NAS Positive Behaviour Support Policy – SO-0029

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Contents:

1. Values Statement:

We believe that every person with autism should be able to live the life they choose.

2. Scope

This policy applies to all National Autistic Society schools, children and adult services where autistic individuals and their families receive direct and indirect support and as an organisation, we have a duty of care towards the individuals and respective families we support. This policy relates to all aspects of individuals' behaviour, across the education, residential and adult settings as well as when out in the community. It should be read, in conjunction with other NAS policies and guidance including: Safeguarding Adults Policy (SO-0194), Safeguarding Children's Policy (SO-0189), Restrictive Practices Intervention

Policy (RPI) (SO-0039), Anti- Bullying Policy (SO-0193), Incidents leading to a near miss reporting and the High- risk support needs framework.

NOTE – This policy incorporates the policy Behaviour Support in Adult Services SO-0027.

3. Purpose

This policy sets out how all NAS/NASAT Services promote and develop an understanding of Positive Behaviour Support (PBS), and its application within all service settings.

It aims to outline the key philosophical underpinning identified within PBS, as a broad framework for developing person centred PBS plans/Combined records, and approaches for individuals receiving a service at the NAS/NASAT.

The strategies identified will be split into the component parts of Positive Behaviour Support, with a focus on Proactive Strategies (every day support strategies for a person that helps to maintain their quality of life), as well as Secondary Prevention Strategies (support for a person when they start to become anxious or aroused) and Reactive Strategies (support when someone is displaying behaviour of concern) , with links to the differing legislation and frameworks applicable across areas of the UK.

4. Introduction

Positive Behaviour Support (PBS) is an evidence-based approach that brings together the value base of person-centred approaches.

It does so with the overall aim of improving the quality of a person's life, and that of the people around them. This includes all individuals throughout their lifespan.

PBS supports human rights and promotes respect, dignity, inclusion and a life without unnecessary restriction. PBS means treating people equally and working in partnership with each individual and their family to improve their quality of life (QoL) and make things better for everyone.

PBS is about providing the right support at the right time for an individual, so they can lead a meaningful, fulfilling and interesting life, participating in activities and learning new skills. It is a long-term multi-component framework (BILD, 2013), following the person throughout their life and providing opportunities within and without each service, so that growth enable each individual and their families to reach their full potential.

PBS uses different methods to gather information to work out what each individual's behaviour means - its function and/or message behind the action. There is a focus on conducting in-depth functional assessments using evidence-based tools to enable staff teams to better understand the individual they support, thus enabling services to improve the support offered.

By doing this, PBS empowers all involved to adopt more efficient, positive, and less harmful ways to fulfil their individual needs. These can range from developmental, educational, social, psychological, biological needs, which forms the foundations for a meaningful and fulfilling life (QoL). This often involves using a range of different

approaches that enhance an individual's life, including functional skill teaching, active support, the development of functional communication skills, the development of emotional self-regulation skills all in the context of the and individual's environment.

There is a recognition that PBS is most effective when it's systems and values are embedded throughout a whole service or organisation. The NAS promotes the use of system level interventions including the SPELL framework, Practice Leadership, Person-Centred Active Support, Reflective practice, Quality of Life Framework and investing and promoting support in staff wellbeing and their development.

5. Terminology & Definitions:

Behaviours that Challenge or Behaviours of Concern:

All behaviour happens for a reason and behaviours that challenge, or behaviours of concern are no different. They are usually occurring because of unmet social, psychological, developmental and/or biological needs.

Behaviours that challenge or behaviours of concern are defined as:

'***Behaviour*** *can be described as* ***challenging*** *when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion*'.

Royal School of Psychiatry (2007; 2016)

They tend to fit into one of the following five higher categories:

- Self- Injury (to include self-harming)
- Behaviour which harms
- Damage to property
- Socially Inappropriate (to include bullying and anti-social behaviours)
- Dangerous occurrence

6. Assessment & Formulation

PBS seeks to understand why people adopt behavioural responses that challenge, so that staff teams are able to plan individual support and interventions to empower the individual in self-management and ultimately meet their individual needs – educational, social, psychological, developmental and biological - to meet those needs in a positive way. This is achieved through - but not exclusively - the use of functional assessment. A functional assessment creates an understanding of the behaviours of concern and the context in which they occur including the individual's strengths, interests, wishes and needs (including their physical and mental health needs) and the characteristics of the social and physical environment, which influence the behaviours of concern.

All assessments will include some elements of the tools outlined below depending on individual need and clinical judgement:

- The development of clear behavioural definitions

- Structure and unstructured interviews with the individual and key people including schools' staff, in the individual's circle of support e.g. functional assessment interview, Brief Behaviour Assessment Tool.
- Direct observation using a variety of tools e.g. momentary time sampling, ABC forms.
- Completion of specific assessments e.g. skill assessments, ecological analysis, preference assessments.
- Completion of rating scales and questionnaires e.g. Motivational assessment scale, Questions about behavioural function.

The assessment process and the development of the corresponding Positive Behaviour Support Plan (PBS Plan and ISP/IPBSS Combined records) should be overseen by a trained professional alongside the individual and their circle of support.

In order to ensure a comprehensive picture of the individual's needs input may be sought from relevant transdisciplinary teams including clinical and therapeutic professionals e.g. Speech and Language Therapists, Occupational Therapists, Psychologists.

6.1 Positive Behaviour Support Plans

The assessment process is used to inform the development of a PBS plan, ISP, IBSP, Combined record. This plan should be individualised, clear and concise. The assessment process will also inform whether an individual requires a support plan. All children and young people as part of their supportive interventions and access to their learning will have a PBS plan. Adults will only have a PBS plan if they need one. It should outline both what support the individual needs every day and also how to respond should an incident occur. Studio III or PBM (Wales only) trained practitioners can advise on least restrictive practices in line with the Use of Restrictive Practices in NAS/NASAT Schools and Services policy.

6.2 Primary Prevention or Proactive Strategies:

Primary prevention or proactive strategies are the main focus of PBS, with an emphasis on improving the individual's quality of life (QoL), as well as the lives of those around them.

Primary prevention strategies should be the main focus of each individual's PBS plan, with clear guidelines for staff on how to implement these strategies across all areas of the individual's life, to promote the development of positive cultures in services, and the creation of capable environments (McGill et al, 2014).

Strategies for Primary Prevention typically focus on the following categories:

Positive interaction - Strategies should describe how to encourage interaction with the person, the person's preferences, and opportunities to increase the person's circle of support.

Support for communication - Strategies should describe how to communicate with the person in order to increase their levels of expressive and receptive communication.

Support for participation in meaningful activity - This should include strategies on how to increase the person's levels of engagement, and how to encourage the person to take an active role in their own life, focusing on meaningful activities.

Consistent and predictable environment - Strategies should include the use of SPELL, and ensure that the plan links with the person's autism and SPELL profile in order to help create predictable environment which honours personalised routines.

Support to establish and maintain relationships/friendships - Strategies should include information on the person's key relationships and ways in which staff can help the person maintain these, as well as focusing on strategies for increasing the person's circle of support and community engagement.

Provision for choice - Clear guidance should be given on how to offer choice to the person including the use of any visual systems, as well as strategies for increasing opportunities for choice and decision making.

Encouragement of independent functioning - This should include information regarding a person's current level of skill across areas, and be based on recent assessments. It should also direct staff to the goals in place for promoting personal development and competence across a multitude of areas.

Personal care and health - This should contain information on how best to support the person to maintain good physical and mental health, as well as information on specific conditions or diagnosis. It should link to the person's health action plans to ensure consistency in support.

Provision of acceptable environments - This should include strategies – where possible - for the removal or reduction of environmental pollutants, and the creation and facilitation of Low Arousal learning environments which promote optimal performance levels. It should also include strategies for supporting the individual when accessing areas that are out of the service domains, for example developing coping and tolerance strategies in accessing all areas of the service, or the use of equipment.

Mindful and skilful carers - This section should focus on the skills needed by the staff teams as a whole supporting the individual, and should link to training opportunities (CPD programmes) both within, and external to the organisation. It should also discuss preferences expressed by the individual on the general characteristics of staff member that supports them, in order to reach the best-good-fit between the individual and staff supporting them (for example, quiet or loud, excitable or Low Arousal).

6.3 Secondary Prevention Strategies:

In the event that an individual's behaviour begins to escalate after the introduction of triggers, secondary prevention strategies are essential in supporting staff to de-escalate the situation, safely manage immediate identified risks to the individual and others and in helping the individual avoid reaching a crisis point. Long-term considerations are also to be considered as part of the individual PBS plan.

There are a number of secondary prevention strategies, and these will always be specific to the individual, and based on the completion of a thorough functional assessment.

Some secondary prevention strategies include (though are not limited to):

Active listening for early warning signs - Being aware of and attending to early indicators/cues and adjusting support in response. Clear descriptions of these early indicators or cue behaviours are to be outlined in the person's PBS Plan.

Verbal interaction - Strategies should explain how to alter the level of verbal interaction with the person once early indicators have been identified.

Problem solving - Strategies should include how to help the person solve the problems, considering how to remove or reduce any triggers present. This should include any changes needed to the environment, as well as interpersonal changes.

Distraction and de-escalation- Strategies should include clear information about the person's strong motivators or reinforcers in order for them to be used as distractions in the event that it is not possible to solve the problem.

Timely use of PRN medication (adults only) - This should link with the person's medication protocol in the event that the person is prescribed emergency medication.

Low Arousal Approaches – Strategies which are adopted to prevent further escalation.

Reactive Strategies:

Even with successful interventions, the complete elimination of behaviours that challenge is rare, and so there may always be some need for the use of reactive strategies.

PBS makes it clear that reactive strategies, inclusive of physical interventions, should be used as a means to bring incidents to a close as safely and in the most dignified way possible. They should never be used as a standalone approach, or outside of the larger framework of PBS, and should always be agreed by a multi-disciplinary or transdisciplinary team.

Reactive strategies should:

- Be tailored to meet individual need, considering the function of the person's behaviour and the person's history to minimize the likelihood of trauma occurring.
- Only be used to establish rapid and safe control over dangerous behaviours
- Be used for no longer than necessary to prevent harm to the person or to others
- They should follow a gradient of support using the least restrictive option
- Be a proportionate response to the level of harm, and be the least restrictive option
- Do not use pain compliance procedures.
- Reactive Strategies may include the use of physical interventions, including self-protective techniques, as well as restrictive physical interventions.

The NAS uses different systems for the training and use of physical interventions across the UK, including the use of Studio III in England, and Positive Behaviour Management (PBM) in Wales. Please see relevant policies in the appendices.

7. Debriefing

7.1 Post- Incident Support and Debriefing:

PBS promotes the use of post incident support for both staff and the individuals we support, with a focus on how to support that person to return to their typical level of arousal (baseline behaviour).

Strategies for Post-Incident support include:

- Providing any necessary medical attention for the person or staff
- Encouraging the person to a quieter area, or removing others from the environment to minimise audience effect
- Implementing person specific relaxation strategies
- Re-engaging the person as soon as they are ready in positive interactions

Debriefing should be offered after the member of staff has had time to reflect on the incident, and should be used as an opportunity for learning. It should encourage the member of staff to consider:

- What happened?
- Why did it happen?
- How did the person feel during the incident?
- What do they think went wrong?
- What do they think they did right?

This should be used to review the individual's PBS plan, to ensure that the strategies outlined within it are suitable, and effective. It can also be used for staff to highlight any needs for further support or training.

As debriefing is not professional counselling, all staff should be made aware of the 'Axa Be Supported Employee Assistance Programme (EAP)' the employee assistance scheme: www.axabesupported.co.uk (800 072 7 072).

7.2 Reducing Restrictive Practices:

Restrictive practices can be defined as:

"any deliberate act to restrict a person's movement, liberty and/or freedom to act independently in order to: Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is taken; and end or reduce significantly the danger to the person or others"

Restrictive practices tend to fit into the following categories:

- Physical Restraint including Breakaway Techniques
- Mechanical Restraint
- Environmental Restriction
- Seclusion
- Long Term Segregation
- Chemical Restraint (Medication)

There are instances where the use of restrictive practices may be necessary to keep the person and others safe, and to minimise the likelihood of harm occurring to the person or others. However, the NAS has a commitment to demonstrate the reduction of restrictive

practices, in line with the Restraint Reduction Networks Training Standards 2019, as well as recent government guidelines.

Please see policy and procedure on the Use of Restrictive Practice in NAS Schools & Services (SO-0039), Anti-Bullying in Schools and children, young people's services policy (SO-0193); Admissions, Remissions and Exclusion Policy (SO-0230)

8. Training

In service training – Extensive training is offered either by the PBS teams or other relevant professionals including transdisciplinary teams, clinical and therapy teams (psychologists, speech and language therapists and occupational therapists) and is tailored to individual needs. Please refer to relevant NAS Policies.

All staff receive training in the physical intervention system relevant to their area e.g. Studio III/PBM (Wales only).

9. Legal Context

The relevant statutory legislation in England and Wales related to **adults** (aged 18 years or above) are:

- The Care Standards Act 2000 (with the associated regulations and national minimum standards)
- The Mental Capacity Act 2005 (applies to those over 16 years)
- Mental Capacity Act Code of Practice for Wales (2016)
- The Human Rights Act, 1998
- The Care Act 2014
- The Social Services and Wellbeing Act 2016

In Scotland the legislation is covered by:

- Regulation of Care (Scotland) Act 2001
- The Adults with Incapacity (Scotland) Act 2000
- The Adult Support and Protection (Scotland) Act 2007
- Human Rights Act, 1998

In Northern Ireland the legislation is covered by:

- Mental Capacity Act (Northern Ireland) 2016
- Human Rights Act 1998
- The Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003
- Health and Social Care (Reform) Act (Northern Ireland) 2009

The relevant statutory legislation in England and Wales regarding **children** and young people includes:

- The Children Act 1996, 2002, 2011
- The Education and Inspections Act 2006
- The Care Standards Act 2000 (with the associated regulations and national minimum standards),
    - The Mental Capacity Act 2005,
    - The Human Rights Act, 1998.

In Scotland the legislation is covered by:

- The Children (Scotland) Act 1995
- The Mental Health Care and Treatment (Scotland) Act 2003

In Northern Ireland the legislation is covered by:

- Safeguarding Board Act (Northern Ireland) 2011
- Children's Services Co-operation Act (Northern Ireland) 2015
- The Children (Northern Ireland) Order 1995.
- Co-operating to Safeguard Children and Young People in Northern Ireland 2017

10. Complaints

Individuals using National Autistic Society services, their parents, friends or family have the right to offer comments and refer to the Complaints Procedure in the case of any disagreement in the management of behaviour. Please refer to the Complaints Resolution Policy further information.

11. Whistleblowing

Employees have a duty to voice any concerns over care practice. Please refer to the Policy on Whistleblowing (HR-0002) for further information. The National Autistic Society is committed to support staff who engage in whistle blowing in good faith. Please refer to Safecall posters for further information.

12. References

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