

Positive Behaviour Support Policy

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Scope

This policy applies to all National Autistic Society schools, young people and adult services that provide support for people where we have a duty of care. This policy should be read in conjunction with other NAS policies including: safeguarding, Restrictive Physical Intervention (RPI) and bullying.

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

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Purpose

This document aims to ensure a common understanding across the National Autistic Society services regarding why autistic people behave in the ways that they do, taking into account the impact of having autism alongside an individual's own life events and experiences. It aims to describe a range of factors which impact upon/contribute to the behaviour of autistic people. This in turn will inform both general strategies that can be effective for many of the people that we support, as well as detailing more individualised proactive and, as a last resort, reactive strategies and considering more complex behaviour of concerns that can challenge individuals and services.

Introduction

Autistic people can see and experience the world in ways that are sometimes very different to those without autism. A consequence of this is that autistic people can behave in ways that are different to what many people might consider 'socially appropriate and socially acceptable'.

The first concern when working with those people in our services who behave differently is to determine whether behaviours that staff may see as 'inappropriate' or different are dangerous for the person displaying the behaviour or to those around them, are illegal or significantly inhibit the individual's access to the community and learning opportunities, or are a sign of heightened anxiety and/or distress. If this is not the case then our role rather than trying to 'change behaviour' is to raise awareness throughout the wider community, working as individuals and as an organisation to change attitudes towards autistic people whose behaviour may appear unusual or different.

Legal context

A variety of pieces of legislation, in England & Wales, Scotland, or Northern Ireland cover the care of children, young people and adults. All relevant legislation is found in the reference section at the end of the policy.

Challenging Behaviour (or Behaviours of Concern)

Some behaviour displayed by people who access NAS services may be described as 'challenging'.

Challenging behaviour can be defined as:

'...behaviour of such intensity, frequency or duration that the physical safety of the person concerned or other people is at serious risk, or the behaviour results in the person only having limited or no access to ordinary community facilities'

Emerson, Eric (2001).

Behaviours that may challenge include those with the potential to cause harm. However, other behaviours, including those related to disengagement, demand avoidance, requests denied, withdrawal from interaction, repetitive routines or questioning, can often challenge staff and services as much as the more obviously physically challenging behaviours.

Factors affecting behaviour:

A variety of factors may influence a person's behaviour and contribute to incidents of challenging behaviours. *Autism itself is not a cause of challenging behaviour. Rather the impact of being on the Autistic Spectrum within this social world combined with other factors such as those highlighted below come together leading the individual to respond differently and display behaviours which challenge others.*

- ***Impact of Autism***

Autism is a lifelong developmental condition which results in 'hard wired' differences in how parts of the brain are structured. Autistic people are likely to perceive, interpret, process and experience the world in a different way.

All autistic people have a dyad of impairments as set out in DSM-5 (08/2015) that affect each individual to a greater or lesser extent. The impairments are:

- ***Social communication and Social Interaction***

Autistic people tend to develop a 'Theory of Mind' at different times or to a different degree as the rest of the population. This means that it is difficult for autistic people to understand that others have independent thoughts and thus different perspectives from their own. This can cause a variety of problems in terms of interacting with others as an autistic person will be at the very least delayed in their ability to understand others' points of view, or struggle to realise that communication is necessary for others to understand and meet their needs. For example, an autistic person may feel thirsty and then become frustrated when a carer or member of staff does not help them to get a drink, before they have asked

Autistic people find it difficult to process and understand the social world. Social rules and conventions that most people learn intuitively often need to be explicitly taught and even then may not be fully understood and applied. Many autistic people want social relationships, but most struggle to know *how* to interact, and experience high levels of anxiety and stress in social situations. Some people with autism may find the social environment so confusing that they withdraw from interacting with others.

- ***Restricted, repetitive patterns of behaviour, interests or activities***

Autistic people have a difficulty with flexibility of thought. Some people with autism may find it very difficult to shift the focus of their attention and may become

stuck/fixated on a particular item or topic of conversation. They are likely to find dealing with novel situations challenging due to difficulties with generalising skills and experiences learnt from other situations. Often autistic people can find change and transition problematic, e.g. transitioning from home to their school or day service, or changes to expected activities. This can contribute to a reliance upon routines and predictability. .

- ***Sensory issues***

Many autistic people also experience differences in the way their sensory processing systems work. Some may be particularly (hyper) sensitive to noise so may hear, become upset or distracted by noise that most people would barely notice. Conversely others may be under (hypo) sensitive to touch so may need to exert extra pressure when touching objects or other people to receive the same sensory feedback.

Most autistic people have issues with sensory processing and integration meaning that they may struggle to process and understand the information coming in from a variety of sensory modalities. They may struggle to filter out irrelevant information and to concentrate on what is necessary.

- ***Additional stressors***

While we must always recognise a person's autism is likely to pose the above challenges, autistic people are just as likely to be affected by other factors which affect their mental health and emotional wellbeing as the rest of the population, and are sometimes at increased risk. Lacking or poor emotional literacy/regulation difficulties can also significantly contribute to incidents of challenging behaviours. Autistic people are also at risk of developing mental health difficulties especially anxiety disorders which again can contribute to the onset of incidents of challenging behaviours.

- ***Life events and experiences***

Autistic people, like others, are affected by life events and experiences such as bereavement including changes (losses) of people supporting, moving house, puberty, family breakdown etc.

- ***Illness and wellbeing***

Illness and pain can affect how a person behaves especially if unable to properly communicate this pain to others.

Autistic people may also suffer from low self-esteem, be bullied and excluded and therefore feel lonely.

Level of Stress

Autistic People often experience high levels of stress. This is true for autistic people across the spectrum – those with limited verbal expression may experience stress and anxiety related to difficulties communicating and understanding the world around them. Those functioning at a higher level may have more insight and awareness into their difficulties and differences in comparison with other people their own age. Those supporting them may overestimate their abilities and hence not always provide effective support.

High levels of stress can emphasise and increase those other difficulties described above.

Positive Behaviour Support

The National Autistic Society follows an ethos of Positive Behaviour Support (PBS)

- PBS seeks to discover the function and/or communicative intent behind behaviours through the use of good quality functional assessment (Incident forms, observations, ABC charts etc.).
- Interventions that teach functionally equivalent alternatives to difficult/challenging behaviours can then be planned.
- It is a non-aversive approach meaning that the focus is on positive behaviours, strengths and skills of autistic individuals and rewards and teaching equivalent new skills, rather than punishments and sanctions.
- There is a focus on determining antecedents to behaviour and then removing or minimizing effects.
- Teaching functional communication that is relevant and useful for the individual is paramount.
- PBS emphasises enhanced community presence, choice participation and a person centred approach to behaviours rather than solely focusing on behavioural change.
- Restrictive practices and physical interventions are kept to an absolute minimum and always used only as a last resort 'There Is No Alternative' (TINA) principle.

General proactive strategies

Good general proactive strategies that take into account the factors that influence the wellbeing and behaviour of autistic people are vitally important to reduce the likelihood, severity and frequency of behaviours that might become problematic for the person themselves, staff or the wider public.

A variety of autism specific strategies can be used that focus on the relative strengths of autistic people and aim to reduce heightened levels of anxiety and distress. These should be adapted to meet individual needs. For example these can include:

- Clear visual supports.
- Use of clear, simple and 'economical' language.
- Structuring the environment in a way that is visually clear to the individual
- Use of structure to help individuals understand what they are doing, how long they might be doing it for and what they will be doing next.
- Use planned transitions for all changes.
- This may include pictorial or written timetable, objects of reference or photographs, timers.
- Low arousal environments.
- Teaching new skills in a calm low arousal environment with these visual supports, before generalising to more 'real life' environments.
- Explaining clearly reasons for decision, boundaries and expectations.

Specific interventions

Proactive

Proactive strategies use knowledge of an individual's likes, dislikes, triggers and cues to behaviour to identify potentially difficult situations and avoid the behaviours of concern from occurring.

This would include: teaching coping and tolerance strategies, stress management and relaxation techniques, changes to the environment, providing alternative ways to meet the same need (function) the behaviour achieves (e.g. use of sensory items to chew on to counterbalance the need for biting), providing structured times for appropriate engagement in activity (e.g.: banging on drum timetabled 3 times a day to fulfil the need to bang on windows).

Reactive

It is important to recognise that overly emphasising the role of physical interventions as a 'management tool' for supporting those with challenging behaviours/behaviours of concern may actually be counterproductive to the cause and increase risk to vulnerable people. Indeed the evidence base supporting such training has been questioned and it has been suggested that the field of training in physical interventions is dominated by commercial interest and a complete lack of evidence base, McDonnell (2009). Reactive strategies are used once a behaviour has occurred to manage the behaviour and aim to de-escalate the situation as quickly as possible.

Reactive strategies include:

De-escalation techniques: reducing demands and requests, removing triggers, distracting and motivating, redirecting, diverting the focus of attention, controlling

sensory input in line with the person's needs (e.g. turning off lights, reducing noise and language).

On some occasions when there is no alternative (TINA Principle) and as a last resort it may be necessary to use a restrictive physical intervention (RPI) to keep the person displaying behaviours which harm or those around them safe – see RPI policy SO-0039.

Individual Behaviour Support Plans (ISPs / BSPs)

Every autistic person will have had different life experiences and have unique characteristics, personalities and interests, as well as dislikes and potential sources of stress. Therefore each person who requires support from NAS services requires their own individual positive support plan.

The people we support will have, where appropriate, an **Individual Behaviour Support Plan (ISP/BSP)** to assist in the management of their anxiety, distress and behaviour. We use the term 'support' as we recognise most behaviour results from unmet needs and therefore we focus on how we must provide support to meet those needs, not solely on the behaviour causing concern. The intention and aim is for people to be increasingly more independent in the management of their own behaviour, learning to self-regulate, developing their wellbeing. All ISPs / BSPs should be written in line with the following principles:

- ISPs / BSPs are drawn up by the staff who know the person well, with advice from other staff with responsibility for behaviour management. Ideally families, the person supported and other stakeholders should be consulted and contribute to these plans.
- ISPs / BSPs may identify motivators (likes), causes/ antecedents/ triggers/ dislikes and sensory issues as relevant. General management strategies may be given as well as specific proactive and reactive strategies for all identified behaviours. The ISP/BSPs should be concise, clear and functional to ensure that consistent behaviour management is achievable across different settings and with different staff.
- Where an individual supported has the capacity to do so, they should have an input into their ISP/BSPs. Where they do not have capacity, the plan should be agreed as in their best interest and agreed by relevant people who are involved in that person's support (family / parent / carers / care manager / social worker / key support staff / stakeholders etc.)
- Each person's ISP / BSP is reviewed as and when required according to individual need. The relevance and effectiveness of each ISP / BSP will be assessed at least annually and modifications made as necessary.

- Strategies used will be evidence based and data will be used to ascertain the effectiveness or otherwise of strategies
- Within 48 hours of a placement starting an initial ISP / BSP should be put in place where required. This should be reviewed regularly during a baseline period and a final ISP / BSP in place by 12 weeks after the placement starting.). The longer term support for that individual must include strategies for proactive intervention that will reduce the use of any restrictive practices.

Where a person has a restrictive practice as part of the reactive strategy in their plan this must be agreed as in the best interest of the individual and the use of the reduction reviewed on a regular basis (at a minimum of six monthly and quarterly for bespoke or enhanced methods of restrictive intervention).

The long term aim will always be to try to empower the autistic individual to be aware of their own triggers and cues and to give them the skills to manage their own behaviours to the best of their ability. Where appropriate, it would be best practice to include a young person or adult in compiling their IBSP. This can assist with our overall aim of helping autistic people to manage their own behaviour.

Self-Injurious Behaviour (SIB)

In our schools between 40% and 60% of the children and young people may at some time exhibit **self-injurious behaviour** of varying degrees of intensity. Self-injurious behaviour can also be seen in adulthood.

In a minority of cases of self-injurious behaviour, the tissue damage from any one incident is serious but for most the injuries are minor e.g. bites that do not break the skin or head tapping. However the cumulative effect of many instances of behaviours such as dropping to the floor on knees, eye poking or head banging could result in permanent tissue damage, so all instances of self-injurious behaviour must be carefully recorded, understood and analysed and inform appropriate individualised positive strategies/interventions to minimise the risk of harm.

The NAS recognises that self-injurious behaviour can be one of the most difficult behaviours to support as it can be resistant to change and emotionally draining for parents, carers and staff. Self-injurious behaviour should be supported using the same analytical, positive and low arousal approaches as any other behaviour that gives rise to concern. The function of the behaviour should be ascertained if possible and the individual taught alternative, less damaging, ways to meet his or her needs.

The following points must be considered when devising an individual support plan for self-injurious behaviour:

- Physical health problems such as headaches, stomach ache, tooth ache or generally feeling unwell can be a trigger for self-injurious behaviour. Appropriate clinical investigations should be sought whenever behaviour changes or intensifies, without there appearing to be a cause.
- Ritualistic, rigid behaviours are often connected with self-injurious behaviour. Physically intervening to stop self-injurious behaviour that is part of a routine can be counterproductive as the person being supported will try to complete the routine later, often when they are in a heightened state of anxiety resulting from the previous prevention.
- The use of head gear to reduce damage from head banging should only be used where there is no other strategy available as in some cases the wearing of head gear can result in the person banging harder to achieve the same effect or more frequent banging.
- Some people who display self-injurious behaviour also have a history of behaviour which harms towards staff and others, sometimes resulting in serious injury. Any direct staff intervention, including the use of a planned RPI, must be carefully assessed in these cases and the risk of greater injury to the person concerned or to staff associated with intervening balanced against the risk of not directly intervening.

Strategy in the Management of SIB:

- Good quality functional assessment based on incident data and any further recording should inform strategies that are adopted. These strategies should be in line with positive behaviour support principles.
- In the first instance staff have a duty of care to intervene to reduce damage caused by these behaviours. However, sometimes the best support strategy to prevent increase in potential injury is to ensure that the individual is as safe and as comfortable as possible but make no direct intervention and/or contact, especially trying to stop the behaviour, until the episode is over. This can result in shorter episodes with less likelihood that the self-injurious behaviour will escalate and result in more serious injury. Such supervision without direct intervention should be agreed with relevant external parties such as parents and the local authority.
- Pain relief and medical investigation should be considered in the presence of new self-injurious behaviours but always agreed as part of a multidisciplinary intervention.

- Chewy tubes, apples, oranges or similar may be offered as safe alternatives to those who may bite themselves, as outlined in the ISP/BSP.
- Pillows or cushions may be used to reduce impact of head banging behaviours.
- People who display self-injurious behaviour often have lower levels of functional communication. Teaching functional communication skills at the appropriate level is a key strategy in trying to reduce self-injurious behaviour.
- Increased structure, extra sensory opportunities, teaching self-regulation and relaxation strategies, and physical exercise can all help reduce frequency and intensity of self-injurious behaviour.
- Staff should try to respond in a calm neutral manner in the presence of SIB and reward and praise appropriate behaviours wherever possible.
- If possible staff should try to redirect the individual to a preferred activity that is incompatible with the self-injurious behaviour. E.g. squeezing a stress ball if engaged in hitting self.
- Self-stimulatory behaviours may have an inverse correlation with self-injurious behaviour, so a decrease in one is associated with an increase in the other. Therefore extra care should be taken when trying to change self-stimulatory behaviours and appropriate, safe alternatives should be taught.
- Where there is any evidence of tissue damage or there is persistent low intensity self-injurious behaviour, first aid for the damage or possible damage must be given.
- Care needs to be taken over the recording of self-injurious behaviour to ensure that persistent low intensity self-injurious behaviour, which could lead to long-term damage, does not go unrecorded. Parents and carers should be informed of any significant incidents involving self-injurious behaviour with the individual's knowledge, where appropriate and possible.
- Providing treatment, support and care for people who exhibit self-injurious behaviour is emotionally demanding. Not all staff are equally confident in managing self-injurious behaviour and some find it more distressing to observe than others.
- Management needs to ensure that the staff supporting people who exhibit more intense self-injurious behaviour have sufficient competence in their ability to fulfil their role.
- The NAS recognises that staff supporting people who show self-injurious behaviour are in a potentially vulnerable position; if the individual sustains serious

injury the quality of their care is likely to be questioned and the reputation of the service may be harmed. Services must ensure that staff are appropriately trained, supported and prepared to deal with challenging situations and at the very least must make sure they are aware of and understand the IBSP of each person for whom they have responsibility.

- In an emergency, staff can only fall back on their professional experience and judgement of the situation, their training, their common-sense, the 'best interest' principle and their over-riding duty of care to wherever possible prevent harm to a vulnerable person. Provided staff act reasonably, proportionately and sensibly, their actions will be supported. Any such emergency action must be carefully recorded on an incident form.

Sanctions

Definition

Reactive strategies: sanctions and natural consequences

A sanction can be defined as any negative consequence applied to an individual in response to undesirable or challenging behaviour.

We believe that any approach biased towards the use of sanctions or aversive consequences in the management of behaviour would be both unethical and ineffective. Our emphasis is, therefore, on the development of person centred, proactive, and positive support, based upon a comprehensive understanding of a child's emotional, behavioural, and educational needs.

A distinction is made between sanctions and natural consequences. Natural consequences represent the outcomes, positive or negative, resulting from a child's actions. We recognise the importance of allowing children to experience the natural consequences of their behaviour. Natural consequences provide a valuable learning experience, enabling the child to establish links between their actions and outcomes. To deny a child the natural consequences of their actions may risk reinforcing an unhelpful or dangerous pattern of behaviour.

Some natural consequences to behaviour might be experienced negatively by the individual. For example, if a reward is contingent upon the demonstration of particular positive behaviours, a child may be unsuccessful in achieving their reward if the target behaviours have not been demonstrated. Natural consequences might also be imposed in the interests of safeguarding the welfare of students and staff. For example, it may be necessary to amend a child's timetable of activities in response to incidents of challenging or dangerous behaviour. If this were to be the case, the natural consequence of the child's behaviour (in terms of missed activities) might be experienced negatively by the individual.

When working with individuals with special needs a sanction is usually taken to mean: **'Any negative consequence applied for unacceptable behaviour'**. Examples might be loss of some recreation time, missing a trip or treat. In the literature and legal guidance a number of other terms are used in place of 'sanctions' such as 'punishment', 'loss of privileges' etc. For clarity only the term 'sanction' is used here.

Sanctions must not be used in adult services without the explicit support of the behaviour support team and a plan to reduce the need for any sanction must accompany the relevant ISP / BSPs. Any sanction must be agreed as in that individual's best interests.

Principles for using sanctions

- The use of sanctions in the NAS is based on a number of principles thus:
- Sanctions would only be used as a planned intervention when PBS alone has not been successful. Sanctions must be agreed by the Multi-Disciplinary Team who agree that it is as in their best interests.
- Any use of sanctions must be based on establishing a positive relationship with the child / individual and must be designed to teach them alternative responses to the behaviour patterns of concern.
- Sanctions should only be used for children and people who staff judge to have the capacity to understand the connection between their behaviour and the sanction. An assessment of this capacity must be undertaken and recorded in that individual's file prior to any sanction occurring.
- Any use of sanctions must be appropriate to the age, understanding and individual needs of the person, and be applied fairly and consistently by staff.
- The sanction used will be proportionate to the inappropriate behaviour.
- Sanctions should be designed to reduce the likelihood of the behaviour reoccurring and reviewed on a regular basis.

Staff will receive information on the use of sanctions as part of their training on supporting child behaviour. **Restorative actions – an alternative to sanctions.**

- Restorative approaches promote accountability and seek to repair any harm caused in a situation. Restorative conversations can happen during the school day, with school staff using restorative language and questions to allow children to understand the impact of their behaviours. Through the restorative conversation, a number of action points may be defined to enable situations to be repaired, and to help foster positive relationships.

- As with the facilitation of natural consequences, restorative actions must take account of the young person's capacity to understand the connection between their behaviour and the outcome.

The restorative conversation can be broken down into four parts with acronym – WARM -

- **W**hat happened – giving everyone in a situation a chance to be heard
- **A**ffected – who has been affected? How have they been affected?
- **R**epair – what actions need to happen to repair the damage?
- **M**ove forward – what needs to happen to ensure this situation does not occur again?

Recording, reporting and monitoring of sanctions

- There should be documented evidence of the Multi-Disciplinary Teams / Best Interest discussion, e.g. minutes that have been agreed by all stakeholders and in that individual's best interest.
- Any use of sanctions should be referenced on the young person's ISP / BSP (e.g. the circumstances and effectiveness) to inform future practice. This will be reviewed in line with ISP / BSP updates on at least a quarterly basis.
- Every use of a sanction must be recorded in the appropriate sanction book / sanction record sheet before the relevant staff member goes off duty.
- Sanction books / records must be made available for inspection when required by proper authority.
- Sanction use must be monitored by senior staff and any frequent use of sanctions without evidence of improvements in behaviour must be investigated.

Training

Staff will receive initial training in Positive Behaviour Support and/ or Studio 3's 'Managing challenging behaviour' three day course as soon as it is feasible for each service and one day refresher sessions every 12 – 15 months.

Staff will receive Understanding Autism training and Positive Behaviour Support training as part of their induction.

Staff will complete Ask Autism Modules on-line training as part of their induction.

Staff will receive appropriate training either delivered internally by the Positive Behaviour Practitioners/Coordinators and/or Psychology, Speech and Language or Occupational Therapy teams (Transdisciplinary Teams (TDT) or other professionals with relevant experience in autism and positive behaviour management; additional specialised training will be sourced externally when the need arises.

Reporting recording and monitoring

- Challenging behaviours (behaviour of concerns) will be recorded using incident recording systems or other data gathering methods to assist in monitoring behaviours, functional assessment, and ascertaining the effectiveness or otherwise of behavioural interventions.
- Where behaviours are recorded routinely, data should be monitored regularly to ascertain trends and patterns.
- Unexplained or sudden changes or increases in challenging or concerning behaviours should always be investigated.
- Regular reports on the incident data for services should be made to the senior staff.
- All serious behavioural incidents should be reported to senior staff immediately.
- Results from behaviour recording or behavioural interventions should be shared with parents and carers, and funding authorities where appropriate.
- Injuries or accidents arising from behavioural incidents must be recorded in accordance with the relevant policies.
- Every use of a restrictive physical intervention (RPI) arising from a behavioural incident must be recorded in accordance with the RPI policy and reported to Senior Management Team as required.
- In some cases an individual may display behaviours that staff are not able to manage with the skills they have been taught or within the environment the person is living or accessing. In this situation it is essential that a care review meeting is called with representation from the family, local authority and the NAS to review the support package and agree on future interventions.
- Self-injurious behaviour that is likely to result in serious permanent tissue damage should, in addition to taking the appropriate emergency action, be discussed at a full case conference with an agreed recommendation to the Director of Adult Services / Director of Educations for Schools.
- Serious or persistent violence and extreme anti-social behaviour – e.g. serious injury or damage such as arson - should, in addition to contacting the police or other relevant agencies, be discussed at a full case conference with an agreed recommendation for further action passed to the Director of Adult Services or the Director of Education Schools.

Responsibilities

Trustees

- Ratification and review of the policy on the management of positive behaviour in services.
- Reviewing reports from the Responsible/Nominated Individual on the incidence of self-injurious behaviour (delegated to the Quality and Risk Committee).

Directors - Adults/Education

- Monitoring of implementation of this policy;
- Ensuring the allocation of internal and external resources ,including clinical, to address the needs of children/young people, adults and staff with regard to the implications of more serious or prolonged behavioural challenges.

Service Managers

- Ensuring and supporting in the implementation of this policy in their service.
- Ensuring that a comprehensive recording and reporting process relating to behaviour support is in place and is regularly reviewed.
- Ensuring that the behavioural support systems in place in the service are used competently through regular monitoring and training of staff.
- Ensuring that support teams develop risk assessments and individual behaviour support plans which detail behavioural support strategies.
- Ensuring plans are shared with the individual, using the method of communication most appropriate to them, parents/advocates, purchasers and other interested agencies, recognising the importance of consent in terms of the fundamental issues of respect and dignity and mental capacity.
- Ensuring that individual behaviour support plans are regularly reviewed and updated in the light of people's development and progress.
- Ensuring that staff have access to advice and support from specialists in behaviour support where necessary. This can be from within services, such as psychology staff and behaviour coordinators, and/or through using external consultants.
- Ensuring that parents and carers are kept regularly consulted on their dependent's response to his or her behaviour support plan and that any

significant events are communicated promptly. Parents and carers should be made aware of serious behavioural matters without delay.

- Ensuring that training in the management of the behaviour of people we support is provided for staff. Where specific training needs to help particular staff support people's behaviour have been identified, ensuring that those staff have access to the advice, training and development opportunities appropriate to their needs.
- Providing regular information to their Area Manager and Director of Adult Services or Executive Director - Schools.

Staff

- To treat all people who use our services fairly, with respect and understanding while having regard for their rights and responsibilities.
- To work always in the best interests of the person, having high expectations of people's behaviour and to strive to ensure that all people work to the best of their ability.
- To assist the people we support to manage and improve their behaviour as part of everyday activities. Helping people to manage their behaviour is just as much a team effort as managing all other aspects of their life.
- To thoroughly familiarise themselves with the current behaviour and person centred support plans for the people they support and consistently apply the strategies described.
- To satisfy themselves that they are clear on what they may and may not do in terms of behaviour support, and to seek clarification as necessary;
- To record and report behavioural incidents as required by the systems in the National Autistic Society service.
- To contribute to the development of support plans.
- To report any changes they notice in the individual's response to their ISP to the team supporting them.
- To use staff review, Support and Supervision, sessions to confirm their understanding of this policy and to seek further explanation or personal development as necessary
- To take part in training in managing challenging behaviour

- To support other staff in the team and demonstrate confidence in each other's skills and abilities to support people.
- To provide appropriate models of behaviour for people they support at all times.
- Personal likes and dislikes and values with regard to culture, age, sex, religion, must not influence staff's approaches.
- To seek help with managing behaviour when necessary; it is not a sign of failure to do this.
- To dress appropriately whilst at work and to adhere to service dress codes when asked.
- To wear clothing to help protect them when working with individuals in crisis as specified on individual Risk Assessments. This will be decided on a case by case basis, having regard to the dignity of the individual and the safety of the staff. Protective clothing shall be as neutral and non-stigmatizing as possible e.g. caps for tying hair back, discreet arm guards and shin guards etc.
- To make judgments in the light of this policy and to act within the service's procedures on managing behaviours of concern. However, as no policy or procedure can cover every eventuality, staff are expected to use their professional judgment and experience when supporting individuals. Staff will be supported when action in good faith follows from such judgments. The following judgments can reasonably be expected of staff:
 - Deciding on the best course of action to keep the people they are supporting, and staff, including themselves, safe.
 - When deciding on the need for action, however rapidly, considering the risk of immediate danger to persons or property.
 - Deciding on the appropriateness of intervention in keeping with the behavioural incident that gives rise to it
 - Taking into account the age and competence of the individual in deciding on the degree of intervention necessary.
 - Whether to intervene in an incident even if the member of staff has not signalled they need assistance.
- Senior staff are responsible for ensuring staff support systems are in place and are being used. This will include ensuring that post incident debriefing is offered to the staff involved.

- Debriefing will be offered on the day of the incident, the recipient can express a choice of who debriefs and the information will be kept confidential.
- Senior staff have a responsibility to demonstrate trust and confidence in the staff's ability to manage the people they are supporting. If shortcomings in such management are identified, senior staff have a responsibility to address these through Support and Supervision and Appraisal.

Staff are expected to implement the approaches and strategies they have been taught in training when supporting an individual who is displaying challenging behaviour.

Debriefing:

- It is essential that all services make good use of the systems in place for staff debriefing and support where they are working with people who show challenging behaviours, including self-injurious behaviours. All staff working with people who show high levels of self-injurious behaviour should have regular supervision in which the emotional impact upon them can be discussed and understood (see Stress at Work policy HR-0024).
- As debriefing is not professional counselling, all staff should be made aware of the 'Health Assured Employee Assistance Programme (EAP)' the employee assistance scheme (0800 716 017).
- It is important for staff to recognise when they need more specialist clinical support in managing self-injurious behaviour, and how to access this. The commissioning authority should always be involved where there are serious incidents of self-injurious behaviour which need further clinical input, and decisions should be made within the context of a multidisciplinary meeting including families wherever possible. Where appropriate, referrals should be made to other relevant services for additional support.
- Staff should also ensure the people we support have a meaningful debrief at their level of understanding after being part of or witnessing incidents. For some this may involve talking about what happened for others it may involve spending some calming time with favoured staff and/or activities. Careful monitoring of people supported need to be ensured.
- Debriefing ought to always be offered and facilitated, however staff will not be made to attend a debriefing if they chose not to.
- Debriefing will always take into consideration confidentiality, respect and safety of the debriefed.

Parents and Carers

To work collaboratively with the service so that the people being supported receive consistent messages about appropriate behaviours.

- To take part in a supportive dialogue with the service about the individual's behaviour, each informing the other promptly if there are causes for concern or celebration.
- To be familiar with and support the strategies in the individual's behaviour support plan, contributing to its development if possible through the ongoing consultation process.
- If parents or carers have concerns over the service's management of their dependent's behaviour to raise the matter with the service in the first instance. If the concerns remain and/or the issues cannot be resolved the complaints procedure can be used.

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 Compliments, Comments and Complaints Policy QS-0009 for further information.

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, Reference to NSPCC whistleblowing poster.

References

- Restrictive Physical Interventions Policy (RPI) SO-0039
- Whistleblowing Policy HR-0002
- Stress at Work policy HR-0024
- Compliments, Comments and Complaints Policy QS-0009
- Complaints Resolution in Schools Policy QS-0010
- SPELL
- Section 21 of the Education Act 2002 as amended by section 38 of the Education and Inspections Act 2006. www.legislation.gov.uk
- Sections 89 and 93 of the Education and Inspections Act 2006
- Section 550A of the Education Act 1996
- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) 2013
- Our Health, Our Care, Our Say, Department of Health 2006
- Use of Reasonable Force – Guide for Head Teachers, Staff and Governing Bodies, 2012, Department for Education
- ‘National Minimum Standards for Residential Special Schools’ DoH 2002
- Rights, Risks and Limits to Freedom, Mental Welfare Commission for Scotland, 2006
- Anti Bullying In schools and children and young people service policy SO-0193
- Emerson, Eric (2001). ‘*Challenging Behaviour: Analysis and Intervention in People with Severe Learning Disabilities.*’
Behaviour and discipline in schools: advice for Head teachers and school staff, Department for Education, 2016.

Legal Context References

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)
- The Human Rights Act, 1998
- The Care Act 2014

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

The latter framework of respecting the right to dignity, respect and freedom underpins the NAS philosophy of care.

Schools must also comply with equalities legislation and the duty to promote the wellness and wellbeing of pupils.

Further guidance / appendices

SO-0029-001 Initial Referral Form – Stage 1

SO-0029-002 Referral Screening Tool – Stage 2