POSITIVE BEHAVIOUR SUPPORT CARE PATHWAY for CHALLENGING BEHAVIOUR

Early identification of Challenging Behaviours
Leading to a referral to the Learning Disability Service

Standards and Principles

Assessment of Challenging Behaviours

Standards and Principles

Forms and Templates

Formulation and Care Plan

Forms and Templates

Intervention Package and Stepped Care Model

Standards and Principles

Review and Evaluation (within 20 weeks)

Standards and Principles

Forms and Templates

Discharge

Standards and Principles
EXECUTIVE SUMMARY

Evidence indicates that 10-15% of people with learning disabilities known to services present with behaviours that challenge, and two thirds of this group can present with more demanding / complex needs. The Challenging Behaviour Care Pathway aims to provide a clear framework for carers / services to follow and to support individuals in a person centred way based on national best practise (Positive and Proactive Care 2014 and National Institute for Clinical Excellence Guidance 2015). It aims to develop skills which will ultimately reduce the person’s need to use behaviours that may increase risks to themselves and / or to others; ultimately it aims to improve a person’s quality of life. Challenging behaviour is not a diagnosis and may serve a purpose for the person with a learning disability; often resulting from interactions between the individual and environmental factors external to the person.

The Challenging Behaviour Care Pathway provides a therapeutic underpinning, along with practical assessment tools which take into account behavioural, biological, psychological and social factors which may be impacting on the individuals’ quality of life. Upon triggering the need for the Care Pathway, the identified Care Coordinator will produce emergency guidelines including a risk assessment. Direct observations, interviews with significant others involved in the individual’s life and a good detailed history will enable a working formulation to be developed.

All interventions will be based on the assessment / data and evidence (from functional analysis). This process can take up to 12 weeks and longer depending on complexity.

All interventions will follow a proactive, active and reactive strategy model. Broader assessment will include the emotional resilience, capacity and resources of carers and the sustainability of the package.

The roles of MDT members are defined throughout the pathway and their roles in the interventions which may include direct individual work, advice, supervision and/or training to support the implementation. Monitoring of the interventions for an agreed period of time is acknowledged as a critical part in supporting the success of the formulated clinical guidelines. Audit and service user feedback outcomes will be collected at the end of each episode of care.
This section introduces the concept of challenging behaviour and outlines the way the multi-disciplinary team would initially assess the situation. It includes an idea of how the CPA process is used and risk assessments needed.

*NICE have published guidelines for managing challenging behaviour in people with learning disabilities, (May 2015)*

**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 1997).

**Prevalence:**

Estimates vary according to the definitions used; from 24 adults with learning disabilities per 100,000 total population challenge at any one time. This indicates that over 12,000 people with LD across England have behaviour that challenges services. In Leicester, Leicestershire and Rutland this would equate to 240 people in need of challenging behaviour support at any one time. This represents a large proportion (%) of community referrals needing this pathway and is therefore pivotal in the learning disabilities business unit success in meeting people’s needs.

The Challenging Behaviour Care Pathway is a structured multidisciplinary approach detailing the main steps in offering a service to people with challenging behaviour. The Care Pathway is intended for use by a multidisciplinary team of health and social care professionals providing a specialist service to people with learning disabilities. It also includes other providers, for instance private or voluntary residential or day care services. The aim of the Pathway is to offer consistency and equity of service response to people referred to the service in order to improve quality of life.

It outlines what a service user can expect from the point of referral to the end of their contact with the service. In line with the research evidence, the Pathway emphasises the need to identify a cause/function for a person’s behaviours, including social, biological and emotional factors. The Pathway is based on a socially enabling model to help a person develop their skills to enable their needs to be met through safe and constructive ways. The idea being that this improves quality of life, leading to a reduction in challenging behaviours and reducing exclusion from the community.

The Pathway focuses on ways of delivering a service that are:

- Fair – equally available to all, taking account of their personal circumstances, culture, and diversity.
- Personalised – tailored and adapted to an individual’s needs and preferences.
- Effective – delivers evidence based care and outcomes that are socially valid and improve quality of life.
- Safe – ensures people are safe particularly when they are vulnerable emotionally.
- Accountable – through audit and monitoring of outcomes and standards included in the Pathway.

The national guidelines (BPS/RCP) recommend that positive behaviour support be the preferred service model. In addition the Mental Capacity Act (2005), and Deprivation of Liberty Safeguards (Dols) (2007); also the Supreme Court Judgement re Dols, Cheshire West March (2014) should be considered when intervening with anyone with Challenging behaviour as part of this or any pathway. Capacity is considered as part of the Core Care Pathway assessment. However, it must be regularly reviewed and the outcome documented through this pathway. Assessments of mental capacity should be decision and time specific. You may need to carry out these in relation to any number of decisions for an individual as appropriate.

The Pathway requires health and social services to work together in a coordinated way so that there are clear actions at each stage of the pathway. The Care Pathway depends on a coordinator to oversee the process, be a point of contact, to enable all parties to be involved in the decision making processes, and to ensure that all information is organised in an effective way.

A Clinical Overview of Challenging Behaviour

1.1 Challenging behaviour continues to be an area of immense clinical need. A sizeable minority of people with learning disabilities show severe and multiple forms of challenging behaviour. The Care Pathway aims to support the service to respond to this need in a coherent, consistent and effective way. It is important to place the Care Pathway and the assessment process within an appropriate framework. It is strongly recommended that clinicians read this section before using the Care Pathway.

1.2 Assessment is not an end in itself. It is common for a person to have been assessed several times for the same challenging behaviours. Assessment should be the process by which information is collected in an efficient manner to guide either:

- The development of efficient and effective services for people with intellectual disabilities and challenging behaviour, or
- The design and implementation of constructional and socially valid interventions for individuals
So it is crucial that we are very clear about the aims of the assessment and the broader context in which the assessment is taking place.

1.3 It is clear that challenging behaviours often have wide ranging personal and social consequences. These may include: impairing the health and/or quality of life of the person, those who care for them and those who live or work in close proximity; abuse, inappropriate treatment, exclusion, depression and neglect (Emerson 2001). It can be argued that the ‘success’ of intervention strategies should be judged against their impact in reducing challenging behaviour, and also in bringing about significant ‘lifestyle’ changes e.g. learning another way to have needs met, increased control and empowerment.

2. Understanding Challenging Behaviour

2.1 The most common reason for assessing a person’s challenging behaviour is to understand the reason why the person is acting in the way they are and subsequently to design supports and interventions that can help them to act in different ways in the future.

2.2 Four problems are frequently encountered when advice is sought for a person’s challenging behaviour. First it is very uncommon for a person with intellectual disabilities to refer themselves for help. Referral decisions are usually made by significant others e.g. care staff, relatives, professionals, without discussing this with the person themselves. It is important to determine, as far as possible, the person’s own understanding of the referral, and where appropriate, that they have consented to the referral.

2.3 Second the nature of the problem may have been conceptualised incompletely by the referrer e.g. the reasons for the referral are often non-constructional (e.g. reduce the troublesome behaviour) without addressing the broader social impact on lifestyle. Third, many referrals may have different agendas e.g. a request for more resources or exclusion. Fourthly, it is important to be clear about questions that the assessment can and cannot address. For example, a functional analysis might suggest a potential role of neurological factors, that would then need further assessment.

2.4 It is important to CLARIFY and DOCUMENT clearly the purpose of the assessment and to negotiate any changes between your aims and the requested reason for referral with the referring agency and if possible with the person themselves. This may help to minimise misunderstandings at a later date.
2.5 Physical causes of challenging behaviour need to be addressed before further detailed assessments take place. An assessment is likely to have the following aims:-

- To identify the biological, psychological and environmental factors that may be contributing to and maintaining a person’s challenging behaviour. For example, change, a confusing environment may be contributing factors.
- To clarify the risks for the person and others.
- To identify alternatives which can serve the same function as the challenging behaviour e.g. if a person needs to leave an environment, he / she could learn a safe way to do this.
- To outline strategies to reduce the need to use the challenging behaviour such as ensuring the environment is tolerable, skill development, direct treatments.

2.6 Assessments need to be undertaken in the context of an understanding of the likely causes of challenging behaviour. Behavioural approaches view challenging behaviour as functional, and in a general way adaptive for a person. It can be thought of as a way in which a person exercises control over their life. Behavioural accounts are interested in the consequences and context of the behaviours.

Communication difficulties are frequently involved in the person’s challenges, for example, someone may communicate their distress through their behaviour. How a person “interprets and understands” a situation can have a significant influence on their behaviour. In addition, a number of common causes include psychiatric disorders, physical conditions causing significant distress, neurological conditions like epilepsy, acute confusional state etc., stressful situations, a significant life event or self-stimulation in the context of sensory impairments. Some of the genetic and developmental conditions can include some forms of challenging behaviour as part of the behavioural phenotype (e.g.: Lesch Nyhan Syndrome, Prader Willi Syndrome, Autism, ADHD etc.).

Neurobiological theories have focused on the role of three classes of endogenous neurotransmitters in influencing behaviour: dopamine, serotonin, (5-Hydroxytryptamene) and the opioid peptides, (in particular B-endorphin). Evidence suggests that dopamine may be involved in self-injury; there may be a link between serotonin and aggression. Self-injury may lead to the release of endorphins which through its analgesic and euphoria inducing properties, encourages self-injury. A full outline of these neurotransmitters is beyond the scope of this section and the reader is advised to seek further information from an appropriate professional.
3. **Identifying Challenging Behaviour**

3.1 Carers and care staff often describe challenging behaviours in very general terms. The first step is to clarify: the how, what, where and when of challenging behaviour. The information needed to answer these questions is likely to come from interviews with people who are in regular contact with the person. If the behaviour is high frequency, or highly predictable, it is important to spend time observing the behaviour.

3.2 Describing the challenging behaviour in clear terms has two aims. First it gives a DETAILED description of the DIFFERENT forms of challenging behaviour shown by the person. Secondly, we need to know about the SEQUENCE OF BEHAVIOURS which lead up to an episode of challenging behaviour. Challenging behaviours rarely occur “out of the blue”. More commonly they follow a sequence during which the person’s behaviour escalates from more appropriate e.g. turning away to less appropriate e.g. hitting out, as ways of attempting to exercise control. Knowledge about sequences can be helpful to develop guidelines for managing challenging behaviour and identification of alternatives to replace the challenging behaviour.

3.3 The information collected needs to be developed in partnership with direct care staff. The information is to be shared and discussed regularly. The key issue is to keep it as simple as possible.

3.4 **Low Frequency, High Impact Behaviours.**

Some challenging behaviours e.g. a major assault do not occur very often but have serious consequences. In these cases, historical information is usually available e.g. case notes, behaviour incident report forms. It is important to consider the accuracy of this information. Difficulties are likely to include inconsistent reporting over time, different informants, and changes in reporting systems.

3.5 **High Frequency Behaviours.**

Monitoring every incident of high frequency behaviour can be very difficult and it may be more useful to sample occurrences of the behaviour. In reality, this will require devising a new recording system. One option is to sample by rate or intensity. For example, if a person hit the wall / door, 10 times or more within the period of an hour, this event would be recorded (sampling by rate). Scatter plots are a useful tool for collecting information on the frequency, timing, and context of an incident.
Carers simply note whether a clearly defined episode of challenging behaviour has occurred within a set time interval. An alternative approach is to restrict recording to a particular setting or time.

4. Understanding the Processes Underlying Challenging Behaviour

4.1 Interventions need to be based on an understanding of the processes underlying the challenging behaviour: a functional assessment. The assessment follows a sequence in which preliminary information is validated through comparison with the results of a more rigorous assessment. In the descriptive phase of a functional assessment the focus is on describing the immediate social and environmental impact of the person’s challenging behaviour. Through this the assessment tries to identify the reinforcement contingencies that are maintaining the challenging behaviour; and the setting events or contextual factors that provide the motivational basis for the challenging behaviour.

4.2 The descriptive information is gathered through a combination of structural interview, rating scales and observation.

- Structured Interview. There are a range of structured interviews that can be utilised to collect subjective information regarding occurrence of behaviours. Demchak and Bossert (1996), O’Neill, (1997). See Section 4 – Information Based Information.

- Rating Scales. The Motivational Assessment Scale (Durand and Crimmins 1992) is commonly used to identify the processes underlying the challenging behaviours.

- Observation. Details about observational approaches are outlined under Section 4. Clinical observations. An individual’s consent must be sought prior to observations and reviewed throughout the process.

4.3 Once sufficient information has been collected, each episode of each form of challenging behaviours should be reviewed to see if it is consistent with any of the four processes which commonly underlie challenging behaviours. Research has demonstrated that the processes include.

- Gaining interaction. The majority of us enjoy spending time interacting with others either talking or involved in some two-way activity.

  People with learning disabilities are no different although they may have learnt to gain ‘attention’ or interaction by behaving in a challenging way.

- Gaining Tangibles such as food, drink or activity.
• Demand or Task Avoidance e.g. getting out of doing something we don’t want to do either now or never. This may be because we don’t like it, we can’t do it or we’re busy.
• Self stimulation. This gives us pleasure internally a nice feeling or this helps us to manage this situation ourselves.

4.4 The findings can lead to a number of ideas or hypotheses about the reasons for and functions of the challenging behaviours. Sometimes, it may be wise to test these hypotheses before developing an intervention. One approach will involve detailed naturalistic observation of the challenging behaviour shown by the person and the events likely to be maintaining this. A second approach could involve an experimental analysis and undertaking a brief ‘mini experiment’ during which aspects of the person’s context that are related to the hypothesised maintaining process are manipulated. These approaches required trained staff and careful supervision. Ethical consideration will be essential. It is strongly recommended that supervision is sought from a relevant senior clinician e.g. a Practice Development Nurse or Clinical Psychologist.

4.5 Identifying Possible Alternatives To Challenging Behaviours.

The aim of a constructional intervention is to replace challenging behaviour with other, more appropriate, behaviours. One aim of the assessment process, therefore, is to identify possible alternatives to challenging behaviour. Some possible strategies are listed below:

• Look at the sequence of behaviours that lead up to challenging behaviour. Are there any earlier links in the chain that could be built on? For example, if the person often tries to ‘wave away’ unwanted demands before finally resorting to aggression, perhaps a manual sign based on waving could be used as a functionally equivalent replacement to challenging behaviour.

• Undertake a general assessment of the person’s existing skills and, in particular, their methods of communication.

5. Next Steps

5.1 The reader is advised to read the following section outlining guidance for each step in the Pathway. Assessment and understanding challenging behaviour can be a complex process and it may be helpful to seek further advice as outlined in section 4.4.

The above summary is based on the following reference:

1. Initial Team Assessment/First Contact

The section comprises of 5 elements to be carried out following a referral to the team.

- Risk assessment, screening tool.
- Physical health check.
- Clear description of challenging behaviour.
- Mental Health screening.
- Summarise previous contacts with service.

**Screen risk assessment**
Complete the ‘Initial Risk Screening Tool’. This tool aims to identify risks associated with the individual. This tool predominantly relates to identifying risk associated with an individual’s mental health.

**Physical health assessment**
Complete the ‘OK Health Check’. This tool aims to ensure a structured, systematic approach in establishing important information about an individual’s health and identifies any contributing physical causation – outstanding health issues must be addressed as far as possible. The ‘Disdat’ is used to assess pain.

**Clear description of Challenging Behaviour**
Complete the ‘Learning disabilities service core information’ document, which aims to provide information regarding the individual’s challenging behaviour, including the intensity, frequency and duration of challenges displayed. This also identifies any known risk factors.

**Mental health screening**
- Any previous history of mental health problems.
- Treatment received and the effect of treatment.
- Are there evidences of mental health problems currently?

**Summary of previous contacts with services**
Identify any past involvement, previous strategies and assessments which may have already been completed. This may involve discussing with staff what they are currently doing to manage the behaviour and whether any former guidelines that had been effective in the past my need revisiting.
2. Decision Making/Identification of Care Programme Approach Co-ordinator

The Care Co-ordinator has responsibility for co-ordinating care, maintaining contact with the Service User ensuring that the CPA Care plan is delivered and reviewed as required. The Care Co-ordinator will be a qualified individual with the requisite knowledge, skills and experience and will in most cases be registered to a profession and be the person “best placed” to oversee Care Planning and resource allocation. The Care Co-ordinator can be of any discipline depending on capability and capacity.

The decision making process consists of four elements:-

• Deciding on the appropriate services.
• Deciding if emergency guidelines are required and the production of these.
• Signpost to other services.
• CPA screening.

1. Following the initial team assessment/first contact the multi-disciplinary locality team will, based on the information gained, allocate the referral/case to the required professional teams based on the stepped care model in this pathway.

   In the stepped model, own role, assessment process and intervention in relation to supporting a client with challenging behaviour which is outlined briefly below. The clinical network be accessed for support at any point during the pathway as the assessment process occurs. They may suggest liaising with another professional group where needed. For instance, Speech and Language Therapy, Clinical Psychology. The Police and/or Social Services will be referred to where the presenting problems identify child protection or safeguarding issues.

2. Signpost to other services

   The decision making process incorporates considerations of signposting to other services and pathways. This will occur when the challenging behaviour pathway does not meet the client’s current needs. This signposting may be internal or external.

   **Internal signposting may include:-**
   • Another professional, e.g. Outreach, clinical psychology, SALT
   • Crisis care pathways.
   • Dementia care pathway.
   • Admittance to the learning disability assessment and treatment unit (under the Mental Health Act 1983 or, as in informal patient.
   • Mental Health Care Pathway.
External signposting:-
- To Mental Health Services.
- To Social Services (if the primary need is of a social content e.g. housing, lack of day/occupational/educational activities.
- To the Police.

3. Emergency Guidelines

Emergency guidelines can be offered to enable the client to maintain community presence. Emergency guidelines will be written by either a group of professionals or a singular professional depending on what the presenting behaviour or problem is.

Emergency guidelines are wrote based on information known about the client at the current time. The emergency guidelines will identify how, and, by whom they will be checked to ensure that they reflect the clients’ needs as the assessment progresses. verified in terms of validity and reliability through further assessment.

Emergency guidelines (see later for details) will attempt to identify known:-
- Risks
- Diagnosis.
- Triggers
- Proactive strategies to behaviours (biological, psychological, social)
- Early signs of deterioration in mental health.
- De-escalatory interventions (biological, how to walk and behave around the client) to any early warning signs.
- Escalators to behaviours.
- Escalators to mental health problems.
- Effective management strategies.
- In-effective management strategies.

Emergency guidelines will additionally advise on “best practice” indicators in relations to the client’s specific needs, for example using research/ evidence/ national guidelines (e.g. NSF, NICE guidelines, DOH) on specific disorders such as:-

- Autism Spectrum Disorders.
- Prader-Willi Syndrome.
- Specific mental health disorders.
- Self- injurious behaviour/self-harm.
- Personality disorder.
- ADHD.
It is acknowledged that services/carers following emergency guidelines may affect the validity of any professional assessment. However it is unethical to not advice where advice can be given which immediately reduces risk to the client and others.

3. **Care Programme Approach Screening**
   
   Identify Co-ordinator. (It may be helpful for this to be an individual familiar with the Pathway.

People on CPA are likely to have some of the following characteristics.

Characteristics to consider when deciding if the support of CPA is needed:

- Severe mental disorder (including personality disorder) with a high degree of clinical complexity.
- Current or potential risk(s) including:
  
  - Suicide, self-harm, harm to others (including history of offending).
  - Relapse history requiring urgent response.
  - Self- neglect/non concordance with treatment plan.
  - Vulnerable adult: adult/child protection e.g.
  - Exploitation e.g. financial/sexual.
  - Disinhibition.
  - Physical/emotional abuse.
  - Cognitive impairment.
  - Child protection issues.
  
  - Current or significant history of severe distress/instability or disengagement.
  - Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse, learning disability.
  - Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies.
  - Currently/related detained under the Mental health Act, or referred to crisis/home treatment team.
  - Significant reliance on carer(s) or has own significant caring responsibilities.
  - Experiencing disadvantage or difficulty as a result of:
    - Parenting responsibilities.
    - Physical health problems/disabilities.
    - Unsettled accommodation/housing issues.
    - Employment issues when mentally ill.
    - Significant impairment of function due to mental illness.
    - Ethnicity (e.g. immigration status; race/cultural issues; language difficulties; religious practices); sexuality or gender issues.
Key groups who would normally need the support of CPA are service users who:

- Have parenting responsibilities.
- Have significant caring responsibilities.
- Have a dual diagnosis (substance misuse).
- Have a history of violence or self-harm.
- Are in unsettled accommodation.
- Are subject to Supervised Community Treatment (SCT) or Guardianship (s.7) under the Mental Health Act 1983.

4. Assessment Process and Feedback

In order for a full functional analysis assessment to be conducted a variety of tools and strategies need to be used.

Three types/areas of information require collection;

1) The review of current and historical records of the identified behaviours and interventions and their effects.
2) Informant based/subjective information.
3) Clinical Observation
4) The review of current and historical records

Current Records
Current care – plans/guidelines/contact/daily record sheets being followed by the clients support agencies need to be reviewed in terms of consistency and effect..

Learning Disability specialist health services will negotiate with commissioned services on the type of records kept and produced during the functional analysis assessment. Training can be offered by LD health services to provide qualitative formats of record keeping for example

- ABC charts.
- Mood Charts (bi-polar, depression, mania)
- General Health (epilepsy, menstrual cycle, diabetes, bowel charts, sleep cycles).

Historical Records
All available records from all agencies previously involved in supporting the client should be reviewed where possible. Particular attention should be paid to previous assessments, their outcomes and recommendations, any previous history of mental health/physical health concerns and major life events.
5. Informant based/subjective information

Informant based approaches provide comprehensive preliminary information regarding the interviewees' opinions regarding the following:

- “topography, frequency, duration intensity, impact and co-variation of the person’s challenging behaviours;
- Medications, medical complaints, sleep cycles, eating routines and diet, daily schedule of activities, predictability, activities, crowding, staffing patterns.
- Specific events or situations (e.g. time of day, setting, activity, identity of carer) which are predictive of either high or low rates of occurrence of the challenging behaviours;
- The consequences of the challenging behaviours;
- Alternative communicative strategies used by the person in context of everyday activities;
- Existing functionally equivalent behaviours;
- The history of previous approaches to intervention.
- Staff beliefs about the causes and/or functions of the person’s challenging behaviour (Hastings, 1996,1997; Oliver et al., 1996);
- The pattern (including its consistency) of the physical and emotional responses of staff to episodes of challenging behaviour (e.g. Mitchell & Hastings, 1998);
- Informal strategies adopted by staff to prevent the occurrence of challenging behaviour” (O’Neill et al 1997, cited in Emerson, 2001, Pg. 82-83.

A wide variety of people involved in the clients day-to-day life need to provide informant based information. Two to three people should be interviewed using one Functional Analysis Interview form (O’Neill et al 1990) where possible. This is a 20 page document usually taking a maximum of 90 minutes to complete. following this as many people as possible who support the client, should be asked to complete Motivational Assessment Schedules (Durand 1990). The MAS take 5-10 minutes and provide a guide overview of the informant's experiences and perceptions of the behaviours (Durant 1990).

3) Clinical Observations

It is paramount that clinical observations are conducted in conjunction and to verify informant based interviews. Clinical observations should be conducted when possible in all environments accessed by the client over a 24-hour clock. Clinical observations provide information on antecedents’ and reinforcing contingencies surrounding the occurrence of behaviours. From this information the functions to the behaviours can begin to be formulated/hypothesised. Clinical observations also provide information about successful strategies currently being employed by those supporting the client.
Ideally the assessment team should conduct observations. Members of this team are trained in a variety of observational techniques;

All observations should record information regarding

- Choices available.
- Activities available – and outcome – the client’s opportunity and ability to adhere.
- Structure/predictability of the day.
- Communication systems used and their effectiveness.
- Frequency and types of engagement.
- Frequency and types of engagement.
- Relationships with other people.
- Interactions with others.

The number of hours of clinical observations required to be conducted is variable. However, Liebourn suggests that at least twenty-five incidences of behaviour should be observed in order to hypothesis accurately and reliably.

Clinical observations should be recorded in both qualitative (descriptive) and quantitative (numerical) formats.

Feedback

Feedback to referrers will be through a written report detailing

Summary Report

- Background information.
- Referral process and requests.
- Assessment process and tools used.
- Feedback from the assessment detailing variables within the environment explaining why the person currently uses the challenging behaviours and reinforcing contingencies.

Information regarding the clients’ skills and opportunities for skill developments in terms of:

- Communications.
- Activities.
Recommendations need to be based on the formulation (see formulation section of care pathway) and are made throughout the report and summarised at the end of the report. The summary should include:

- Recommendations that are proposed:
- Interventions;
- All services responsibilities for the implementation of recommendations;
- Future joint working.
- Training needs of service;

NB report writers will have supervision in terms of clinical report writing. Reports are published in an agreed service format.

Reports are additionally published in an accessible version for the client.
References


SECTION 2: EARLY IDENTIFICATION OF CHALLENGING BEHAVIOUR

TRIGGERS FOR THE CHALLENGING BEHAVIOUR CARE PATHWAY

- Behaviour that is a risk to self or others, (include suicide risk)
- Behaviour that is of a safeguarding concern
- Behaviour that is high frequency with high intensity
- Behaviour with low frequency but high intensity
- Behaviours leading to quality of life reduction
- Behaviour that is leading to exclusion from community
- Behaviour that could result in the loss of accommodation
- Behaviour that without intervention could lead to offending behaviour
- Behaviours that are unusual for the individual and the reason for the behaviour is unclear
- Individuals displaying challenging behaviour are living alone or with unpaid carer’s at home
- If people are physically restraining an individual and are not trained to do so.
SECTION 3: INFORMATION FOR USERS & CARERS

Royal College of psychiatry leaflet re “Mental health and challenging behaviours”

Patient Related Outcome Measures (PROM)
What we want GPs to know about our care pathway

The challenging behaviour pathway

Ensures appropriate person centred support for service users and carers in a timely and evidence based way. It will be supported by a clinical network of people with expertise and special interest in working with people whose needs challenge services. Includes multi-agency risk assessments and CPA processes where needed to ensure effective communication and promote joint and safe working in this complex area.

Proactive stepped care with range of interventions from direct work to offering consultancy and advice to facilitate the work of others.

You would first refer to the specialist learning disabilities team and after core information is collected the team will decide which pathway is most appropriate to meet the person’s needs. Initial triage will determine whether the situation is urgent and requires immediate intervention.
SECTION 5: REFERRAL TO LEARNING DISABILITIES SERVICE

Follow core care pathway process to Community Teams Pathway meeting
Examples of some questions to support assessment

Structured Interview to Determine the Immediate Impact and Contextual Control of Challenging Behaviour.

Ask each question separately for each form of challenging behaviour shown by the person.

1. What are the activities or settings in which the behaviour typically occurs?
2. What typically happens when the behaviour occurs (i.e. what do you or others typically do)?
3. Are there particular event or activities that usually occur just before an instance of challenging behaviour? Please describe.
4. Are there particular events or activities that you usually avoid because they typically result in challenging behaviour? Please describe.
5. Are there particular events or activities that you encourage because they DO NOT result in challenging behaviour? Please describe.
6. What does ............ appear to be communicating with their challenging behaviour? Please describe.
7. 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.
8. Does their challenging behaviour appear to be related to their mood or emotional state? Does this change following an episode of challenging behaviour. Please describe.
9. Does the behaviour appear to be influenced by environmental factors (noise, number of people in the room, lighting, music, temperature)? Please describe.
10. Does the behaviour appear to be influenced by events in other settings (e.g. relationships at home)? Please describe.

Source: Modified from Demchak and Bossert (1996).

Guidelines re use of DIRECT OBSERVATION for assessment of challenging behaviours

- Direct observation techniques essentially involve counting and recording the frequency and/or duration of defined behaviours
- In the field of learning disabilities, direct observation is most often used to determine levels of defined behaviours before, during and/or after treatment
- Direct observations may be useful in describing facets of the environment and life of a person or the effects of alterations in the environment
Why use Direct Observation?

- To help in a functional analysis, e.g. to help in the creation of hypotheses about the function of behaviour (analogues)
- To evaluate the effectiveness of behavioural programmes or chemotherapy, i.e. to determine levels of specified behaviours before, during and after a treatment intervention
- To describe facets of the environment and life of an individual or effects of alterations to the environment
- To compare two services, e.g. on engagement levels

General characteristics of direct observation

Ethical implications

- Informed consent or consent
- Changing behaviour as the result of your presence
- When do you stop?
- When do you intervene?
- When do you get over being present but not helping?

Strengths

- Provides data other than from (direct or indirect) verbal (self)-report
- Provides relatively objective data
- Provides an opportunity for in-depth study of behaviour, non-verbal communication and the physical and social environment
- Allows immersion in the whole context of the program

Limitations

- Time-consuming and often expensive
- May seem intrusive to program staff and participants
- Observers need extensive training
- Conflict over role may arise (e.g., to what extent can observer be a participant
- Direct observation allows only one “pass” at the data collection, thus to collect all the necessary data at the observation, careful plans must be made before starting.

Main areas where direct observation is used

- Functional Analysis
- Behavioural Treatment Procedures
- Evaluation of the effects of medication
• Evaluation of the effects of environmental change
• To compare two services, e.g. on engagement levels

**Possible target behaviours in direct observation**

• Desirable client behaviours (language, self-help skills)
• Undesirable client behaviours (hyperactivity, stereotypical behaviours, self-injury)
• Staff behaviours
• Parent behaviours

**Before you get started:**

• Which behaviours am I interested in?
• How should I record?
• How am I going to define the behaviours?
• In which situations am I going to record the behaviours?
• What type of recording should I do?
• What method should I use to record the behaviours, e.g. pen and paper, video, Psion
• What types of analyses am I going to want to do?
Momentary Time Sampling

(MTS)

- Only slightly different from interval recording
- The occurrence or absence of behaviour is noted at a specific moment of time
- Although the observation period is again divided into intervals, the behaviour is recorded only if it is observed at a specified 'moment' within the interval, usually at the beginning or the end
- Not concerned with occurrence of behaviour at other times
- For measuring behaviours that occur a fair proportion of the time

Deciding which behaviours to focus on and how many to record

- Deciding which behaviours to focus on depends on the question we want to answer / our hypothesis
- Start with a large list and cut them down to a manageable size – if you try to do too many you will lose accuracy
- Do some naturalistic observations to see what you are interested in
- You may have had a referral to look at a specific behaviour (and already have an experimental hypothesis? – but don’t be too blinkered!!
- Casual observation is useful for making hypotheses (e.g. that Basil shouts a lot), but to measure these hypotheses more accurately we would have to define the behaviour that we were interested in more accurately

How are we going to define the behaviour(s) – Topography?

If you are going to measure observed behaviour, you first have to be clear about what it is you are looking for. Casual observations are needed in order to define the behaviour and to decide how to measure it.

You will need:

- Clear, precise and unambiguous definitions of the categories and units of behaviour that you are going to observe. What is meant by ‘he hits people’ or ‘he has a temper tantrum?’
- To say what your definition does and does not include.
- To be clear about when behaviour starts and when it ends.
- You will need to do this in order to measure the behaviour reliably, so that another person watching the same behaviour would record it as the same as you.
In which situations are we going to record the behaviours?

Is it going to be more accurate / useful to record the behaviour as it occurs in the natural setting, in a laboratory environment, or to set up experimental conditions (analogues) within the natural environment?

What type of recording do we want to do?

Now we have a better idea of what we are talking about and what we want to find out, but in order to measure the behaviours we need a method of recording – formal or systematic observation.

So how are we going to measure the behaviour that we have defined?

- Our goal is to obtain a record of the person’s behaviour that is complete and accurate. The type of observation method chosen depends on the behaviour you want to observe. However, it is impractical to record all human behaviour, except in very brief observation periods. You need to know what to omit and the different techniques of recording omit different facets of the stream of behaviour.

Methods of Systematic / Formal Observation

There are a number of variables to consider when choosing an observation technique:

- What type of behaviour do I want to observe?
- Do I observe continuously (throughout the observation period) or discontinuously (sampling only discrete points in the observation period)? i.e. will the measurement attempt to detect and record all instances of the behaviour or to sample from possible occurrences?
- For how long do I want to measure the behaviour and over how many sessions?
- Do I use paper and pencil methods, video recording or more sophisticated methods such as the Psion?
- How do I want to analyse the data? Not all observation and recording methods lend themselves to all types of analyses.

For example:

- Persistent high-rate behaviour occurring throughout the day, e.g. high rate self-injury:
  - Best advised to observe several brief periods (1/2 hour or less) each day for several days
  - Low frequency behaviours which occur only at particular points of the day
- Best advised to time your observations carefully to coincide with the target behaviour(s). If the timing is unpredictable then you may have to spend whole days observing or arrange for carers to do some recording for you.
- The more infrequent the behaviour, the longer the observation period will need to be

**Direct Observation: Continuous Recording**

- This requires the observer to watch and record behaviour throughout an observation period and to record events as they occur in uninterrupted time.
- Both total number of times and the pattern of a behaviour can be identified. It retains information on *sequences* of behaviour.
- Observation periods are scheduled so that all occurrences of the target behaviour are likely to be detected and recorded providing a perfect reproduction of the behaviour.
  - Descriptive Recording
  - Event count
  - Duration Recording
  - CTS

**Descriptive Recording**

- Involves writing a brief description of the behaviours observed within a time frame. You could also use a Dictaphone or a video film to transcribe at a later date.
- This can be extremely inaccurate if no decisions are made in advance about which behaviours are of interest as you cannot record every response.

**Event Recording**

- The observer is simply required to note all occurrences of a target behaviour over the observation period.
- Primary concern = number of times the behaviour occurs over a set period of time (frequency count).
- It is best to record the *exact* time that the behaviour occurs – gives information on *when* and *how often*.
- Data expressed as a rate over a period of time, e.g. ten head-bangs per minute; aggressive outburst (hits another person) once an hour.
- ABC charts can be useful when requesting carers to collect information on your behalf.
Advantages

- Easy to use when observers are certain which behaviours to record. The behaviours of interest can be listed and the observer may simply record when they occur
- A very effective method of recording the level of brief, infrequent and discrete items of behaviour
- Participant observers can record whilst engaged in other tasks
- Better than time sampling for giving a more precise picture of the actual frequency of behaviour

Disadvantages

- It is not appropriate for:
  - Behaviours of variable duration when the total amount of behaviour is to be measured, because a record of frequency only may be an inaccurate reflection of the total time for which an individual displayed the behaviour
  - Recording brief behaviours which are so fast that they cannot be counted
- Behaviour must have a clear beginning and end
- It only measures one dimension of behaviour, so other types of information are lost (e.g. duration, intensity and quality of behaviour)

Duration Recording

Involves recording the total length of behaviours. Used for behaviours which last for more than a second or two, particularly for those which can vary in length?

Response Duration

Amount of time person spends engaged in target behaviour during an observation session. Time between initiation and cessation of a response

Response Latency

The time between a specific stimulus and the response

Inter-response Time

Time between successive responses
Duration Recording

Advantages

- Better than time sampling for giving a more precise picture of the actual duration (% duration) of behaviour
- Can be transformed into frequency data, % of total time and average response duration measures
- Can be used by participant observers with low rate responses

Disadvantages

- Demanding of observer time – impractical to record duration of more than one behaviour at a time in this manner. Psion’s make it easier
- Difficult if high rate or behaviour has unclear beginning or end

Continuous time Sampling

(CTS)

- Recording of events as they occur in uninterrupted time, along with some indication of the time that has elapsed during and between responses
- Records every instance of a behaviour so that the results provide a perfect reproduction of the behaviour
- Any or all of the 26 letter keys on the Psion are allocated to each of the behaviours / events to be observed
- Each key can be allocated either to count the behaviour or measure the duration of the behaviour
- Both total number of times and the pattern of a behaviour can be identified
- Can have some “mutually exclusive” keys

Advantages

- A more sophisticated measure of both frequency (event) and durations for large numbers of behaviours
- Provides data on the “stream” of behaviour
- Can be used to test function of behaviours and the relationship between behaviours and environmental events more accurately
- Permits precise pinpointing of disagreements between observers

Disadvantages

- Very difficult for observers
- May require costly equipment. Usually requires mechanical recording device
- Responses must have clear beginnings and ends
**Direct Observation:**

**Discontinuous Recording**

- Discontinuous methods of recording entail repeatedly *sampling* periods of time, as opposed to continuous observation.
- Normally the periods of time sampled are brief and are regularly spaced throughout the observation session.
- The intervals between observation samples are usually used for recording.
- The shorter the intervals, the more accurate the data is likely to be.
- Because behaviour is a continuous phenomenon, methods of discontinuous measurement will always introduce some degree of inaccuracy.

  - Whole Interval Recording
  - Partial Interval Recording
  - Momentary Time Sampling

**Interval Recording – Whole and Partial**

- Two of the most frequently employed methods of observational recording.
- Involves noting the occurrence of absence of particular behaviours during an observed *interval* of time.
- Each observation period divided into equal intervals that are separated by a shorter recording interval. The behaviour is either recorded at the end of the time interval (e.g. 20 secs), or there is a time interval for observing (e.g. 15 secs) separated by a shorter recording internal (e.g. 5 secs).

**Whole Interval Recording**

- Behaviour has to persist throughout entire interval to be scored.
- Method typically employed when observer wants the behaviour under study to occur almost all of the time, e.g. correct posture, appropriate work behaviour (if you want to increase desired behaviours).
- Provides information on the *percentage of time* spent engaging in the behaviour.

**Partial Interval Recording**

- Interval is scored for the behaviour if the behaviour occurs at all during the interval.
- A more sensitive measure for detecting relative changes in the level of behaviour.
- Typically employed when observer wants behaviour under study to occur very infrequently or when the behaviour occurs for only short periods and would therefore be missed if Whole Interval recording was to be used.
- Provides information on the *percentage of intervals scored*, rather than the percentage of time spent engaging in the behaviour.
Interval Recording – Whole and Partial

Advantages

- Superior to MTS when a measure of frequency, not duration is required
- Applicable to a wide range of behaviours
- Useful where beginnings and ends are unclear

Disadvantages

- Confounds frequency and duration – provides information on only the percentage of time that the behaviour was observed to occur
- May underestimate (Whole Interval) or overestimate (Partial Interval) behaviour
- Because both methods require continuous monitoring they can only be employed by someone who has no other responsibility than to observe the behaviour

Momentary Time Sampling

Advantages

- Provides more accurate estimate of absolute behaviour levels:
  - In time sampling the behaviours have either occurred or not occurred at the point sampled, whereas in interval recording the behaviour may have occurred several times, or continuously, or only on one brief occasion
  - Research has shown that this method is more likely to accurately reflect the true percent duration of a behaviour than interval recording
- Convenient, easy to use
- Useful when measuring multiple behaviours or subjects
- Good for responses without clear beginnings or ends
- If long time intervals are employed this frees the observer to perform other tasks between checks

Disadvantages

- Provides information on only the percentage of time that the behaviour was observed to occur
- May miss low rate / short duration responses
- Does not allow measurement of "stream" of behaviour – unless samples taken frequently, the continuity of behaviour may be lost
- It may be difficult to code behaviour that is viewed only momentarily
Video Recording

Advantages

- Increased objectivity
- Can replay as often as you want, so helpful when scoring in ambiguous, e.g. when so much is going on at one time that it is difficult to record it all
- Can use slow motion analysis for behaviours that occur very quickly
- Can be used when other observers may not be present so that they can be shown later

Disadvantages

- You need to get consent from client / organisation
- Can take a long time to analyse
- Person being videoed may become distracted by the video equipment

Reactivity

The fact that someone knows that their behaviour is being observed can affect their behaviour – **observer effector reactivity**

Two Types

- Changes in the behaviour of the person being observed when they are observed

- Changes in the participant observer’s behaviour when they are conducting the observation (observer bias)

Potential Sources of Reactivity

- Conspicuousness of the observer and / or recording equipment
- Interaction of physical characteristics of the observer and person observed, e.g. age, gender
- Personal attributes of the observer which may determine changes in the behaviour of the person being observed
- What the observer is hoping to find!
- Observer drift (possibly due to the complexity, rate, context of behaviour being observed)
How To Overcome Reactivity

- Use observation procedures where the observers and their equipment are invisible
- Tell the people that you are planning to observe that you are going to observe them, but not exactly when
- Try and attract as little attention as possible by your dress and behaviour
- Get the people you are observing to habituate to your presence
- Try to avoid observer interaction and eye contact during sessions
- Stand somewhere where you will not be in the way of ongoing activities

Reliability and Validity

- Behavioural data are **reliable** to the degree that measurements from independent observers are consistent or in agreement
- Behavioural data are **valid** to the extent that they represent the behaviour in which we are interested

Ways of Measuring Observer Accuracy

- Comparing his / her direct observational record with a ‘criterion’ record for the same observation session:
  - Automatic event recorders
  - Filming observation periods
- Comparing his / her direct observational record with that of a second observer

Increasing the Reliability of Observation

- Clear definitions and categories of behaviours
- Observer training
- Avoidance of observer drift
- Avoidance of biasing expectations

Increasing the Validity of Observation

- Beware of observer effects
- Need to demonstrate the validity of data collected in artificial settings
- Assume situation specificity
Data reliability: Inter Observer Agreement

Reasons for measuring inter-observer agreement:

1. Ensures behaviours in question have been accurately defined – good inter-observer agreement indicates that the behaviour is defined in an objective manner
2. Ensures the definitions are being employed in an unbiased and conscientious manner
3. Helps to convince others that the experimental results are to be believed
4. Provides information on whether the absolute level of behaviour reported is believable

N.B.

For MTS and interval recording it is also necessary to report the percentage of agreement on the non-occurrence of the behaviour

When using event or frequency recording it is only necessary to report the agreement on the occurrence of the behaviour

Measuring Inter-Observer Agreement: Percent Agreement

For interval recording and MTS the total reliability level is given by:

\[ R\% = \frac{\text{number of intervals observers agreed on}}{\text{Total number of intervals}} \times 100 \]

Full agreement would produce a figure of 100% and complete disagreement, a figure of 0%

Likelihood of chance agreement is highest when the behaviour is extremely rare (many possible chance agreements on non-occurrence) or extremely common (many possible chance agreements on occurrence)
**Low Frequency Behaviours: Occurrence Reliability**

A measure of whether observers agreed that a behaviour occurred

\[
R_{\text{Occ}} = \frac{\text{number of intervals observers agreed behaviour occurred}}{\text{number of intervals either observer scored behaviour occurred}} \times 100
\]

**High Frequency Behaviours: Non-Occurrence Reliability**

A measure of whether observers agreed that a behaviour did not occur

\[
R_{\text{Non-Occ}} = \frac{\text{Number of intervals observers agreed behaviour absent}}{\text{Number of intervals either observer scored behaviour absent}} \times 100
\]

**Threats to Reliability**

- Observer bias
- Tiredness
- Lapses of concentration – pay attention to the wrong things
- Boredom
- Change definitional criteria part way through
Emergency Outreach Guidelines

Name:  
DOB:  
NHS No:  

Emergency guidelines are written in response to a crisis referral to reduce anxieties and risks posed as soon as possible. They are preliminary guidelines and are written from basic information obtained from initial visits.

Refer to any previous care plans / guidelines

Identified Behaviours:

1)  
2)  
3)  
4)  
5)  
6)  
7)  

Pro-active strategies:

Pro-active strategies plan how to avoid identified triggers:

Identified triggers:

•  
•  
•  
•  

All staff to be aware of triggers and behaviours

Outreach named nurse to give ideas on how to avoid triggers.
All staff to be aware of guidelines and follow consistently – service to identify team leader or person responsible for cascading guidelines through to staff team

**Communication:**

Use clear simple language when communicating

Consider amount of information being given. If this is too much it will increase anxieties.

Allow time for information to be processed

Ensure communication systems are used to increase understanding and reduce anxieties: objects of reference, signing, pictures, photos.

**Choices and Requests:**

Limit choices or do not offer choice, if this increases anxiety

Identify likes & dislikes of client

<table>
<thead>
<tr>
<th>Known likes:</th>
<th>Dislikes:</th>
</tr>
</thead>
</table>

**Routine and Predictability:**

Structure time with activities and interests.

Document any routines the client can be directed to, that help reduce anxieties. This will also promote consistency from staff.

Staff to follow routines and have a planned approach to any changes to routine.

**Environmental Pollutants (factors in the environment that may act as triggers):**

Ensure the environment is suitable for the person i.e. consider if it too noisy, quiet, busy, hot, cold, over stimulating or not stimulating enough.

Consider health and general wellbeing of person and meet needs accordingly i.e. pain relief, medical advice.
Active Strategies:

Active strategies identify early warning signs and help to reduce anxieties.

Early warning signs / Initial signs of anxiety: complete on initial visit

1) 
2) 
3) 

Ensure identified triggers are minimised / removed

Remove client to quieter environment if possible

Remove others away from environment if possible

Communication:

Use calm clear voice when communicating

One person to lead communication (one person to speak at any one time).

Use any communication systems in place

Consider reducing the levels of communication i.e. increased use of symbols, pictures and objects. Reduce verbal communication

The more anxious a person is the less they are able to communicate and understand communication.

Offer reassurance if needed

Choices and Requests:

Reassess how choices or requests are made / presented.

Reduce demands

Structure and routine:

Attempt to divert with activities – see list of likes

Re-direct to familiar and preferred routines
Environmental Pollutants:

Give space and reduce noise if requested

Consider use of PRN medication if prescribed

Reactive Strategies:

Reactive strategies are used when proactive and/or active strategies have not been used or are not effective in maintaining safety and reducing risk:

Observe and monitor situation

Keep communications to a minimal

If anxieties remain, repeat active strategies

Any physical / restrictive interventions need to follow the identified services accredited positive behavioural support model: Scip, CPI, etc.

Document all behaviours, triggers, signs of anxiety and effective and non-effective strategies to develop guidelines further

Inform senior staff, medics, community nurse – as appropriate

Ensure debrief of individual with learning disability and carers/staff has occurred.

( LINK debrief tool)
There is a need for an agreed Outreach approach in response to the receipt of an URGENT request for assessment / intervention.

1) On receipt of an URGENT request via telephone call, the Qualified staff taking the referral will determine the nature of the referral.
   
   If it is to assess an individual in the community who poses an immediate risk to themselves or others by virtue of presenting behaviours. (Normal pathway):

2) If the person is not currently active; refer to the Outreach ‘Urgent referral Protocol’, to aid the determination of level of need for involvement. If a proposed admission to the Agnes unit is required, Outreach to contact Psychiatry to request an URGENT joint visit for the individual referred.
   
   i) An initial functional assessment interview needs to be completed at time of the visit.
   
   ii) If it likely that with additional direct support an admission can be averted, from initial assessment draw up emergency guidelines.
   
   iii) If additional support is required, arrange for a second staff (if available) to visit to further the assessment and support guidelines.
   
   iv) The qualified staff undertaking leading the visit will be the named nurse until discussed and re-allocated at team meeting.
   
   v) Arrange for additional support visits, dependent on priority of case and resources available.
   
   vi) If it is agreed that an admission to the Agnes unit is required, outreach staff to support as part of MDT involvement.
<p>| | | |</p>
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3) If the case is active; staff to check that guidelines are in place to advise on what needs to be said to the individual or carers. If a visit is required need to assess level of risk posed by the individual and the environment they live in. If there are any concerns, 2 staff to visit. Ensure any issues of concern are documented and passed onto appropriate professionals.

Patients have the right to see their health records, subject to certain exemptions, and to have them kept in confidence (Access to Health Records Act 1990). Each entry must be legible, concise, relevant, objective, signed and dated. Further supplies of this form available from General Admin. Office, Leics. Frith Hosp.
Outreach Crisis Pathway

Receipt of 'urgent' referral from services

Assessment of level of Crisis using urgent referral protocol

Arrange joint visit with Psychiatrist, undertake initial assessment (FA)

Discuss use of emergency guidelines

Case Allocated in emergency due to risk to self/others.

Arrange additional support as required

Case managed in the community as per outreach care pathway.

If risks & need for treatment (active mental health) indicate the need for admission.

Outreach gives clinical support re admission to treatment unit or mental health inpatient unit

Outreach supports discharge into the community

Return to Pathway
SECTION 8: NON-URGENT REFERRAL

Assessment templates

- ABC charts including frequency and intensity.
- Aberrant behaviour checklist
- Challenging behaviour attribution scale
- Direct observations
- Guernsey leisure activity scale
- Modified overt aggression scale
- Motivational assessment scale
- Positive goals
- Quality of life measure
- Patients related outcome measures (PROMS)
- Friends and family feedback

Instruction for ABC Analysis

<table>
<thead>
<tr>
<th>Time:</th>
<th>Record the time the incident was initiated.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting and Activity:</td>
<td>Describe the setting where the behaviour occurred and the ongoing activity just prior to the incident</td>
</tr>
<tr>
<td>Start:</td>
<td>If the behaviour lasts for more than a minute, record the time that the problem started</td>
</tr>
<tr>
<td>Stop</td>
<td>If you recorded the time the behaviour started, record the time that it ceased (stopped) occurring.</td>
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<tr>
<td>Other Antecedents:</td>
<td>Describe any events happening just prior to the problem or at the same time of the problem that may have contributed to its occurrence. Some of these might include the following:</td>
</tr>
<tr>
<td>a)</td>
<td>The presence of a particular person</td>
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<td>b)</td>
<td>Something another person might have done</td>
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<tr>
<td>c)</td>
<td>A demand, request, order, question etc.</td>
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<tr>
<td>d)</td>
<td>Another client’s behaviour</td>
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<tr>
<td>e)</td>
<td>Task</td>
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<td>f)</td>
<td>Pain illness, accident</td>
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<td>g)</td>
<td>Time of day</td>
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You might include speculations about what you think set the behaviour off.
**Description of behaviour:**

Describe exactly what the client did. Describe it in such a way that it paints a picture of the action. For example:

a) The client hit ______ with her fist in the face.

b) The client hit the window with his head and broke the window.

c) The client screamed loud enough to be heard 50 feet away, threw herself on the ground, kicked her feet, pounded with her fist on the floor.

**Consequences:**

Describe what staff and clients did after the behaviour occurred. Describe also what the client achieved from the behaviour. For example:

a) Jimmy gave him back his toy.

b) Staff gave him what he wanted.

c) Staff withdrew their request.
# ABC Analysis

**Client’s Name:** ______________________________________

**Date:** ___________________________

**Interventionist:** ______________________________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Description of Setting, Location and Activity</th>
<th>Start Time</th>
<th>Stop Time</th>
<th>Other Antecedent Events</th>
<th>Brief Description of Behaviour</th>
<th>Consequences or reactions and Comments</th>
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Institute for Applied Behaviour Analysis
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Return to Pathway
FUNCTIONAL ANALYSIS INTERVIEW FORM

Person with challenging Behaviour(s):

DoB: Sex: M / F Date of Interview

Interviewer: Respondent(s)

NHS No:

A. DESCRIBE THE BEHAVIOUR(S)

1. What are the behaviours of concern? For each, define the topography (how it is performed), frequency (how often it occurs per day, week, or month), duration (how long it lasts when it occurs), and intensity (what is the *magnitude* of the behaviours [low, medium, high?] Does it cause harm?)

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Topography</th>
<th>Frequency</th>
<th>Duration</th>
<th>Intensity</th>
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2. Which of the behaviours described above occur together? (e.g. occur at the same time, occur in a predictable ‘chain’, occur in response to the same situation)

Always more than one:

- Scream/rip
- Scream/pinch/scratch
- Pinch/rip
B. DEFINE POTENTIAL ECOLOGICAL EVENTS THAT MAY AFFECT THE BEHAVIOUR(S)

1. What medications is the person taking (if any), and how do you believe these may affect his/her behaviour?

2. What medical complications (if any) does the person experience that may affect his/her behaviour (e.g. asthma, allergies, rashes, sinus infections, seizures)?

3. Describe the sleep cycles of the individual and the extent to which these cycles may affect his/her behaviour(s).

4. Describe the eating routines and diet of the person and the extent to which these routines may affect his/her behaviour(s).

5. Briefly list below the person’s typical daily schedule of activities.

<table>
<thead>
<tr>
<th>Time</th>
<th>Activities</th>
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<tr>
<td>6:00</td>
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</table>
6. Describe the extent to which you believe activities that occur during the day are predictable for the person. To what extent does the person know the activities that will be happening, when they will occur and the consequences (e.g. when to get up, eat dinner, shower, go to school/work etc.)?

7. About how often does the person get to make choices about activities, reinforcers, etc.? In what areas does the person get to make choices (e.g. food, clothing, social companions, leisure activities)?

8. Describe the variety of activities performed on a typical day (exercise, community activities, etc.)

9. How many other people are in the setting (work/school/home)? Do you believe the density of people or interactions with other individuals affect the targeted behaviour(s)?

10. What is the staffing pattern? To what extent do you believe the number of staff, training of staff, quality of social contact with staff etc., affect the targeted behaviour(s)?
11. Are the tasks/activities presented during the day boring or unpleasant for the person, or do they lead to results that are preferred or valued?

12. What outcomes are monitored regularly by staff (frequency of behaviour(s), skills, learned, activity patterns)?

C. DEFINE EVENTS AND SITUATIONS THAT PREDICT OCCURRENCES OF THE BEHAVIOUR(S)

1. Time of Day: When are the behaviours most likely? Least Likely?
   
   Most Likely
   
   Least Likely

2. Time of Setting: Where are the behaviours most likely? Least Likely?
   
   Most Likely
   
   Least Likely

3. Social Control: With whom are the behaviours most likely? Least Likely?
   
   Most Likely
   
   Least Likely
4. Activity: What activity is most likely to produce the behaviour? Least Likely?

Most Likely

Least Likely

5. Are there particular situations, events etc. that are not listed above that ‘set off’ the behaviours that cause concern (particular demands, interruptions, transitions, delays, being ignored etc.)?

6. What would be the one thing you could do that would be most likely to make the undesirable behaviours occur?

D. IDENTIFY THE ‘FUNCTION’ OF THE UNDESIRABLE BEHAVIOUR(S), WHAT CONSEQUENCES MAINTAIN THE BEHAVIOUR(S)?

1. Think of each of the behaviours listed in Section A and define the function(s) you believe the behaviour serves for the person (i.e. what does he/she and/or avoid by doing the behaviour?)

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>What Does He/She Get</th>
<th>What Does He/She Avoid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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</tbody>
</table>
2. Describe the person’s most typical response to the following situations.

(a) Are the above behaviour(s) (more likely), less likely, or unaffected if you present him/her with a difficult task?

(b) Are the above behaviour(s) (more likely), less likely, or unaffected if you interrupt a desired event (eating an ice cream, watching TV)?

(c) Are the above behaviour(s) more likely, less likely, or (unaffected) if you deliver a 'stern' request/command/reprimand?

(d) Are the above behaviour(s) (more likely), less likely, or unaffected if you are present but do not interact with (ignore) the person for 15 minutes?

(e) Are the above behaviour(s) more likely, less likely, or (unaffected) by changes in routine?

(f) Are the above behaviour(s) (more likely), less likely, or unaffected if something the person wants is present but he/she can’t get it (i.e. a desired object that is visible but out of reach)?

(g) Are the behaviour(s) (more likely), less likely, or unaffected if he/she is alone (no one else is present)?
E. DEFINE THE EFFICIENCY OF THE UNDESIRABLE BEHAVIOUR(S)

1. What amount of physical effort is involved in the behaviours (e.g. prolonged intense tantrums vs. simple verbal outbursts etc.)?

2. Does engaging in the behaviours result in a “payoff” (getting attention, avoiding work) every time? Almost every time? Once in a while?

3. How much of a delay is there between the time the person engages in the behaviour and gets the “payoff”? Is it immediate, a few seconds, longer?

F. DEFINE THE PRIMARY METHOD(S) USED BY THE PERSON TO COMMUNICATE

1. What are the general expressive communication strategies used by or available to the person? (E.g. vocal speech, signs/gestures, communication books/boards, electronic devices, etc.) How consistently are the strategies used?
2. Indicate which behaviours the person exhibits to achieve the following functions:

<table>
<thead>
<tr>
<th>Communication Function</th>
<th>Complex Speech (sentences)</th>
<th>Multiple Words (not sentences)</th>
<th>One word utterance</th>
<th>Other Utterances (whine, shout)</th>
<th>Complex Signing</th>
<th>Single Signs</th>
<th>Shakes Head</th>
<th>Pointing</th>
<th>Leading (pulls hand)</th>
<th>Grab/Reach</th>
<th>Gives Objects</th>
<th>Increased Movement (Hyperactivity)</th>
<th>Move away/leave situation</th>
<th>Fixed Gaze</th>
<th>Facial Expression</th>
<th>Aggression</th>
<th>Self – Injury</th>
<th>Other – property destruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request attention</td>
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<td>Request help</td>
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<td>Request preferred food/objects/activities</td>
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<td>Request a break</td>
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<td>Show you something or someplace</td>
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<tr>
<td>Indicate physical pain (headache, cut, sickness)</td>
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<td>Indicate confusion</td>
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<td>Protest or reject situation that you have created</td>
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</table>
3. With regard to receptive communication ability:

   a) Does the person follow verbal requests or instructions? If so, approximately how many? (List if only a few)

   b) Is the person able to imitate physical models for various tasks or activities? (List if only a few)

   c) Does the person respond to signed or gestural requests or instructions? If so, approximately how many? (List if only a few)

   d) How does the person indicate yes or no (if asked whether he/she wants to do something, go somewhere, etc.)?
G. WHAT EVENTS, ACTIONS, AND OBJECTS ARE PERCEIVED AS POSITIVE BY THE PERSON?

1. In general, what are things (events/activities/objects/people) that appear to be reinforcing or enjoyable for the person?

H. WHAT “FUNCTIONAL ALTERNATIVE” BEHAVIOURS ARE KNOWN BY THE PERSON?

1. What socially appropriate behaviours/skills does the person perform that may be ways of achieving the same function(s) as the behaviours of concern?

2. What things can you do to improve the likelihood that a teaching session will occur smoothly?

3. What things can you do that would interfere with or disrupt a teaching session?
I. PROVIDE A HISTORY OF THE UNDESIRABLE BEHAVIOURS AND THE PROGRAMS THAT HAVE BEEN ATTEMPTED

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>How long has this been a problem?</th>
<th>Programs</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td>10</td>
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</tbody>
</table>
Remember to ask/check or signpost whether:

1) Health Action Plan
2) Person Centred Plan
3) Communication Passport

Has been completed, is ongoing or not completed for this person.
# The Mini – ‘OK’ Health Check

**NAME…………………………………………………………………**

**DATE………………………………………**

Does the person require support/intervention for any of the following needs?

<table>
<thead>
<tr>
<th><strong>YES/NO</strong></th>
<th><strong>Is there a care plan for this?</strong></th>
<th><strong>Are there any other written instructions?</strong></th>
<th><strong>Are there any record charts in use for this?</strong></th>
<th><strong>Is a professional worker involved?</strong></th>
<th><strong>Date it was last reviewed?</strong></th>
<th><strong>Does it need further input?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes = 1</td>
<td>No = 1</td>
<td>No = 1</td>
<td>No = 1</td>
<td>No = 1</td>
<td>Long ago or never = 1</td>
<td>Yes = 1</td>
</tr>
</tbody>
</table>

1. Weight related issues
2. Bowel activity
3. Dietary needs
4. Sleep problems
5. Pain control * (DIS-DAT?)
6. Pressure area care *
7. Mobility difficulties
8. Foot care/ conditions
9. Bladder activity
10. Breathing problems *
11. Blood Pressure *
12. Circulation problems *
13. Epilepsy *
14. Skin conditions
15. Physical disability
16. Physiotherapy exercises
17. Posture and balance
18. Oral hygiene
19. Ears and hearing
20. Mental health issues *

**TOTAL**

**Return to Pathway**
SCORE

0 .............. 20 .............. 35 .............. 50 .............. 70 .............. 90 .............. 110 .............. 120 .............. 140

Any other concerns: (e.g. sight/vision)

Nurse completing assessment: ..............................................
Guidance: on completing the Mini OK health check

To complete when completing the functional analysis interview form.

This is the initial physical health assessment undertaken by a qualified nurse when 1st assessing level of challenge/ suitability for outreach (in line with operational policy guidelines).

1. The assessment needs to be completed with a carer that knows the patient well and has access to the required information:
   - That there are care-plans, charts or records of health issues that the patient requires support or intervention in, or not.
   - Also when health concerns have been reviewed, e.g. dental appts.

2. Ideally there would be a cut off score, above which an action is required; referral to CLDN, need to make GP appointments etc. What is important is to consider health issues that have not been assessed, recorded or reviewed.
   - The person needs support, but there is no care plan.
   - There are no record charts.
   - The absence of a professional worker and/or
   - An extended time between review.

3. Health issues that need to be actioned, will require either your initial advice for carers to act on (e.g. to book appointments), and/or your signposting the carer to the GP or appropriate specialist. If there are more than one/two easily resolved issues or you feel that a fuller OK health check is indicated, the ‘active professional' will need to refer onto a CLDN.

4. Any ongoing or unresolved physical health may indicate a potential impact on behaviour. These need to be given your clinical consideration in relation to the way the patient presents: nature of physical health and level of challenges.
Motivation Assessment Scale:

**Name:** ____________________________________________  **Rater date:** _________________________________________

**Behaviour description**

________________________________________________________________________

________________________________________________________________________

**Setting description**

________________________________________________________________________

________________________________________________________________________

**Instructions:** The Motivation Assessment Scale is a questionnaire designed to identify those situations in which an individual is likely to behave in certain ways. From this information, more informed decisions can be made concerning the selection of appropriate prevention, distraction and management strategies. To complete the questionnaire, select one behaviour that is of particular interest. It is important that you identify the behaviour very specifically. ‘Aggressive’, for example, is not as good a description as ‘hits his sister’. Once you have specified the behaviour to be rated, read each question carefully and circle the one number that best describes your observations of this behaviour.

<table>
<thead>
<tr>
<th>0 = Never</th>
<th>1 = Almost Never</th>
<th>2 = Seldom</th>
<th>3 = Half the Time</th>
<th>4 = Usually</th>
<th>5 = Almost Always</th>
<th>6 = Always</th>
</tr>
</thead>
</table>

Return to Pathway
<table>
<thead>
<tr>
<th>Questions</th>
<th>Never</th>
<th>Almost Never</th>
<th>Seldom</th>
<th>Half the time</th>
<th>Usually</th>
<th>Almost Always</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Would the behaviour occur continuously, over and over, if this person was left alone for long periods of time? For example, several hours.</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>2) Does the behaviour occur following a request to perform a difficult task?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>3) Does the behaviour seem to occur in response to your talking to other people in the room?</td>
<td>0</td>
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<td>2</td>
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<td>4</td>
<td>5</td>
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<tr>
<td>4) Does the behaviour ever occur to get a toy, food or activity that he or she has been told they cannot have?</td>
<td>0</td>
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<tr>
<td>5) Would the behaviour occur repeatedly, in the same way for very long periods of time if no one was around? For example, rocking back and forth for over an hour.</td>
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<tr>
<td>6) Does the behaviour occur when any request is made of this person?</td>
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<tr>
<td>7) Does the behaviour occur whenever you stop attending to this person?</td>
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<tr>
<td>8) Does the behaviour occur when you take away a favourite toy, food or activity?</td>
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<tr>
<td>9) Does it appear to you that this person enjoys performing the behaviour? (It feels, tastes, looks, smells and/or sounds pleasing?)</td>
<td>0</td>
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<td>6</td>
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</tbody>
</table>

Questions

Never | Almost Never | Seldom | Half the time | Usually | Almost always | Always
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<th></th>
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<tbody>
<tr>
<td>10) Does this person seem to do the behaviour to upset or annoy you when you are trying to get him or her to do what you ask?</td>
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<td>11) Does this person seem to do the behaviour to upset or annoy you when you are not paying attention to him or her? For example if you are sitting in a separate room, interacting with another person.</td>
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<td>12) Does the behaviour stop shortly after you give the person the toy, food or activity he or she has requested?</td>
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<td>13) When the behaviour is occurring, does the person seem calm and unaware of anything else going on around him or her?</td>
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<td>14) Does the behaviour stop occurring shortly after (one to five minutes) you stop working or making demands of this person?</td>
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<td>15) Does this person seem to do the behaviour to get you to spend some time with him or her?</td>
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<td>16) Does the behaviour seem to occur when this person has been told that he or she can’t do something he or she had wanted to do?</td>
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<tr>
<td>Results</td>
<td>Sensory</td>
<td>Escape</td>
<td>Attention</td>
<td>Tangible</td>
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**Total Score**

**Mean score**

**Relative ranking**

The questionnaire is designed so that you look at what response you gave to each question and you insert the number for that question next to it. You then complete this process for all 16 questions and add up the total score in each of the four columns. The column with the highest number is the likeliest function of the behaviour. This is, however, not a definitive answer and other forms of data collection, such as ABC charts, should be used to gain a wider picture.
Steps to Success
We are teaching............ (the persons name) to do............. (task)

<table>
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<tr>
<th></th>
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<th>Fill in this record by outlining each step with coloured pens each time you teach the skill. Put the date and your initials in the top cloud</th>
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<tbody>
<tr>
<td>1</td>
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<td>1st Session</td>
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Return to Pathway
Green = can do       Blue = difficult       Red = risky
We will move on to a new skill when he or she has ………………………………………………

### Keeping Track

Name ……………………. Wk/ending ……………..  ✓ = participation in activity  ✓ = offered opportunity but refused

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<td>Cooked lunch</td>
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<tr>
<td>Prepared snack</td>
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<tr>
<td>Cooked evening meal</td>
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<td><strong>WASHING UP</strong></td>
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<td>Used dishwasher</td>
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<td>Dried up</td>
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<td>Put dishes away</td>
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<td>Did big shop in supermarket</td>
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<tr>
<td>Bought fruit, veg, meat etc. from specialist shops</td>
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<tr>
<td>Put shopping away</td>
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<td>Bought personal goods</td>
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</tr>
<tr>
<td><strong>GARDENING &amp; MAINTENANCE</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Worked in the garden</td>
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<tr>
<td>Cleaned the car</td>
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<tr>
<td>Did decorating or other DIY</td>
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<tr>
<td>Did electrical repairs</td>
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<td>Cleaned windows</td>
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<td>Made bed</td>
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<tr>
<td>Cleaned living room</td>
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<td></td>
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<tr>
<td>Cleaned bedroom</td>
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# Keeping Track

## CLOTHES

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<th>W</th>
<th>T</th>
<th>F</th>
<th>S</th>
<th>S</th>
<th>Total</th>
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<td>Hung things in garden</td>
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<td>Used tumble drier</td>
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<td>Folded clothes</td>
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<td>Ironed clothes</td>
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## TRIPS OUT

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<th>F</th>
<th>S</th>
<th>S</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Went for a walk</td>
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<tr>
<td>Used public transport</td>
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<td></td>
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<tr>
<td>Car journey or taxi</td>
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<tr>
<td>Meal/drink at pub or cafe</td>
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<td>Cinema or show</td>
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<td>To other:</td>
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## WORK/DAYTIME ACTIVITY

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<th>T</th>
<th>F</th>
<th>S</th>
<th>S</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Went to work</td>
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<tr>
<td>Attended training centre</td>
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</tr>
<tr>
<td>Sport &amp; recreation</td>
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<td></td>
<td></td>
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<td></td>
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<tr>
<td>Other day care</td>
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## VISITS

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<th>F</th>
<th>S</th>
<th>S</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had visits from</td>
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<td></td>
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<tr>
<td>Visited</td>
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<tr>
<td>Had professional consultation with:</td>
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<tr>
<td>Outreach</td>
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<td></td>
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<tr>
<td>Community nurse</td>
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Return to Pathway
THE GUERNSEY COMMUNITY PARTICIPATION
AND LEISURE ASSESSMENT

CLIENT: ……………………………………………………………………………………

AGE: ……………………………..    SEX: ……………………………

Overleaf is a list of potential activities or contacts clients may have access to.

In the column labelled **FREQUENCY** please indicate how often they do this;

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Never</td>
</tr>
<tr>
<td>1</td>
<td>Very occasionally</td>
</tr>
<tr>
<td>2</td>
<td>3 monthly</td>
</tr>
<tr>
<td>3</td>
<td>Monthly</td>
</tr>
<tr>
<td>4</td>
<td>Weekly</td>
</tr>
<tr>
<td>5</td>
<td>Daily</td>
</tr>
</tbody>
</table>

Please indicate in the column labelled **SUPPORT** whether they usually are;

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>DEFINITION</th>
<th>NOTES</th>
</tr>
</thead>
</table>
| 1      | Supervised                  | Supervised = Either:
|       |                             | a) Onus of choice and control lies with carer **OR**                  |
|       |                             | b) A major part of carers attention is concerned with vigilance of the individual, **OR** |
|       |                             | c) A & b                                                               |
| 2      | With carers, but not supervised | Carer = relative or paid member of staff                              |
| 3      | Unaccompanied               | -                                                                     |
| 4      | With a peer group           | Peer Group = includes all those who do not fulfil criteria of carer   |
For those activities that are seasonal e.g. beach, try to reflect how often the person would do this at the appropriate time of year.

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>FREQUENCY</th>
<th>SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A) Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor (GP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentist</td>
<td></td>
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</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B) Public Transport</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Train</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taxi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aeroplane</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Please specify)</td>
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<td></td>
</tr>
<tr>
<td><strong>C) Indoor Leisure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Craft</td>
<td></td>
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</tr>
<tr>
<td>Games</td>
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<tr>
<td>T.V</td>
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</tr>
<tr>
<td>Videos</td>
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<tr>
<td>Music (Listen)</td>
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<tr>
<td>Music (Play)</td>
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<td>Pets</td>
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<tr>
<td>Other (Please specify)</td>
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<tr>
<td><strong>D) Leisure, Sport &amp; Recreation</strong></td>
<td></td>
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</tr>
<tr>
<td>Fair/Fete/Festival</td>
<td></td>
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<tr>
<td>Museum/Art Gallery</td>
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<tr>
<td>Sport (Participation)</td>
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<tr>
<td>Sport (Spectator)</td>
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<tr>
<td>Exercise/Aerobic Class</td>
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<tr>
<td>Cycling</td>
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<tr>
<td>ACTIVITY</td>
<td>FREQUENCY</td>
<td>SUPPORT</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td>Cinema</td>
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<tr>
<td>Theatre</td>
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<tr>
<td>Concert</td>
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<td>Park</td>
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<td>Holiday</td>
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<td>Sailing</td>
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<td>DIY</td>
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<tr>
<td>Gardening</td>
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<td>Other (Please specify)</td>
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**E) Social**

<table>
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</thead>
<tbody>
<tr>
<td>Disco</td>
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<tr>
<td>Pub</td>
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<tr>
<td>Party</td>
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</tr>
<tr>
<td>Restaurant/Café</td>
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<tr>
<td>Friend's house</td>
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<tr>
<td>Neighbour’s Home</td>
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<tr>
<td>Social Club (Integrated)</td>
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<td>Social Club (Segregated)</td>
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<tr>
<td>Other (Please specify)</td>
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</table>

**F) Facilities/Amenities**

<table>
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<td>Local Shop</td>
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<tr>
<td>High Street Store</td>
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<td>Post office</td>
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<tr>
<td>Hairdresser</td>
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<td>Supermarket</td>
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</table>

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>FREQUENCY</th>
<th>SUPPORT</th>
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</thead>
<tbody>
<tr>
<td>Chemist</td>
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<tr>
<td>Bank/Building Society</td>
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<td>Place of Worship</td>
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<tr>
<td>Other (Please specify)</td>
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</tbody>
</table>
SCORING

1. **Range**

Add up the number of regular activities (a score of 2 or more in the frequency column)  

2. **Independence**

**Supervision score**; add the number of activities scoring 1 in the support column.  

**Accompanied score**; add the number of 2’s in the support column.  

**Solitary activity score**; add the number of 3’s in the support column.  

**Peer activity score**; add the number of 4’s in the support column.  

3. **Amount**

Add up the number of very frequent activities (a score of 4 or more in the frequency column).  

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GCPLA
SCORE SUMMARY SHEET

<table>
<thead>
<tr>
<th>Category</th>
<th>Range</th>
<th>Supervision</th>
<th>Accompanied</th>
<th>Solitary</th>
<th>Peer</th>
<th>Busy</th>
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<tr>
<td>A Services</td>
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<td>B Public Transport</td>
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<tr>
<td>C Indoor Leisure</td>
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<tr>
<td>D Social</td>
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<td></td>
</tr>
<tr>
<td>E Leisure, Sport and Recreation</td>
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<tr>
<td>F Facilities/Amenities</td>
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<td><strong>Total</strong></td>
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<tr>
<td><strong>Community</strong></td>
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<td><strong>Total minus C Scores</strong></td>
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<tr>
<td><strong>Leisure (C+E)</strong></td>
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</tr>
</tbody>
</table>

Range = Number of regular activities (a score of 2 or more in frequency column)
Supervision = Number of activities scoring 1 in the support column
Accompanied = Number of activities scoring 2 in the support column
Solitary = Number of activities scoring 3 in the support column
Peer = Number of activities scoring 4 in the support column
Busy = Number of very frequent activities (a score of 4 or more in the frequency column)
### OPERATIONAL DEFINITIONS OF ITEMS WHOSE MEANING IS NOT SELF EXPLANATORY

<table>
<thead>
<tr>
<th>Item</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>Either as a patient or visitor.</td>
</tr>
<tr>
<td>Police</td>
<td>Either going to a police station or talking to a policeman or policewoman.</td>
</tr>
<tr>
<td>Games</td>
<td>Include board games, jigsaw, puzzles, computer games, etc.</td>
</tr>
<tr>
<td>Pets</td>
<td>The subject will organise the majority of the care for a pet which they own.</td>
</tr>
<tr>
<td>Sport</td>
<td>Includes competitive sport only.</td>
</tr>
<tr>
<td>Concert</td>
<td>Any organised public musical performance.</td>
</tr>
<tr>
<td>Walking</td>
<td>Walking for its own sake as in ‘going for a walk’ does not include functional walking i.e. getting from A to B.</td>
</tr>
<tr>
<td>Disco</td>
<td>Includes any social event that involves dancing to music (not covered under other categories, e.g. party, concert).</td>
</tr>
<tr>
<td>Party</td>
<td>Any organised gathering of people for the purposes of celebration or social intercourse (with or without dancing).</td>
</tr>
<tr>
<td>Restaurant</td>
<td>Includes “fast food” establishments and “take-away”.</td>
</tr>
<tr>
<td>Friends Home</td>
<td>Visit to the home of a person who is not a relative or paid staff.</td>
</tr>
<tr>
<td>Neighbours Home</td>
<td>Visit to house immediately next door to their own.</td>
</tr>
<tr>
<td>Social Club (Integrated)</td>
<td>Includes attendance at a club which is not especially for disabled people or designed for disabled people to meet non-disabled people.</td>
</tr>
<tr>
<td>Social Club (Segregated)</td>
<td>A club designed for disabled people or for disabled people to meet non-disabled people e.g. PHAB</td>
</tr>
<tr>
<td>High Street Shop</td>
<td>Includes departmental stores and all other shops in a town centre or shopping complex.</td>
</tr>
</tbody>
</table>
Aid for intervention & implementation planning/Organisational Model for Treatment Planning (LaVigna et al 1989)

<table>
<thead>
<tr>
<th>Ecological Manipulations</th>
<th>Proactive Strategies</th>
<th>Direct Treatments</th>
<th>Reactive Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Positive programming</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Time line for intervention implementation schedule

<table>
<thead>
<tr>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May (1\textsuperscript{st} deadline)</th>
<th>June</th>
<th>July (2\textsuperscript{nd} deadline)</th>
</tr>
</thead>
</table>
### Functional Communication Training Data Sheet

<table>
<thead>
<tr>
<th>Training days (date)</th>
<th>Number of training trials attempted</th>
<th>Number of successful trials</th>
<th>Best response</th>
<th>Frequency of problem behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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</tr>
</tbody>
</table>

Figure 5-1. A typical data sheet used during functional communication training. The “best response” is recorded to facilitate the rapid progress of training steps.
Plan how you are going to provide more opportunities for constructive activity, including the alternative behaviours identified in this step.

<table>
<thead>
<tr>
<th><em>What to do</em></th>
<th><em>Where</em></th>
<th><em>Who (Staff) responsible</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>Place</td>
<td>Staff</td>
</tr>
<tr>
<td>0700</td>
<td></td>
<td>1500</td>
</tr>
<tr>
<td>0800</td>
<td></td>
<td>1600</td>
</tr>
<tr>
<td>0900</td>
<td></td>
<td>1700</td>
</tr>
<tr>
<td>1000</td>
<td></td>
<td>1800</td>
</tr>
<tr>
<td>1100</td>
<td></td>
<td>1900</td>
</tr>
<tr>
<td>1200</td>
<td></td>
<td>2000</td>
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<tr>
<td>1300</td>
<td></td>
<td>2100</td>
</tr>
<tr>
<td>1400</td>
<td></td>
<td>2200</td>
</tr>
<tr>
<td>1500</td>
<td></td>
<td>2300</td>
</tr>
</tbody>
</table>

Return to Pathway
<table>
<thead>
<tr>
<th>Mode</th>
<th>Verbal</th>
<th>Physical</th>
<th>Visual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Function</th>
<th>Demands</th>
<th>Neutral Social</th>
<th>Praise</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SECTION 9: GUIDANCE ON PROFESSIONAL ROLES IN THE CHALLENGING BEHAVIOUR PATHWAY

This section gives an idea of how different professionals in the team might offer at different steps of the stepped care approach in the challenging behaviour pathway.

Community Nursing

Occupational Therapy

Psychiatry

Psychology

Physiotherapy

Speech and Language Therapy

Community Nurses Role

Step 1
- Qualified Nurses – Basic challenging behaviour training
- Advice on monitoring behaviour
- Sign posting to other services
- Advise of relationship to mental health/genetic conditions
- Encourage visiting GP/Dentist for a full medical check to consider any underline causes
- Advise on completion of Communication passport
- Qualified nurse, who is competent in delivering training and has attended challenging behaviour awareness training or post registration course in challenging behaviour.
- One off training sessions to raise awareness in others or brief involvement to offer advice or sign post to other services.
- Medical staff/psychology may provide some of this advice and sign posting but not training. (Recognise other professions have limited resource for this role).

Step 2
- Sign posting to other services
- Primary care services to meet people with LD needs, support to GP to monitor behaviour especially if pain/illness thought to be trigger
- Individual training or support, for example training to recognise triggers, proactive management plans for medication to manage incidents of behaviour with no other involvement.
- Supporting behavioural management protocol development prior to training.
- Suggest HAP/Communication Passport/Emergency grab sheet
- Advice on behaviour related to epilepsy
- Qualified nurse, who is competent in delivering training and has attended challenging behaviour awareness and has post registration course in challenging behaviour.
- One off training sessions to raise awareness in others or brief involvement to offer advice or support monitoring with GP.
  Medical staff/psychology may provide some of this advice and sign posting but not training. (Recognise other professions have limited resource for this role).
- Qualified role
  o F/A interview
  o Initial assessment
  o PCP with individuals
  o Proactive Active Reactive guidelines – consistent approach
  o ABC charts
- Nursing Assistant role
  o Observation – feedback
- Training
  o Challenging Behaviour
  o ABC charts
  o Weekly meetings to facilitate
- Other professionals
  o Cross over with O/R Team
  o SALT role and Communication Passport
- Revisit work already completed previously

**Step 3**
- Qualified Nurse role
  o Complete more detailed behavioural assessment and A&E Grab sheet
  o Establish baseline monitoring of behaviour
  o Care co-ordinate case (may be eligible for CPA) and ensure referral to other MDT members
  o Check GP completed Health check and baseline medical tests
  o Support and advice to family/carers
  o Individual based training
  o Support to understand behaviour and any underline conditions and causes/treatment options/medication in liaison with Psychiatrist/Psychologist.
  o Dependent on presentation and type of behaviour look at any related issues, mental health or epilepsy or environment/placement.
  o Consider referral to other pathways, Autism/Mental Health.
- Develop protocols on triggers and proactive and reactive management of behaviour and protocol for interventions with medication/restraint in liaison with Psychiatrist/Neurologist/SCIP/MAPA team.
- Advise on risks and management.
- Establishing relapse indicators
- Referrals to other specialist services and social care

- **Nursing Assistant role**
  - Regular monitor medication compliance where needed.

- **Behaviour observation and monitoring and sleep hygiene – how to complete charts**

- **Skills and Knowledge – Challenging behaviour training**
  - Qualified nurse, who has attended further challenging behaviour training (Diploma).
  - Involvement could be for month’s dependant on success of establishing management of behaviour.
  - Medical/psychology staff may provide some of this. (Recognise other professions have limited resource for this role).

**Step 4**

- **Qualified Nurse role (as step 3 with additional points below)**
  - Complete more detailed behavioural assessment around particular type of behaviour
  - Establish more detailed monitoring of behaviour if not responding to treatment, including direct observations if necessary
  - Referral to Outreach team
  - Support and advice to family/carers research additional support groups (for example: genetic conditions related to behaviour)
  - Support and advise on risks to others
  - Nursing assistant (as step 3)

- Qualified nurse, who has attended further challenging behaviour training.
- Involvement could be for month’s dependant on success of establishing management of behaviour and may require relapse monitoring.
- Medical staff/psychology may provide some of this. (Recognise other professions have limited resource for this role)
Occupational Therapist Role

Step 1:
- General information / training regarding sensory integration / modulation.
- Quick baseline assessment.
- Environmental assessment, in terms of the physical/social demands in the environment.
- Interest checklist, observational assessments.
- Advice and guidance regards the assessments completed.

Step 2:
- Gather core information.
- Basic introduction to challenging behaviour to the staff team.
- Meaningful activities assessment, link with SALT re: communication.
- Environmental assessment, in terms of the physical/social demands in the environment providing an holistic view.
- Interest checklist.

Step 3:
- OT’s use a range of different assessment methods looking at functional and cognitive skills, for activities of daily living, activity levels, sensory needs and wellbeing, in order to understand challenging behaviours and make appropriate advice/recommendations.
- Depending on problem areas identified the following strategies may be useful for supporting individuals presenting challenging behaviours.
- Environmental recommendations.
- Activities of daily living recommendations.
- Advice and guidance on appropriately grading activities.
- Practical day to day coping strategies linked to psychological strategy such as relaxation techniques, anger management, anxiety management, coping strategies and positive thinking.
- Planning and structuring meaningful daily routines.
- Sensory processing, sensory diet, sensory modulation clinic.
- Provision of equipment.

Occupational Therapist Role in Mental Health/ Challenging Behaviour/Forensic

The primary goal of the Occupational Therapist (OT) is to enable people to participate in activities of everyday life. OT’s engage clients using activities that are meaningful and purposeful to them to assess and treat the physical psychological and social needs of the individual and their environment to enable them to reach or retain their optimum potential.

An individual’s behaviour can significantly affect the services/activities they access as well as the services/activities affecting the individual. Therefore OT’s use a range of different assessment methods looking at functional and cognitive skills, for activities of daily living, activity levels, sensory needs and wellbeing, in order to understand challenging behaviours and make appropriate advice/recommendations.
Depending on problem areas identified the following strategies may be useful for supporting individuals presenting challenging behaviours.

- Environmental assessment and recommendations.
- Activities of daily living assessment and recommendations.
- Grading activities.
- Relaxation techniques, anger management, anxiety management, coping strategies and positive thinking.
- Planning and structuring meaningful daily routines.
- Sensory processing.
- Work in conjunction with other MDT members and carers.
**Psychiatrist's Role**

- **Step 1**
  - Work in partnership with primary care to ensure understanding of potential physical causes of challenging behaviour, and management of exacerbation of behaviour. This is undertaken through one to one communication with the GPs, developing and delivering appropriate training as required etc.

- **Step 2**
  - Advice to all members of the MDT team about potential causes of behaviour including ruling out physical causes and consideration of mental illness. Involvement would be largely be liaison and advice with/to MDT rather than direct patient review.

- **Step 3**
  - Review of mental health, gathering information from records and review of patient including mental state examination and risk assessment. Discussion of case with the MDT Psychiatric formulation of behaviours and bio-psycho-social care plan (with MDT involvement). Consideration of medical treatment for mental health problem or challenging behaviour. Review of the effectiveness of treatment. Involvement would include regular reviews and discussion with MDT, including CPA meetings.

- **Step 4**
  - Regular review to consider aetiology of behaviour. Liaison with all members of the MDT and involvement in CPA meetings. Reviews to include full mental state examination and risk assessment. Psychiatric formulation of behaviours and biopsychosocial care plan (with MDT involvement). Management of escalating behaviour through referral to relevant agencies and/or consideration of use of medication after behavioural/psychological techniques. Initiate admission to inpatient unit or detention under MHA (1983) if appropriate. Liaison with Police and Social Services regarding safeguarding concerns. Involvement will be frequent in crisis and regular out-patients thereafter. Supervise the inpatient care where admission is required and act as the responsible clinician (RC) for the detained patients. Ensure an appropriate discharge package is in place and facilitate timely discharge of the patients to the community based least restrictive care appropriate to the needs of the individual.
Clinical Psychologist

Step 1

Enabling others to work with LD and challenging behaviours. – Clinical psychology – could offer this as part of MDT training re recognising functional communication of behaviours e.g. CB as showing pain. Offer as package to 3rd sector and primary care. Would anticipate that other members of the MDT would usually be able to deliver training. However for specialist external services for instance for complex service user groups such as mental health and CB or forensic and CB or Borderline personality disorder and CB, then a senior clinical psychologist might be involved in delivering the package. All bands of psychologist would be involved in development of basic package re theory/practise links. Band 8b/c/d for more complex.

Step 2

Consultation

If intervention not working psychology would look at systemic factors/emotional dynamics that stop intervention working. Band of psychologist would depend on situation and need for expertise in a particular issue.

Risk assessment support from CLDN

Step 3

1. Consultation and supervision (ongoing, infrequent) Qualified band
2. Advise re loss/adjustment issues. Theories of attachment (impact of institutional history) Informing formulation using psychological theory
3. Has anyone offered opportunity for her to talk about life history
4. Where is she as a person? Emotional world? Any band of CP could talk to service user but 8b/c needed to ask these questions of the clinical team and critically question

Step 4

HCR20 risk specialist assessments and management approach. Complex anger management. (for complex and risky cases). Band 8a and above, possible 8c/b for very risky and complex. No-one else does this for this type of person. Protocol based anger management can be offered through groups (as outlined at SLAM) with support from CP.

Systemic family work (8a and above as need additional systemic training)

Diagnostic assessment of ASD (but tend to refer on if mild LD) (all bands of qualified psychology; or Psychiatry might do this)
Not protocol driven (psychology practitioner 2). Psychology practitioner 3 needed. (Ot’s and CN’s offer psychological practitioner type 2 anger work but not appropriate in this scenario)

Developing emotional literacy work

Multi-theoretical formulation work to frame MDT working – clinical psychologist bands

**Clinical Psychology**

All qualified are qualified at post-gradulate Doctoral level

Supervision skills/trainig/consultation skills/change management and service issues. More experienced work at more organisational/team dynamics levels as well as additional training in particular therapies. E.g. CBT/psychological therapies e.g. CBT/psychodynamic/systemic, narrative, attachment theories, cognitive analytic, DBT.

Specialist assessments e.g. forensic and/or risk assessments (step 4); cognitive – WAIS to assess problem solving/strengths and weaknesses to inform team who are working at step three levels.
Physiotherapist’s Role

The Physiotherapy role in this pathway is in relation to mobility assessment and falls prevention/advice. This sits in the Complex Physical Health Care Pathway but we have highlighted the pertinent parts below.

Step 1/2:

Education and Support

- Signpost to GP, Orthotics, Specialist mobility centre for wheelchairs, refer to specialist LD services e.g. outreach, SALT

Assessment

- Triage or phone call to find out more information; speak to MDT member if open to other services.

Step 3/4:

Education and Support:

- Advise carers on safe practices when using equipment
- Liaise with generic Physiotherapy services where they need support /advise when treating clients on this pathway.

Assessment:

- Frat Falls assessment and care plan (part of core assessment)
- General Physiotherapy Assessment to identify Physiotherapy needs
- Mobility and falls assessment to include Tinetti, Berg balance, Elderly mobility scale
- Physical activity assessment.
- Postural Management assessment if indicated.

Intervention:

- Falls prevention work.
- Liaison with orthotics re footwear.
Speech and Language Therapist’s Role

Step 1/2:

Education and support: A range of education, supervision and mentoring activities to enable mainstream services to address the communication and dysphagia needs of people with learning disability and challenging behaviour. The aim is to enable them to make reasonable adjustments and meet the 5 Good Communication standards and safe eating and drinking guidelines.

Assessment: Provide a brief assessment of the specific communication environment in relation to the 5 Good Communication Standards.

Provide tools to support services to develop a basic communication passport for an individual.

Skilling staff to recognise communication and eating and drinking issues and make appropriate referrals.

Intervention: Onward referral and signposting

Provide findings of an individual’s communication or eating and drinking assessment to support mainstream services to address their communication or eating and drinking needs.

Provide mentoring and support for staff working in mainstream services to enable them to make reasonable adjustments in relation to communication and challenging behaviour.

Provide general advice, information and resources to support safe eating and drinking.

Provide information and guidelines on best practice. Share resources and tools to support good communication.

Joint working with staff from other services.

Support the development and use of communication passports to inform other staff of the best ways of communicating with individuals.

Step 3:

Education and support:

Specific training to support learning disability environments to meet the communication or eating and drinking needs related to challenging behaviour.

Individualised communication or eating and drinking training for staff supporting individuals referred to the service.
Assessment:

Formal and/or informal assessment of communication involving both the individual and their key communication partners. The aim is to identify areas of communication difficulty experienced by the individual and communication partners.

Assessment will consider behaviour as having a communicative function.

This will lead to the completion of a formulation providing a framework for describing any communication issues and the development of an action plan which will recommend proactive, active and reactive communication strategies, underpinned by clinical reasoning.

Intervention:

Direct work with an individual to enhance their communication skills.

Work with key communication partners to develop their communication skills.

Supporting improvements in the communication environment.

Interventions will be framed within the 5 Good Communication Standards and in terms of Proactive, Active and Reactive strategies.

Step 4:

Education and support:

Specific training to support learning disability environments to meet the communication or eating and drinking needs related to challenging behaviour.

Individualised communication or eating and drinking training for staff supporting individuals referred to the service.

Assessment:

Formal and/or informal assessment of communication involving both the individual and their key communication partners. The aim is to identify areas of communication difficulty experienced by the individual and communication partners.

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**Intervention:**

Direct work with an individual to enhance their communication skills.

Work with key communication partners to develop their communication skills.

Supporting improvements in the communication environment.

Interventions will be framed within the 5 Good Communication Standards and in terms of Proactive, Active and Reactive strategies.

NB At tier 4 there will be a need for greater multidisciplinary working, cases may be more urgent and complex, requiring more intensive input.
SECTION 10: FORMULATION AND CARE PLAN – WITHIN 12 WEEKS

A formulation has been defined as:

A detailed description of the presenting problem and its history taken from the various sources of information which have been collected as part of the assessment process. A series of alternative explanatory hypotheses deriving from a range of biological, psychological, and social perspectives are brought together. Evidence from the assessments is used to dismiss or support one or more of these hypotheses, and those remaining are then elaborated into an individualised model which takes account of aetiological and maintaining factors, precipitants, risk factors and strengths. The model is developed in collaboration with the client. This model is then used to plan and design an intervention.

Professor Mike Wang. 2005

A formulation is best regarded as a hypothesis, or set of interconnected hypotheses, about the nature of the presenting problem and its development. It usually contains informed ‘guesses’ about causal and functional relationships between variables/events, and the central problem. It has two main functions:

1. To guide a clinical intervention with clear reasons for the choice of approach.
2. To aid the establishment of criteria for evaluation of an intervention.

The Guidelines prepared by the British Psychological Society and The Royal College of Psychiatrists (2006), takes the view that a functional analysis and diagnosis are both integral features of the assessment of challenging behaviours and should be carried out by all clinicians, either individually or in collaboration. Formulation is not just a feature of a psychological intervention. Formulation is part psychotherapeutic practice. A diagnosis should be seen as an enhancement to the assessment process in helping to clarify aetiological factors, prognosis and the nature of interventions and possible outcomes.

There is no one ‘correct’ way to carry out a formulation and this may be presented in different formats including text and visual flow charts. The method and form will be influenced by the theoretical model being used and the purpose of the formulation.

The Challenging Behaviour Pathway is supporting a model of functional analysis, and is based with a learning theory model. A good example of a formulation, using this model, is outlined in a paper by: McGill Peter, Clare Isabel, and Murphy Glynis, (1996), Understanding and Responding to Challenging Behaviour: From Theory to Practice, Tizard Learning Disability Review, Volume 1. The example outlines the relevance of the person’s context, the environmental context and the influence of setting events and antecedents. The explanation outlined gives clear implications for an intervention.

Examples of this formulation are outlined below.
Example of a Formulation

**Personal, Historical Factors**
Long term and temporary
- e.g. limited skills, pain

**Environmental Context**
Persistent and temporary
- e.g. carer views about

**Antecedents and Triggers**
- e.g. limited opportunities, demands

**Internal World – Thoughts, Feelings**
- e.g. fear
- I am not loved

**Challenging Behaviours**
- e.g. hitting
- self-harm

**Consequences**
- Individual
  - Escape
  - Avoid demands

- Consequences
  - Carers
  - Challenges end

*Return to Pathway*
Care plans should be explicit in how staff should respond to the target behaviour.

Be clear about how the individual communicates and ensure that a communication system is in place.

Potential triggers to the behaviour are identified clearly and addressed.

Positive programme that outlines:

- skill development to replace challenging behaviours,
- or other positive strategies aimed to help the person manage their own behaviour
- structured activity programme,
- environmental changes needed.
- Emotional support approaches to enable relationships to develop and increase self-esteem.
- Direct treatments e.g. gradual exposure, skill building.
- Clear rationale for any psychoactive medication and the circumstances under which PRN medication is to be used.

Reactive/physical strategies are agreed and written within a legal framework (see appendix xx for details) and are safe and consistent.

Services strengths and weaknesses are identified. This relates to readiness to take on changes needed to support the individual in addressing challenging behaviour.

Consider staff/carer training needs and have clear action plan for delivery of these.

Sign post to other services where appropriate and consider joint working, supervision with PDN or clinical psychologist.

There is a clear written care plan for managing crises including those that might occur ‘out of hours’. This must be communicated and agreed by everyone involved. Refer to trust policies on sharing of information.
A MORE SOPHISTICATED MODEL OF CHALLENGING BEHAVIOUR

Personal Context

<table>
<thead>
<tr>
<th>Temporary</th>
<th>Persistent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>Life events</td>
<td>Sensory impairment</td>
</tr>
<tr>
<td>Psychiatric state</td>
<td>Communication difficulty</td>
</tr>
<tr>
<td>Fatigue, etc.</td>
<td>Limited ability, etc.</td>
</tr>
</tbody>
</table>

Prior

| Non-demanding Activity/inactivity | Demand |

Antecedent

<table>
<thead>
<tr>
<th>Temporary</th>
<th>Persistent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heat</td>
<td>Climate of social control, etc.</td>
</tr>
<tr>
<td>Crowding</td>
<td></td>
</tr>
<tr>
<td>Noise</td>
<td></td>
</tr>
<tr>
<td>Recent demands, etc.</td>
<td></td>
</tr>
</tbody>
</table>

Environmental Context

Thought

‘I don’t know how to handle this’

Feeling

‘I wish this would stop’

Behaviour

Aggression

Consequence

Escape from demand

Taken from Tizard Learning Disability Review VOLUME 1 ISSUE 1
A MORE SOPHISTICATED MODEL OF CARER RESPONSE TO CHALLENGING BEHAVIOUR

Personal Context

<table>
<thead>
<tr>
<th>Temporary</th>
<th>Persistent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>Lack of skill in managing aggression</td>
</tr>
<tr>
<td>Life events</td>
<td>Difficulty in coping with fear</td>
</tr>
<tr>
<td>Psychiatric state, etc.</td>
<td>Lack of skill in selecting &amp; presenting demands, etc.</td>
</tr>
</tbody>
</table>

Prior

- Presents demands

Antecedent

- Aggression

Thought

- ‘I don’t know how to handle this’

Behaviour

- Remove demand

Feeling

- ‘I wish this would stop’

Consequence

- Aggression stops

Environmental Context

<table>
<thead>
<tr>
<th>Temporary</th>
<th>Persistent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jobs need doing</td>
<td>Social control by manager</td>
</tr>
<tr>
<td>Heat</td>
<td>Participation</td>
</tr>
<tr>
<td>Crowding</td>
<td>important to service philosophy</td>
</tr>
<tr>
<td>Noise</td>
<td>Recent aggressive episodes, etc.</td>
</tr>
</tbody>
</table>

Return to Pathway

Taken from Tizard Learning Disability Review VOLUME 1 ISSUE 1
SECTION 11: INTERVENTION PACKAGE AND STEPPED CARE MODEL

Interventions:

1. Care plans should be explicit in how staff should respond to the target behaviour.
2. Be clear about how the individual communicates and ensure that a communication system is in place.
3. Potential triggers to the behaviour are identified clearly and addressed.
4. Positive programme that outlines:
   - Skill development to replace challenging behaviours,
   - Or other positive strategies aimed to help the person manage their own behaviour
   - Structured activity programme,
   - Environmental changes needed.
   - Emotional support approaches to enable relationships to develop and increase self-esteem.
   - Direct treatments e.g. gradual exposure, skill building.
   - Consider CBT anger management approaches (15-20 hours in total)
   - Sensory interventions should only be implemented following a functional assessment to establish the individual’s sensory profile.

5. Clear rationale for any psychoactive medication and the circumstances under which PRN medication is to be used. Medication should only be considered if risks are high and behaviours severe. Only prescribe a single drug, side-effects to be reviewed after three to four weeks and stop if no effect after six weeks. PRN should be prescribed for the shortest time possible.
6. Reactive/physical strategies are agreed and written within a legal framework and are safe and consistent.
7. Services strengths and weaknesses are identified. This relates to readiness to take on changes needed to support the individual in addressing challenging behaviour.
8. Identify the person who will be responsible for delivering and co-ordinating the interventions in the person’s usual environment (i.e. those outside the specialist LD health team)
9. Consider staff/carer training needs and have clear action plan for delivery of these.
10. Sign post to other services where appropriate and consider joint working, supervision with PDN or clinical psychologist.
11. There is a clear written care plan for managing crises including those that might occur ‘out of hours’. This must be communicated and agreed by everyone involved. Refer to trust policies on sharing of information.

Return to Pathway
### Stepped Care Model – Challenging Behaviour Pathway

This table shows how a stepped approach might be used in the challenging behaviour pathway:

#### Step 1
- Provide advice, causes of challenging behaviour, advice on risks and preventative information.
- Make GP aware of pathway, learning disability workers and who to contact if situation deteriorates or in the event of a crisis.
- Physical checks – signpost to GP.
- Advice as needed i.e. signpost challenging behaviour foundation, staff training.

#### Step 2
- GP has ruled out any physical causes.
- Check if individual has a HAP, PCP, Communication Passport / system in place.
- Identify Lead (Care co-ordinator).
- Shared care agreement (define roles).
- History collection and previous intervention / guidelines.
- Ask families / carers what works / what doesn’t.
- Risk assessment.
- Functional assessment i.e. ABC charts, identify triggers, environmental assessment.
- Assess / advice on person centred, proactive, active and reactive strategies and establish a baseline.
- Look at organisations training / ability.
- Support development of emergency guidelines.
- Consultation with outreach, PDN for CB and or psychology.
- Actively reinforce development of incompatible behaviours.
- Promote engagement in activities – signpost to other services.
- Staff training – challenging behaviour, risk assessment and active support model.
- Support staff to develop and implement guidelines.

#### Step 3
As above.
- Consider CPA.
- Care co-ordinator health care specialist.
- Detailed risk assessment.
- Consider any safeguarding issues.
- Multidisciplinary assessment.
- Formulation.
- Assessment of sensory processing for individuals with autism.
- More focused observations at key times.
- Staff support / supervision / debriefing.
  - Clear detailed written guidance regarding person centred triggers, proactive, active, reactive interventions (may include physical interventions).
  - Direct intervention.
  - Staff training, implement communication systems and positive behaviour support strategies.
  - Team meetings increase staff awareness of models i.e. wieners model of helping behaviours.
  - Supervision from O/R PDN or psychology.
  - Debrief, reflective proactive group, stress management.
  - Regular reviews.

### Step 4

- Immediate risk.
  - Intensity of health team support increased.
  - Revisit risk assessment, crisis, care plan – out of hours support.
  - Intensive inter/multidisciplinary support.
  - Increase access to external support and may facilitate easy access to this, i.e. police.
  - Define roles.
  - Direct intervention “on the job” coaching.
  - Clear communication system.
  - Availability of trained staff to support the individual and facilitate problem solving.
  - Individual psychological support / advice.
  - Robust person centred guidelines / management plans.
  - Incident analysis.
  - Increase frequency of team meetings to ensure effective communication.
  - Consistent staffing support.
  - Consider pharmacology.
  - Local inpatient care.
  - Regular review.
  - Agree shared way forward – shared care agreement.
  - Longer term work and maintenance plans.
  - All above within the legal framework.
The following are case examples where the different steps of care might be used.

**Step 1**

**Background**

Jamie is a young man with severe – moderate level of LD. He lives at home with his family. He attends college 5 days a week and goes out socially with his family at weekends.

**Trigger for Challenging Behaviour Care Pathway**

Jamie’s college reported that he had appeared unhappy recently with almost daily occurrences of self-injurious behaviours mainly targeted at his cheeks, but has now included hitting his ears with force.

**Assessment**

Jamie’s parents take him to see his GP to rule out any physical causes. College reports corroborate parents’ assessment that self-injury appears worse during meal / drink times. GP checked ears and feels that Jamie’s wisdom teeth may be causing him some discomfort and advises dental visit.

**Intervention / Treatment**

GP advises regular pain relieve and softer diet until seen by dentist. Dentist confirmed that Jamie’s wisdom teeth were impacting and referred to the local hospital for treatment.
Step 2

Background
Alison is 34 years. She has a moderate learning disability and lives in her own flat. Alison has 24 hour support. Staff support Alison to access day activities x 5 days a week. Alison can become extremely anxious on occasions.

Trigger for the Challenging Behaviour Care Pathway
2 of the support staff have reported that they are having problems with Alison refusing to get out of the car hitting out at staff when they ask her to get out.

Assessment
Alison has a health action plan and has recently attended her yearly health check, so any physical causes ruled out. Alison’s Social Worker makes a referral to the local LD team to look at identifying why Alison is displaying challenging behaviour with 2 of her support workers. The Community nurse completes a functional analysis interview form with all 3 staff and asks for ABC charts to be completed.

Intervention
The Community Nurse through the initial assessment work quickly identified that Alison’s support workers were very inconsistent in the way they worked with Alison. She suggested that all 3 staff members meet up to look at Alison’s likes / dislikes and how they individually work with her, sharing their approaches, particularly Jenny’s who has never experienced any of the behaviours the other 2 have. The care staff met with Alison’s family who had a wealth of information about how to support Alison in a meaningful way avoiding triggers / situations that they were aware could result in Alison hitting out at staff. The Community Nurse, OT and Speech and Language Therapist provided a basic introduction to challenging behaviour for the staff and made a referral to the person centred planning team to support the staff to work alongside Alison to develop her person centred plan. The CLDN also facilitated the staff team to write Alison’s proactive, active and reactive care plans and risk assessment.
Step 3

Background

Bernie is 44 years old. She has a history of Autism, Bipolar disorder, epilepsy and a long history of challenging behaviour. Bernie has spent most of her life living in institutional type settings with other individuals who also display challenging behaviours. Bernie has recently moved to a supported living environment (4 flats with a communal area).

Trigger for Challenging Behaviour Care Pathway

Bernie is experiencing high anxiety levels, she is unable to sleep and is refusing to participate in any personal hygiene activities spitting and hitting out at staff frequently. Staff also report that Bernie is damaging property and slapping her face with the palm of her hand. Bernie is at risk of placement breakdown due to staffs lack of confidence, refusal to work with her.

Assessment

Because of the frequency and intensity of the behaviours in particular self-injury. An outreach nurse is identified as the care co-ordinator. A risk assessment is completed and emergency guidelines written. Physical causation ruled out by GP. Historical records contained lots of details about behaviours but little about when things are good and previous interventions. The Psychiatrist increases the Carbamazine as this acts as a mood stabiliser also. A sleep hygiene programme is instigated, initial? night sedation may be introduced. The Speech and Language Therapist recommends using objects of reference and photographs to make life more predictable. The OT commences a sensory assessment. Direct observations at key times, ABC recordings, functional analysis interview forms x 2-4 and MAS x 8 questionnaires completed with family / carers. Self- injurious behaviour and destruction to property appear to have a sensory function and aggression towards others appeared to serve the function of escape. Initial formulation fed back to staff team and guidelines written identifying triggers, relapse indicators for Bipolar disorder, proactive, active and reactive interventions including safe holding

Return to Pathway
Step 4

Background

Amy is a 21 year old lady described as having mild Learning Disability and Asperger Syndrome. She lives with her elderly grandparents. She spends most of her time at home with few social network or meaningful activities. She has a history of challenges to services and members of the public. The Police have recently been involved.

Trigger for Challenging Behaviour Care Pathway

Amy was referred by a Mental Health Psychiatrist to look at functional analysis within the home environment around aggressive behaviours. Amy has been threatening people in the local community, visiting local pubs being disruptive and confrontational. She has been verbally abusive to shop assistants.

She is not allowing any visitors to her grandparents’ house, making them feel like prisoners in their own home. She can become extremely verbally aggressive and intimidating. This increases the risks not only to others but also places herself at risk of retaliation from members of the public. She is also at risk within her home environment with wider family members threatening to attack her. Neighbours were continually complaining about the noise levels she would make, singing songs at the top of her voice all hours of the day and night. She would also spend long periods of time watching the neighbours through the fence. Family dynamics were generally poor.
Assessment and Intervention

Amy was screened onto CPA, Outreach became the Care Co-ordinator and completed initial risk screen and put in emergency guidelines. Psychology also became involved. An HCR20 risk assessment was completed. It quickly became apparent that the guidelines were ineffective as the family due to all the stresses were not able to implement them. Family continued to call the Police out but once the Police arrived they would say that everything was ok. Boundaries were lacking / confusing. Amy and her family were well known in the area and local places i.e. pubs / clubs etc. would make exceptions for her behaviour and if she was taken anywhere new places were expected to be tolerant. She needed skilled people to support her and implement boundaries. Outreach and Psychology worked closely with the Police and Social Services and Amy informed what the consequences to her behaviour would be. Psychology attempted to provide Anger Management in context which required the family to model it, they couldn’t.

An MDT involving the family concluded that there was no more that could be done with the dynamics in the current environment.

Plan

Need to reduce anxiety. Accommodation flat alone with Commissioned Support and Outreach to provide x 7 days day-care until Commissioned Service in place. Visual timetables introduced.
Amy initially responded well but stopped engaging stating it as her own flat and stopped letting people in. She became nocturnal and complaints from neighbours increased. She became very vulnerable with drug dealers trying to get her to run for them. She was very vulnerable and if anyone said hello Amy would regard them as being her best friend. Amy began returning to her family home and threatened a neighbour with a knife on one occasion; she was cautioned and told to stay away from the family home. Amy ignored the caution and went straight back. She was arrested and remanded. Amy functioned well in the prison environment due to its structure and predictability which needed to be replicated on the outside.

Amy was not ready to live alone and could not live with emotional other people. Amy is living within an adult placement with 2 very experienced carers who are able to put clear boundaries in place as per MDT recommendations. She has support workers who visit daily and regularly attends probation.

Amy spends a lot of time on the computer and although is not really engaging in a lot of activities her anxiety levels are low. The HCR20 was updated in an MDT and shared widely with services who support Amy. The Care Plan clearly outlines triggers, proactive, active and reactive strategies and exactly how to respond to Amy’s behaviours. Amy is beginning to engage with Psychology who are working on Anger Management and her vulnerability.

Outreach are facilitating family visits weekly which Amy is coping well with and the family are able to leave when Amy starts to become anxious or over focused.

Future work is to look at introducing Occupational Therapy to assess Amy’s skills and to explore Short Break opportunities in a structured environment.
Training packages and requirements

Training requirements for CB Pathway

- All staff will have basic awareness of challenging behaviour and autism awareness
- All staff to attend 3 day Proact SCIP UK which includes de-escalation training as mandatory. Or similar BILD accredited course.
- All staff will have mandatory working with risk, CPA, safeguarding training.
- All staff have training in total communication approaches
- Ideally 1 member of each team will have training in applied behaviour analysis
- All staff to have observation, ABC chart training, active support principles
- All staff to have interviewing skills
- All staff to have training in how to administer data collection tools i.e. O’Neil interview forms. MAS and ABAS choice.

All LD community staff

to have attended SCIP-uk, except psychiatry who attend MAPPA.

Outreach

Formal qualification in behavioural analysis i.e. violence and aggression module.
- facilitation and change management skills
- Supervision training

PDN

All of the above and advances qualification in behavioural analysis

Supervision training, change management and service issues.

Clinical Psychologists

Doctoral level training in variety of theoretical models and approaches relevant to challenging behaviour including behavioural analysis and CBT.
Post-qualification supervision skills / training
STANDARDS AND PRINCIPLES

➢ Clear evidence that the intervention is formulation driven and person centred.

➢ The person’s care plan should describe how the person will be supported in ways that address their rights, inclusion, choice and independence. This should be agreed jointly with the individual or shared with them and the rationale explained.

➢ A written care plan should be available in the clinical notes that includes; Proactive, active and reactive strategies. Should be informed by the relevant risk assessment e.g. RIO risk assessment, HCR-20, RSVP. These must be updated on an ongoing basis.

➢ The Royal College of Speech and Language Therapists have produced the 5 Good Communication Standards which set out what good communication looks like for people with learning disabilities. (2013)

The standards are:

1. **Standard 1**: There is a detailed description of how best to communicate with individuals
2. **Standard 2**: Individuals with communication needs are supported to be involved with decisions about their care, their services and their lives
3. **Standard 3**: Communication partners use competently the best approaches to communication with individuals
4. **Standard 4**: Opportunities, relationships and environments are created that support individuals to communicate
5. **Standard 5**: Individuals are supported to understand and express their needs in relation to learning disabilities
SECTION 12: REVIEW AND EVALUATION - WITHIN 20 WEEKS

Evaluation

The following should be systematically evaluated:

1. Clear evidence that the plans are implemented by the support teams.
2. Ensure that protective and maintenance factors have been introduced as recommended in the intervention care plan for increasing quality of life.
3. Measure the impact of the intervention on the target behaviours and the impact on the person’s quality of life – by comparing current frequency and intensity to baseline.
4. Measure the use of restrictive practice and physical interventions and psychotropic medications.
5. Monitoring and evaluation by health professionals should continue for minimum of eight month period (in line with current evidence base).
6. Consider if further assessment is needed.
7. Consider if formulation and then interventions need adjusting in light of the evaluation.

Monitoring and maintenance

1. Assess access to other services and constructive activities.
2. Check person centred plan is in place, detailing how the person wants to be supported when distressed.
3. CPA review. Review risk management and relapse indicators.
4. Write final summary assessment report.
5. When appropriate, write final closing letter stating rationale for closure.
6. There should be a clear agreement about how crises can be managed.
Review templates and Outcome Measures - Tools

Repeat those used in baseline to assess intensity and frequency of challenging behaviours and quality of life.

For example:-

- ABC charts including frequency and intensity.
- Aberrant behaviour checklist
- Challenging behaviour attribution scale
- Direct observations
- Guernsey leisure activity scale
- Modified overt aggression scale
- Motivational assessment scale
- Positive goals
- Quality of life measure
- Patients related outcome measures (PROMS)
- Friends and family feedback

Standards and principles

- Intervention is co-ordinated within a clear system
- There are regular care reviews which outline the evaluation process in terms of impact on the person’s quality of life and impact on others.
Closure and Transfer

Discharge or transfer from the pathway should be clearly co-ordinated between agencies using existing review procedures. Following the completion of an intervention a written summary should be provided of work that has been undertaken and any recommendations.

Indicators of successful intervention could include the following:

- Within the service or care environment there is a shared understanding of the functions of an individual’s behaviour and shared ways of responding to it.
- Reduction in the frequency, intensity and severity of the behaviour.
- A stimulating environment offering opportunities for participation in activities.
- An emphasis in positive and constructive communication and interaction between staff / carers and service user.
- Able to provide the support required, skill development and manage behaviours during times of crisis with a clear individual person centred plan.

In some instances despite support training and good monitoring it may be evident that the carer / service is unable or unwilling to carry out recommendation for a variety of reasons such as lack of knowledge and skills or other organisational constraints.

The challenging behaviour may still be seen as entirely located with the individual with a learning disability and consequently these value conflicts may impede the use of proactive skills. In these circumstances collaboratively with individual their needs should be clearly outlined and communicated to relevant managers, commissioners or inspectorates.

Triggers for re-referral

As per original triggers for pathway
Standards and principles

BPS 11 Clinical Standards British Psychological Society

1. Assessment and interventions are delivered within the current legal framework, taking full account of the MCA MH Act, DOLs, H+S, Scie guidance etc.

2. A detailed risk assessment is carried out with individuals who present severely challenging behaviour to ensure that intervention are appropriately and systematically targeted.

3. For each person who presents with severe challenging behaviour there is a written assessment that takes account of relevant factors about the person, their environment and the behaviour.

4. There is a multifaceted written formulation that takes account of possible diagnosis, psychological and relationship factors. This formulation has been developed from the assessment, and leads to an appropriate intervention.

5. There is clear evidence that the intervention has person centred approaches at its core.

6. Interventions are written down and are derived from the formulation and include – primary preventative strategies and early crisis intervention.

7. There is clarity about how ‘crisis’ will be managed with clear links to mental health and other services when required.

8. Each person whose behaviour challenges services will have their care co-ordinated within a clear system.

9. Effective processes will be used to ensure that everyone supporting the person has the necessary skills and knowledge to carry out the intervention.

10. The intervention will be fully evaluated in terms of the behaviour and the impact of the behaviour on the persons’ quality of life and on others.

11. There is a system in place across an authority for auditing the standards for service provision that are described in the guidelines.
SECTION 14: VARIANCE

Variance analysis is a critical part of using this care pathway. Variance can identify deviations from the expected pathway and if so, for what reasons. This can be used to amend the care pathway itself or the processes followed. Variance will be monitored through RIO systems via the assessment and treatment waiting times and can also be recorded on the CORE information when the care pathway is identified.

LD Care Pathway

<table>
<thead>
<tr>
<th>Date assigned to Care Pathway</th>
<th>Status</th>
<th>Care Pathway</th>
<th>Date Closed</th>
<th>Comments</th>
<th>Variance Record</th>
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<tbody>
<tr>
<td>31 July 2014</td>
<td>Current</td>
<td>Challenging behaviour</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>
Challenging Behaviour Pathway audit questions

1. Is there written evidence of a baseline assessment?

2. Did the assessment include Behavioural, Biological, Psychological and Social factors?

3. Was the assessment multidisciplinary?

4. Is there a written formulation?

5. Has a treatment plan been documented?

6. Is there clear evidence of what intervention (s) or treatment is being used?

7. Are behaviour support plans in place and have copies been given to the individual/carers.

8. Were appropriate physical checks carried out prior to intervention if required?

9. Has the capacity of the individual for valid consent to involvement of services been assessed and consent obtained and documented.

10. If the person does not have capacity to consent, have the Best Interest Meeting and decisions been documented?

11. Has a risk assessment been completed/updated?

12. Have baseline measures been completed – intensity, frequency of behaviours; quality of life measures? – what opportunities have changed for the person?

13. Are guidelines being implemented as they were written?

Return to Pathway
SECTION 16: GENERAL REFERENCES

- DoH (2014) Positive and Proactive care: reducing the need for restrictive interventions

- Transforming care: A national response to Winterbourne View Hospital, (2012)

- Mental Health Crisis Care Concordat Improving outcomes for people experiencing mental health crisis (February 2014)


- Deprivation of liberty safeguards (DoLs) March 2014 (Cheshire West).


- Royal College of psychiatry leaflet re “Mental health and challenging behaviours”


• Prescribing of psychotropic drugs to people with Learning disabilities and/or autism by general practitioners in England. June 2015.


• Supporting people with a learning disability or autism who have a mental health condition or display behaviour that challenges. Local Government Association ADASS and NHS England. 2015.

• Transforming Care for people with Learning Disabilities-Next Steps. January 2015.

• Guidance for Staff Welfare and Support. LPT Policy.

**Further guidance**

Is available from the Challenging Behaviour clinical network

Useful links:

[http://www.challengingbehaviour.org.uk](http://www.challengingbehaviour.org.uk)


NHS protect – Email - [Policy@nhsprotect.gsi.gov.uk](mailto:Policy@nhsprotect.gsi.gov.uk)
SECTION 17: RESPONSIBILITIES OF THE CARE-CO-ORDINATOR FOR CHALLENGING BEHAVIOUR PATHWAY FOR AN INDIVIDUAL

The care co-ordinator is responsible for co-ordinating care, maintaining contact with the service user ensuring that the CPA care plan (or other care plan for managing challenging behaviours if the individual is not on CPA), is delivered and reviewed as required. The care co-ordinator will be a qualified member of staff with appropriate training to fulfil this role. Examples would be Outreach or community nurse, clinical psychologist, speech and language therapist, psychiatrist.

Staff in community learning disabilities service are trained in the use of SCIP-up approaches which focus on understanding why behaviours arise so that people can be supported in ways that avoid triggering behaviours. Techniques to cope with challenging behaviours are non-aversive and aim to support people and to help others manage challenging behaviour.

Psychiatrists are trained in the use of MAPPA as an alternative to SCIP-uk. All staff on the Agnes unit (inpatient unit for adults with learning disabilities) are trained in the use of MAPPA.
SECTION 18: CONTACT LIST

Mrs Lynne Moore, Practice Development Nurse 0116-225 5206
Dr Bridget Cryer-Rolley, Consultant Clinical Psychologist 0116-225 5322
Mrs Gemma Clarke, Outreach Nurse 0116-295 3231