

PRACTICE LOG

Prepared for module ECCH7002

Title:

Practice log which draws upon a health/well-being issue that you have been introduced to in your practice. The practice log should include:

- The presented issue
- Links to relevant theories and practice
- How you have responded/would respond as a practitioner

THE INDIVIDUAL & THE CONTEXT

Rebecca is an eighteen year old girl with autism, who lives in a residential setting for young people who have learning disabilities. Rebecca is non-verbal, and she often demands attention from staff, residents, and others around her. Her attention grabbing tactics can often be aggressive, particularly if her demands for attention are not met immediately. Rebecca exhibits certain aggressive behaviours that include throwing objects, hitting herself, lashing out at those around her in her immediate personal space, and running away and hiding. The staff at the residential home are at a loss with strategies in how they can effectively manage Rebecca's behaviour, and due to the frequency with which she behaves this way, she often misses out on planned, fun activities due to the unpredictable nature of her outbursts. This in turn, has led to

Rebecca's behaviour escalating further, and as a result, she will often display challenging behaviour on a daily basis.

There is currently a support plan in place for Rebecca, in which it states that Rebecca's favourite hobbies are painting, listening to music and playing on her Nintendo Switch.

Unfortunately, Rebecca has had some of these privileges removed from her due to her ongoing behavioural problems.

WHAT IF THE SITUATION REMAINS UNCHANGED?

It would be fair to suggest that there is clearly an unidentified root cause which is causing Rebecca to feel distressed and to display challenging behaviours, which as is stated, are escalating. The purpose of this practice log is to identify what could be the underlying causes of Rebecca's behaviour, and how staff and those working closely with Rebecca could support her during this time. It will also explore how they can effectively manage her behaviour with successful behaviour management techniques which are evidence based, and also minimise the risks associated with her challenging behaviour. The question of why Rebecca is demanding attention needs to be addressed.

Rebecca is severely distressed, and she has had the hobbies and social activities she enjoys removed from her. Not only has this exacerbated her behaviour and challenging outbursts further, but calls into question how ethical it is to remove those activities when she may not have the mental capacity to understand what is happening or why it is happening to her.

So far, any attempts made by the practitioners to alleviate the behaviour issues have been unsuccessful. Arguably, there does not appear to have been huge efforts to support Rebecca holistically, and whatever interventions have been attempted, they have only served to cause Rebecca further distress and to even cause her to feel punished. This may explain some of her aggressive outbursts.

It is a grave concern that the only remaining option in this situation, if things remain as they are currently, then staff and carers working with Rebecca will have no other option than to use physical restraint in order to protect Rebecca and others from injury.

UK Government guidelines on the use of restraint with children and young people with autism spectrum disorders says that “children and young people with...autistic spectrum disorders and mental health issues may often respond with challenging behaviour when they are confronted with situations they do not understand...” and also, “measures to prevent or address it can be developed with the involvement of the person, and their family, careful assessment, and multi-agency planning and support”, (UK Government, 2017, p.7).

It is clear from looking at UK Government recommendations that Rebecca has clearly reached the stage where she feels that displaying challenging behaviour is her only means of expressing herself. There needs to be effective changes fast, which include Rebecca as much as possible. There does not appear to be any strategies here which are working, and staff and those who care for her are in dire need of practical support and guidance in order to help manage Rebecca’s outbursts and even forge a new pathway for her to develop new behaviours.

When used correctly, the use of physical restraint has been shown to have a therapeutic and calming effect, (Mind, 2013), however, overuse of physical restraint and even improper use of it

as a behavioural management technique can be damaging, not only emotionally and mentally to the individual, but it can cause injury and even death. It can even bring trauma to other residents who are witnesses to such an event. A culture of fear may develop in the care home if this happens.

Casting a thought back to the Winterbourne View case has shown practitioners that using the wrong techniques can be abusive (Panorama, 2011).

THE PRACTITIONER'S RESPONSE & PSYCHOSOCIAL BEHAVIOUR MANAGEMENT STRATEGIES

Understanding non verbal autism is a fundamental need for the practitioner working with Rebecca. Non verbal autism is a subset of autism spectrum disorders, and practitioners should seek to educate themselves on this disorder as much as possible in order to be able to provide effective support for those they're supporting. Rebecca's health and well-being can be supported and improved by practitioners working in a way which is enabling, and promotes advocacy and empowerment. Holism is key - which is a view of health promotion which values well-being, and not just the absence of disease (Green and Tones, 2010).

Autism is described as a neurodevelopmental disorder. Autism is characterised by certain difficulties in social interactions and communication. Autistic people may also present with repetitive and restrictive patterns of interest and behaviour, with researchers noting that rates of aggression are higher in people with an autistic spectrum disorder; this is in comparison with other developmental disabilities. Aggression is linked with negative outcomes and decreased quality of life. These negative outcomes are more likely for children and young people and their carers when the child or young person with ASD behaves aggressively, (Fitzpatrick et al. 2016).

In the first instance, anyone working with and supporting Rebecca needs to delve deeper into why Rebecca is displaying such challenging behaviour. It's important to point out that practitioners should avoid labeling Rebecca herself as challenging; there are clearly other triggers here at play which are causing her behaviour to be challenging. That is the first priority; separating the individual from the behaviour; which will aid the practitioner in becoming less judgemental and this can in turn lead to better outcomes for Rebecca.

The practitioner must make efforts to understand the situation from Rebecca's point of view. This is the key to supporting her in a person centred way, and to finding out the triggers for Rebecca's behaviour. There could potentially be a number of factors to Rebecca's outbursts, and the practitioner must start by looking at the various areas that could be affecting Rebecca's health and well-being. There really could be potentially several variables in this situation which are causing Rebecca's extreme behaviour. The practitioner should look at the following areas and whether there are any issues in them that could explain what is happening and how to make it better for Rebecca. There could be issues in these factors: environmental, emotional, medical, biological, psychological and cognitive. The practitioner needs to explore each area fully.

It would be essential to write down Rebecca's daily routine and patterns, in order to begin in identifying potential behavioural triggers. There could be something in Rebecca's daily routine that is triggering her outbursts. It could be something very simple which sets off a negative chain reaction.

Evidently, Rebecca has issues with communication. She cannot express appropriately what is bothering her and making her feel the need to express her emotions in such a dangerously demonstrative way. From looking at the situation and the context, it is evident that Rebecca

cannot communicate verbally, and this has clearly had negative impacts on her because it means that whatever Rebecca is feeling or thinking, she cannot express this through speech and language. If a person cannot use speech and language to communicate, they need other ways in which they can be heard.

Children and young people with ASD often present with an inability to control emotions. These are often labelled as 'meltdowns'. This is simply when things get too much; it can also be known as a sensory overload.

Someone without an autistic spectrum disorder will be able to function in a state which is known as emotional regulation. For example, if you were driving a car and someone swerved in front of you, your heart rate and anxiety levels would increase, you might even beep the horn in frustration at the other driver's incompetence and carelessness, however, you would more than likely continue to drive the car safely on towards your destination, in spite of the unforeseen challenge that just happened. This is emotional regulation. Someone with ASD cannot do this so well; someone with an ASD would find it very difficult to modify their emotions and behaviours to fit the context. Poor emotional regulation (which can manifest itself in uncontrolled anger and aggression) can be a sign of a psychological problem, (Mazefsky and White, 2014).

Alongside the poor emotional regulation is the lack of means in which Rebecca can communicate with those around her. This inevitably will cause great difficulty and distress for her. Research has shown that people with autism do not process information in the same way that those without autism do, and cannot filter out important information from non important information. This often leads to what is known as an "overload", which is when the autistic person cannot process any more information at all, (National Autistic Society, 2017). For non

verbal autistic people, they need their families and staff working with and supporting them to find other creative ways to communicate with them, and most importantly, for the individual to be able to express themselves.

There is diversity among individuals with autism, and indeed non verbal autism. Everyone is an individual, and it would be wrong to make sweeping generalisations about Rebecca or her diagnosis. Research on non-verbal autistic children and young people has shown that between 25-50% of children who are diagnosed with autistic spectrum disorder (ASD) have language development issues to the extent that they never develop spoken language beyond only a few utterances or phrases. In the world of autism research, non-verbal autistic people are underrepresented, (Patten et al. 2013). The lack of research pertaining exclusively to non-verbal individuals only does not excuse the practitioner from wider reading and research, and therefore it could be suggested that a cascade type approach could work; that means looking at methods that have been shown to work, and perhaps implementing some of these could prove to be successful for non-verbal children and young people with autism, and for Rebecca herself.

Rebecca's early childhood is not mentioned in the context above, but what is known by researchers is that in children with autistic spectrum disorders is that the bulk of speech and language learning happens before the age of five, and sadly, that means that if a child with ASD has not had that foundation before this age, they are very unlikely to grasp speech and language development later than this (Vernay et al. 2017).

It is therefore, perhaps in Rebecca's best interests, that practitioners do not try to overwhelm Rebecca with learning speech and language skills, but look at ways in which they can support her to communicate independently. It is unclear from the description of the context whether there are any forms of augmentative communication being used by the staff in the care home,

however, it would be fair to suggest that if they had already been using these methods, then research has shown that Rebecca would be unlikely to behave in this way (The Challenging Behaviour Foundation, 2014). It can be assumed then that staff are not using augmentative communication techniques to support Rebecca to express herself.

PECS (Picture Exchange Communication System)

Developed in 1984 in order for individuals with non-verbal autism to be able to communicate, PECS was designed by Dr Andrew Bondy and Loris Frost MS CCC/SLP as part of the Delaware Autistic Programme. Its purpose was to teach autistic children a quick, functional and self-initiating way to communicate, (National Autism Resources, 2020). PECS (Picture Exchange Communication System), is an example of a successful augmentative communication technique. The way in which PECS works is that the individual with autism has many cards with pictures on them; anything and everything could be on these cards, which makes PECS highly individualistic and person centred. In Rebecca's case, if she were given PECS cards, she could choose any of those cards and hand them to someone in order to initiate communication. For example, a card with a picture of a meal on it could be handed to staff who would then know that Rebecca was hungry. Another example could be a card with a sad face on it, which would communicate to staff and carers that she was feeling sad.

PECS is a very effective and simple means of initiating socialisation and communication, and in Rebecca's case, could help to alleviate some of the tension in the home. Rebecca would have greater autonomy and independence over her own personalized set of cards, and she can hand these to someone around her, initiate communication, her needs can then be identified, and as such a successful resolution can be sought. The PECS cards can depict anything; including activities, feelings, places, daily routines etc. They are a very diverse resource. Research has

shown PECS to be successful, and that non-verbal individuals who used PECS actually began to start communicating verbally, and as a direct result, challenging behaviours were shown to decrease and socialisation increased (Flippin et al. 2010). The downside to PECS is that Rebecca at some point or another may not have a particular card she may need, and therefore, it might be that there are the odd occasions where she may have another outburst if for example she cannot find the relevant card or may not have the card she needs for that given moment. Despite this shortcoming, the addition of PECS as a form of augmentative communication to Rebecca's support plan would improve her communication abilities vastly, and it should therefore be integrated into Rebecca's support plan immediately. Staff and those working with Rebecca should be supported with training in order for them to be able to implement PECS and to understand how to introduce this form of communication to Rebecca. This strategy is not only a proactive approach, but it is also preventive, as it could prove to stop Rebecca from having an outburst by pre-empting any communication issues and therefore minimize the likelihood that Rebecca will act out.

Positive Behaviour Support (PBS)

Positive behaviour support is a strengths based approach to behaviour management, and can support the individual through positive strategies, to change their behaviour. This is not a method for chastising and punishing the individual, and this is especially important for Rebecca who is at a disadvantage in not having any form of communication with those around her. It is vitally important to recognise that the theory behind PBS is not to change the person themselves but to support the individual to adopt a new set of behaviours in order to minimise the risks to themselves and to others, (The Challenging Behaviour Foundation, 2014).

It has not been stated in the contextual description whether the staff have had to use physical restraint on Rebecca, but it could easily escalate to the point at which they might need to use this in order to protect Rebecca from injuring herself or others. Arguably, the use of restraint is a reactive strategy, and the use of reactive strategies should be avoided. Reactive strategies are already being implemented unsuccessfully by the staff in the care home (for example, the removal of privileges and planned activities).

Studies have shown PBS to be very effective at minimising the need to use physical and potentially distressing intervention strategies such as restraint or other reactive interventions (Jones, 2014). According to the Positive Behaviour Foundation (2014), who are a third party organisation which supports those with complex needs, PBS has four main phases:

PHASE ONE: Appearance - how the behaviour appears.

PHASE TWO: Rate - the frequency the behaviour occurs.

PHASE THREE: Severity - how severe the behaviour is becoming or has become.

PHASE FOUR: Duration - the length of time that the behaviour lasts.

PBS also explores the potential triggers to challenging behaviour, which includes looking at sensory, environmental, sights, sounds, smells, emotions such as anxiety, worry, and even biological factors such as being unwell, being hot or cold or allergies, and these triggers can be monitored through a colour coded system. There are many variables which could affect a person who has non-verbal autism, and cause challenging behaviour.

As well as the four phases of identification of the challenging behaviours, the colour coded phases can be used in order to make continuous assessment of Rebecca's behaviour and mood. This could be very helpful for staff and carers supporting Rebecca. These are:

GREEN - calm and relaxed.

AMBER - Aroused mood/potential anxiety level increase, distressed.

RED - challenging behaviour incident has occurred.

BLUE - Individual is calming down but vigilance should be maintained.

The aim of the colour codes are so that staff and carers can monitor Rebecca's emotional and behavioural state constantly. The aim for all staff and carers is that Rebecca is kept in the green phase, and out of amber and red as much as possible. PBS can be used alongside PECS cards to monitor any warning signs that Rebecca might be about to have an outburst and to bring about a calming resolution. There may be occasions when the proactive strategies fail, and as a result, incorporating reactive strategies in the event this may happen is essential.

Studio 3

Studio 3 is a concept that reinforces the belief that to ignore an individual's behaviour is damaging to them and can cause unnecessary distress. The theory behind Studio 3 is that the person displaying the challenging behaviour is clearly in a state of distress and the reactive strategy to deal with the escalated behaviour is a technique called the Low Arousal Approach, (Studio 3, Nd).

The Low Arousal Approach focuses on the practitioner implementing techniques which seek to reduce stress, anxiety, fear, aggression and frustration. This is a strategy that could be

successfully implemented into Rebecca's support plan with the right staff training as it is clear that Rebecca is in a crisis and this approach not only aims at reversing a crisis, but also preventing one from taking place.

The Low Arousal Approach is a set of solutions which are low intensity, and as a result, can deactivate a scenario which has become volatile (Studio 3, Nd), with research reinforcing that low arousal approaches are very successful at bringing a crisis to a calm resolution (McDonnell et al. 2015).

Examples of low arousal strategies include the avoidance of direct eye contact, the removal of potential triggers, the avoidance of noisy or crowded places, and staff and carers should avoid using body language or postures which could be interpreted as intimidating or aggressive, and speaking in a tone of voice which is non aggressive and calm.

The incorporation of low arousal approaches has also been shown to lower the necessity of physical restraint (McDonnell et al. 2015).

It is important to be mindful that although the goal and aim of these behaviour management strategies are to transform chronic and severe challenging behaviour issues, there may be times where despite your very best efforts as a practitioner, Rebecca may have an acute outburst. The goal is to minimise the behaviour and the risk, eradicating it entirely, although aspirational, may not always be realistic. Remember, you are dealing with a non-verbal individual with what would appear to be severe ASD and communication issues. Do your best, and keep Rebecca's well-being at the forefront.

PHARMACOLOGICAL INTERVENTIONS: THE USE OF MEDICATION, OTHER THERAPIES, & CO-EXISTING MENTAL HEALTH DISORDERS.

Another avenue which must be explored and investigated in Rebecca's case is whether she may have a coexisting mental health disorder. It is entirely possible that Rebecca may be experiencing mental health problems alongside her diagnosis of an ASD, and as a result, diagnostic tools for autism and its treatment should not be the only source of support for her (NICE, 2017).

We know from research that individuals with a learning disability or an autistic spectrum disorder are at an increased vulnerability to mental health problems, and they are at greater risk of developing a mental health disorder or a mental health problem compared with people in the general population. Autism itself is not a mental health condition, however by and large practitioners often fall into error by either treating the mental health disorder, or the autism, and there is considerable lack of support for autistic young people with a mental health disorder, (Mind, 2015).

Many of Rebecca's behavioural outbursts could not only be the exacerbated traits of an autism spectrum disorder, but also a potentially pre-existing, and quite possibly an undiagnosed, mental health problem. So far in this practice log we have covered non-medicated, behavioural and social management tactics for tackling the challenging behaviour, but it might be beneficial to conduct a mental health assessment on Rebecca and to even trial (with extreme caution and with medical supervision and support) medication which may help Rebecca with what clearly could be anxious behaviours.

Co-existing mental health problems alongside a learning disability such as an autism spectrum disorder, also known as co-occurring disorders or a dual diagnosis, is strongly associated with poorer outcomes and prognosis, low life quality and well-being, and an increased need and

demand for agency and professional help and support, (Wood and Gadow., 2010, Vannucchi et al., 2014, Seltzer et al., 2004, Matson and Cervantes., 2014, Lainhart., 1999).

This is clearly a big risk in Rebecca's case and the right response in this situation would be to refer her for a mental health assessment. However, strong emphasis needs to be placed on differentiation; the professional practitioner, whether a psychiatrist or a psychologist, who conducts the assessment, and this includes further support on any potential diagnosis, needs to ensure that they do not neglect one diagnosis in order to "fix" the other. This means, we do not ignore the ASD in order to treat the mental health disorder, and likewise we do not ignore the mental health condition in order to manage and support the ASD; both need careful and intentional support and the different needs have to be addressed separately, but also remembering that Rebecca is one person. This would require a holistic approach and this means looking at Rebecca as a whole person. The practitioner needs to keep in mind that with every decision, Rebecca's best interest, and this also means involving Rebecca in the decisions which affect her life as much as is practicably possible, whilst also navigating the ethical discussion around mental capacity.

According to the National Autistic Society (2018), 40% of individuals with ASD present with one or more symptoms of anxiety at one time or another. In the general population, this is 15%, (National Autistic Society, 2018). These figures show us that it is entirely plausible that Rebecca may have a mental health issue alongside her ASD diagnosis. Both the British Association of Counselling and Psychotherapy (2016), and the National Autistic Society (2018) support the use of Cognitive Behavioural Therapy (CBT) alongside medications such as Prozac and Seroxat as therapies for those with ASD and a mental health condition. The use of medication should

begin at small doses, as children and young people with ASD have been found to be more sensitive to these types of medicines, with tolerability and variation in disorders important factors to consider, (Doyle and McDougle, 2012, National Autistic Society, 2018).

The efficacy of second generation antipsychotic medicines has also been shown to offer some relief and success in the reduction of aggression in individuals with autistic spectrum disorders. There is evidence to suggest that the use of pharmacological interventions such as SSRIs (selective serotonin reuptake inhibitors) has had some degree of success, with some researchers linking autism spectrum disorders with abnormalities in serotonin function. However, although these medicines have shown therapeutic benefit to those with ASD, there are some dangers with SSRIs which include agitation and activation; worth noting also is that tolerability and efficacy can be entirely individual, (Kolevzon et al. 2006, Fitzpatrick et al. 2016).

In terms of CBT, NICE guidelines from 2018 suggest the following considerations:

- CBT needs to be adapted to the individual; this includes method of delivery.
- Emotion recognition training.
- A structured cognitive approach which is more concrete.
- Increased use of visual aids, information and other tools.
- Simple and easy to understand cognitive activities.
- The involvement of loved ones and family in therapy sessions.
- Regular breaks to help with attention maintenance.
- Incorporating the person's interests into the therapy sessions.

(NICE, 2018).

These techniques could be implemented to help Rebecca and they do need to be explored as her issues could stem from a mental health issue which has been misdiagnosed and mismanaged.

It is very important to remember that Rebecca is non-verbal; and a mental health assessment might prove challenging. Modifying the assessment methods would be vital, due to the fact that it might prove difficult to identify any functional issues or mental health problems in a child or young person with communication difficulties (NICE, 2018).

WELL-BEING SUPPORT PLAN

Going forward, there needs to be major changes to Rebecca's support plan. One proposed change to this plan would be to change the plan from a support plan to a well-being plan. This change would emphasise the holistic and person-centred way of working in which practitioners should be striving for. The term 'well-being' also supports a whole person approach, which is in line with a strengths based perspective, rather than from a deficit perspective. E.g., The questions we should be asking are along the lines of "what can this person do independently, what are their strengths and, and how can we promote well-being?", rather than, "what are this person's weaknesses and problems, where are they lacking and how do we fill the void?". The latter questions are ones which tend to be the focus of traditional support plans. A whole person approach acknowledges the context in which the person is in. Rebecca's life in its entirety needs to be taken into consideration, (Larkin, 2013). This is absolutely vital.

If we are completely honest, Rebecca's current support plan is inefficient at best, and negligent at worst. It is not fit for purpose. Not only is a change in strategy needed along with various changes in behaviour management tactics, but the way practitioners think about and seek to tackle the issue. The attitude and approach of those supporting Rebecca will ultimately

determine its success. If they approach it from a defeated and negative viewpoint, then this has a significant impact on how these new techniques will work. Changing the angle and perspective of how we view what we can do to support Rebecca better is the first step in proactive support. We do not want to cause Rebecca to become overly dependent on services, but rather, how can the service supplement Rebecca and help her to achieve greater independence, autonomy, better life outcomes and fulfill her unrealised life potential.

The well-being plan really could be tailored to Rebecca's individual needs; it could include anything and everything which would support Rebecca to achieve optimum well-being. Not only the usual likes and dislikes, dietary needs or medication etc, it would definitely include all the new augmentative communication strategies, but it should mostly be a reflection of Rebecca as a person. What matters to her, what's important to her. Well-being can be as individual and unique as the person.

Some suggestions of what could be included are exploring what works and does not work for Rebecca, and the plan could be built around these. Drawing from Rebecca's previous experiences, good and bad, will also help to shape the well-being plan. It could include her strengths and challenges (this word is much more positive and affirming than 'weaknesses') which relate to her autism spectrum disorder. It would greatly increase the staff's ability to identify and preempt any outbursts, (Mind, 2015).

The well-being plan should be a working document; something read by every staff member and practitioner who works with Rebecca. They should include Rebecca in the formation of such a plan, and it should be under constant review. It should be brought to every meeting concerning Rebecca's care, and referred to regularly.

CONCLUSION

As practitioners, it is vital that any distress to the individual being supported is minimised, and this is especially true for those who have autistic spectrum disorders. There is evidence to suggest that for those with ASD, the most effective way to support the individual to make positive behavioural changes and to encourage positive behaviour patterns is prolonged exposure to these new routines and models (Dixon et al., 2013).

Helping Rebecca to manage her distress and challenging behaviour will require staff and those supporting her to be persistent, determined, and consistent with the new routines and augmentative communication techniques. These new strategies are long overdue in Rebecca's case, and it will require perseverance to help Rebecca to accept and become accustomed to new norms. This is true for staff; they need to be supported to learn new strategies to help support Rebecca; to carry on supporting her in the current form could have disastrous consequences, and the need for change is an urgent one. A mixture of psychosocial and pharmacological interventions might be the answer to solving Rebecca's distress and certainly warrant a large effort by staff and carers, because behind the behaviour is a person, with feelings, emotions, thoughts and views, and she is in a very vulnerable state, and practitioners have a duty of care to help to support and enable Rebecca to have a positive outcome. With the right support package and interventions, it will be possible to enable Rebecca to have a full and satisfying life, free from distress and anxiety.

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