
Cambridgeshire
County Council

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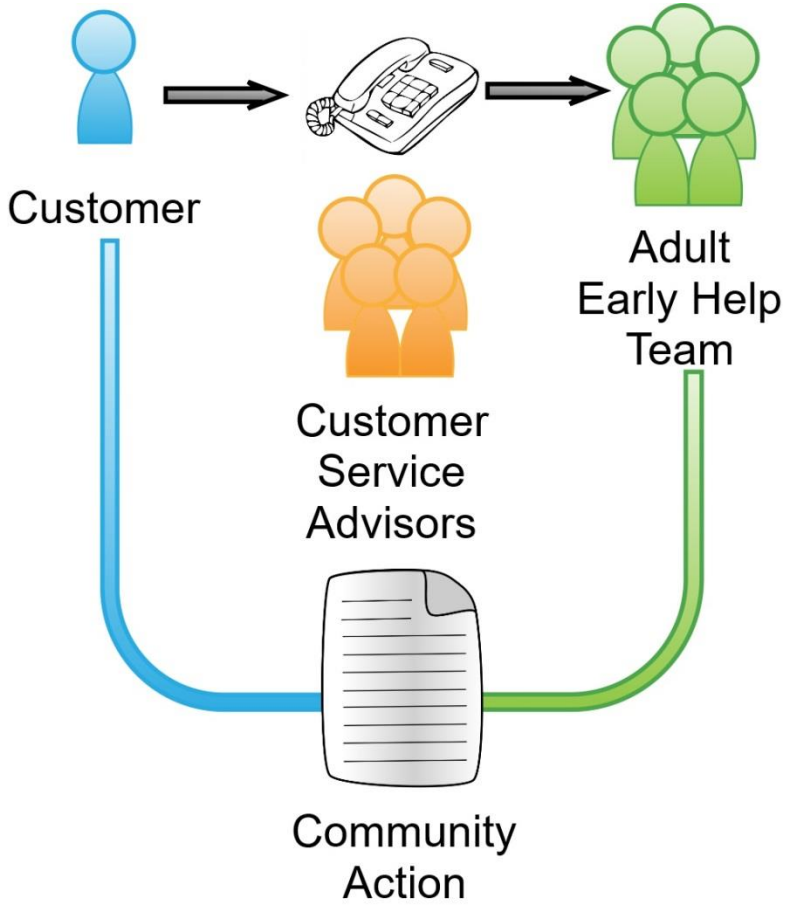
Early intervention and prevention
Adult Early Help Team

Stuart Brown – Team Manager

Cheryl Ging – Senior Social Worker

Who are Adult Early Help?

Our Approach



- Phone or face-to-face in-depth conversations.
- Focus on prevention and wellbeing.
- Build a plan around the customer, looking at outcomes and aspirations.
- Make use of natural and local support within the community.
- Break the link to long term care and promote empowerment and independence.
- Reduce hand offs to other teams and ensure early resolution.

Case examples

Andrew's mum called the team to request a Carers Assessment as she was at the end of her tether and wanted support to manage her son.

Andrew has a diagnosis of Autism and OCD. He was previously engaging with the Adult Autism Team but this relationship had broken down impacting on his behaviour and daily activities.

A visit was made and fortunately Andrew was there and happy to speak to me alongside his mum.

What did I do……. I listened to Andrew

What did he do …….. Andrew now works three days a week in a shop

Any thoughts or questions?

For referrals into service use:

Referral.centreadults@cambridgeshire.gov.uk

0345 045 5202

For advice from the team use:

Phone: 01480 373440

Email: Adult.EarlyHelp@cambridgeshire.gov.uk

Aim for today

- What is PROACT-SCIPr-UK®?
- What can it offer?
- How does it work?
- Who is it appropriate for?

PROACT-SCIPr-UK®

- P - Positive
- R - Range of
- O - Options to
- A - Avoid
- C - Crisis and use
- T - Therapy

- S - Strategies for
- C - Crisis
- I - Intervention and
- P - Prevention
- r - revised, used in the
- U - United
- K - Kingdom

PROACT-SCIPr-UK® GOALS

To improve the quality of life for the individual by providing staff with the necessary skills to provide a therapeutic environment.

To develop a proactive approach in the management of crisis.

To increase the competence and confidence of all those who deal with crisis.

PROACT-SCIPr-UK® is

…..a whole approach supporting individuals who challenge, providing a framework for how we work

Mission Statement

It is the intent of PROACT-SCIPr-UK® to minimise the use of physical interventions and to emphasise sound behavioural support strategies based upon an individual's needs, characteristics and preferences

PROACT-SCIPr-UK® Philosophy

- Early intervention
- Gradient approach
- Calming
- Prevention
- Encourages team work
- No pain or panic
- Encourages us to plan how we are going to work with an individual
- Physical interventions are just one small element of the whole programme

Levels of course on offer

- Induction
  - Duration: Approx 2.5 hours
  - Brief overview of PROACT-SCIPr-UK®
  - PI's as identified by risk assessment
  - Staff need to then attend full course
- Introductory & Foundation
  - Duration: 2 days
  - Requirement of Annual Refresher
- Refresher
  - Duration: 1 day
  - Course update / changed every year
- Instructor
  - Duration: 5 days
  - Requirement of annual Recertification

What the courses cover

- Understanding Behaviour / Challenging Behaviour
- Beliefs, Values & Attitudes & Reflective Practice
- Understanding the needs of individuals you support
- Positive Behaviour supports vs Behaviour Control
- Communication
- Calming Techniques / Gateways to Proactive Management
- The Whole Approach
- Managing the environment
- Legal Issues
- H&S (Positional Asphyxia)
- Staff support & Debriefing
- Record Keeping & Risk Assessment
- Lesson plans
- Presentations
- Assessment processes

Overview of support provided through PROACT-SCIPr-UK® Team

- Provide support with the development of behaviour plans
- Support / work with staff teams to put plans in place
- Work with differing PROACT-SCIPr-UK® services that support the same individual to develop a consistent way of working
- Provide support to parents, encourages positive working continues through from home -- day service -- out reach -- respite services -- moving on in own home / supported living.

PROACT-SCIPr-UK®

Who is it for?

Staff

Childrens services

Adults services

Older peoples services

Most importantly

Service Users

Parents

Family members

Carers

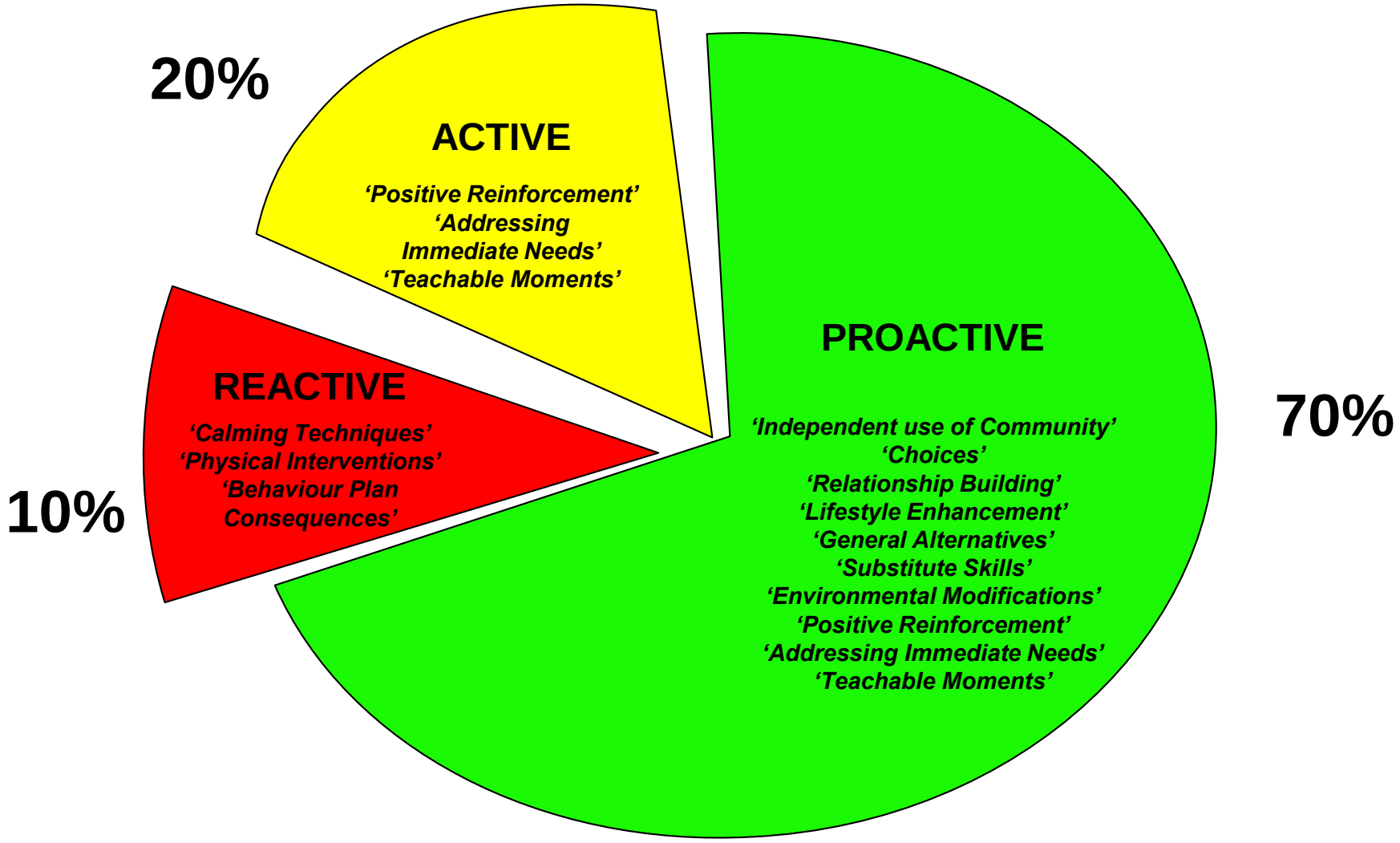
Providers that have signed up?

- CCC is now a PROACT SCIPr UK® Centre, this enables us to train instructors within our services and PVI and we can offer the ongoing support you don't usually receive from a training provider.

- Some providers access our training in PROACT-SCIPr-UK®
  - Cambridge Regional College
  - Branching Out
  - Edmund Trust
  - Parents / Carers

- Some providers access other types of behaviour training

The PROACT-SCIPr-UK® Gradient



PROACTIVE

Supporting Positive Behaviour

- Lifestyle Enhancement
- Environment Changes
- Response to Behaviour
- Teaching/ Maintaining Substitute Skills
- Teaching / Maintaining General Alternatives

The Whole Person Approach

- Person Centred Planning
- Communication
- Environment
- Opportunities for Leisure
- Relaxation
- Community
- Structure of the Day
- Direct Treatment Strategies

Whole Approach

- **The ‘whole approach’ looks at:**
- Organisation
- Staff
- People and families we support

PROACT-SCIPr-UK® in Cambridgeshire

- Learning Disability Services
- Children Services
- Dementia Services

ACTIVE

Triggers

- Triggers are environmental, situational or physical factors that set off an individual's challenging behaviour.
- They may include the care environment, interventions, activities, objects, thoughts, feelings, pain or discomfort.
- Once identified, many triggers can be avoided. That is why observing, identifying and documenting potential triggers can be the first part of a proactive strategy for minimising stressful or distressing situations.

Early Warning Signs

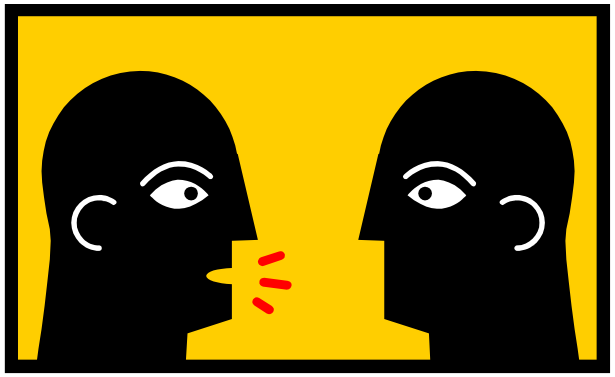
- Early Warning Signs (EWS) are behaviours which often precede challenging episodes.
- They may be obvious or they may just leave staff feeling uncomfortable.
- Staff need to be aware of EWS and recognise them so they can effectively de-escalate a situation. EWS to challenging behaviour are specific to individuals, so they can often be recognised from earlier episodes.

Escalators – that make things worse

- Asking a question rather than making a statement
- Restarting confrontation by making difficult demands
- Being spoken about
- Being talked over, others speaking for them
- Others reactions – bored, embarrassed, puzzled
- Patronised or talked down to
- People becoming angry or being blamed for not understanding situations
- Others dismissing things as not important

Be aware of what you are communicating

- Pre-judging
- Not listening
- Criticising
- Engaging in a power struggle
- Ordering
- Threatening
- Minimising
- Arguing



THE MESSAGES WE SEND

WORDS (the actual words spoken)	7%
TONE (the way we say the words)	38%
NON VERBAL COMMUNICATION (including body language)	55%

Albert Mehrabian(1971)

Calming Techniques

- Speak in a clear, calm voice
- Empathise
- Modelling
- Humour
- Only 1 person at a time
- Active listening
- Distraction
- Reassure
- IF appropriate remind them of the natural consequences of their behaviour
- Planned ignoring
- Eye Contact
- Close proximity
- Touch support
- Limitation of space
- Body posture
- Redirect
- Facial expressions

REACTIVE

PROACT-SCIPr-UK® Plans

Who agrees plans?
How often are they reviewed?

Legislation & Guidance:

- BILD Code of Practice – for minimising the use of restrictive physical interventions: planning, developing and delivering training 4th edition
  - Available from: http://www.bild.org.uk/our-services/books/positive-behaviour-support/bild-code-of-practice/ (£18 for an A5 copy)
- Ensuring Quality Services
  - *www.local.gov.uk/.../10180/12137/L14-105+Ensuring+quality+services/085fff56-ef5c-4883-b1a1-d6810caa925f*
- A Positive and Proactive Workforce
  - *www.skillsforcare.org.uk/Document-library/Skills/Restrictive-practices/A-Positive-and-proactive-workforce-WEB.pdf*
- Positive and Proactive Care: reducing the need for restrictive interventions
  - https://www.gov.uk/government/publications/positive-and-proactive-care-reducing-restrictive-interventions
- MCA / DoLS

Definitions:

Restrictive Interventions:

- Deliberate acts on the part of other person(s) that restrict an individual'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 undertaken; and
  - End or reduce significantly the danger to the person or others;

    and
  - Contain or limit the person's freedom for no longer than is necessary

Definitions:

- Physical Restraint:
  - Any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person
- Mechanical Restraint:
  - The use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control
- Long-term Segregation:
  - A situation where a person is prevented from mixing freely with other people who use a service
- Seclusion:
  - The supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving
  - Its sole aim is the containment of severely disturbed behaviour which is likely to cause harm to others
- Chemical Restraint:
  - The use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed / violent behavior, where it is not prescribed for the treatment of a formally identified physical or mental illness

The safe and ethical use of all forms of restrictive interventions:

- Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering or humiliation
- There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken
- The nature of the techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm
- Any action taken to restrict a person’s freedom of movement must be the least restrictive option that will meet need
- Any restriction should be imposed for no longer than absolutely necessary
- What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent
- Restrictive interventions should only be used as a last resort

Training restrictive physical interventions

- Multi-disciplinary risk assessments
- Prescribed individualised interventions
- Consent / MCA / DoLS
- Proactive -- 70% focused
- Active -- 20% focused
- Reactive -- 10% focused
- Ongoing monitoring and reviewing in all areas……

Any Physical Interventions should be:-

- Used as part of a person-centred approach
- Used when preventative steps have failed
- Used until the individual is calm
- Used only as a last resort
- Used when consent has been obtained
- Evaluated frequently and regularly
- Recorded

Any interventions depend on:-

- Training (and keeping your skills up to date)
- Speed and Control
- Timing
- Judgement
- Gradient Support
- A rational response not an emotional response

Johnny – TAG bikes

Johnny was very isolated before joining TAG bikes, spending most of his time at home and did not engage in any services. Eight months after joining TAG bikes he attends three days a week and has shown determination to succeed and make new friends, widening his social support network.

Johnny was attending the project on arranged transport but explained that he wanted to change this and increase his independence, he now cycles to and from TAG four days a week on a bike reconditioned by the project. This has had huge benefits to both his mental and physical health.

In Johnny's words he now feels ‘part of something special’ and has made great friends. Johnny has been interviewed as part of the media coverage and has helped to create videos for the facebook page.

Individuals who know Johnny from outside the project have commented on his increased motivation and confidence since starting at TAG bikes.

Johnny also completed the bikeabiility level 1 and 2 awards to support him to cycle safely on the roads, these courses are directly funded by the income from selling refurbished bikes.

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Day Opportunities

Tina Laws – Positive Behavioural Support Coordinator

B attends Tennyson Lodge and can often display high levels of anxiety, he will use his behaviour to demonstrate that he is not happy.

These behaviours usually escalate and can include:

- Pacing up and down and winding hands together
- Says things that are not related to the here and now, i.e. xxxx is dead isn't she
- Shouts questions at you like "Can I watch xxx tonight" or "I can have the Television on later can't I"
- Grabbing other peoples wrists or forearms whilst shouting the questions very close to the other persons face
- Shaking staff whilst holding their arms
- Grabbing other peoples clothes whilst shouting
- Hits out if he does not get a response or the response he wants

After discussing these behaviours with the staff team where he lives it became apparent that this anxiety was around his routine at home and watching the TV there and within the centre.

Tennyson staff heard support staff from his home saying *'we are not talking about that*' when he was dropped at the centre; this appeared to cause anxiety and B was very upset.

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Day Opportunities

Tina Laws – Positive Behavioural Support Coordinator

Proactive Guidelines and plans were created and all staff followed these:

- Staff to answer B's questions at least twice and then ask him to repeat and reaffirm he had heard the answer.
- Ask B to inform staff that he was upset and why he was upset so staff could understand and help him
- Staff will tell B what is happening that day
- If it's down time for him offer TV
- Have timetabled times for TV at the centre
- Speaking alarm clock that informs him it is time for the TV

All staff consistently followed this plan and B settled into a routine at Tennyson, support staff at home also reported a reduction in anxiety and behaviours which were challenging. Although staff within his home were not PROACT-SCIPr-UK® trained they were able to use the plans and follow the proactive guidelines . B also attends another day service and they have noted similar behaviours which are causing difficulties for B. Tennyson staff team and Tina are now working with this service to share the guidelines and plans to ensure consistency across the three services.

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Respite and Supported Living

Andrew Jones – Operations Manager

Russell Street respite unit recently supported a 32 year old male on an emergency basis as his previous supported living placement had broken down.

The individual is blind, has a diagnosis of Peter's Anomaly and learning disability. He has ulcerative colitis and had a stoma bag fitted 5 years ago. His hearing is within the normal range though he can be sensitive to sudden loud noises. He appears to be very sensory orientated. He enjoys bouncing up and down on a small trampoline and will do this for quite some time. He enjoys being read to and will clearly ask staff to do this activity with him. He has a cassette which he flicks up and down between his fingers and thumb quite quickly a few inches from his face. His verbal communication is limited to soft hums and uses basic Makaton, some of which he has modified to his own version, to let staff know what he wants.

He is comfortable in getting around his own and familiar environments without support by feeling along walls and doorways.

He displays self-injurious and behaviours that challenge services and others. This resulted in a head wound that was difficult to heal as he would bang his forehead against sharp corners/objects. This was a pre-existing wound when he came to us and he was displaying this behaviour 2-3 times a day at his last placement. This reduced while he was with us and to generally happening once every 2- 2 ½ weeks. He appears to seek out a very sharp edge to bang his head on (he will feel along a wall to find a corner, or will overturn the dining room table to use the edge of the table). If you try to intervene he will try to bite and scratch whoever is near. Once he has banged his head, the incidents tend to de-escalate quickly and he will generally return to his room and allow staff to administer first aid. He is always very compliant with this and also going to hospital to have the wound either stitched or stapled as necessary.

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Respite and Supported Living
Andrew Jones – Operations Manager

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Following the majority of the incidents we managed to identify where we have missed a sign that this was going to happen, or not been able to react quickly enough. The incidents can happen very quickly and appear out of the blue, although as just said, generally we have been able to pin point the reason and amend our ways of working to ensure that particular element doesn't occur again. There have been a couple of instances where we have been left scratching our heads and unable to identify what has gone wrong for him on those occasions.

We have had some good support from speech and language, psychology and nursing and have formulation meetings every 2 weeks to review our support which are really helpful. We also sought support form Loddon, who licence and validate our use of PROACT SCIP in Cambridgeshire. We have combined this with a clear reflective practice with staff in our post incident debriefing process that allows us to support the staff and come up with different approaches and ways of working that reduce the need for these behaviours

All of this work allowed us to support the service user to access a new placement in a successful manner, as the support plans and guidelines that we were able to develop and provide to the new staff team were current and reflected the challenges at the time. This made the transition much smoother and more likely to be successful and is a clear example of how we have enhanced the life of someone we support.

Questions???????

Contact details

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Team Manager – Adult Early Help

Tina.laws@cambridgeshire.gov.uk

Positive Behaviour Support Coordinator