

Some stories from the Positive Behavioural Support Team

Story One

A new service was set up to support two individuals who had been 'living' in a long stay hospital. One of the individuals was John, a 50 year old with limited verbal speech and a dual diagnosis of learning disability & Autism. There was a lot of anxiety by the professionals as he could exhibit a number of behaviours including screaming, property destruction and of more serious concern physical aggression towards others, inclusive of punching, scratching, pinching, slapping, shoving & kicking.

By getting to know the individual before and during the move into his new home, it became clear that the behaviours were in fact his way of communicating that he felt uncomfortable, unhappy or unwell. He was having difficulty communicating his emotions. He found making choices and being able to say 'no' difficult as historically he had been 'taught' to be compliant with staff requests. His new team didn't want this to continue for him, they wanted him to be independent and in control of his life.

What was clear from the time when John moved into his own home was the issue was one of the quality of staff support, not the quantity. Initially, a number of professionals advocated a physical management this was developed into a breakaway & diffusion plan eliminating restrictive restraint techniques which would have been ethically questionable in relation to the Mental Capacity Act (2005). What was actually needed was bespoke service with the focus on enablement & empowerment. Through this approach John would be positively engaged and have control over his life.

This was achieved in a number of ways. Firstly, in consultation with SALT John was provided with an individualised communication program that all staff were trained in so he had ways of saying 'no', expressing his emotions and could have control over what he did. This was done through the use of emotion cards, yes/ no cards and a visual timetable, utilising actual photos of his preferred activities. Part of the programme was also to teach John how to use these tools and to move from a very structured approach to increasing his choice and control over activities. Over time the visual timetable was developed further into social story boards, so that it could be communicated to John when known difficult times and events were to happen and how he would be supported through these. In particular over time he learnt how to request and wait a short time, if this could not be obtained immediately.

Within a month of the plan being put in a Staff meeting reported that things were '*greatly improved*'.

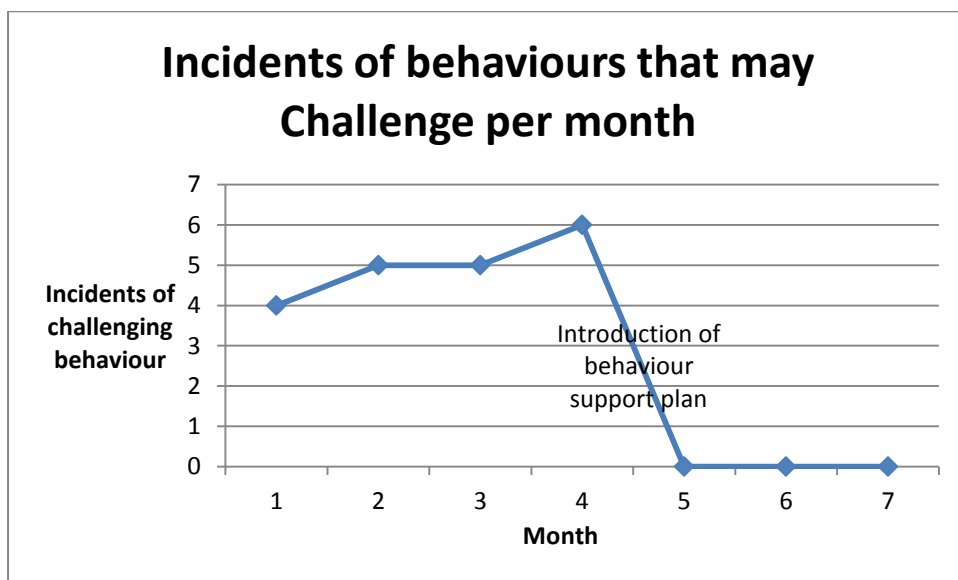
Comments of staff were:

It's really helped with his expression & knowing what he wants to do means there is not a sense of frustration, its great he can lead the way – Staff A

I have really enjoyed working on skills teaching and seeing the positive impact this has had on his day to day living, it's so refreshing to look to the future rather than constantly fire fighting – Staff B

It really gave the team confidence having good reactive plans and gave us the confidence to work with John on improving his skills rather than being guarded – Staff C

In the first full year of implementation on the behaviour plan, recorded incidents of behaviours that could challenge had fallen from a high of 90 per month to 0 within 8 months and stayed at 0 for the following four months.



Story Two

Jenny lives in a supported Living service she shares with 4 others. Jenny is in her 50's and has spent the majority of her life in a long stay hospital since a young child and has lived in the community for the past 10 years.

Jenny was referred for very high rate 'pica' behaviour. Pica refers to the ingestion of non-edible items and Jenny was selecting items such as fabric and paper and was going to extreme lengths to obtain these items often impinging on others belongings, personal space and bodies to obtain them putting not only herself but her peers at risk.

An assessment was undertaken and the function of the behaviour was identified as something likely to have developed in early childhood as a comforting and self-stimulatory behaviour. It was also identified that at time Jenny was hungry and had limited skills or opportunity to express hunger or indeed get herself something to eat.

So to increase Choice and Control a strategy was developed whereby every time Jenny made an attempt to obtain a non-edible item to put in her mouth or was found to have a non-edible item in her mouth, she was offered an alternative choice of an edible item as far as possible replicating the size and texture of those non edible items she was selecting. Jenny was given free access to these edible items and taught skills to 'help herself' whenever she wanted and importantly she was reinforced by praise and congratulations for accepting the

edible alternative. Alongside this staff actively supported Jenny to become more involved in preparing her own meals and trying new recipes.

In conjunction with this strategy it was also evident Jenny was lacking fun things in her life to do and to keep occupied. Staff had become so occupied with the behaviour and the possible risks, that inadvertently access was being limited to the community. Therefore, the staff team worked with Jenny to look at new opportunities, the only premise was the starting point. That was what did Jenny want to do? The only question after that was how to support her to achieve it? A new schedule of activities was developed and communicated to Jenny through the introduction of a visual timetable.

Work continues to improve Jenny's support and her lifestyle.