalence studies vary in their findings. The Scottish Health Needs Assessment Report quotes that the prevalence of hearing impairment varies from12.3% to 47%. Over 50% of people with Down's syndrome are known to have significant hearing impairment (NHS Health Scotland, 2004).

Hearing problems have been linked with challenging behaviour. Timehin (2004) found that in a population of individuals with hearing impairment living in the community, 62% had problem behaviours and 34% had self injurious behaviour. This figure is larger than figures of challenging behaviour quoted for the general learning disability population.

Offenders
Whilst there is a dearth of research evidence regarding the incidence of communication disorders in the learning disabled forensic population, evidence is emerging regarding significant levels of communication difficulties amongst young offenders in the general prison population (Johnson and Hamilton 1997, Bryan 2004). It seems reasonable therefore to assume that considering the high incidence of communication disorder in the learning disabled population that there is likely to be a high prevalence of undiagnosed communication impairment amongst the forensic learning disabled population. Researchers acknowledge that there is a need for more research in this area.

Communication & Behaviour
A number of papers have identified connections between difficulties with understanding language, expressive language and challenging behaviour. Communication impairment has been identified as one of the personal core risk factors for challenging behaviour (Emerson 2001). Mansell (2007) reports that at least 45% of individuals whose behaviours challenge, present with significant impairments of communication.

The link between expressive communication difficulties and behaviour has long been acknowledged (Cheung Chung et al. 1995; Carr and Durand 1987; Gath 1994; Bott et al 1997). The challenging behaviour is seen as a form

of non-verbal communication; a functionally equivalent behaviour. The role that receptive communication difficulties play in challenging behaviour has received less recognition (Kevan, 2003; Chadwick and Kevan, 2004). Comprehension difficulties are often hidden because people with a difficulty understanding often use contextual and situational clues to make sense of their environment as well as their knowledge of regular routines to anticipate events. Abstract concepts which refer to things that cannot be seen or touched are particularly difficult for many people who have learning disabilities to understand. The language used to describe time (yesterday, today and tomorrow), tense markers, emotions and grammatical concepts such as negatives are particularly difficult to understand.

A number of researchers have described the link between the behaviour of support staff and challenging behaviour. Hastings and Remington (1994). In a review of the research literature on the behaviour of staff found empirical evidence to support the hypothesis that staff's actions affect clients' challenging behaviours. They also found that observational studies have shown that staff respond inconsistently to challenging behaviours and many of their responses may actually reinforce behaviours. Research has shown that paid carers regularly over-estimate the comprehension ability of the service user that they are caring for (Bartlett and Bunning, 1997; McConkey et al. 1999; Purcell, et al. 1999; Bradshaw, 2001; Banat et al. 2002). This results in a mismatch between the complexity of language that they use and the comprehension level of the service user this mismatch, may result in misunderstanding, anxiety, communication breakdown and conflict.
A number of treatment approaches have acknowledged the links between communication breakdown and challenging behaviour and therapeutic management aimed at supporting and enabling communication has been shown to result in reductions in challenging behaviour (Carr and Durand, 1985; La Vigna et al. 1989; Durand, 1990; Carr et al. 1993; Emerson, 1995; O'Neill et al. 1997; Thurman, 1997).

Some studies have questioned the notion that there is a clear link between communication and challenging behaviour. A meta-analysis of prevalence and cohort studies by McClintoch, Hall and Oliver (2003), identified evidence of trends to indicate links between the severity of intellectual disability, poor communication and autism as risk factors, however, the authors indicated that the interpretation of results is difficult because these variables overlap in a number of ways. These authors identified a clear need for further research to statistically

evaluate the relative contribution of each of these variables. Another study by MacLeod, Morrison, Swanston and Lindsay (2002) which investigated the effect of the relocation of four people with severe learning disabilities from an institution to a shared house in the community found that whilst the communication skills of these individuals improved there was also a significant increase in challenging behaviour. The reason for this is unclear; the authors suggest that one explanation might be that that the individuals responded to the increased opportunities by increasing the variety of their behaviours. It is evident therefore that whilst it is generally accepted that there are links between communication impairment and challenging behaviour there is a need for more rigorous research particularly in relation to the role of comprehension impairment.

Key Messages

- Communication difficulties impact on all aspects of daily life and is fundamental to learning new skills, making choices, forming and maintaining relationships and making the most of choices and opportunities
- Communication impairment is a risk factor for challenging behaviour
- There is often a mismatch between the complexity of language staff use and the comprehension levels of people with a learning disability

Module 3: Supporting Communication

Unit 2: Communication and Positive Behavioural Support

By the end of this unit you will be able to:

- Demonstrate understanding of communication assessment in relation to functional analysis
- Critically examine how communication supports contribute to the positive behavioural support model

Communication Assessment in Relation to Functional Analysis

The communication assessment will focus on the presenting behaviours in an attempt to identify whether they serve a communicative function for that individual. The assessment involves analysis of the individual's comprehension, expression, interaction and social skills and of the communication of communication partners. It will involve:

- Previous communication assessments
- Hearing assessment
- Observation of the service user in a variety of environments and with a variety of communication partners.
- Interviews with the people who know that individual well.
- The use of formal assessments.

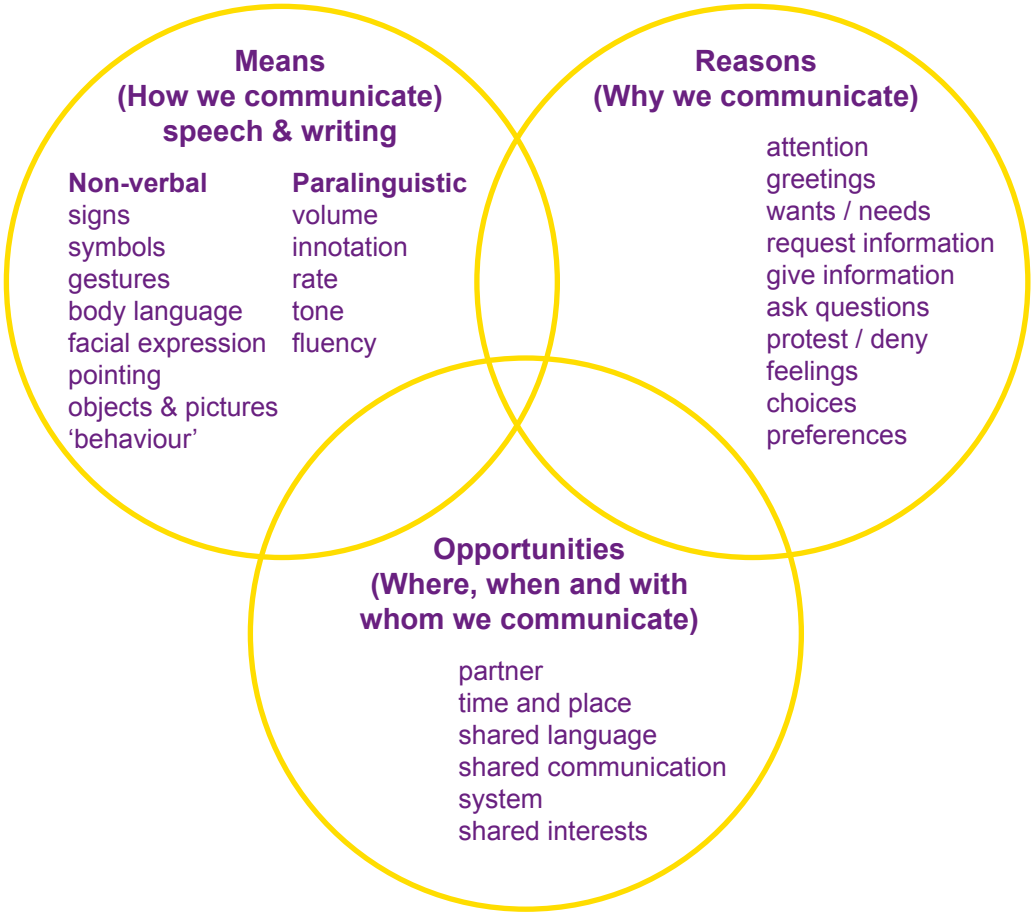
The individual's means of communication is described in terms of whether it is primarily verbal or non-verbal and whether the individual uses a symbolic communication system such as; speech, signing or symbols or a system that is idiosyncratic to that person. Language assessment will involve assessment of key word understanding and a linguistic analysis.

Interaction skills will be assessed in terms of the person's ability to understand and use non-verbal communication skills. Conversation skills will be assessed where appropriate.

The "Means, Reasons and Opportunities" communication model (Money 1997, 2002) is regularly used by Speech and Language Therapists (SLTs). It provides a framework within which to consider the person and their communication environment and incorporates both a clinical and social model of communication. The clinical model is more impairment focused and involves analysing the person's means of communication and any clinical factors that affect the person's ability to get their message across. The social model addresses communication in relation to environmental barriers, which prevent successful communication for example the use of complex language by the other person in the communication exchange or restricted life experience resulting in limited topics to talk about.

Module 3: Supporting Communication

Means, Reasons and Opportunities Model
(Money, 1997)



Module 3: Supporting Communication

Activity 3.2.1: Means, Reasons and Opportunities

Think of an individual that that you know, who has a severe learning disability and communication difficulties. Write a list of all their means of communication (how they communicate). Then think about their weekly routine in terms of the reasons they have to communicate (why they communicate). Finally think about the opportunities that they have to communicate (when, where and with whom). Additionally can you identify behaviours that serve a communication function for that person? Spend about 45 minutes on this activity.

Module 3: Supporting Communication

Communication and the Positive Behavioural Support Model

The overall treatment goals in terms of the positive behavioural support model will be to maximise the person's communication effectiveness and that of their communication partners. This may be achieved through the introduction of ecological strategies aimed at changing the communication environment and/or positive programming in the form of interventions designed to develop the person's communication skills. Where a behaviour has been identified as having a communication function for the person, the goal would be to teach the person a more appropriate and effective way of communicating this; for example, a person who is damaging the kitchen door because he hits it when he wants food, might learn to use a picture to ask for food. However, is widely recognised that an approach aimed only at changing the individual, will result in limited success. Money (1996) compared three different approaches to delivering a speech and language therapy service to people with learning disabilities. She found that whilst working directly with the person and their communication partner and working indirectly by providing teaching for communication partners did result in communication changes, only the combination of both approaches resulted in statistically significant changes

Ecological Strategies; adapting the communication environment.

The importance of the communication environment and particularly the role of the significant people in that environment in enabling successful communication have previously been discussed. Intervention is unlikely to result in a significant change in the client's communication without environmental changes. The provision of a Total/Inclusive Communication Environment (Jones 2000) is good practice for anyone with a severe learning disability. Inclusive communication is:

"An approach, which seeks to create a supportive and effective communication environment, using every available means of communication to understand and be understood"

(RCSLT 2003).

Inclusive communication is about enabling individuals with a communication difficulty, and the people with whom they communicate, to express themselves and understand each other well. It means, providing additional, alternative and consistent means of communication to enable people to access information and services and so maximise the opportunities they have to participate in all aspects of daily living.

Module 3: Supporting Communication

The provision of a supportive communication environment will involve ensuring the development and provision of inclusive communication standards by the service provider to ensure that:

- Information is provided in accessible formats
- Staff receive training about inclusive communication and, more specifically, about the communication of the people that they are supporting
- Good information for staff about the persons' means of communication (how they communicate) and how staff can most effectively communicate with them.

Photos, Pictures and Symbols

Photos, pictures and symbol systems such as Rebus (Widgit), PCS (Boardmaker 2001), Bonnington Symbol System (Lothian) and Bliss, enable people who are unable to read to communicate. Symbol systems are easier to learn than the written word because one symbol represents one meaning and many symbols are pictographic i.e. they look like the meaning they represent. The more abstract the meaning the more difficult it is to convey pictorially. The word "toilet" is unambiguous and can be represented by a picture of a toilet; however there are many ways to represent the word "hot"; hot food, feeling hot, the sun, fire and so on…

Pictures and symbols are presented and used in a variety of ways to enable individuals to understand events and to communicate their needs and emotions. The may be used for communication boards and books, calendars, diaries, timetables, sequencing boards, social stories, labelling places and objects and for making written information more accessible to people who are unable to read. Technology has enabled a more creative production of accessible materials through the use of symbol databases, digital cameras and Internet resources such as Google image search.

It is however worth noting, that visual systems, in common with all communication systems, must be learned. The addition of pictures or symbols is not sufficient in itself to make the information immediately accessible.

Staff Training

Training will provide basic information about communication and the principles of inclusive communication. It will enable staff to look at the daily life of their clients so that they are able to provide reasons and opportunities to communicate throughout the day, offering and enabling informed choice.

Training may involve the use of video recording of person/carer interaction. Video Interaction

Guidance (VIG) (Biemans 1991, Burton 2002) is a technique that aims to improve interaction through the review of successful communication situations.

Communication Passports

A communication passport (Millar 2003) provides detailed easily accessible information about how an individual communicates so that communication information can be passed on to new staff. They are particularly important to ease transitions. A passport is not a list but a synthesis of information useful to help other people to be 'the best he/she can be (Millar 2005). Passports must be reviewed and up-dated regularly to be useful.

Positive Programming

Positive programming will generally involve setting measurable goals that have been identified during assessment. The treatment will aim to develop communication specific communication skills by for example, developing interaction or language skills, improving speech intelligibility or teaching alternative and augmentative communication systems such as signing, symbols or the use of a voice output communication aid. Treatment will involve the use of specific speech and language therapy techniques some of which will be described in the next section.

Developing Interaction Skills
Intensive Interaction

Intensive interaction is an approach primarily developed for use with people with severe and complex learning disabilities who are at a pre-verbal communication stage and have significant difficulties with fundamental interaction skills (Nind & Hewitt 2001). It has been developed from the research into parent-child interaction and involves responding sensitively and intuitively to the verbal and non-verbal behaviours of the person in ways that engage their attention by reciprocating verbal and non-verbal behaviours and systematically extending interactive exchanges. It is about giving positive interaction experiences with the emphasis on communication being fun and valuing interactions that occur throughout the day, for example, during care tasks and mealtimes.

Social Skills Therapy

Social skills are usually worked on in group therapy. Generally the aim is to raise awareness of appropriate social communication behaviours such as use of eye contact, listening and turn taking, or conversational skills such as initiation, topic maintenance and conversation closure and practising these behaviours through structured group activities and discussions.

Module 3: Supporting Communication

Chat Books/Bags

For people who have difficulty in initiating and maintaining conversation a “chat book or bag” which contains information related to their life and interests such as photos, pictures, leaflets and small objects can be an invaluable aid to interaction.

Language Therapy

Language therapy will involve a number of specific, speech and language therapy techniques to develop comprehension and expression. These techniques may involve developmental, linguistic or cognitive neuropsychological approaches depending on the language disorder diagnosis.

Alternative Augmentative Communication (AAC) Systems

These are systems that are used as an addition to speech where the individual has a problem with intelligibility or instead of speech for people with no speech. The choice of AAC system will depend on many factors including: cognitive level, language comprehension, symbolic level of understanding, hand function, the general interests of the individual and most importantly, the environmental support available.

All AAC systems require significant support from others in the AAC user’s environment for successful implementation. The selection of appropriate vocabulary is also of crucial importance

Manual Signing Systems

Makaton and Signalong are both sign-supporting systems mainly used by people with learning disabilities. They are based on British Sign Language. The system is used by both partners in the communication exchange with the relative or paid carer speaking and signing the key words (information carrying-words). Signing is usually recommended for individuals who are using some natural gesture. The use of key-word-signing is a valuable aid to understanding for people with comprehension difficulties, even when they may not use sign to express themselves.

Objects of Reference/Signifiers

“Objects of reference” is a term that describes the use of objects as a means of communication (Ace Centre 2003, CALL Centre) They are used by deaf blind people as a communication system (Ockelford, 2002, Bell 2010) but are also used by people who have no speech and do not respond to photos, pictures and symbols. They can be used to help the person understand what is going to happen next. The object is presented

to the person immediately before an activity and thus becomes associated with the activity. For example, a towel is given to the person immediately prior to a bath. The person gradually learns that when they are given the towel they will have a bath. Once the person has learned to associate objects with activities, they may begin to communicate choices using the objects. Objects of reference may also act as a bridge to the use of more abstract communication systems (Hayton 2004).

Voice Output Communication Aids

These are computerised devices, which allow individuals to have a voice. They involve a display, which can be fixed or dynamic (the screen changes to reveal different pages usually categorised by topic and accessed via a menu). The display may have pictures, symbols or letters on it. The communication aid user can access the device directly by touching the screen or by a scanning system operated with a switch. The machine's voice may be digital (recorded human voice) or synthesised. Machines vary in complexity. As with all AAC systems successful implementation requires a lot of support from people in the individual's environment, particularly in relation to identifying and programming appropriate vocabulary into the machine. If, for example, support staff have limited technological skills/knowledge, a successful outcome is unlikely. The machines are expensive, relatively unwieldy to carry around if the person is mobile, prone to breaking and make excellent missiles; a particular challenge when working with this client group. The more complex machines can take many years to learn to use but can enable individuals to potentially access a very large vocabulary. Successful implementation is particularly dependent on good communication opportunity planning.

Techniques Involving Pictures and Symbols Talking Mats

Talking Mats (Murphy 1998, Bell & Cameron 2003) is a technique involving the use of pictures or symbols to help people with communication difficulties to express their views.

Picture Exchange System (PECS)

PECS (Bondy and Frost 2002) is an approach which was originally devised for use with autistic children. It teaches people with little or no speech to use pictures in order to communicate needs and uses a behaviourist approach with people receiving an immediate reward for choosing a picture.

Social Stories

These were originally for use with children with

Autistic Spectrum Disorder (Gray 1995, 2000) and they are proving to be useful for adults with learning disabilities and challenging behaviour.

They are a way of teaching socially appropriate behaviour by using simple language, illustrated with pictures or symbols, to explain the events that occur in a social situation. The story must adhere to a specific format in terms of the types of sentences used. The characters in the story demonstrate a specific appropriate behaviour in that situation. The story enables the person to learn how to behave in that situation, what other people may be thinking and feeling and how they are likely to react.

Conclusion

People with learning disabilities with complex psychological and behavioural needs are highly likely to have difficulties with communication both in expressing themselves and in understanding what is said to them. Staff supporting these people will often underestimate the communication abilities of the individuals in their care. There is some evidence to suggest a link between communication disorders and challenging behaviours. The implementation of treatments aimed at supporting and developing communication can contribute to a reduction in challenging behaviours.

Activity 3.2.1: Communication Support

Thinking about the person you identified in activity 1. What communication supports might you recommend for that person? Spend about 20 minutes on this activity.

Module 3: Supporting Communication

3 Well done - you have now completed Module 3: Supporting Communication

You may find it helpful to note any particular issues you would like to note below:

Similarly, there may be areas covered in this module that you will find helpful to discuss further with your supervisor. You may find it helpful to list them below:

Module 4: An Exercise in Detective Work

Module 4: An Exercise in Detective Work

Module 4 consists of eight units and explores functional analysis of behaviour starting with the ABC model and then working through mediator analysis, motivational analysis, ecological analysis, describing behaviour, antecedent analysis, consequence analysis and impressions of meaning. This section of the learning resource is intended to allow you to build and reflect on your knowledge and skills on the Functional Analysis of Behaviour, particularly as it relates to your own service and role. Some learners may already be very familiar with some sections of the material but it is respectfully suggested that you still take a little time to reflect on each of the topic areas. However, best use of this module is probably achieved by focusing on the areas you are less familiar with and exploring these in more detail through the exercises, references and in consultation with your supervisor. Although some of the activities relate to general issues you will find it helpful to have a particular service user that you are very familiar with in mind as you work through these units.

By the end of this module you will be able to:

- Identify how to develop working hypotheses about challenging behaviour
- Understand different levels of assessment which can be applied to functional analysis
- Understand the benefits of going beyond a simplistic behavioural model of behaviour for the person and their carers

Unit 1: Starting with ABC's

ABC's

The foundations of functional assessment are found in the Applied Behaviour Analysis literature (see Hanley et al. 2003 for review). Such analyses deliberately focused on those aspects of behaviour that can be observed and clearly defined and described. Commonly these defined behaviours would be measured in the context of the "ABC" model, although sometimes only an "AB" model might be used:

Antecedents - What could be observed to have happened before the target behaviour occurred?

Behaviour - The behaviour observed.

Consequences - What could be observed to take place following the behaviour?

The information about Antecedents can be used to identify factors that make a behaviour more likely to occur (although it is not much help at identifying factors that make the behaviour less likely to occur as it focuses primarily on situations when the behaviour is present).

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The description of the Behaviour can be used to identify changes in the pattern of the behaviour itself (such as intensity, duration, sequence of actions etc.).

The information generated about Consequences can provide detail about responses (or lack of responses) to that behaviour that may be seen to be reinforcing the target behaviour.

Historically, much of the focus of intervention following such “ABC” analyses concentrated on adjusting the consequences following that behaviour. The emphasis now has moved to a much greater focus on the antecedents.

The use of ABC charts can regularly be found in service settings and clinical experience has suggested that these are being used in a number of different ways.

Activity 4.1.1: ABC Charts

How are ABC charts used in your service, or in the key services you support? Spend about 30 minutes on this activity. In your response you should consider the following:

The extent to which ABC forms are completed accurately/consistently?

The extent to which forms are individualised for specific service users and behaviours?

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Activity 4.1.1: ABC Charts

The time period over which recordings take place?

How quality of recording is monitored?

Activity 4.1.1: ABC Charts

How well sequences of behaviour are represented?

How well the recordings represent 'observed' behaviour rather than opinion?

Module 4: An Exercise in Detective Work

Activity 4.1.1: ABC Charts

How effectively the data from ABC forms is analysed (and by whom)?

How effectively the data from ABC forms is used to alter practice in supporting the individual concerned?

Activity 4.1.1: ABC Charts

If ABC forms are not used, how else is this information captured and to what extent does that meet the above issues?

Moving to Positive Behavioural Support
Return and reread the review article by Allen et al. (2005) on positive behavioural support that you were introduced to in Module 1: An Overview on positive behavioural support. This article includes the essential characteristics of PBS.

Module 4: An Exercise in Detective Work

Activity 4.1.2: Essential Characteristics of PBS

Consider the essential characteristics of positive behavioural support reported by Allen et al (2005) Which of these are reflected in the way your service operates (or in the key services you support). If not currently achieved what steps could you take to improve this? Spend about 45 minutes on this activity.

Essential Characteristic	How well is this achieved in the service(s) I work in?	What could be done to improve this?
It is values-led in that the goal of behavioural strategies is to achieve enhanced community presence, choice, personal competence, respect and community participation, rather than simply behaviour change in isolation.		
It is based on an understanding of why, when and how behaviours happen and what purposes they serve (via the use of functional analysis).		
It focuses on altering triggers for behaviour, in order to reduce the likelihood that behaviour will occur.		

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Essential Characteristic	How well is this achieved in the service(s) I work in?	What could be done to improve this?
It uses skill teaching as a central intervention, as lack of critical skills is often a key contributing factor in the development of behavioural challenges.		
It uses changes in quality of life as both an intervention and an outcome measure. It achieves reductions in behaviour as a side-effect of the above.		
It has a long-term focus in that challenging behaviours are often of a long-term nature and successful interventions therefore need to be maintained over prolonged periods.		
It has a multi-component focus, reflecting the facts that challenging behaviours are often multiply determined and that users typically display multiple forms.		

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Essential Characteristic	How well is this achieved in the service(s) I work in?	What could be done to improve this?
It reduces or eliminates the use of punishment approaches.		
It includes both proactive strategies for changing behaviour and reactive strategies for managing behaviour when it occurs, because even the most effective change strategies may not completely eliminate risk behaviours from behavioural repertoires.		

Functional Understanding of Behaviour

In practice, for some cases, a well constructed interview with a good informant may provide enough information to start to develop an initial functional assessment for a behaviour. However, this is very reliant on the quality of information provided by the informant. Even although the vast majority of informants are trying to be helpful the information is often not as detailed as it might be. This is influenced by a number of factors, including:

- the personal experience of the interviewee in interacting with the person might be different from other carers
- the interviewee's attributions of what is causing the behaviour might skew their responses
- the interviewee might not want to be critical of others involved in supporting the person
- the interviewee might be overly critical of others involved in supporting the person ("I never have a problem with him" etc.)

- the interviewee might have limited direct experience of working face to face with the person
- the interviewee may have their own agenda about what support they believe the person requires
- certain behaviours may be viewed by the interviewee as much more important to discuss than others
- the interviewee might feel a need to be defensive about how challenging this particular individual's behaviour is and may emphasise this in their responses.

These are natural human responses that are typical of what occurs in many interactions and it is very important to remember that most interviewees are trying to do their best for the person they support. A number of these limitations can be managed through the use of interviews with more than one carer, use of direct observation and examination of data available from records, or indeed interviewing the service user themselves.

Emerson's (1998) "Structured Interview to Determine the Immediate Impact and Contextual Control of Challenging Behaviour" allows you to consider in detail a range of factors when carrying out your assessment.

Activity 4.1.3: Factors to Consider

Work your way through the questions detailed by Emerson (as listed in the table on the next pages).

How often do you routinely consider each of these factors when considering the challenging behaviour presented by people you support (i.e. in day to day practice rather than when carrying out a functional analysis)?

Also consider how far sufficient information about each of these areas can be achieved by interview alone?

Take your time with this activity.

Once you have done this, think about one of the behaviours of a person you support and complete the questions for that behaviour. If time allows you will probably find it beneficial to repeat this exercise for one or two other behaviours displayed by that individual (by copying the pages) and comparing the similarities and differences in your responses for the different behaviour types.

Module 4: An Exercise in Detective Work

"Structured Interview to Determine the Immediate Impact and Contextual Control of Challenging Behaviour" Emerson (1998)
Behaviour Type: _____

Question	Response
What are the activities or settings in which the behaviour typically occurs?	4
What typically happens when the behaviour occurs (i.e. what do you or others typically do)?	4
Are there particular events or activities that usually or often occur just before an instance of challenging behaviour? Please describe.	
Are there particular events or activities that you usually avoid because they typically result in challenging behaviour? Please describe.	

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Question	Response
Are there particular events or activities that you encourage because they DO NOT result in challenging behaviour? Please describe.	
What does ……. appear to be communicating with their challenging behaviour? Please describe.	
Does their challenging behaviour appear to be related to a specific medical condition, diet, sleep pattern, seizure activity, period of illness or pain? Please describe.	
Does their challenging behaviour appear to be related to their mood or emotional state? Does this change follow an episode of challenging behaviour? Please describe.	

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Question	Response
Does the behaviour appear to be influenced by environmental factors (noise, number of people in the room, lighting, music, temperature)? Please describe.	
Does the behaviour appear to be influenced by events in other settings (e.g. relationships at home)? Please describe.	

Referral Information

On receipt of a referral in relation to challenging behaviour remember that it can be very helpful to ask the question "Why this referral of this person for this behaviour at this time?" This can be very important in determining the appropriateness of a referral and the level of assessment that is required.

Think about referrals you have made or received in the past. What made you or others decide that 'now' was the time to make a referral? This decision can be influenced by a wide range of factors including: significant changes in behavioural presentation; being 'ground down' by a particular behaviour; feeling that you are not doing all you might to support an individual; a shift of focus to this individual after someone else has moved on; increased awareness of availability of a service; pressure from managers

to 'do something'; as part of a systematic service improvement; to get proof that the service needs more resources and many others.

Your initial 'detective work' is likely to vary according to the response to the "Why now?" question. For example, if the referral is made because new behaviours of concern have emerged recently you are likely to be particularly interested in whether any new things were happening in the individual's life at the time the new behaviour emerged. If however, the behaviour(s) involved in the referral are ones that have been present for a long time the initial question may be more about why the carers (or others) have chosen now to make a referral for support. Ultimately the same types of functional analysis may be carried out for that individual but in terms of understanding environmental and mediator factors the nature of the referral can provide useful initial information.

Description of the Person

Services often have a huge amount of information available in case notes about individuals. However, consider how much of this is routinely available in a form that is easily accessible in services? Furthermore, whilst many services do collect and record the information there can be a question about the extent to which they apply this effectively in day to day practice. There is often a great deal of activity supporting individuals but unless good assessment is utilised effectively there is a danger that much of this activity is built on assumptions rather than an accurate picture of the person. Examples of this problem can be found in relation to assumptions that are made about an individual's level of communication, for example the "He understands everything you say", effect. Another example that is often found is where a socially skilled person will appear to be much more able intellectually than is actually the case. This can lead to expectations being set too high for that individual which can create areas of significant tension which can result in behaviour that is challenging. There is also a challenge for services in how they ensure that they are systematically building on an individual's existing skills to develop their quality of life.

Key Messages

- ABC charts are regularly used in practice and a cornerstone of the assessment process but consider the issues relating to accuracy and consistency
- There is usually a lot of information already available in case notes and client records
- Consider why the referral is being made now

Module 4: An Exercise in Detective Work

Unit 2: Mediator Analysis

Activity 4.2.1: Mediator Analysis

In this activity you are asked to identify the factors that could facilitate change occurring for an individual and the barriers that could get in the way in a hypothetical service. Consider your own service (or one you are very closely involved with) and, where appropriate the service user you are focusing on. Use the factors identified by Doyle and Owens (2007) as detailed below. Take your time with this activity. In addition to allowing you to reflect on your 'own' service this exercise should provide you with an idea of how feasible a positive behaviour support approach may be in your service, or to identify what barriers to this would need to be tackled to allow it to be implemented.

Factors that can facilitate change	How well placed is your service in relation to this factor?
Enthusiasm/motivation for change on the part of the client and his/her support network.	
Understanding by the client and support network about how the recommendations will effect change.	
Time.	
Availability of other people to assist with implementation (e.g. family members, staff).	
Access to other relevant services (e.g. respite, advocacy, mental health).	

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Barriers to future acceptance and implementation of recommendations	How relevant is this factor in your service?
Access and positive attitude to training and implementation.	
Emotional/mental health factors (e.g. a client in an active phase of mental illness, parent with mental illness (e.g. Depression), parental/staff stress.	
Lack of people resources to assist with implementation (e.g. not enough staff, father spending long hours away from home working).	
Cultural and religious contexts (e.g. recommendations may be inconsistent with or not have taken account of the cultural background of the family or staff.	
Socio-economic factors (e.g. a client or family may not have the financial capacity to purchase recommended sensory equipment).	
Lack of motivation by the client or support network to change	

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Barriers to future acceptance and implementation of recommendations	How relevant is this factor in your service?
Lack of knowledge, skills and experience to implement recommended support strategies.	
Lack of resources to promote change (e.g. training).	
The client does not or cannot understand how the recommendations will cause change.	
Poor communication, liaison and coordination between the client, multiple service providers and others in the support network.	

Key Messages

- Mediator analysis is the analysis of the people and factors that may affect the delivery of the positive behaviour plan
- The abilities (which includes resources, values and attitudes) of staff and/or family carers to deliver the positive behaviour plan is crucial to its success

Module 4: An Exercise in Detective Work

Unit 3: Motivational Analysis

When considering a motivational analysis for an individual in the context of positive behavioural support it is very important not just to think about probable reinforcers in relation to their potential for use as structured reinforcers as part of a specific intervention but also more widely in terms of the general quality of life and experience of an individual. There can be a danger of us getting into a particular mindset about what is positively reinforcing for service users because certain things have previously been used as reinforcers. The next activity gives you an opportunity to reflect on this.

Activity 4.3.1: Inventory of Favourite

The next pages contain two copies of an "Inventory of Favourite Things" reported by McClean and Grey (2007).

Firstly, you should complete the Inventory scoring it (honestly!) for yourself.

You should then repeat the exercise scoring it for your perception of how it would apply to the service user you have chosen to focus on. Spend about 45 minutes on this activity.

Module 4: An Exercise in Detective Work

Inventory of favourite things (McClean & Gray 2007) Completed for: Me!

The items in this questionnaire refer to things that might give a person pleasure or satisfaction. Please rate how much the person enjoys each of the following by placing a number (1 to 5) in the appropriate space.

1 = Not at all **2 = A little** **3 = A fair amount** **4 = Much** **5 = Very much**

Snacks
What kind?
a. ☐
b. ☐

Meals
What kind?
a. ☐
b. ☐

Drinks
What kind?
a. ☐
b. ☐

Preparing food ☐

Possessions
Jewellery ☐
Clothes ☐
Magazines ☐
Computer games ☐
Skate board ☐
Diary ☐
Bicycle ☐
Other possessions?
a. ☐
b. ☐
c. ☐
d. ☐

Entertainment
Watching TV ☐
Cinema ☐
Pub ☐
Renting video ☐
Concert or show ☐

Sport
Playing soccer ☐
Playing hurling ☐
Playing football ☐
Swimming ☐
Riding a bike ☐
Skating ☐
Bowling ☐
Horse-riding ☐
Fishing ☐
Table tennis ☐
Going to a match ☐
Visit to Old Trafford ☐
Painting ☐
Pottery ☐
Playing snooker ☐
Playing pool ☐
Card games ☐

Other?
a. ☐
b. ☐
c. ☐

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Music

- Playing an instrument ☐
- Singing ☐
- Dancing ☐
- Buying CDs ☐
- Listening to music ☐

Excursions

- Ride in a car ☐
- Visiting relatives ☐
- Visiting friends ☐
- Going to beach ☐
- Having picnic ☐
- Going out to dinner ☐
- Going for a walk ☐
- Visiting the zoo ☐
- Shopping for clothes ☐
- Going to the library ☐
- Going on the train ☐
- Bus trip ☐

Other

- a. ☐
- b. ☐
- c. ☐

Social interaction

- Playing with children ☐
- Playing with adults ☐
- Hugs, kisses ☐
- Sleepovers ☐
- Coffee with others ☐
- Party with friends ☐

Other

- a. ☐
- b. ☐
- **c.** ☐

Academic

- Reading ☐
- Writing ☐
- Magazines ☐
- Being read to ☐
- Science ☐
- Social studies ☐
- Physical education ☐
- Maths ☐
- School ☐
- Leave class early ☐
- Free time ☐
- Doing responsible job ☐
- Video after class ☐

Domestic activities

- Setting the table ☐
- Making the bed ☐
- Baking ☐
- Repairing ☐
- Working outside ☐
- Going on messages ☐
- Cooking ☐
- Washing car ☐
- Sewing ☐
- Shopping ☐
- Exempt from chores ☐

Personal appearance

- Getting new clothes ☐
- Putting on make-up ☐
- Getting a haircut ☐
- Manicure ☐
- Massage ☐
- Visit to beautician ☐
- Perfume or aftershave ☐
- Wearing jewellery ☐
- Having picture taken ☐

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Other events	
Staying past bedtime	
Earning money	
Free time	
Having a pet	
Taking a bath	
Jacuzzi	
Multi-sensory room	
Steam room	
Aromatherapy	
Feeding animals	
Listening to stories	
Compiling music tape	
Decorating own room	
Choosing own bedtime	
Sleeping late	
Chairing a meeting	
Magazine subscription	
Being centre of attention	
Leave work early	
Choose type of work	

Tokens	
Stars on chart	
Special badges	
Certificates	
Points	
Money	
Note home	
Other	
a.	
b.	
c.	
d.	
e.	

Module 4: An Exercise in Detective Work

Inventory of favourite things (McClean & Gray 2007) Completed for:

The items in this questionnaire refer to things that might give a person pleasure or satisfaction. Please rate how much the person enjoys each of the following by placing a number (1 to 5) in the appropriate space.

1 = Not at all **2 = A little** **3 = A fair amount** **4 = Much** **5 = Very much**

Snacks
What kind?
a. ☐
b. ☐

Meals
What kind?
a. ☐
b. ☐

Drinks
What kind?
a. ☐
b. ☐

Preparing food ☐

Possessions
Jewellery ☐
Clothes ☐
Magazines ☐
Computer games ☐
Skate board ☐
Diary ☐
Bicycle ☐
Other possessions?
a. ☐
b. ☐
c. ☐
d. ☐

Entertainment
Watching TV ☐
Cinema ☐
Pub ☐
Renting video ☐
Concert or show ☐

Sport
Playing soccer ☐
Playing hurling ☐
Playing football ☐
Swimming ☐
Riding a bike ☐
Skating ☐
Bowling ☐
Horse-riding ☐
Fishing ☐
Table tennis ☐
Going to a match ☐
Visit to Old Trafford ☐
Painting ☐
Pottery ☐
Playing snooker ☐
Playing pool ☐
Card games ☐
Other?
a. ☐
b. ☐
c. ☐

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Music

- Playing an instrument ☐
- Singing ☐
- Dancing ☐
- Buying CDs ☐
- Listening to music ☐

Excursions

- Ride in a car ☐
- Visiting relatives ☐
- Visiting friends ☐
- Going to beach ☐
- Having picnic ☐
- Going out to dinner ☐
- Going for a walk ☐
- Visiting the zoo ☐
- Shopping for clothes ☐
- Going to the library ☐
- Going on the train ☐
- Bus trip ☐

Other

- a. ☐
- b. ☐
- c. ☐

Social interaction

- Playing with children ☐
- Playing with adults ☐
- Hugs, kisses ☐
- Sleepovers ☐
- Coffee with others ☐
- Party with friends ☐

Other

- a. ☐
- b. ☐
- **c.** ☐

Academic

- Reading ☐
- Writing ☐
- Magazines ☐
- Being read to ☐
- Science ☐
- Social studies ☐
- Physical education ☐
- Maths ☐
- School ☐
- Leave class early ☐
- Free time ☐
- Doing responsible job ☐
- Video after class ☐

Domestic activities

- Setting the table ☐
- Making the bed ☐
- Baking ☐
- Repairing ☐
- Working outside ☐
- Going on messages ☐
- Cooking ☐
- Washing car ☐
- Sewing ☐
- Shopping ☐
- Exempt from chores ☐

Personal appearance

- Getting new clothes ☐
- Putting on make-up ☐
- Getting a haircut ☐
- Manicure ☐
- Massage ☐
- Visit to beautician ☐
- Perfume or aftershave ☐
- Wearing jewellery ☐
- Having picture taken ☐

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Other events	
Staying past bedtime	
Earning money	
Free time	
Having a pet	
Taking a bath	
Jacuzzi	
Multi-sensory room	
Steam room	
Aromatherapy	
Feeding animals	
Listening to stories	
Compiling music tape	
Decorating own room	
Choosing own bedtime	
Sleeping late	
Chairing a meeting	
Magazine subscription	
Being centre of attention	
Leave work early	
Choose type of work	

Tokens	
Stars on chart	
Special badges	
Certificates	
Points	
Money	
Note home	
Other	
a.	
b.	
c.	
d.	
e.	

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Having completed the Inventory for both yourself and your selected service user take some time to reflect on the similarities and differences between the two sets of results. Are there any things that surprised you when you compared the two sets of results? How far are any differences the result of different opportunities and experience of community participation rather than differences in intellectual ability? How many of the things that you think would give your identified service user pleasure or satisfaction do they currently have reasonable access to? How much of a difference might it make to their life (and as a side-effect, their behaviour) if they did have access? Can any of this be achieved for them?

In completing this exercise we suspect that you might have been a little bit surprised by some of the items. For example, the inclusion of soccer and football might have confused you, and as for hurling in a Scottish context – surely it should be shinty? One of the beauties of this particular inventory is that it is an excellent example of something that has been developed for a particular cultural context (i.e. in an Irish setting, where the 'football' is presumably Gaelic Football). Having said that, I'm not sure why there is the specific reference to Old Trafford! When looking for pleasurable or satisfying things (that sounds much better than 'reinforcers', doesn't it) feel free to be creative and add many more items to the list of possibilities. As a further thought, we suspect that some of you may have given your service user (if not yourself) a low rating on "chairing meetings". Do not assume this to be the case as there are now many examples, particularly through the self-advocacy movement, of service users being fully involved in chairing meetings and getting as much pleasure as anyone else from doing so.

Finally, in relation to your personal Inventory of Favourite Things, you may well wish to keep this private, however do consider how helpful it might be if you were to leave it lying around in the weeks before Christmas for you partner/friends/relatives to see. It might just prevent you having to be polite about presents you don't really like!

Key Messages

- It is important to all of us to have opportunities to do things that are rewarding for us
- We should look to support people with a learning disability to increase choice, opportunities and positive experiences in their daily life

Module 4: An Exercise in Detective Work

Unit 4: Ecological Analysis

A large number of areas can be considered in relation to ecological analysis, some of which can be observed and measured (such as use of communication supports, staffing levels, noise level etc) and others of which are much more nebulous (such as attitudes and service culture). The focus on ecological and environmental factors was one of the key strengths of the development of non-aversive approaches to behaviour. The questions which follow were produced by Donnellan et al. In their very influential book "Progress Without Punishment" in 1988. Although now over 20 years old (as can be seen in a little of the language used), the questions that are being asked are none the less still relevant for services today.

Activity 4.4.1 Ecological Analysis

Consider the following questions from Donnellan et al. (1988) in relation to the service user you are focusing on.

1. *"Does this client have the opportunity and/or skills to make choices that are reasonable for his age and ability?*

2. *Does he have freedom of movement? How often can he decide when he wants to eat; go to bed; get up; interact; and postpone or prolong an activity, an event, or an interaction? Are such options provided routinely and in a manner that promotes the development of necessary choice-making skills?*

Activity 4.4.1 Ecological Analysis

3. *Does this learner have the opportunity to interact socially with non-handicapped peers and other citizens on a routine basis and in a manner that enables him to acquire such social skills?*

4. *What are the communicative, social, and general functioning skills of the individuals with whom he spends his instructional, vocational, and recreational time?*

Activity 4.4.1 Ecological Analysis

5. *How often is positive physical contact available for this learner? Does he have a choice? What opportunities are available, and in what manner is it appropriate for him to express affection physically?*

6. *Is there a variety of things for the learner to do spontaneously, during breaks and leisure time, without depending on staff to provide them? Do staff provide such activities, when and as appropriate?*

Activity 4.4.1 Ecological Analysis

7. *Do staff interact with the individual in a chronological-age-appropriate social manner? How often do staff interact with the learner? Do they do so only when giving instruction?*

Activity 4.4.1 Ecological Analysis

8. *How many different kinds of environments does this learner have access to in a given day or week? Is instruction confined to one setting, or is he given frequent opportunities to learn chronological-age-appropriate and functional skills in a variety of natural environments?*

Activity 4.4.1 Ecological Analysis

9. *How many years has he been in this environment? What are the opportunities for advancement, for learning new and higher-paying jobs, for moving on to other preferred vocational or residential settings?*

Activity 4.4.1 Ecological Analysis

10. *With how many different staff members is he in contact in a day? With how many nonhandicapped peers? How often does this change? How is he informed of the change? Is the milieu one that is interesting, supportive, and acknowledges the individual's right to be treated with dignity and respect?"*

Key Messages

- Ecological assessment identifies where environments can be improved to increase community presence, meaningful relationships, choice, competence and respect

Module 4: An Exercise in Detective Work

Unit 5: Description of Challenging Behaviour

This unit looks at describing the behaviour under consideration clearly and objectively. To assist you in doing this it is recommended that you look at the Positive Practice newsletters which were produced by IABA and can be accessed at **www.iaba.com/newsltr.html.** A number of these newsletters include articles on "Definition of a problem behaviour" and give case examples with detailed information on how their behaviour can be described.

The next activity asks you to do this for the service user you are considering. You should complete this exercise for at least one behaviour displayed. You may wish to repeat this exercise for one or two additional behaviours that the person displays (by completing copies of the form on the next pages). This will firstly give you practice at completing descriptions for different types of behaviour, and secondly, will allow you to compare the similarities and differences in the patterns of behaviour the service user displays.

Once you have completed the description of the behaviour, which should include topography, cycle, course and strength of behaviour, you should then consider how that behaviour would most efficiently and effectively be measured to assist in your functional analysis and also as a potential baseline of behaviour prior to future interventions. Take your time with this activity.

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Activity 4.5.1: Describing Behaviour

Type of Behaviour: _____

Topography of the Behaviour	
What the behaviour looks like.	
Observable characteristics of the behaviour.	
Measurable characteristics of the behaviour.	
Description of the physical characteristics that signal that the behaviour has occurred.	

Module 4: An Exercise in Detective Work

Activity 4.5.1: Describing Behaviour

Cycle	
Onset and offset criteria, i.e. The behaviour has started when... The behaviour has ended when...	
Course (i)	
Precursors to behaviour (i.e. things the person typically does prior to onset of this behaviour)	
Topography of behaviour as it develops over the course of an episode.	

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Activity 4.5.1: Describing Behaviour

Course (i)	
Other things the person does during an episode of this behaviour.	
Description of the person's emotional expressions during an episode of this.	
Post-cursors to a behaviour (i.e. what the person typically does once an episode is over).	

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Activity 4.5.1: Describing Behaviour

Course (ii)

What do the following look like?

Phase 1 - Calm presentation	
Phase 2 - Escalation / build up	
Phase 3 - Climax	
Phase 4 - De-escalation	
Phase 5 - Recovery	

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Activity 4.5.1: Describing Behaviour

Strength	
Frequency - How often does this behaviour occur?	
Duration - How long does this behaviour last for?	
Severity - What direct impact does this behaviour have?	
Latency - How long is there between known triggers and occurrence of this behaviour?	
Measurement	
How can this behaviour be measured most efficiently and effectively in this service?	

Module 4: An Exercise in Detective Work

History of Problems

"...the past is myself, my own history, the seed of my present thoughts, the mould of my present disposition".
Robert Louis Stevenson.

A traditional 'pure' behavioural approach would not take the history of individuals into account in the analysis of behaviour. However, it is now generally recognised that it does need to be taken into consideration if we are to have a truly person-centred approach to functional analysis.

If we are all brutally honest with ourselves most of us probably have grudges, bitterness, past embarrassments, disappointments etc. from our history that still affect our behaviour today that would be virtually impossible for even the most highly skilled behavioural observer to identify. For example, there are probably some names you would never give a child of yours based on someone you knew years ago! Fortunately, for most of us there are also lots of positive life events such as loving relationships, nice surprises, successes and other nurturing experiences that allow our past to positively influence our present.

We know from the literature, and no doubt clinical experience, that people with a learning disability are more likely to have had greater experiences of loss, rejection and abuse than in the population as a whole. We should therefore not be surprised that for some people this can potentially have a significant influence on their challenging behaviour.

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Activity 4.5.2: History

Take a few minutes to think about service users you have worked with in the past who have had very negative experiences in their lives. How has this affected their behaviour? Has sufficient account been taken of this in the way they have been supported? If so, in what way did this make a difference? If not taken account of, why not, and what effect might this have had? Spend about 20 minutes on this activity.

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History of Previous Interventions

Good information about the effectiveness or ineffectiveness of previous interventions can provide very helpful information for your functional analysis of behaviour for an individual. Remember that it is important not only to consider whether previous interventions were effective or not, but to ask the question of why this was the case. For previously ineffective interventions it is particularly important to try to determine the extent to which this was due to the design of the intervention being ineffective, or whether it was in the implementation of this design. You will also need to take service user and carer experiences of previous interventions into account when designing future interventions. This is particularly important if there is consideration of repeating an intervention that is very similar to one that has not been found to be effective in the past. If repeating such an intervention, care will have to be taken to inform those involved why this is the most appropriate approach and of the steps that are to be taken to improve the possibility of a successful outcome on this occasion.

Key Messages

- Behaviours should be described clearly and objectively in such a way that anyone seeing the behaviour would recognise it
- The history of problems should be considered

Module 4: An Exercise in Detective Work

Unit 6: Antecedent Analysis

The next activity utilises questions in the Doyle & Owens (2007) guide which you may find helpful in identifying potential antecedents for a particular type of behaviour.

Activity 4.6.1: Antecedent Analysis

Answer the following questions in relation to one of the types of behaviour displayed by the service user you are focusing on, as if you were being asked them by an interviewer carrying out a functional analysis. Reflect on which questions you find easy and which you find hard to answer and consider why this might be the case.

Interview questions about the antecedents

Time of day:	
When are the behaviours most likely?	
Least likely?	
When (at what times) does the behaviour occur?	
During what time in the client's daily routine does the behaviour seldom/never occur?	
At what time in the client's daily routine does the behaviour usually occur?	

Module 4: An Exercise in Detective Work

Setting / Location:	
When are the behaviours most likely?	
Least likely?	
Where does the behaviour usually occur?	
Where does the behaviour seldom/never occur?	
Social Influences / Social Control:	
With whom are the behaviours most likely?	
With whom are the behaviours least likely?	
With whom does the behaviour usually occur? (e.g., staff, clients, community member)	
With whom does the behaviour seldom/never occur?	

Module 4: An Exercise in Detective Work

Activity:	
What activity is most likely to produce the behaviour?	
What activity is least likely to produce the behaviour?	
What things usually happen before the behaviour?	
During which parts (activity) of the client's daily routine does the behaviour seldom/ never occur?	
At what parts (activity) of the client's daily routine does the behaviour usually occur?	

Module 4: An Exercise in Detective Work

Personal Influences / Perspective:	
If it is possible for the client to provide verbal answers then he or she can be asked:	
What were you thinking about at the time?	
How did you feel?	
What caused you to (do that)?	
What was happening around you?	

Module 4: An Exercise in Detective Work

Additional Interview Questions:	
If I could give you a million dollars to cause the behaviour to happen, to show me what it was like, what could you do to ensure it happened?	
What else could you do to ensure the behaviour occurred?	
In relation to a particular behaviour / chain of behaviours what would happen if:	
The client was ignored for a short or long period of time?	
The client was left alone for a period of time, with no interaction or interruption from others?	
You presented them with a difficult task or a task they have not done before?	
A preferred activity was interrupted by someone or another activity request?	

Module 4: An Exercise in Detective Work

Additional Interview Questions:	
A non preferred activity was interrupted by someone or another activity request?	
There was a change in an established routine? Or where there is no set / formal routine, there was a disparity between what the person expected was going to happen and what actually happened?	
The client was reprimanded or chastised for something he / she had done?	
Someone gave the client a harsh request or demand?	
The client was denied an item or activity that he / she would want upon being shown?	
If they did not get what they wanted immediately upon their request?	
If they were asked to wait for either a specified or unspecified period of time?	

Module 4: An Exercise in Detective Work

Questions About a Specific Incident That May Have Occurred Recently:	
Ask the staff member to think back to the last time this happened and describe:	
What led up to this happening?	
What did you think and feel?	
Who else was around, what did they do?	
What did you see first….?	
What happened next/afterward?	

Module 4: An Exercise in Detective Work

Questions About a Specific Incident That May Have Occurred Recently:	
How typical was this occasion compared to other days?	
How typical was this behaviour compared to other days?	
Was the first time it happened different?	
What could have made a difference in preventing this incident?	
What do you think caused the challenging behaviour?	

Module 4: An Exercise in Detective Work

When conducting a lengthy functional analysis interview it is always worth remembering how it feels to be on the receiving end of such questioning!

Key Messages

- Antecedent analysis can help identify the factors which are more likely to make the behaviour occur
- Antecedent analysis can help you identify strategies to reduce the likelihood of the behaviour occurring
- Life experiences can have a significant effect on behavioural presentation

Module 4: An Exercise in Detective Work

Unit 7: Consequence Analysis

Doyle and Owens (2007) suggest that there are general questions that should be asked (via observation, behavioural records or questioning of the service user or staff) regarding consequences of behaviour. These are:

- What do people normally do now when the behaviour occurs?
- From the client's perspective what has been gained by the behaviour?
- From the client's perspective what is being avoided by the behaviour?

The most important thing to stress in responding to these is the phrase "From the client's perspective". The key to a good consequence analysis is the skill of being able to interpret what is happening from the point of view of the particular individual involved. The knowledge you have gained about the wider skills, experiences, interactions and history of the individual you are focusing on can be very important in informing such interpretation. The following two exercises may be of assistance in helping you to answer the above questions for the service user you are focusing on.

Activity 4.7.1: Consequence Analysis

Answer the following questions from Willis et al. (1993) for at least one of the behaviours utilised by the service user you are focusing on. Spend about 30 minutes on this activity.

The last time the behaviour occurred, what was done?	
What reactions do people have when the behaviour occurs?	

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Activity 4.7.1: Consequence Analysis	
What do parents/teachers usually do when the behaviour occurs?	
What do others usually do when the behaviour occurs?	
What methods have been used in the past to manage the behaviour, and how have they worked?	
What effect does the behaviour have on others?	
What actions seem to improve the behaviour when it occurs?	
What relieves the situation?	

Module 4: An Exercise in Detective Work

The following categories of types of consequences are identified by Doyle & Owen (2007). Indicate in the table below how likely it is for each of these to be a consequence for the service user and behaviour you are focusing on. Spend about 30 minutes on this activity.

Consequence	Unlikely	Possible	Probable	Definite
Anxiety reduction – e.g. via rituals, control, PRN, orderliness, predictability and routine				
Escape – e.g. end or break from a task, situation or demand; avoid a crowd or disliked people.				
Social interaction – e.g. via positive or negative interaction, this includes encouragement, comfort, punishment and to reduce future expectations.				
Activity – e.g. either requesting a desired or a time filling activity. Some activities are intrinsically desirable or desirable because they are either predictable or relieve boredom.				
Sensory – e.g. the behaviour feels good or painful, it may be pain reducing or distracting. It may also act to dissipate excess energy.				
Tangible – e.g. food, toy or any desired item.				

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Consequence	Unlikely	Possible	Probable	Definite
Social image – e.g. some clients may prefer to be seen as "bad" or "criminal" rather than "disabled", for others peer pressure may be a factor.				
Attention seeking – e.g. many of our clients rely on others to obtain what they want.				
Help – e.g. elicit or reject assistance.				
Social control – e.g. given access to favourite people / reject unfavoured people.				
Ignored or no consequence – e.g. this is where the environment apparently continues regardless of the behaviour.				

Having completed the above tables you should now return to the original questions:

- What do people normally do now when the behaviour occurs?
- From the client's perspective what has been gained by the behaviour?
- From the client's perspective what is being avoided by the behaviour?

Key Messages

- Consequence analysis can help you identify the responses that may be reinforcing the behaviour
- The key to good consequence analysis is being able to interpret what is happening from the point of view of the client

Module 4: An Exercise in Detective Work

Unit 8: Impressions of Meaning

Activity 4.8.1: Impressions and Analysis of Meaning

In discussion with your supervisor, consider the information that you have generated about at least one of the behaviours displayed by the service user you have been focusing on. "Why does the person perform the behaviour?"

In your answer you should provide (as far as is possible from the information you currently have available):

- *The antecedents and ecological factors*
- *The behaviour itself*
- *How the environment responds to the behaviour and possible reinforcers for the behaviour*
- *A clear statement on what you believe are the functions of the behaviour*

Impression and analysis of meaning of _____ behaviour.

Module 4: An Exercise in Detective Work

Outcomes

As part of the activities above you were asked to consider how an identified behaviour could efficiently and effectively be measured in order to inform your functional analysis, provide a baseline for the occurrence of that behaviour and this potentially a measure of behaviour change as a key outcome of any subsequent intervention.

You will also recall from the essential characteristics of a positive behavioural support approach reported by Allen et al. (2005) that "it is values-led in that the goal of behavioural strategies is to achieve enhanced community presence, choice, personal competence, respect and community participation, rather than simply behaviour change in isolation", and "it uses changes in quality of life as both an intervention and an outcome measure". It is therefore best practice that consideration is given at the functional analysis stage to what other potential outcomes might be utilised.

Emerson (2001) provides the following suggestions of possible ways of assessing the socially significant outcomes of intervention.

Module 4: An Exercise in Detective Work

Outcomes	Potential approaches
Reductions in severity of challenging behaviour	⊕ Observational methods ⊕ Inspection of injuries ⊕ Structured interview with person and/or informants ⊕ Analysis of incident reports ⊕ Inspection of injuries received
Family and/or care staff have a better understanding of why the behaviour occurs	⊕ Structured interview ⊕ Visual analogue or Likert rating scale ⊕ Modified versions of checklists designed for staff
Increased participation in community-based activities	⊕ Diaries ⊕ Structured interview with person/informants ⊕ Visual analogue or Likert rating scale ⊕ Checklists or questionnaires
Increased engagement within the home	⊕ Direct observation ⊕ Diaries ⊕ Visual analogue or Likert rating scale ⊕ Structured interview with person/informants ⊕ Checklists or questionnaires
Improved interpersonal environment within the home	⊕ Visual analogue or Likert rating scale ⊕ Structured interview with person/informants ⊕ Checklists or questionnaires
Person learns alternative way of getting needs met	⊕ Observational methods ⊕ Structured interview with person/informants

Module 4: An Exercise in Detective Work

Outcomes	Potential approaches
Increased friendships and relationships	⊕ Diaries ⊕ Visual analogue or Likert rating scale ⊕ Structured interview with person/informants ⊕ Checklists or questionnaires
Family members and/or care staff learn effective coping strategies	⊕ Visual analogue or Likert rating scale ⊕ Structured interview with person/informants ⊕ Checklists or questionnaires
Improved relationships between family member and/or care staff	⊕ Visual analogue or Likert rating scale ⊕ Structured interview with person/informants ⊕ Checklists or questionnaires
Person is able to stay living with their family or in local community	⊕ Visual analogue or Likert rating scale ⊕ Structured interview with person/informants ⊕ Checklists or questionnaires
Person has greater control, more empowered	⊕ Visual analogue or Likert rating scale ⊕ Structured interview with person/informants ⊕ Checklists or questionnaires
Person has more frequent social contact	⊕ Direct observation ⊕ Diaries ⊕ Visual analogue or Likert rating scale ⊕ Structured interview with person/informants ⊕ Checklists or questionnaires

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Outcomes	Potential approaches
Effective supports are put in place	⊕ Diaries of service contacts ⊕ Visual analogue or Likert rating scale ⊕ Structured interview with person/informants ⊕ Checklists or questionnaires
Person is more contented, more self-esteem	⊕ Diaries of service contacts ⊕ Visual analogue or Likert rating scale ⊕ Structured interview with person/informants ⊕ Checklists or questionnaires
Others change their perception of the person	⊕ Visual analogue or Likert rating scale ⊕ Structured interview with person/informants
Reduction in the use of aversive methods and restrictive procedures	⊕ Analysis of medication records ⊕ Recording time spent in restraint/seclusion ⊕ Analysis of records detailing restriction of liberty ⊕ Analysis of risk-taking policies for the person

Activity 4.8.2: Measuring Outcomes

Thinking about the service user you have been focusing on, which of the above potential outcomes would be most appropriate for you to measure. In making your decision you should maintain a focus on what is likely to be most significant for that individual from their point of view as well as considering what may be important (and practicable) from a service point of view. How could you measure this outcome in practice for this individual? Spend about 45 minutes on this activity.

Module 4: An Exercise in Detective Work

Key Messages

- Your impression of meaning is your 'best guess' but should clearly emerge from your assessment process
- Outcome measures should include quality of life measures as well as the reduction of challenging behaviours

4 Well done - you have now completed Module 4: Functional Analysis of Behaviour

You may find it helpful to note any particular issues you would like to note below:

Similarly, there may be areas covered in this module that you will find helpful to discuss further with your supervisor. You may find it helpful to list them below:

Module 5: The Design, Implementation and Evaluation of Multi-Element Plans

Module 5: The Design, Implementation and Evaluation of Multi-Element Plans

Introduction

This module considers the techniques typically used to gather and interpret assessment data in leading to a working hypothesis in order to design multi-element behavioural support plans. The module should be used to promote self-directed learning, with further support available from your supervisor. It continues to be acceptable for learners to work together to develop solutions on the subject matter, and it is expected that you will use the content of the module to think through your work with a client/ patient in conjunction with your supervisor.

By the end of this module you will be able to:

- Utilise a framework for collating data, which understands challenging behaviour in the context of the person's social, personal, and environmental context.
- Detail how to intervene and evaluate the effectiveness of a behavioural support plan

Unit 1: Designing Positive Behaviour Support Plans

A positive behaviour support (PBS) plan is designed to increase adaptive behaviour and no longer has just a narrow focus on decreasing behaviour.

Instead, it offers a multi-element approach that is values led and aims to:

- Understand why behaviour occurs.
- Reduce the likelihood of challenging behaviour.
- Ensure skills teaching is a central intervention.
- Establish quality of life as an intervention and outcome measure.
- Reduce/avoid the use of restrictive interventions (e.g. punishment, restraint, seclusion, etc).

In other words, there is a long-term focus to any PBS plan and reductions in behaviour could almost be viewed as a 'side effect'.

A positive behaviour support plan can also be referred to as a:

- Behaviour Support Plan,
- Behaviour Intervention and Support Plan,
- Lifestyle and Behaviour Support Plan,
- Multi-Element Support Plan,
- Behaviour Management Plan,
- Behaviour Support and Intervention Plan.

The recommendations for each person will be different and will depend upon the factors contributing to the person's behaviour, his/her current environment, the function of their behaviour, and their available supports.

Module 5: The Design, Implementation and Evaluation of Multi-Element Plans

In positive behavioural support the term multi-element support plan refers to a support plan that considers and includes strategies such as ecological changes, positive programming and focussed support.

These proactive strategies should be the main focus of interventions with reactive strategies only being used as a last resort and in the least restrictive manner.

<table>
<tr><th colspan="3">Proactive Strategies</th><th>Reactive Strategies</th></tr>
<tr><td>Ecological

Changes</td><td>Positive

Programming</td><td>Focussed

support</td><td>Active & reactive strategies</td></tr>
<tr><td colspan="3">Reducing challenging behaviour over time</td><td>Situation management</td></tr>
</table>

Module 5: The Design, Implementation and Evaluation of Multi-Element Plans

Activity 5.1.1: Positive Behavioural Support

In Module 2: Positive Behaviour Support with people with a learning disability who have offended you were introduced to 'Gordon' in Unit 2 and in Unit 3 you developed a care plan for 'Gordon. Using the table below, identify from activity 2.3.1 and the model answer given in appendix where your interventions for "Gordon" fit within a multi-element support plan. Spend about 40 minutes on this activity.

Proactive Strategies	
Strategies	**Interventions from Gordon's care plan**
Ecological Strategies - aimed at reducing the occurrences of events or situations in the person's environment identified as potential factors increasing the likelihood that the person may present challenging behaviour	
Environmental manipulation ⊕ Personal adapted space ⊕ Communal areas ⊕ Vehicles ⊕ Minimising triggers ⊕ Maximising preferred activities ⊕ Empowerment	

Module 5: The Design, Implementation and Evaluation of Multi-Element Plans

Strategies	Interventions from Gordon's care plan
Interaction styles ⊕ Communication systems ⊕ Attend ⊕ Active listening ⊕ Role modelling ⊕ Social interaction	
Expectations ⊕ Staff ⊕ Peers ⊕ Others	
Schedules - routines ⊕ Timetables ⊕ Personal care routines ⊕ Daily routines	
Non contingent reinforcement ⊕ Free access and choice	

Module 5: The Design, Implementation and Evaluation of Multi-Element Plans

Strategies	Interventions from Gordon's care plan
Positive Programming - Aimed at developing the person's coping and tolerance skills for events of situations in which the currently present challenging behaviour.	
General Skills ⊕ Age appropriate ⊕ Functional ⊕ Reinforcing ⊕ Generalisation	
Functionally equivalent ⊕ Communication training ⊕ Independence training	
Functionally related ⊕ Choice making ⊕ Leaving a room ⊕ Put jacket on when cold ⊕ Rules	
Coping and tolerance ⊕ Crowded places ⊕ Waiting ⊕ Noise ⊕ Relaxation	

Module 5: The Design, Implementation and Evaluation of Multi-Element Plans

Strategies	Interventions from Gordon's care plan
Focussed Support - Aimed at supporting the person when unavoidable events occur that the person has not yet learnt to cope with. These strategies are intended to prevent a recognised but unavoidable behavioural trigger leading to an incident of challenging behaviour.	
Schedules of reinforcement ⊕ Suitable for person/behaviour	
Medication ⊕ Therapeutic ⊕ Support other interventions	
Antecedent control transitions ⊕ Handover ⊕ Finishing tasks/activities ⊕ Moving home	
Individual Guidelines ⊕ To support person in areas of known difficulties	

Module 5: The Design, Implementation and Evaluation of Multi-Element Plans

Reactive Strategies	
Strategies	**Interventions from Gordon's care plan**
Reactive Strategies - Aimed at bringing about rapid and safe control of challenging behaviour of the above strategies are unsuccessful in preventing the behaviour from occurring, including Strategies for Crisis Intervention and Prevention (SCIP)	
Calming techniques ⊕ Verbal/non verbal ⊕ Facilitate communication ⊕ Facilitate coping ⊕ Listen and understand ⊕ Active listening ⊕ Relaxation strategies	
Redirection ⊕ Competing or incompatible activities	

Module 5: The Design, Implementation and Evaluation of Multi-Element Plans

Strategies	Interventions from Gordon's care plan
Introduce humour ⊕ Personal space awareness	
Geographical positioning ⊕ Self or objects ⊕ Awareness of exits	
Counter intuitive strategies ⊕ Diversion to objects/activities ⊕ Diversion to stereotypic activities ⊕ Strategic capitulation	

Module 5: The Design, Implementation and Evaluation of Multi-Element Plans

Strategies	Interventions from Gordon's care plan
Stimulus control/change ⊕ Instructional control ⊕ Interact and distract	
Physical Intervention ⊕ As a last resort	

Once you have completed this activity consider - did shifting the emphasis to a multi-element support model give you further ideas/strategies that could be used with Gordon - if yes what were they?

Module 5: The Design, Implementation and Evaluation of Multi-Element Plans

Activity 5.1.1: Use of Multi-Element Support Plans

See Appendix 1 for the paper below:

McDonald, A. & Hume, L. (2009) The use of multi-element behaviour support planning with a man with severe learning disabilities and challenging behaviour. ***British Journal of Learning Disabilities****, 38, 280-285.*

Take your time reading the article and feel free to make notes, underline or highlight key points. This article provides an example of work done with an individual and his staff team, which helped to reduce challenging behaviour and provided him with an improved service and quality of life.

Module 5: The Design, Implementation and Evaluation of Multi-Element Plans

Activity 5.1.1: Use of Multi-Element Support Plans

Think about your learning from days 3 and 4. Design a PBS Plan for your identified case. Take about 45 minutes on this activity and then:

Make notes in the space below and next, and discuss with your supervisor.

Recommended Reading

http://www.iaba.com/positive_practices/Vol_I_No_1.pdf

Module 5: The Design, Implementation and Evaluation of Multi-Element Plans

ECOLOGICAL MANIPULATIONS (Changes to the Environment)

POSITIVE PROGRAMMING (Skill Development)

Module 5: The Design, Implementation and Evaluation of Multi-Element Plans

DIRECT SUPPORT (Ways to Prevent Behaviour)

REACTIVE STRATEGIES (Ways to respond to behaviour)

Module 6: From Paper to Practice

Module 6: From Paper to Practice

Module 6 consists of two units and explores some of the individual and organisational barriers to implementing a positive behaviour support model in practice and explores how to reduce the impact of these.

Unit 1: Organisational and Individual Barriers

By the end of this unit you will be able to:

- Identify the individual and organisational barriers to implementing PBS
- Reflect on the individual and organisational barriers within your service

Activity 6.1.1: Barriers to Implementing PBS

Read the following article (Appendix 1): Emerson, E. and Emerson, C., (1987). Barriers to the effective implementation of habilitative behavioural programs in an institutional setting. Mental Retardation, Vol. 25, (2), pp.101-106.

This article is a little dated but they say the old ones are the best?

We need you to consider established environments - not necessarily institutional based when reading this article.

Take your time reading the article and feel free to make notes, underline or highlight key points. While referring to the article answer the following questions below and over the page. Spend about 45 minutes on this activity.

Once you have answered the questions it would be a good idea to review your answers and highlight the issues identified that could relate to your service. Remember there are no right or wrong answers it is important you have a good understanding of the service you are supporting.

13. What were the findings relating to staff knowledge of behavioural methods?

14. How useful did staff find behavioural methods?

15. *What barriers did staff identify?*

16. *What systematic recommendations are made to address these issues?*

Activity 6.1.2: Family Carer's Perspectives

Read the following article (appendix 2)
G. Wodehouse & P. McGill. (2009). Support for family carers of children and young people with developmental disabilities and challenging behaviour: what stops it being helpful? Journal of Intellectual Disability Research volume 53 part 7 pp 644–653

This article discusses parent's perceptions of families who had received specialist advice regarding their child's challenging behaviour. Take your time reading the article and feel free to make notes, underline or highlight key points. While referring to the article answer the following questions below. Spend about 45 minutes on this activity.

Once you have answered the questions it would be a good idea to review your answers and highlight the issues identified that could relate to your service. Remember there are no right or wrong answers; it may be useful to consider are specialist services part of the problem or part of the solution?

Module 6: From Paper to Practice

1. *Identify 4 key themes of parent's perceptions of professional support.*

2. *What recommendations are made to address these issues?*

3. *Identify some issues that apply to you as a professional - We will discuss these on day 5.*

Module 6: From Paper to Practice

Activity 6.1.3: Individual and Organisational Barriers

From the 2 activities you have just completed lit all the organisational and individual barriers under each heading below. Highlight any that are relevant to yourself or your service and then discuss these with your supervisor. Spend about 30 minutes on this activity.

Individual Barriers	Organisational Barriers

Module 6: From Paper to Practice

Key Messages

- Areas identified that can cause barriers to implementation of PBS include: staff knowledge of behavioural methods, value placed on the interventions used, poor communication systems, sufficient numbers of well trained staff, support from behavioural specialists.

Module 6: From Paper to Practice

Unit 2: Capable Environments

By the end of this unit you will be able to:

- Analysis of the characterises of those responsible for implementing PBS plans
- Utilise a problem solving approach to overcoming barriers to implementing Positive Behaviour Support

Introduction

Unit 1 introduced the barriers which can impede the implementation of Positive Behaviour Support. Within this unit you will explore how these issues have an impact within the services you will be implementing your Behaviour Support Plan and identify methods to address these issues.

Capable Environments

- Organisational structure
- Appropriateness of response
- Delivery of Service
  - Staff skills
  - Staff numbers
  - Staff deployment
- Attitudes and attributions
- Stability and focus

Goodness of Fit

- Characteristics of the person for whom the plan is designed
- Variables related to the people who will implement the plan
- Features of the environments and systems within which the plan will be implemented

Contextual Fit

The congruence between behavioural support plan features and a set of variable that seriously affect the development and implementation and therefore the effectiveness of those plans (Albin et al. 1993).

Contextual fit means that the support plan is:

- highly computable with values and skills of key stakeholders
- sustainable
- unique to the individual and their environment
- responsive to changes in the situation
- comfortable for people working with it
- more likely to result in long-term, effective behaviour support

Staff Experiences and Satisfaction Questionnaire (SESQ) Adapted

The SESQ can be used to assess the knowledge and attitudes of staff working in services and can help you in your assessment of the 'capable environment' and contextual fit.

Module 6: From Paper to Practice

Activity 6.2.1

In discussion with your supervisor arrange for the completion of the SESQ within the staff team who will be delivering positive behaviour support.

This questionnaire comprises four sections. Please try to answer the questions as accurately and honestly as you can and please do not confer with any of your colleagues – we need your individual response to the questions. This questionnaire is about your experiences and satisfaction at work.

The questionnaires will be completely confidential and the comments/responses from individual questionnaires will not be shared with anyone and will not be traced back to you.

It is not necessary for you to write your name on this questionnaire Instead, please fill in below an identification code, so that we can match this questionnaire to any further questionnaires we may administer in the future. This should consist of the first three letters of your mother's maiden name and the day and month in which you were born. If, for example, your mother's maiden name was White and you were born on the 3rd March, your identification code would be WHI0303.

Your identification code:

Please enter this code at the beginning of each section of the questionnaire. You do not have to complete all sections at once, please complete each section in your own time and when you have completed all sections, please seal them in the envelope provided and leave for collection by

_____

on _____.

Alternatively, please feel free to post your questionnaires back to:

Thank you very much for taking the time to fill in this questionnaire.

Linda Hume
Challenging Behaviour Nurse Specialist
01383565104

Module 6: From Paper to Practice

SECTION A

For the following questions please tick ☑ the relevant boxes. Please do not write any additional comments on the form unless asked to do so.

1) Are you **male** ☐

or **female** ☐

2) Please indicate which age category you fit into.

Up to 21 years	☐	21-25 years	☐	26-30 years	☐	31-35 years	☐	36-40 years	☐	41-45 years	☐
46-50 years	☐	Over 50 years	☐								

3) *Optional* Please indicate which group best describes your ethnic origin or descent.

4) Do you have a disability?

Yes ☐ No ☐

Module 6: From Paper to Practice

5) How long altogether have you been working in services for people with learning disabilities? .

Less than 6 months	☐	6 months to 1 year	☐	1 - 5 years	☐	6- 10 years	☐	More than 10 years	☐

6) Where did you work before coming to your current service?

- ☐ Learning Disability hospital or hospital for people with mental health problems
- ☐ Community based housing. If yes, how many residents? _____
- ☐ Day service for people with learning disability or mental health problems
- ☐ Other job in social care sector (please specify) _____
- ☐ Other (please specify) _____

7) How long have you worked at your current service?

Less than 6 months	☐	6 months to 1 year	☐	1 - 5 years	☐	6- 10 years	☐	More than 10 years	☐

8) What is your current position? _____

Module 6: From Paper to Practice

9) Are you **full-time** ☐ or **part-time** ☐

If **part-time** how many hours do you work during an average week? _____

10) Do you work a night shift ☐

or a day shift ☐

or a mixed shift ☐

11) How long is your average shift?

Less than 5 hours	☐	5-8 hours	☐	8-11 hours	☐	More than 11 hours	☐

12) How many days have you been absent from work over the past 12 months?

None	☐	1-5 days	☐	6-10 days	☐	11-15 days	☐	16-20 days	☐	More than 20 days	☐

13) How many people with learning disabilities use the service in which you work?

Module 6: From Paper to Practice

14) Please indicate ***how many*** of the service users with whom you work have the following needs and characteristics (e.g. if you work with 3 people with a mild learning disability, all of whom have challenging behaviour and one has epilepsy then please write 3 in the box next to "mild to moderate learning disabilities, 3 in the box next to "Challenging Behaviour" and 1 in the box next to "Epilepsy"):

- ☐ Mild to moderate learning disabilities
- ☐ Severe and profound learning disabilities
- ☐ Challenging behaviour
- ☐ Physical impairments
- ☐ Sensory impairments
- ☐ Epilepsy
- ☐ Communication difficulties

15) Do you have any professional or academic qualifications (e.g. nursing qualification, social work qualification or degree in learning disability and challenging behaviour, NVQ)?

Yes ☐ No ☐

If **Yes** please go to Question 16

If **No** please go to Question 17

Module 6: From Paper to Practice

16) Please specify the qualification/s you hold and the year awarded.

Qualification	Year Awarded

continued over...

Module 6: From Paper to Practice

Qualification	Year Awarded

Module 6: From Paper to Practice

17) Please indicate whether you have received training in any of the following areas over the past ***two*** years and the date you attended/completed the course.

Title of training	Date attended / completed
Induction	
Health and Safety	
Food Hygiene	
Person Centred Planning	
Active Support	

continued over...

Module 6: From Paper to Practice

Title of training	Date attended / completed
Induction	
Makaton or other communication training	
Adult Protection	
Causes of challenging behaviour	
Behaviour Management Skills	

continued over...

Module 6: From Paper to Practice

Title of training	Date attended / completed
Induction	
Risk Assessment	
Fire Training	
Manual Handling	
Other:	

continued over...

Module 6: From Paper to Practice

Title of training	Date attended / completed
Induction	
Other:	

18) Please list any training that you have not undertaken but from which you feel you might benefit.

Module 6: From Paper to Practice

SECTION B **Identification code:** | | | | | | | |

For the following questions please tick ☑ the relevant boxes, being careful to tick **within** the box. Please do not write any additional comments on the form unless asked to do so.

1) How would you rate your overall job satisfaction?

Very dissatisfied		Slightly dissatisfied		Neither satisfied nor dissatisfied		Fairly satisfied		Very satisfied	

2) How satisfied are you with the following aspects of your work?

Aspect of working in care services	Very dissatisfied	Slightly dissatisfied	Neither satisfied nor dissatisfied	Fairly satisfied	Very satisfied
Income					
Job security					
Holiday/sick pay entitlements					
Number of hours worked					
Flexibility of hours					
Ease of travel to work					
Management by your line manager and other senior staff					

Module 6: From Paper to Practice

2) How satisfied are you with the following aspects of your work?

Aspect of working in care services	Very dissatisfied	Slightly dissatisfied	Neither satisfied nor dissatisfied	Fairly satisfied	Very satisfied
Supervision by management/team leaders	☐	☐	☐	☐	☐
Relationships with co-workers	☐	☐	☐	☐	☐
Opportunities for advancement	☐	☐	☐	☐	☐
Public respect for the work you do	☐	☐	☐	☐	☐
Your personal development at work/training provided	☐	☐	☐	☐	☐
Your own accomplishments	☐	☐	☐	☐	☐
Developing your skills	☐	☐	☐	☐	☐
The level of challenge posed by your job	☐	☐	☐	☐	☐
The actual tasks you do	☐	☐	☐	☐	☐
The variety of tasks you do	☐	☐	☐	☐	☐
Opportunities to use your own initiative	☐	☐	☐	☐	☐

Module 6: From Paper to Practice

2) How satisfied are you with the following aspects of your work?

Aspect of working in care services	Very dissatisfied	Slightly dissatisfied	Neither satisfied nor dissatisfied	Fairly satisfied	Very satisfied
The physical work conditions	☐	☐	☐	☐	☐
The level of responsibility you have	☐	☐	☐	☐	☐
Relationships with service users	☐	☐	☐	☐	☐
The philosophies/values of your organisation	☐	☐	☐	☐	☐
Your relationship with senior management	☐	☐	☐	☐	☐
The amount of contact you have with senior management	☐	☐	☐	☐	☐

3) Please tick one response for each of the following questions, which relate to your feelings about your line manager.

	Always	Usually	Sometimes	Rarely	Never
Does your manager let you know about plans and tasks for your day-to-day work?	☐	☐	☐	☐	☐
To what extent does your manager give you instructions and orders?	☐	☐	☐	☐	☐

Module 6: From Paper to Practice

3) Please tick one response for each of the following questions, which relate to your feelings about your line manager.

	Always	Usually	Sometimes	Rarely	Never
Does your manager understand your viewpoint?	☐	☐	☐	☐	☐
When your manager gives you a task, does s/he set clear guidelines for completing it?	☐	☐	☐	☐	☐
When a problem arises in the course of your work, does you manager ask your opinion on a solution?	☐	☐	☐	☐	☐
Do you feel free to use your initiative in tackling problems encountered on a day-to-day basis?	☐	☐	☐	☐	☐
Does your manager treat you fairly?	☐	☐	☐	☐	☐
Does your manager require you to report on your progress?	☐	☐	☐	☐	☐
Is your manager concerned about your personal problems?	☐	☐	☐	☐	☐
Is your manager strict about observing regulations?	☐	☐	☐	☐	☐

Module 6: From Paper to Practice

3) Please tick one response for each of the following questions, which relate to your feelings about your line manager.

	Always	Usually	Sometimes	Rarely	Never
Is your work time wasted through lack of planning on the part of your manager?	☐	☐	☐	☐	☐
When you do your job well, do you receive recognition for this from your manager?	☐	☐	☐	☐	☐
Can you talk to your manager regarding your work?	☐	☐	☐	☐	☐

	Completely	In most things	Not really	Not at all
Do you think your manager trusts you?	☐	☐	☐	☐
How much can you trust your manager?	☐	☐	☐	☐
Do you know what your manager expects of you?	☐	☐	☐	☐
Does your manager live up to your expectations of what a manager should do?	☐	☐	☐	☐

	Very likely	Quite likely	Uncertain	Quite unlikely	Very unlikely
How would you rate you likelihood of leaving your current employer within the next 12 months?	☐	☐	☐	☐	☐

4) How often do you have supervision with your line manager?

Never	☐	Once a year	☐	Once every six months	☐	More often than once every six months but less often than once a month	☐	Once a month	☐	More often than once a month	☐

5) How satisfied are you with the frequency of your supervision sessions with your line manager?

Very dissatisfied	☐	Slightly dissatisfied	☐	Neither satisfied nor dissatisfied	☐	Fairly satisfied	☐	Very satisfied	☐

6) Is supervision meaningful and useful for you?

Always	☐	Usually	☐	Sometimes	☐	Rarely	☐	Never	☐

Module 6: From Paper to Practice

7) Please tick one response for each of the following questions, which relate to your feelings about the people you work with.

	Extremely well	Very well	Fairly well	Not so well	Not at all
How well do the members of your team work together?	☐	☐	☐	☐	☐
How well do you get on with your co-workers?	☐	☐	☐	☐	☐
How well do the members of your team trust each other?	☐	☐	☐	☐	☐

	Always	Usually	Sometimes	Rarely	Never
Do your co-workers help you with your work when you need it?	☐	☐	☐	☐	☐
Are your co-workers willing to listen to your problems?	☐	☐	☐	☐	☐
Do your co-workers act upon advice and guidance you give at work?	☐	☐	☐	☐	☐

Module 6: From Paper to Practice

8) How often are team meetings held in your service?

Never	☐	Once a year	☐	Once every six months	☐	More often than once every six months but less often than once a month	☐	Once a month	☐	More often than once a month	☐

9) How satisfied are you with the frequency of team meetings?

Very dissatisfied	☐	Slightly dissatisfied	☐	Neither satisfied nor dissatisfied	☐	Fairly satisfied	☐	Very satisfied	☐

10) Are the team meetings meaningful and useful for you?

Always	☐	Usually	☐	Sometimes	☐	Rarely	☐	Never	☐

Please ONLY complete Question 11.1 to 11.11 below if you are a support worker. If you are a manager, then please move onto Question 12.

Questions in this section relate to your direct line manager or supervisor in your work supporting service users. This might be, for example, the home or day centre manager, a deputy manager or a team leader.

Module 6: From Paper to Practice

11.1 How often does your direct line manager spend time watching how you support service users (Do not include when this person works as a support worker on shift)? (Please tick one box only).

More than once a week	Weekly	More often than monthly but less than weekly	Monthly	Less than monthly
☐	☐	☐	☐	☐

11.2 What do they focus most on when they spend time watching you (please tick one)?

1. Getting everyday activities and chores done efficiently	☐
2. Involving service users in activities	☐
3. Administration and paperwork	☐
4. Don't know	☐
5. Other (please specify)	

Module 6: From Paper to Practice

11.3 When they watch how you work, do they show you how to work well with the service users you support? (please tick one)

Always		Usually		Sometimes		Rarely		Never	

11.4 Do they tell you how well they think you are doing? (please tick one)

Always		Usually		Sometimes		Rarely		Never	

11.5 Do you find this feedback helpful? (please tick one)

Very unhelpful	Quite unhelpful	Neither helpful or unhelpful	Quite helpful	Very helpful

11.6 Do they correct you when they think you could support service users better? (please tick one)

Always		Usually		Sometimes		Rarely		Never	

Module 6: From Paper to Practice

11.7 When you have a problem supporting a particular service user, do you feel you can approach your manager for help? (please tick one)

Always		Usually		Sometimes		Rarely		Never	

11.8 If they give you advice on problem-solving, is it helpful?

Very unhelpful	Quite unhelpful	Neither helpful or unhelpful	Quite helpful	Very helpful

11.9 In a typical supervision session, which of the following do you discuss? (Please tick all that apply)

1. Personal issues	
2. Supporting service users to participate in activity	
3. Paperwork/form filling/admin	
4. Relationships with individual service users	
5. Relationships with other members of staff	
6. Issues of personal development, training needed etc.	
7. Any other issue (please specify) _____ _____ _____	

☐ Please indicate which one of these you typically spend most time discussing in supervisions. Please write the number representing the one you spend most time on. (e.g. if you spend most time discussing paperwork then please write “3”)

Module 6: From Paper to Practice

11.10 In a typical team meeting which if the following do you discuss (please tick all that apply).

1. Paperwork, records and admin	☐
2. Supporting service users to participate in activity	☐
3. Health care and safety of service users	☐
4. Housework and smooth running of the home	☐
5. Any other issue (please specify) _____ _____ _____	

☐ Please indicate which one of these you typically spend most time discussing in team meetings. Please write the number representing the one you spend most time on. (e.g. if you spend most time discussing paperwork then please write "1")

11.11 Does your direct line manager give you constructive feedback in supervision on how you support service users?

Always	☐	Usually	☐	Sometimes	☐	Rarely	☐	Never	☐

Module 6: From Paper to Practice

12) When answering the following question, imagine a scale running from one to five and tick the box that measures how much you think each statement applies to your job.

	Very False				Very True
	1	2	3	4	5
I am certain about how much authority I have	☐	☐	☐	☐	☐
Clear, planned goals and objectives exist for my job	☐	☐	☐	☐	☐
I know that I have divided my time properly	☐	☐	☐	☐	☐
I know what my responsibilities are	☐	☐	☐	☐	☐
I know exactly what is expected of me	☐	☐	☐	☐	☐
Explanation is clear of what has to be done	☐	☐	☐	☐	☐
I have to do things which should be done differently	☐	☐	☐	☐	☐
I receive a task without the staff to complete it	☐	☐	☐	☐	☐
I have to bend or ignore a rule or policy in order to carry out a task	☐	☐	☐	☐	☐
I work with two or more groups who operate quite differently	☐	☐	☐	☐	☐
I receive incompatible requests from two or more people	☐	☐	☐	☐	☐
I do things which are apt to be accepted by one person and not accepted by others	☐	☐	☐	☐	☐

Module 6: From Paper to Practice

13) Please look at the list of tasks below and

- indicate approximately how much of your time you would spend on each of these tasks in an average shift.
- indicate how difficult you find carrying out each task.

So, for example, if you spend more than two hours per shift meeting personal care needs of people and you find that task quite difficult then you would tick the two columns indicated in the example in the shaded row of the table.

Responsibilities/tasks	Time spent on task				Difficulty of task		
	No time spent on task	Less than 1 hour	1-2 hours	More than 2 hours	Very difficult	Quite difficult	Not difficult
Example: Meeting personal care needs of service users (e.g. washing, dressing, feeding)				✓		✓	
Meeting personal care needs of service users (e.g. washing, dressing, feeding)	☐	☐	☐	☐	☐	☐	☐
Housework for service users (cooking, cleaning, laundry)	☐	☐	☐	☐	☐	☐	☐
Talking to service users	☐	☐	☐	☐	☐	☐	☐
Teaching service users new skills	☐	☐	☐	☐	☐	☐	☐
Implementing behaviour programmes	☐	☐	☐	☐	☐	☐	☐

Module 6: From Paper to Practice

Responsibilities/tasks	Time spent on task				Difficulty of task		
	No time spent on task	Less than 1 hour	1-2 hours	More than 2 hours	Very difficult	Quite difficult	Not difficult
Planning shifts and activity	☐	☐	☐	☐	☐	☐	☐
Helping service users to access and use community facilities (shops, cinemas, leisure centres, etc.)	☐	☐	☐	☐	☐	☐	☐
Dealing with parents/relatives	☐	☐	☐	☐	☐	☐	☐
Dealing with professionals (Doctors, speech and language therapists, psychologists, social workers, etc)	☐	☐	☐	☐	☐	☐	☐
Administration/paper work	☐	☐	☐	☐	☐	☐	☐
Helping service users to do activities around the home (cooking, cleaning, etc.)	☐	☐	☐	☐	☐	☐	☐
Helping service users to develop friendships.	☐	☐	☐	☐	☐	☐	☐
Administering medication	☐	☐	☐	☐	☐	☐	☐
Other tasks (please list):							
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

Module 6: From Paper to Practice

14) Please consider the following tasks and, from your perspective, rank the five most important tasks (1 = most important) for each of the following: (a) yourself as a member of staff (b) the service users and (c) your manager. So for example, if you feel that meeting personal care needs is the most important task to yourself then place a 1 in column (a). If it is also the most important task to the service users, place a 1 in column (b). If it is the second most important task to managers place a 2 in column (c). The shaded row gives illustrates this example. You should end up with five tasks ranked in column (a), five in column (b) and five in column (c).

Responsibilities/tasks	Importance of task		
	(a) To you as staff	(b) To service users	(c) To your manager
Example: Meeting personal care needs of service users (e.g. washing, dressing, feeding)	1	1	2
Meeting personal care needs of service users (e.g. washing, dressing, feeding)			
Housework for service users (cooking, cleaning, laundry)			
Talking to service users			
Teaching service users new skills			
Implementing behaviour programmes			
Monitoring service user progress and activity			
Planning shifts and activity			

Module 6: From Paper to Practice

Responsibilities/tasks	Importance of task		
	(a) To you as staff	(b) To service users	(c) To your manager
Planning and implementing community activities for the service users.			
Dealing with parents/relatives			
Dealing with professionals (Doctors, speech and language therapists, psychologists, social workers, etc)			
Administration/paper work			
Helping service users to do activities around the home (cooking, cleaning, etc.)			
Helping service users to develop friendships.			
Administering medication			
Other tasks (please list):			

Module 6: From Paper to Practice

SECTION C **Identification code:** | | | | | | | |

For the following questions please tick ☑ the relevant boxes, being careful to tick **within** the box. Please do not write any additional comments on the form unless asked to do so.

1) Please read the following brief description:

Sophie is a young woman who has severe learning disabilities. Sometimes, Sophie is aggressive toward the people who care for her and live with her. She will kick and punch people, pull their hair and physically push them (sometimes so forcefully that people fall to the ground).

Consider how likely it is that the following statements are reasons for Sophie behaviour in the way described above. You have been given very little information compared to the information you might have if you worked with Sophie. Therefore simply think about the most likely reasons for someone like Sophie behaving in this way.

Please give you responses to each of the possible reasons by ticking one box to indicate whether you think it is very unlikely, unlikely, equally likely and unlikely, likely or very likely to be a reason for Sophie's behaviour.

	Very unlikely	Unlikely	Equally likely or unlikely	Likely	Very likely
She is given things to do that are too difficult for her	☐	☐	☐	☐	☐
She is physically ill	☐	☐	☐	☐	☐
She does not like bright lights	☐	☐	☐	☐	☐
She is too tired	☐	☐	☐	☐	☐
She can't cope with high levels of stress	☐	☐	☐	☐	☐

Module 6: From Paper to Practice

	Very unlikely	Unlikely	Equally likely or unlikely	Likely	Very likely
Her house is too crowded with people	☐	☐	☐	☐	☐
She is bored	☐	☐	☐	☐	☐
Because of the medication she is given	☐	☐	☐	☐	☐
She is unhappy	☐	☐	☐	☐	☐
She has not got something she wanted	☐	☐	☐	☐	☐
She lives in unpleasant surroundings	☐	☐	☐	☐	☐
She enjoys it	☐	☐	☐	☐	☐
She is in a bad mood	☐	☐	☐	☐	☐
High humidity makes her uncomfortable	☐	☐	☐	☐	☐
She is worried about something	☐	☐	☐	☐	☐
Because of some biological process in her body	☐	☐	☐	☐	☐
Her surroundings are too warm/cold	☐	☐	☐	☐	☐
She wants something	☐	☐	☐	☐	☐
She is angry	☐	☐	☐	☐	☐
There is nothing for her to do	☐	☐	☐	☐	☐

Module 6: From Paper to Practice

	Very unlikely	Unlikely	Equally likely or unlikely	Likely	Very likely
She lives in a noisy place	☐	☐	☐	☐	☐
She feels let down by someone	☐	☐	☐	☐	☐
She is physically disabled	☐	☐	☐	☐	☐
There isn't much space in her house	☐	☐	☐	☐	☐
She gets left on their own	☐	☐	☐	☐	☐
She is hungry or thirsty	☐	☐	☐	☐	☐
She is frightened	☐	☐	☐	☐	☐
Somebody she dislikes is nearby	☐	☐	☐	☐	☐
People do not talk to her very much	☐	☐	☐	☐	☐
She want to avoid uninteresting tasks	☐	☐	☐	☐	☐
She does not go outdoors very much	☐	☐	☐	☐	☐
She is rarely given activities to do	☐	☐	☐	☐	☐
She wants attention from other people.	☐	☐	☐	☐	☐

The following questions (2-17) is about challenging behaviour. Please read each question Carefully and then tick the box next to the statement that you most agree with. Only tick one box for each question.

2) If a client displays challenging behaviour only when she is left alone and usually stops when she is told not to, the best thing to do is:

- ☐ Keep telling her to stop when she displays challenging behaviour so that the challenging behaviour does not continue.
- ☐ Try not to leave her alone.
- ☐ Ignore her when she displays challenging behaviour.
- ☐ Assess her medication levels and revise them as necessary.

3) If a client displays challenging behaviour only when people is interacting with him and stops as soon as they move away, the best thing to do is:

- ☐ Assess medication levels and revise them as necessary.
- ☐ Try and leave him on his own as much as possible.
- ☐ Move away when the challenging behaviour occurs to prevent it from continuing.
- ☐ Continue the interaction regardless of the challenging behaviour.

4) If a client only displays challenging behaviour when something she wants is denied but stops as soon as the thing is given to her, the best thing to do is:

- ☐ Not to deny her the things she wants.
- ☐ Not to give her the thing when she displays challenging behaviour.
- ☐ To assess her medication levels and revise them as necessary.
- ☐ To give her the things she wants to prevent the challenging behaviour from continuing.

5) Which of the following is the best definition of a client's self-injurious behaviour if it was being used in a treatment programme:

- ☐ Any contact between head and object.
- ☐ Any painful head banging.
- ☐ Any quite hard contact between head and object.
- ☐ Any attempt to cause injury to the head.

6) When trying to teach a client to keep her hands in her lap instead of self-injuring, which is it most important to do in the early stages:

- ☐ Reward her every time her hands is in her lap.
- ☐ Keep reminding her to put her hands in her lap if she has self-injured.
- ☐ Reprimand her for not putting her hands in her lap.
- ☐ Give her extra helpings of her favourite food at lunchtime if her hands have been in her lap for most of the morning.

7) If a client displays challenging behaviour only when he is asked to do a difficult task and stops when the task is removed temporarily, the best thing to do is:

- ☐ Keep removing the task temporarily whenever he displays challenging behaviour to prevent the behaviour from continuing.
- ☐ Continue to present the task regardless of the challenging behaviour.
- ☐ Not present difficult tasks.
- ☐ Check medication levels and revise them as necessary.

Module 6: From Paper to Practice

8) When trying to decrease the head hitting of a client what is the best way of finding out if you is succeeding:

- ☐ Record at the end of the day how much time has been spent head-hitting.
- ☐ Ask someone to rate on a 5-point scale the client's well being at the end of each day.
- ☐ Keep a written record of the number of head hits for each day.
- ☐ Look at the site of the self-injury to see if there is bruising or abrasions at the end of each week.

9) Before beginning a programme to decrease a client's challenging behaviour, which of the following is it most important to know:

- ☐ Whether the current medication has been recently reviewed.
- ☐ What usually happens before and after the challenging behaviour.
- ☐ Whether the client understands the programme.
- ☐ Whether all staff respond to the challenging behaviour in the same way.

10) A client who likes attention is usually told to stop when he self-injures. It is decided to ignore the self-injurious behaviour when it occurs. What is most likely to happen?

- ☐ The self-injury will increase because he is angry about being ignored.
- ☐ The self-injury will decrease because the attention is withheld.
- ☐ The self-injury will decrease and then increase as the person tries harder to gain attention.
- ☐ The self-injury will increase and then decrease because attention is withheld.

Module 6: From Paper to Practice

11) A client self-injures by scratching his face and gloves is used to prevent the injuries becoming infected. The gloves stop the scratching and he often puts them on himself or requests them. The best thing to do is:

- ☐ Leave the gloves on all the time.
- ☐ Only put the gloves on when he has not scratched.
- ☐ Only put the gloves on when he has scratched very badly.
- ☐ Put the gloves on as soon as he scratches to prevent further injury.

12) What do you understand by the term ‘Learning Disability’? Please answer in your own words.

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13) Please identify any causes of learning disability of which you are aware and state at what stage these might occur (before, during or after birth).

14) Which of the following are O'Brien's Five Accomplishments? (Please ensure that you tick one box per item i.e. Either "yes", "no" OR "Don't know").

	Yes	No	Don't know
Respect	☐	☐	☐
Choice	☐	☐	☐
Independence	☐	☐	☐
Community presence	☐	☐	☐
Individualization	☐	☐	☐
Community participation	☐	☐	☐
Cure	☐	☐	☐
Competence	☐	☐	☐

15) What do you understand by the term ‘normalisation’?

	Tick one box
A process which is designed to improve a person’s competencies and extend development to its optimum potential	☐
An attempt to make people normal	☐
An attempt to make people with learning disabilities conform to society’s norms and expectations	☐
The enhancement of individual rights, autonomy and access	☐
The creation, support and defense of valued social roles for people who are at risk of devaluation	☐
An attempt to provide a lifestyle as close to normal as possible	☐
Other (please state):	

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SECTION D **Identification code:** | | | | | | | |

For the following questions please tick ☑ the relevant boxes, being careful to tick **within** the box. Please do not write any additional comments on the form unless asked to do so.

1) Please read the following statements and indicate whether you agree or disagree with each of them.

People with learning disabilities…	Strongly Agree	Agree	Uncertain	Disagree	Strongly disagree
Do not have the ability to live supported in the community	☐	☐	☐	☐	☐
Can learn new skills	☐	☐	☐	☐	☐
Should be allowed to sit and do nothing if that is their choice	☐	☐	☐	☐	☐
Should be helped to find appropriate jobs in the community, regardless of their level of ability.	☐	☐	☐	☐	☐
Do not have the same rights as anyone else to access public activities and facilities	☐	☐	☐	☐	☐
Should be encouraged to manage their own finances	☐	☐	☐	☐	☐
Should not have the opportunity to access Direct Payments	☐	☐	☐	☐	☐

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People with learning disabilities…	Strongly Agree	Agree	Uncertain	Disagree	Strongly disagree
Have the right to marry	☐	☐	☐	☐	☐
Have the right to start a family with the appropriate support	☐	☐	☐	☐	☐
Staff cannot be expected to understand the “odd” or “difficult” behaviour of people with learning disabilities	☐	☐	☐	☐	☐
People with challenging behaviour should be left alone and not asked to take part in activities	☐	☐	☐	☐	☐
Service users should be involved in the selection of staff who work in their service	☐	☐	☐	☐	☐
Staff should spend most of their working day talking with service users and helping them participate in day-to-day life.	☐	☐	☐	☐	☐
Staff should always respect the personal choices of service users, even if they might suffer as a result	☐	☐	☐	☐	☐

People with learning disabilities…	Strongly Agree	Agree	Uncertain	Disagree	Strongly disagree
Staff should involve service users in making decisions about the day-to-day running of the service	☐	☐	☐	☐	☐
Enabling service users to participate in everyday household activity and community activities is more important than keeping the home clean and tidy	☐	☐	☐	☐	☐

2) Please indicate your level of agreement for the following statements:

Community Care is better than Institutional Care…	Strongly Agree	Agree	Uncertain	Disagree	Strongly disagree
For Carers/support workers	☐	☐	☐	☐	☐
For the community	☐	☐	☐	☐	☐
For all people with learning disabilities	☐	☐	☐	☐	☐
For all people receiving services (elderly, mentally ill, children, people with disabilities, etc.)	☐	☐	☐	☐	☐

Thank you for taking the time to complete this questionnaire. Could you please check that you have answered all the questions and that you have only ticked one box for each question.

Thank you for your help.

Appendix 3 Operational Definitions

What:	
⊕ Do you want people to do - describe in tangible way	
When:	
⊕ How often do they need to do it	

Appendix 3 Operational Definitions

What:	
⊕ Who is responsible	
When:	
⊕ will your standard be measured: How would anyone know it has been achieved	
Statement:	

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Unit 3: Periodic Service Review

Periodic service review (PSR) is a quality improvement system to help assess the level of quality in services and improve quality. PSR can be used to measure to what extent the service is meeting its outcomes.

Activity 6.3.1: Periodic Service Review

Follow the link below to the NHS Evidence Learning Disability Bulletin - feel free to read this all - very interesting. However for this activity scroll down to page 5 where you can link to the following article:

http://warwickshire.ldpb.info/images/NHS_Evidence_newsletter_41_August_2010_Final.PDF_1_.pdf

Module 6: From Paper to Practice

PSR Review date: _____

Facilitator: _____

Participants: _____

	+/0
1. Periodic Service Review (PSR):	
a) **Implementation:** A "+" is scored if PSR graph shows at least four data points for previous 30 days.	
b) **Progress:** A "+" is scored if PSR graph shows current status of at least 85% or best score ever was achieved within previous 30 days.	
2. Data Collection:	
a) **Data Collection:** A "+" is scored if ABC Sheet has been fully filled out for each day for the previous 7 days	
b) **Weekly Reliability Records:** A "+" is scored if Reliability graph has formal reliability score for prior month and meets established criteria.	
c) **Summary Graphs:** A "+" is scored if summary graphs of occurrence and episodic severity are up to date.	
d) **Summary Graphs:** A "+" is scored if for any reliability ratings that do not meet the standard, there is a plan in place to address this.	

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	+/0
3. Ecological Strategies: **Interpersonal environment:**	
a) **Staff protocol: Interaction style.** A "+" is scored if there is a protocol on file to direct staff supporting Linda in their communications and interactions with each other	
b) **Staff protocol: Separation.** A "+" is scored if there is a protocol on file to direct staff supporting Linda in their communication of separation from staff.	
c) **Communication Board.** A "+" is scored if the communication Board is on display and reflects the current days schedule.	
Programmatic environment:	
d) There is a protocol and risk assessment completed for any new activity plus board maker symbol or photo to identify the activity.	
Physical environment:	
e) A progress plan for redecoration has been devised with set target dates for completion	
f) Storage areas and a chalk/drawing board have been established and are accessible	
4. Positive Programming:	
a) General Skills -	
• **Making a snack.** A "+" is scored if the last scheduled training session has been carried out and training data were collected and summarized.	
• **Shaking hands.** A "+" is scored if the last scheduled training session has been carried out and training data were collected and summarized.	

	+/0
• **Putting on karaoke machine.** A "+" is scored if the last scheduled training session has been carried out and training data were collected and summarized.	
b) Functionally Equivalent Skills	
1. **Requesting time with staff.** A "+" is scored if the last scheduled training session has been carried out and training data were collected and summarized.	
b) Functionally Related Skills	
1. **"I don't understand"**. A "+" is scored if the last scheduled training session has been carried out and training data were collected and summarized.	
c) Coping and Tolerance Skills.	
1. **Waiting in line.** A "+" is scored if the last scheduled training session has been carried out and training data were collected and summarized.	
Focused Support:	
a) Density of preferred activities. A "+" is scored if Linda's weekly diary shows that she has been out at least 3 times in the past week taking part in a new community activity, i.e. one that has only been offered within the last month.	
5. Reactive Strategies	
a. Problem solving protocol . A "+" is scored if there are protocols in the file indicating how staff are to respond to Outburst behavior, including the different levels of episodic severity that have been defined and the relevant responses to each.	

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	+/0
6. Staff Development and Management Systems.	
a) **Staff training.** Records show that all staff, including seasonal are trained to the basic induction level of competence to work in a learning disability service. (5 identified courses)	
b) **Protocols.** A "+" is scored if there is an active protocol for all items listed on the active protocol list following the agreed upon format. (Pro-rated credit is provided, e.g., 5/12=.42)	
c) **Three Tiered Training.** A "+" is scored if staff training records indicate they have been trained to the third tier for each of their responsible protocols. (Pro-rated credit is provided.)	
d) **Procedural Reliability Checks.** A "+" is scored if Checks have been carried out for all active protocols as scheduled for prior month and agreed upon standard has been met. (Pro-rated credit is provided.)	
e) **Team Meetings.**	
1. **Protocol Sub-committee.** A "+" is scored if last scheduled meeting was held and minutes show standard agenda was followed.	
2. **Supervision.** A "+" is scored if a supervision session was held in previous month for each staff member and minutes show standard agenda was followed.	

Module 6: From Paper to Practice

	+/0
7. **Quarterly Review and Progress Report.** A "+" is scored if last quarterly progress report follows standard format and is dated within prior four months.	
Score Achieved	
Score Possible	**29**
Percentage of Score Achieve to Score Possible	

Module 6: From Paper to Practice

PSR Template

PSR Review date: _____

Facilitator: _____

Participants: _____

	+/0
8. Periodic Service Review (PSR):	
c) **Implementation:** A "+" is scored if PSR graph shows at least four data points for previous 30 days.	
d) **Progress:** A "+" is scored if PSR graph shows current status of at least 85% or best score ever was achieved within previous 30 days.	
9. Data Collection:	
e) **Data Collection:** A "+" is scored	
f) **Weekly Reliability Records:** A "+" is scored if	
g) **Summary Graphs:** A "+" is scored if	
h) **Summary Graphs:** A "+" is scored if	
10. Ecological Strategies: Interpersonal environment:	
g) **Staff protocol:** A "+" is scored if	
h) **Staff protocol:** A "+" is scored if	
i) **Communication Board.** A "+" is scored if	

	+/0
Programmatic environment:	
j)	
Physical environment:	
k)	
l)	
11. Positive Programming:	
a) **General Skills -**	
• A "+" is scored if	
• A "+" is scored if	
• A "+" is scored if	
b) **Functionally Equivalent Skills**	
• A "+" is scored if	
c) **Functionally Related Skills**	
• A "+" is scored if	
d) **Coping and Tolerance Skills**	
• A "+" is scored if	
Focused Support:	
• A "+" is scored if	

	+/0
12. Reactive Strategies	
• A "+" is scored if	
13. Staff Development and Management Systems.	
f) A "+" is scored if	
g) A "+" is scored if	
h) **Three Tiered Training.** A "+" is scored if staff training records indicate they have been trained to the third tier for each of their responsible protocols. (Pro-rated credit is provided.)	
i) A "+" is scored if	
j) **Team Meetings.**	
• A "+" is scored if.	
1. **Supervision.** A "+" is scored if a supervision session was held in previous month for each staff member and minutes show standard agenda was followed.	
14. Quarterly Review and Progress Report. A "+" is scored if last quarterly progress report follows standard format and is dated within prior four months.	
Score Achieved	
Score Possible	
Percentage of Score Achieve to Score Possible	

Module 6: From Paper to Practice

Key Messages

- PSR can be used to promote and support a process of continuous quality improvement within services

Conclusion

In this unit you have identified some of the complexities around implementing Positive Behaviour Support. It is important to link with your supervisor and develop an action plan to address these issues.

6 Well done - you have now completed Module 6: From Paper to Practice

You may find it helpful to note any particular issues you would like to note below:

Similarly, there may be areas covered in this module that you will find helpful to discuss further with your supervisor. You may find it helpful to list them below:

Module 7: Supporting and Educating Others

Module 7: Supporting and Educating Others

Module 7 consists of two units enabling you first to explore and then develop your own skills in regard to providing support and education to others in your workplace. It is not an extensive review of the literature, but will provide an update for those of you that have studied this topic previously and will link to further sources and resources for those of you who are interested in finding out more. It will allow you to identify the components of a good learning environment and organisational identity. This will enable you to examine the qualities of strong leadership and coaching skills. In turn this will support you in implementing positive behavioural support in practice and supporting others to deliver a positive behavioural support model.

By the end of this module you will be able to:

- Demonstrate the knowledge skills and confidence to provide support and education to others delivering positive behavioural support.
- Demonstrate the ability to create a positive learning environment.
- Develop coaching and mentoring skills.

Unit 1: Positive Learning Environments

Duffield at al (2011) identify that leaders play a critical role in creating and maintaining a positive work environment. They believe that there are certain leadership attributes that enable them to effect the environment in a positive manner.

These include:

- Visibility
- Accessibility
- Consultation
- Recognition
- Support
- Gives positive feedback

Module 7: Supporting and Educating Others

Activity 7.1.1: Leadership Characteristics

Reflect on your role as a leader. Do you think that you have the attributes identified above and if you do, how are these visible to the people that you work with?

Activity 7.1.1: Leadership Characteristics

Now identify if there are other leadership attributes that you believe are important.

Module 7: Supporting and Educating Others

In an action research study Mash et al (2008) identified that leaders can influence positive changes in healthcare environments. They suggest that the organisation should be seen as a "living system" and that participation within that system is critical. They suggest that organisational change can be enhanced by a process of what they term "Outcome Mapping". They go on to describe the steps of outcome mapping.

They are:

- **Step 1: The Vision**

  Developing a shared vision of the ideal.

- **Step 2: The Mission**

  Defining how and who will be involved in realisation of the vision.

- **Step 3: Boundary Partners**

  Identifying the people in other groups who you would like to influence or change in order to achieve the mission.

- **Step 4: Outcome Challenges**

  Describe the changes in behaviour or activities that they would like to see.

- **Step 5: Progress Markers**

  Identify the steps along the way in terms of outcomes.

- **Step 6: Strategies**

  Defining the activities that each person will engage with in order to achieve the progress markers.

This way of viewing the leaders role in change may be useful when thinking about the introduction of positive behavioural support.

Mentorship

You may have identified in the activity above that one of the characteristics of a leader is being able to mentor people within the workplace effectively. Race and Skees (2010) would agree with you. Indeed they suggest that effective mentors not only promote professional development and empowerment of the workforce they have a positive impact on healthcare organisations. They suggest that good mentorship results in improved care, high quality and improved patient outcomes. Obviously in this programme these things are very important since you will be seeking to mentor the people you work with to enable them to develop the skills that are required to use positive behavioural support.

Module 7: Supporting and Educating Others

The roles of the mentor according to Morton-Cooper and Palmer (2000) and Ali and Panther (2008) include:

- Advisor
- Role model
- Coach
- Problem solver
- Teacher
- Supporter
- Organiser and Planner
- Counsellor and Guide

Clements et al (2009) suggest that mentors offer 'unforgettable perspectives' especially when sharing their own experiences. We will explore this concept further later in the unit when we look at the use of narratives. Many authors have detailed the attributes of good mentors and after a literature review Andrews and Wallis (1999) suggest that they include:

- Friendliness
- Good humour
- Patience
- Effective interpersonal skills
- Approachability
- Professional development abilities

There are also according to Hodges (2009) factors that have a negative impact on mentoring. These include:

- Poor Communication
- Differing expectations
- Lack of trust
- Lack of appreciation of everyday life circumstances

Activity 7.1.2: Attributes of the Mentor

Having considered the views of the above authors what do you think about the positive and negative attributes identified?

Module 7: Supporting and Educating Others

Can you think back to when you saw a good piece of mentorship in practice and now identify why you think that it worked so well.

Morton-Cooper and Palmer (2000) describe three factors within the mentoring role and in her research Wareing (2010) demonstrated a strong correlation with these. They are:

- Personal work - Promoting self development, confidence and creativity
- Functional Work - Teaching, coaching, counselling and role modelling
- Facilitation - Assisting in interpersonal relationships, networking, sharing and trust

Whereas Spouse (2003) identifies two elements to mentoring. Namely befriending and coaching. She also suggests that the eventual aim is for the mentee “to fly solo”. Others have also tried to describe the phases of the mentor relationship. Andrews and Wallis (1999) identify three distinct phases. These are:

- Initiation
- Working
- Termination

On the other hand Nagle et al (2009) identify the stages of mentoring as:

- Teaching
- Guidance
- Empowerment

Module 7: Supporting and Educating Others

Whichever model you use they all suggest that the relationship changes as the mentor increases their skills. This is particularly important since your eventual goal is for the people you work with to be able to use the elements of positive behavioural support independently, although still in conjunction with the multi-disciplinary team and the relevant support from others such as clinical psychology.

It can be seen that mentorship is an active role that requires good planning. You need to consider these phases in relation to the work based learning that you wish to encourage. Hodges (2009) identifies that good use of learning contracts, the foundation of ground rules and the use of information all help in creating this active mentoring relationship. Ousey (2009) identifies that day to day care can be used as an opportunity for learning with the mentor first demonstrating or role modelling the care then observing the mentor providing care and giving constructive feedback.

Key Messages

- People with leadership skills can influence positive change in practice
- Effective mentors promote professional development of others and improve outcomes for people in health and social care services

Module 7: Supporting and Educating Others

Unit 2: Learning Support

Let us first think about why learning support in the workplace is necessary. Morton-Cooper and Palmer (2000) argue that learning support enables us to build relationships of value that nurture and sustain us in our personal and working lives. They identify that learning support is necessary as:

1. A defence against feelings of disorientation, disillusionment and burn out
2. A framework for clarifying human values
3. A way to recover meaning in social relationships
4. As a means of providing skill rehearsal and providing access to appropriate role models in the workplace
5. As a device for evaluating and disseminating best practice in health care
6. As a way of acquiring emotional literacy

A defence against feelings of disorientation, disillusionment and burn out

It will not be a surprise to find that working with and caring for people whose behaviours are perceived as challenging can at times make people anxious and stressed. It has been identified that the situations we find ourselves in can be explored in order to clarify the moral, ethical and interpersonal issues. One way of doing this which has indeed been used throughout the units of this programme is the use of narratives. Benner et al (1996) describes two kinds of narratives:

- Constitutive or sustaining narratives
- Learning narratives

The first of these depict situations that constitute the person's understanding of what it is to be a carer and allows us to examine our belief systems and our value bases. They can be used to examine both negative and positive experiences. Indeed it is suggested in the literature that positive narratives can be used to enable us to learn how to give praise constructively. This in turn can sustain us when things are not going so well.

The learning narratives are broader in their intent in that they challenge us to question our beliefs and practices and to see where these are flawed. However these narratives are not about apportioning blame or revealing inadequacies but about learning about and exploring practice.

Module 7: Supporting and Educating Others

Activity 7.2.1: The Benefits and Constraints of using Narratives

On day 1 of this programme you were asked to consider a case study and a minute of a meeting (see appendix 1). These were real accounts of what happened to one individual. Think now about the benefits and constraints of using this approach then list these below.

Benefits

Constraints

It can be seen that the use of narratives can be an excellent way of exploring what is underpinning practice and why people behave in certain ways. It is apparent however that it does require both time and effort to produce these.

Module 7: Supporting and Educating Others

Activity 7.2.2: Using Narratives in Practice

Think about your own area of practice and a particular area relevant to positive behavioural support and identify experiences that you could use with the workforce then list these below.

Now think and then articulate how you could find the time to use this approach in practice

Module 7: Supporting and Educating Others

A framework for clarifying human values

In Module 1 you explored the term values based care in all its complexities. It is apparent that any organisation has its own value system and certainly positive behaviour support succeeds when all the organisation and team share the same beliefs and value systems. It is identified that we become socialised to the values within our workplaces. Research suggests that there may be two components to socialisation one formal and one informal. The formal socialisation includes processes such as induction, training and supervision are thought now to have less effect on the individuals attitudes and values. Whereas the informal socialisation that occurs at the level of the peer group can impact on the individual's attitude and values. The team that you work in therefore can have a significant contribution to the building of a coherent values system.

It is clear that the leader as discussed earlier in this unit can have an impact on the followers in the team. Indeed Van Dick and Schuh (2010) identify that if the leader as a high organisational identity - in this instance the implementation of positive behavioural support - they are likely to increase the organisational identity of those that they work with.

Thus your belief in positive behavioural support and the attitudes and values associated with it can be described as work related behaviours which will increase in the staff that you work with the more that they are exposed to them.

A way to recover meaning in social relationships

The ways that we develop and build meaning are affected by the relationships we make both at work and in our personal life. Meanings then make up our environment for each other and they are constantly manipulated in our interactions with each other and in the decisions made by ourselves or others. Meanings however are open to multiple and conflicting interpretations and may or may not be shared.

Activity 7.2.3: Multiple and Conflicting Meanings

Re read the minute from the first day (appendix 1). Then consider do the different professional and the family share the same meaning around care?

Describe the commonality of meaning

Describe the discrepancies in meaning

Explanations of meaning can help us to identify our immediate needs and long term values and could therefore be useful in enabling others in the workforce to do the same.

Activity 7.2.4: Explanations of Meanings as a Teaching Tool

Can you identify how the exploration of meaning can be used as a teaching tool?

It is identified by Morton-Cooper and Palmer (2000) it can be a very difficult process to get to meaning that are truly shared. They go on to suggest that it is useful to explore the Rhetoric that invades our professional lives.

The Rhetoric of Positive Behavioural Support

Morton–Cooper and Palmer (2000 p20) describe rhetoric as:

"the language and concepts employed to persuade and influence people"

In order to examine the meanings and values that underpin rhetoric we would like you to use the philosophy for the area where you work. Once you have this complete the following exercise.

Activity 7.2.5: Philosophy of Care

Having obtained a copy of your philosophy could you now either underline or highlight all the positive values that are stated within it.

Now identify how many positive statements there are.

Are there any negative statements?

Having completed the above activity you will have a highlighted a number of statements that have been used to underpin the care that you provide.

One will probably have been to provide person centred care. It is important now that you reflect on this.

Activity 7.2.6: What is Person Centred Care?

List what you think is person centred care.

Now compare your list with another learner or your supervisor

Are there similarities? Are there differences?

Person centred care was chosen for this activity as it is clear that no area in their philosophy statement would identify that they will not provide person centred care. However it is clear that not all areas do actually provide person centred care and even if they do what individual members of the team mean when they say they are providing person centred care differs.

Let us now think of this in terms of positive behavioural support. Many areas say that they are using this approach and yet there is scant evidence of positive outcomes for the people they provide care for.

Activity 7.2.7: Positive Behavioural Support

Reflect on and then document how you will enable the people that you work with develop a shared meaning of what positive behavioural support is. (It may help to revisit the exercise that you did in Module ? about the characteristics of positive behavioural support)

Are there visible things that you would see on a day to day basis in an area that has a shared meaning of positive behavioural support?

As a means of providing skill rehearsal and providing access to appropriate role models in the workplace

Morton–Cooper and Palmer (2000) suggest that when providing learning support there is opportunities for learning concrete skills in practice. In using positive behavioural support you have to master a number of complex activities. Some of these will be observable behaviours for example the tone of voice you use and the stance you use. These are the kind of skills which Aukes et al (2009) describes

in their “Float Model” as the visible part of the fisherman’s float. This is the part that is above the water and they use this to describe the behaviours that we can see. These visible skills are relatively easy to role model and then be copied by the people that you work with.

Activity 7.2.8: Role Modelling Visible Skills

Think about some of the visible skills that you use in the implementation of positive behavioural support. Now identify the process of how you would role model these skills.

How would you enable the people you work with practise these skills?

How and when would you give feedback?

Module 7: Supporting and Educating Others

The way you give feedback is particularly important. Morton–Cooper and Palmer suggest that it should be positive and constructive. Indeed students in the research undertaken by Dolmans et al (2008) identified that insufficient supervision and feedback were both factors that inhibited learning. It is clear that if you wish to teach people within your workforce the skills to use positive behavioural support you will need to think carefully about:

- Role modelling
- Supervision
- Giving feedback

It is also important according to Dolmans et al (2008) to promote self assessment, self reflection and self directed learning. In the "Float Model" Aukes et al (2009) identify the hidden parts or mental parts of behaviour are the bit of the float that is below the water. These behaviours of "expert thinking" "clinical reasoning" and "scientific thinking" are all things which cannot be observed by others as they are not visible. Now let us examine some of the unobservable hidden skills.

Activity 7.2.9: Role Modelling Hidden Skills

Look back at the activity that you did in module 3 on antecedent analysis. Now identify how you would role model the skills that are required to carry out this analysis.

How would you ensure that the person you are working with knows what you are thinking / observing?

As a device for evaluating and disseminating best practice in health care

It is identified by Morton–Cooper and Palmer (2000) that providing learning support does not automatically lead to best practice. They do however suggest that it can create the right environment for practice to flourish in that where there is trust and openness in the workplace people feel free to discuss care and to explore new innovative ways of managing care. They may also feel more able to challenge care. Thus the environment that you looked at earlier in this unit could lead to a happier workplace that in turn enhances the outcomes for the people that you are providing care for.

As a way of acquiring emotional literacy

Morton-Cooper and Palmer (2000) suggest that learning support can enable people to develop emotional literacy. They suggest that this is a way of voicing the emotions that they feel when dealing with the complex people that we come across on a daily basis. Indeed they suggest that if we can't find a way of voicing our emotions then we are emotionally illiterate and at risk of personal failure and burnout. Thus we need to identify ways and times to articulate our frustrations in a positive manner so that we can identify new ways of thinking and acting.

Conclusion

In this module you have explored and developed your own skills in regard to providing support and education to others in your workplace. You have identified the components of a good learning environment and explored organisational identity. You have also examined the qualities of strong leadership and coaching skills. It is anticipated that this will support you in implementing positive behavioural support in practice and supporting others to deliver a positive behavioural support model.

Key Messages

- Learning support can help build relationships and improve working environments
- Narratives can help explore and promote learning from complex situations as well as having use as a learning tool to support and educate others
- Developing and promoting positive learning environments 'fits' well with a values based practice philosophy

7 Well done - you have now completed Module 7 Supporting and Educating Others

Module 7: Supporting and Educating Others

You may find it helpful to note any particular issues you would like to note below:

Similarly, there may be areas covered in this module that you will find helpful to discuss further with your supervisor. You may find it helpful to list them below:

Appendix 1: Case Study and Extracts from Meeting

Appendix 1: Case Study and Extracts from Meeting

Case Study 1: David

David is a 38 year old man with autism who has a moderate learning disability. He lives at home with his father and mother. For many years he has attended a voluntary organisation day centre where he gets 1:1 support. David's day centre has generally met his needs throughout this time. David has had respite opportunities and the social work department has put in place direct 1:1 support in his community but neither has been deemed successful.

David is generally an affable character who will actively seek your attention. He can be keen to help and it has been reported that at his day centre he is sorely missed by both clients and staff when he is absent. David also presents with significant challenging behaviour. This has resulted in him being admitted to hospital or removed from the family home and removed from respite. On one occasion he was transferred from an inpatient ward in the local psychiatric hospital to the intensive psychiatric care unit. The health professional's opinion is that David's difficulties arise from social factors and that hospital is an inappropriate placement to manage any crisis.

Most of the incidents in respite or at home have involved the police but fortunately the consequences of the behaviour have been managed without anyone suffering any serious physical injury. The vast majority of incidents have been managed with no need for restraint but at home and in his respite settings parents and staff have received a punch or a kick resulting in minor injuries. The presence of a secondary party and/or removal from the immediate settings has deescalated the behaviour at least for the interim period.

Historically there was a concern that David suffered from a bipolar disorder and he was prescribed haloperidol and carbamazepine retard but the parents and David's day centre reported no significant improvement in his mood. Equally the parents reported that the use of as required medication seemed to exacerbate David's anxiety as he actively fought off its effect.

David's behaviour does appear to be anxiety driven and can last for weeks at a time. His requests will be incessant and he will demand an immediate response. When David's request cannot be met e.g. wanting to live in a house on his own, wanting to attend respite, go to a perceived girlfriends for tea or demanding that a member of staff or other client is sacked, his

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behaviour will gradually escalate from incessant repeated requests, to verbal abuse and ultimately to screaming, shouting and damaging furnishings. Should he try to leave the vicinity and parents or staff attempt to intervene then it would appear that this is a clear antecedent for physical aggression.

David can also be possessive about his parents and who he deems to be his identified member of staff. This can result in "jealousy" and an altercation with either other clients or staff members. David complains that his parents are too restrictive and repeatedly states he wants to live on his own. His idea of living on his own means without any support and that this would give him the opportunity to not "go to his work" and watch TV all day His social worker and respite workers agree that David could not possibly live on his own but do share his belief that he could have more choice and responsibility in his life.

David's parents are concerned that the philosophies of care e.g. empowerment, advocacy, inclusion, etc are destabilising David's mood and undermining his structured programme. They feel David needs to make sense of the world. They feel he is getting unrealistic expectations and this in turn increases his arousal level.

He has recently been admitted to a social work residential unit.

Extracts from an adult protection review meeting

FSW = Field Social Work
RU = Residential worker
H = Health Professional
VO = voluntary organisation (day care)

Setting the scene
A pre-meeting was held prior to the parents' attendance. This was to give all professionals an opportunity to share third party information. Despite an explanation being given to the parents the parents resent the approach of having a pre-meeting, viewing it as professional's conspiring.

Pre meeting
Professional FSW1- advised the meeting that David's visits had been sporadic and informed the meeting that although the current agreement was that David could use the residence as respite and for crisis management this was causing significant managerial problems and the inconsistency was detrimental to David. David has stayed in the unit 65 days out of a possible 92 days.

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Professional RU1 - stated that his manager could no longer sustain the 1:1 support in this situation. If a decision was not made today to make the placement permanent then either the 1:1 was withdrawn or an alternative resource would have to be found.

Professional FSW1 - stated that he doubted if anyone had the power to make such an arbitrary decision.

Professional H1 - stated that this was scandalous and tantamount to blackmail. She questioned how this was supposed to fit into the consultation process or assist in healing the working relationships.

Professional RU1 - advised that although he disagreed with the ultimatum he believed that the inconsistency and excessive family contact was adding to David's anxiety. This made it impossible to achieve an accurate assessment and develop the intensive support plan that was necessary for David's well being.

Professional H1 - said she was pleased that after 56 days the department thought it appropriate to undertake an assessment. She thought that the previous 56 days was an ideal opportunity to assess David's anxiety. She was concerned that up to this point all of David's behaviours appear to be contributed to contact with the family. This is in contradiction to the history where David has presented with challenging behaviour in every setting he has lived in.

Professional FSW 2 - stated that David's parents were still not happy with an array of issues. This included David going to bed early, refusing to shave and his eating habits, the latter resulting in a slight increase in weight. The parents also expressed concern that staff were limiting when they could call and when David could come home.

Professional FSW3 - said that she had spoken to the family's advocate and informed him that the department would not support the family's application for welfare guardianship. The family's advocate would advise that it was his belief that without this support the family would be unlikely to succeed. He would therefore advise the family to work with the department to achieve the best outcome for David.

Professional FSW1 - stated that given the past history with the family. The inconsistency of their responses and now a complete a breakdown in trust it was likely that the situation was likely to get worse rather than improve. Even if they

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agreed to David's permanent residence it was unlikely that they would cooperate and it was essential that the department pursued welfare guardianship.

Professional H2 - stated that as things currently stand David's parents can take him home at any time and advised that the department should expedite their application for welfare guardianship.

Professional VO - Regardless of who has the final say over David's care he feels that unless David's parents have a central role in his life then David will not be happy. Despite all the issues he clearly loves them and it has shown he misses regular contact with them.

The meeting

David's Mum - David is allowed to anything he likes in the unit. The staff are filling his head with nonsense. He is allowed to stay in bed all day; he smokes (he does not smoke at home), he does not go to work, and he wets all day. The only reason you want to keep him in the unit is because of the guardianship order.

Professional RU1 - the only reason we wanted to keep David in the unit for longer was to minimise any escalation in his behaviour over the holiday period. A shorter period at home would be easier to manage in regards to David's re-admission. It will be difficult for us to find staff at short notice over the holiday period.

David's Dad - All we need is medication for David. For 8 years I have been asking for something to take the edge of him. It has got markedly worse in the last 2 years since staff started filling his head with rubbish.

Professional SW1 - I think to be honest the department have been too family focussed rather than David focused. I think it is time we put David's needs first.

Professional H2 - It is important that we view David as an adult. We need to let him make choices despite his disability. It is not unusual for people with a learning disability to mature at a later age and we witness a personality change.

Profession H1 - How do we decide when and what David can make decisions on. For example if he keeps changing his mind about where he lives. We cannot be selective in what choices David makes to fit whatever argument we wish to support.

Professional RU1 - I still think it is imperative that we all work together. The family have to support us and us them.

Appendix 1: Case Study and Extracts from Meeting

Professional FSW3 - If we had done that there would be no need for a guardianship order.
Identify the clear value statements in the extracts
Identify 4 value statements (2 positive and 2 negative) that could assist or deter progress in any PBS programme and why.

Discuss and make notes how these issues could be managed in setting up a PBS team, within this group of professional's and carers.

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NHS Education for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HD

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