Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Supporting Behaviour That Challenges

Stephanie Carr and Dr Mark Lovell

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- 14.00 Welcome and introduction
- 14.05 Stephanie
- 14.55 Mark
- 15.25 Panel discussion
- 15.55 Thanks and closing comments
- 16.00 Close of webinar

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Supporting Behaviour That Challenges; Primary and Fundamental Approaches to Supporting Need

Stephanie Carr

Clinical Service Lead, Behaviours that Challenge

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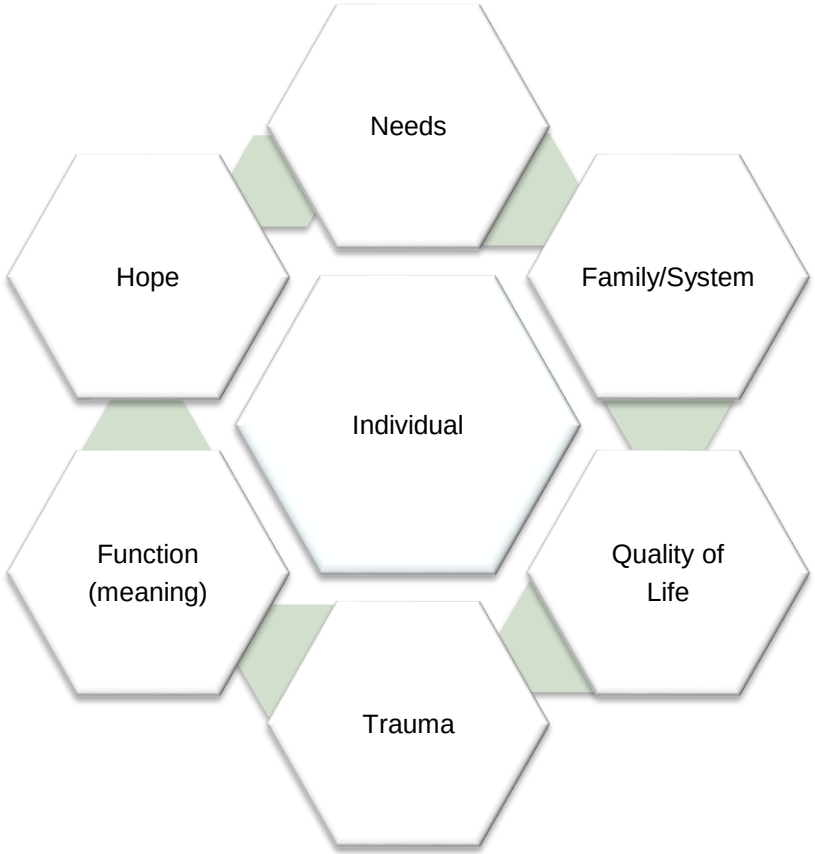
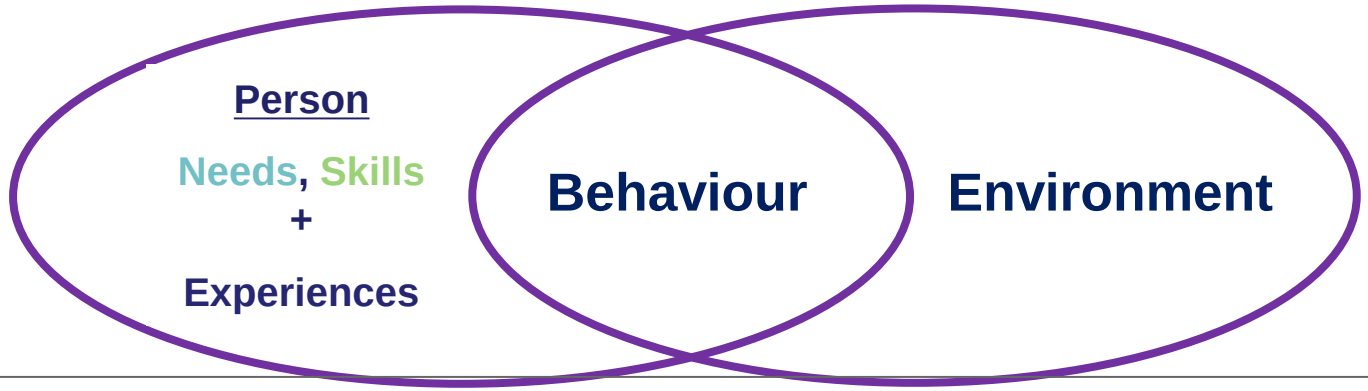
Moving towards a context based model



Relationships between personal characteristics and environments



Structure, Routine, Predictability, Sensory Preferences, Physical Comfort, Free from Pain, Understanding, Orientation, Mood

I don't really know what that word means, I have no coping skills, I'm really good at thinking about that, This is what I like to do

I like this place, This place is super scary it reminds me of, I've been restrained by someone who looks just like you, someone left suddenly, someone important to me died and it doesn't make sense, last time I did this I got that and that was good

Teeth, Tums and Bums

Check that physical health!

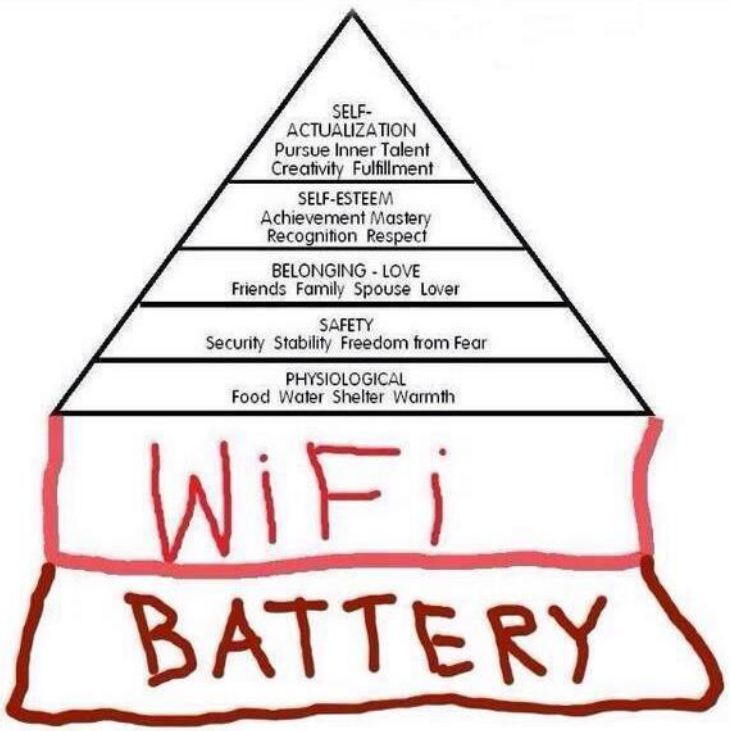
Needs

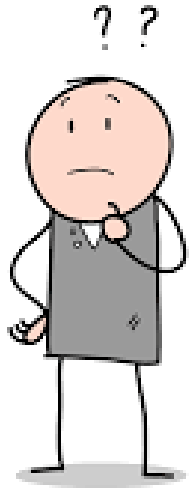
Are you getting everything you need?

Are we ‘reasonably adjusting’ for all of your needs?

Do you feel safe?

If you have a diagnosis (or on your diagnostic journey) does everyone understand this? And do they understand what it means to/for you?





Family and System

Does your family have enough…..?

Are your family supported?

Who is doing the helping?

What kind of support are your family asking for?

What kind of support are your family ready for?

What's the value of fancy professionals when you don't have enough?

Quality of Life

In children's services it's easily to look at family life and it's quality rather than the child's life what's quality for/to them.

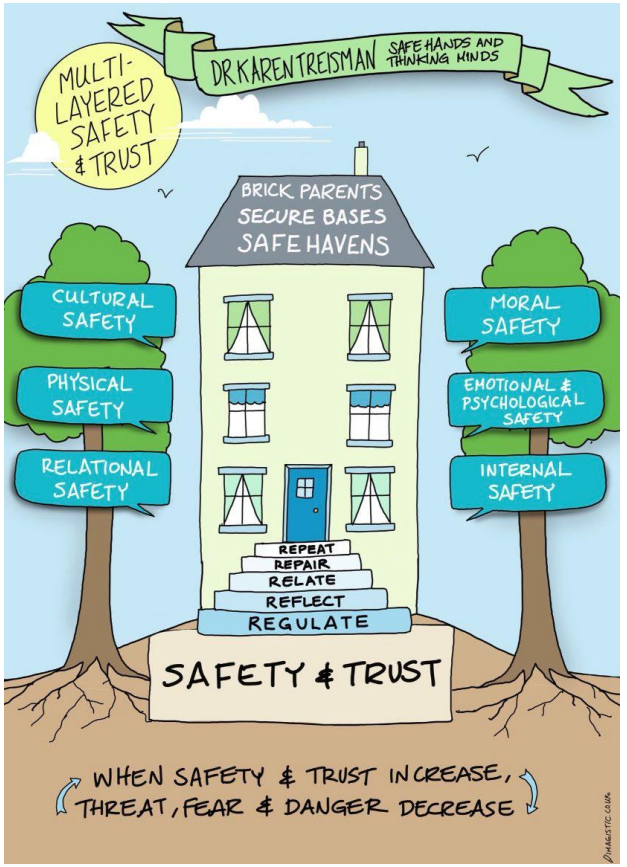
How often do we have focus on behaviour rather than happiness?

Can we expect behavioural change when QoL doesn't support it?

Using QoL as an outcome measure?

Trauma

- If you have a neurodiversity should we assume trauma due to strains and conflicts of living in a neurotypical world with neurotypical expectations?
- Are you routinely screening for ACEs? Or considering how to prevent/reduce impact?
- Are we being 'informed' by a person's trauma, asking 'why' rather than acting to contain/shut it down (of course while maintaining safety)
- How do we support practitioners to have non blaming but transparent conversations about trauma?



And then some PBS

- It's a framework of support rather than an intervention.
- It supports the construct that behaviour is about unmet need (what's the big WHY?) and helps us have a person centred and values based approach to understanding that need.
- It gives us some tools to help us assess that need (Functional Assessment) and a structure of graded support.
- Usually you will have a plan which will be implemented, supported and monitored, it's not a quick fix and needs the 'system' to be able in a place to tolerate change; it needs some **hope** (more on this in a moment).

Function and Meaning

- Escape and Avoidance
  - I feel so anxious I couldn't possibly do that!
- Attention and types of attention
  - Will someone take you away from me?
- Sensory feedback
  - This distracts me from that other pain that's always there
- Tangible Gain
  - Getting that thing made me feel so good last time, and I'd love to feel like that again

Self Injury

Be mindful

- Chronicity
- Long term harm
- Visibility
- Priority
- Emotional Impact on System/Counter Transference

Find your psychological support

Skills

- Who needs to know what & who needs to learn what?
- Long term planning, if we never start we will never finish

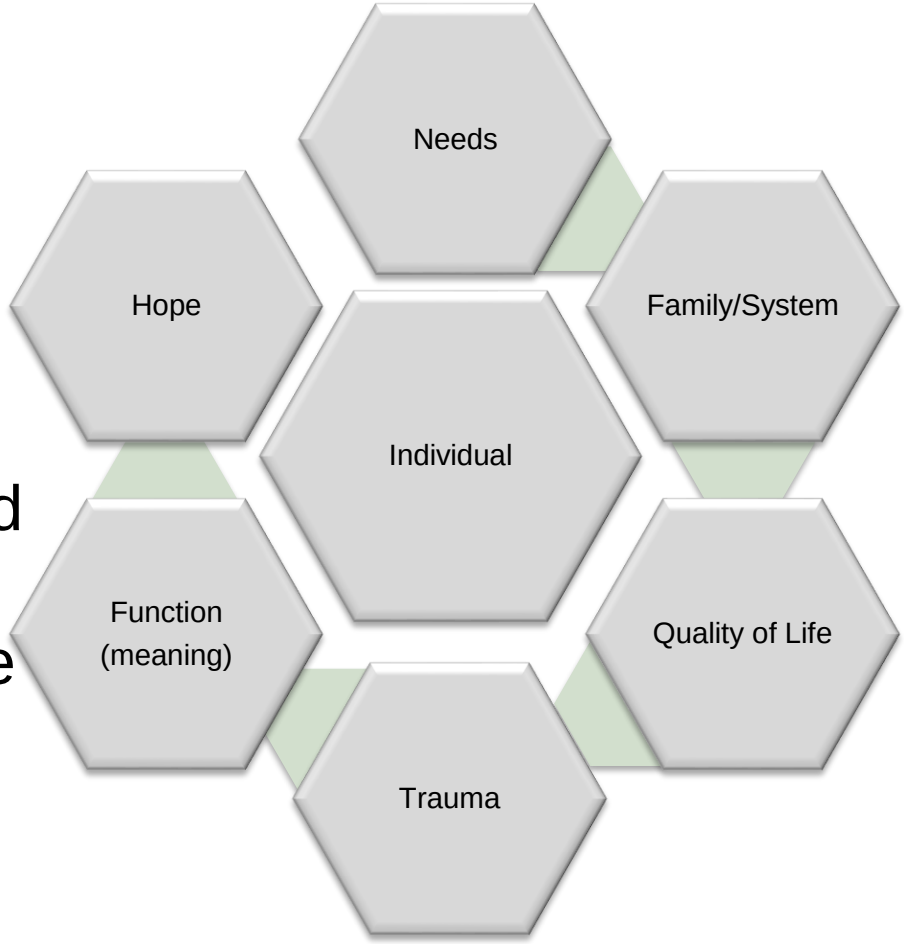
- Functional Equivalents
- Self soothing (how to find your calm)
- Saying ‘no’/declining (and other’s listening)

Restrictive Practice and Interventions

- Recognise and challenge interventions and strategies that are shaming or aversive.
- Recognise impact of repetitive use of Physical Interventions and long term exclusionary practises (it's Trauma again).
- Having a plan that aims to reduce restrictive interventions when assessment suggests it's the best way to keep everyone safe (we can't keep that door locked forever)

Hope

- Interventions without hopeful systems have limited efficacy
- Positive Family Interventions and integrated team working encourage situations that allow change to occur, minimising harm for all.



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‘Medical’ Treatments for Behaviour That Challenges

Dr Mark Lovell

Consultant Child and Adolescent Intellectual Disability Psychiatrist

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Physical health

- Assessment: Systematic review of systems- Neuro, musculoskeletal, skin, GI, GU, Cardiac, Respiratory, endocrine, blood, dental, sensory
- Consider conditions that cause:
- Pain
- Discomfort- hunger, itching
- Confusional states eg Epilepsy
- ‘Irritable’ states eg Sleep, Glucose
- Energy levels eg Electrolytes, Iron
- Eating/feeding- eg PICA/ADHD and Iron deficiency.

Mental Health

- Anxiety- particularly change/transition/fear of the unknown, PTSD, ICD, phobias, generalised
- Bereavement/loss
- adjustment reactions to events/triggers
- Mood- depression/bipolar
- Psychosis- schizophrenia
- Complex Trauma
- Conduct disorders (aggression, refusal, breaking rules)
- Catatonia eg in ASD

Neurodevelopmental Conditions

- ADHD- impulsivity, attention, hyperactivity (emotional regulation, frustration)
- ASD- social communication, repetitive behaviours(aggression, self injury, emotional regulation)-
- ID- IQ, adaptive behaviours (understanding, skill sets)
- Tics- motor, vocal (social acceptance)

TREAT THE CAUSE!

- Otherwise you are allowing the cause to continue- ethics!
- Go earlier in a chain: trigger-anxiety-anger
- You need to have looked thoroughly for a cause 1st
- Physical interventions may not be just medication
- If treatable side effects, treat them too, or change medications

Hyperarousal as symptom

- Awareness of duration of the hyperarousal- may settle before a PRN treatment would help
- Frustration
- Anger
- Aggression

- Sometimes you have not identified a cause, or the cause can't be treated or treating the cause is taking too long- to manage risk/reduce distress you may need to treat the symptom.

Medical options for hyperarousal as a symptom

- Sedating agent:
- Antihistamine- eg promethazine
- Benzodiazepine eg lorazepam, diazepam
- Antipsychotic eg Risperidone, Aripiprazole

Considerations- Why?

- STOMP-STAMP campaign
- Effects- what do we want it to do?
- Side effects (of the medication, of the effect, sedating agents may lead to inhibition)
- Evidence base- the research
- Licensing- Risperidone has a short term license for serious aggression in ASD or Conduct Disorder (becomes off license after 6 weeks)
- Guidance eg NICE, CBF, Maudsley

Considerations- Who?

- Who is this treating?
- Who does it benefit?
- Preferences- of the person, parents etc

Considerations- What?

- Choice of medication type
- Choice of specific medication
- Available preparations- dose options, liquids, tastes, ability to swallow tablets
- Awareness of doses, rate of change, monotherapy, side effects, interactions.

Considerations- Where?

- Specific to situations/locations eg home vs school,

Considerations- When?

- Duration of action- PRN vs regular (pros and cons)
- When to start
- When to stop
- How long for?
- Exit strategy?
- Timings- over the day, over the week, weekends, holidays

Considerations- How?

- How will we know if it's worked?
- Balance of risks- to the person, to others
- Ability to monitor for harm?
- Difficulties with getting blood tests, blood pressures, ECGs etc
- Legislation- children act, mental capacity act, mental health act

Remember for Behaviour That Challenges management:

- Often Socio-psycho-bio
- Bio-psycho-social (only when a clear physical/mental health cause is identified)

Conclusion: Clinical experience

- The more experienced and skilled the MD/MA team are, reduces the likelihood of prescribing solely for the symptom of hyperarousal

- Need for good social support- respite, activities
- Good educational support
- Good support for parents/carers
- A skilled team in understanding PBS, attachment, communication, sensory, physical and mental health identification.