Behaviours of Concern Policy

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Introduction and Aims

1. Introduction:

The Children's Trust understands behaviour as a form of communication. We apply a Positive Behaviour Support approach and functional behavioural analysis to develop an understanding of the function of behaviour, the internal and external factors that influence it in order to inform effective ways of supporting new learning and responding to behaviours that challenge.

The Children's Trust is committed to meeting the Restraint Reduction Network's training standards and continuously aims to reduce the use of restraint across the organisation by providing training, focusing on prevention, de-escalation and reflective practice. It is also recognised that the use of proportionate physical

intervention, as a last resort, may be necessary when there is an immediate risk to child or staff safety due to risk behaviour.

2. Aims:

2.1 To support a positive approach that aims to develop an understanding of the emotional needs of children and young people at The Children's Trust and any associated behaviours that may be of concern.

2.2 To encourage and maintain a positive, safe, caring environment and ethos where everyone: children and young people, their families, staff and volunteers are valued and respected.

2.3 To facilitate the highest safety standards, well-being and quality of life for children and young people, families, staff and volunteers by identifying the most appropriate methods of supporting and understanding presenting behaviours and promoting good practice through positive and least restrictive approaches.

2.4 For all clinical staff to attend mandatory Positive Behaviour Support and safety techniques training in order to promote a shared understanding and consistent approach to supporting behaviours that challenge.

2.5 To work within the contractual requirements for paediatric neurorehabilitation for NHS England.

2.6 To meet the statutory requirements of Care Quality Commission and OFSTED.

2.7 To deliver a service that's in keeping with National Clinical Excellence Guidelines.

3. Definitions:

The National Institute for Health and Care Excellence describe how behaviour that challenges is "not a diagnosis" and acknowledges that whilst it may present a challenge to services, family members or carers "it may serve a purpose for a person with a learning disability" (NICE, 2015 Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges. p.6).

3.1 Behaviours of concern in children and young people

Child brain injury is a major risk factor for developing difficulties with emotional regulation. Challenges with behavioural regulation can also be persistent and continue in children and young people up to 10 years after the injury (Anderson, Godfrey, Rosenfeld and Catroppa, 2012). These difficulties can greatly impede the child's own progress within their rehabilitation program, with behavioural and social

consequences of brain injury seen as contributing to levels of long term family distress. Ylvisaker, Turkstra, Coehlo, Yorkston, Kennedy, Sohlberg and Avery (2007) in a systematic review conclude that positive behaviour support can be considered an evidence based intervention in supporting the needs of young people with acquired brain injury. It is also noted as an effective intervention for family directed approaches to behaviours that challenge in community settings (Fisher, Bellon, Lawn and Lemon, 2018).

There are many personal and environmental factors that can impact on behaviour. These include pain, physical health issues, communication difficulties, and environmental factors. In addition, the evidence base indicates that challenging behaviour and mental health difficulties can co-occur and be expressed as challenging behaviour (Bernard and Turk, 2009; Emerson and Hatton, 2007).

Individuals with intellectual disabilities and challenging behaviour are known to be at risk of exclusion, abuse and restrictive practices. A number of inquiries have highlighted both the urgent need to improve care provision and commissioning of services for individuals with intellectual disabilities and the challenges to implementing and sustaining change. These have included Winterbourne View (2012a), Cornwall (2006), Sutton and Merton (2007) inquiries into institutional abuse in services for people with intellectual disabilities. Most recently Stopping Over Medication of People with Learning Disabilities (STOMPwLD) (NHS England, 2016) renews the commitment to reducing the use of medication prescribed with the aim of reducing challenging behaviour and acknowledges the prioritisation of psychological or other interventions.

The term 'behaviours of concern' may refer to:

- Behaviour that is not viewed to be appropriate to the developmental age or ability of the child or young person.
- Behaviour that limits the child or young person's ability to take part in their rehabilitation or education.
- Behaviour that affects the relationships of the child or young person with their family, friends and other people.
- Behaviour that has a significant impact on the young person's ability to maintain positive social interactions/relationships and to participate in everyday activities.

There are likely to be a number of underlying factors that contribute to the likelihood of behaviour that challenges:

Acute distress following major trauma

- Many people will have a transient stress reaction in the aftermath of a major trauma – this is normal and understandable but may interfere with their ability to cope
- Acute distress is not necessarily pathological or a precursor to subsequent psychological disorder but, in the acute phase of treatment, it can affect

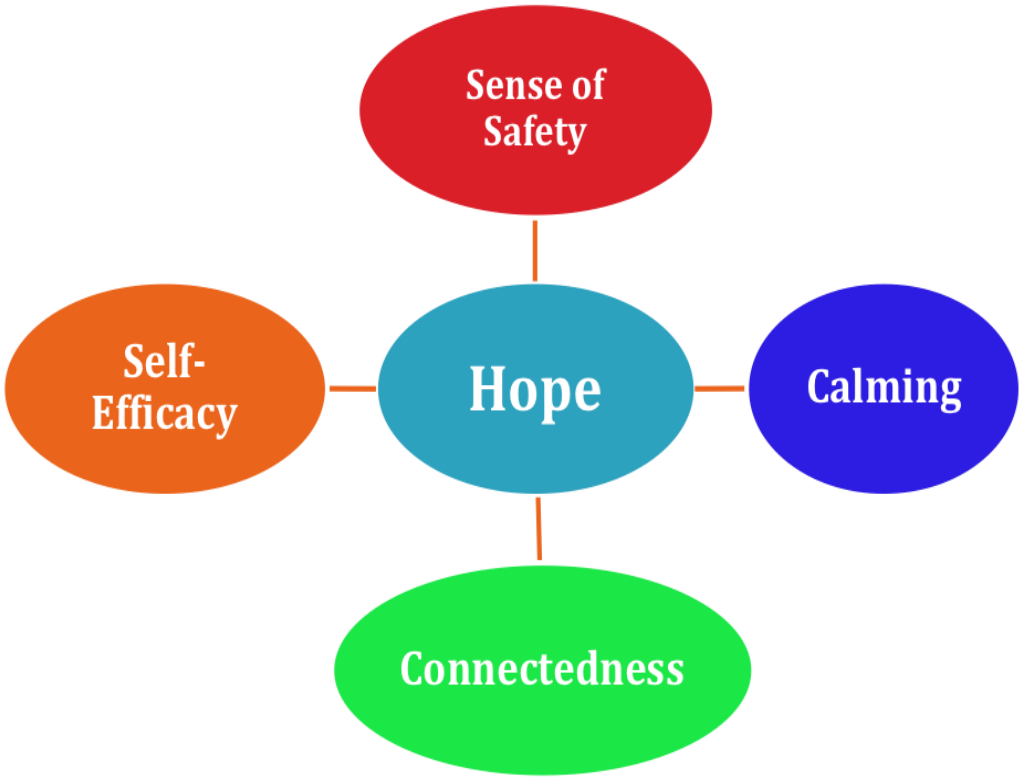
relationships with medical teams, engagement with treatment and management
- While a large proportion of people will recover with basic support prolonged arousal or distress is a risk factor for longer term PTSD and other mental health difficulties
- Psychological morbidity is linked to poorer physical health outcomes, reduced quality of life and mortality post discharge

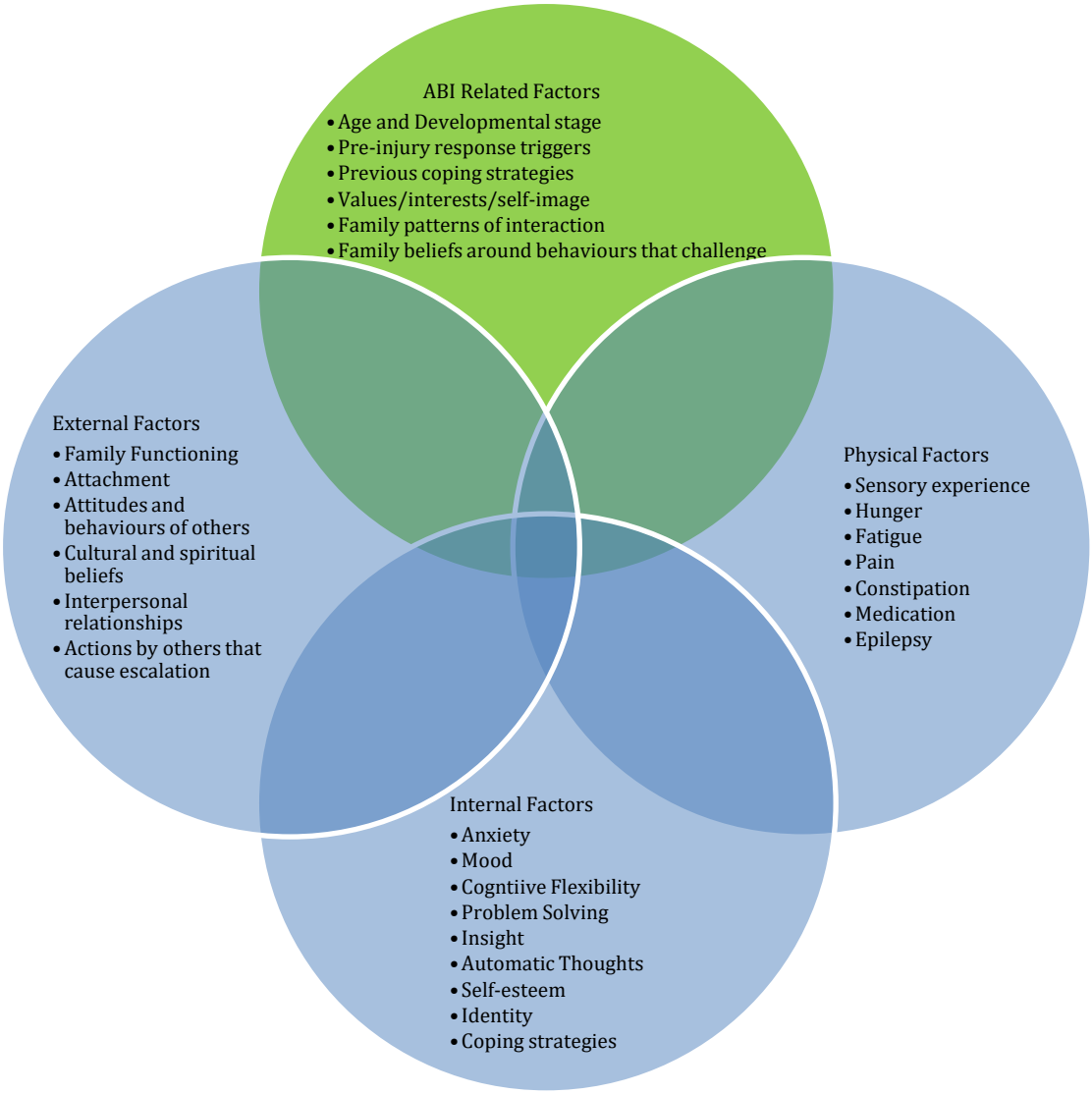
- As children / young people recover from a brain injury they can pass through a number of stages
    - Post traumatic coma
    - Post traumatic delirium
    - Post traumatic amnesia
    - Post traumatic dysexecutive syndrome

Post traumatic amnesia is the period in which the patient is unable to store and recall ongoing events. The most obvious symptom is the loss of memory for the present time. The person may recognise family and friends but be unable to process the fact that they are in hospital or have had an injury of some kind.

Other symptoms of PTA include:
- Confusion, agitation, distress and anxiety
- Safety seeking (wanting to go home)
- Uncharacteristic behaviours such as violence, aggression, swearing, shouting, disinhibition
- Inability to recognise familiar people
- Tendency to wander
- In some cases people may be very quiet, docile, loving and friendly

5 intervention principles that can help promote resilience and recovery following major trauma (Hobfoll et al., 2007)


Sense of Safety
Self-Efficacy
Hope
Calming
Connectedness


ABI Related Factors
• Age and Developmental stage
• Pre-injury response triggers
• Previous coping strategies
• Values/interests/self-image
• Family patterns of interaction
• Family beliefs around behaviours that challenge
External Factors
• Family Functioning
• Attachment
• Attitudes and behaviours of others
• Cultural and spiritual beliefs
• Interpersonal relationships
• Actions by others that cause escalation
Physical Factors
• Sensory experience
• Hunger
• Fatigue
• Pain
• Constipation
• Medication
• Epilepsy
Internal Factors
• Anxiety
• Mood
• Cogntiive Flexibility
• Problem Solving
• Insight
• Automatic Thoughts
• Self-esteem
• Identity
• Coping strategies

4. Principles of Positive Behaviour Support

Positive Behaviour Support (PBS) is an approach to developing an understanding of the purpose and function of behaviour for children and young people. It views behaviour as a form of communication and aims to understand the triggers and factors that reinforce behaviours in order to positively support the development of alternative behaviours.

The Children's Trust approach behaviour through an ecological systems theory approach (Bronfenbrenner, 1975). This means that children and young people exist within the context of their environment, their relationships with others and the systems in which they live. Approaches to supporting behaviours and young people's wellbeing therefore needs to think about the context of the child or young person and consider their support needs across a range of settings and within the context of their relationships and never in isolation.

The NICE guidance (2015) relating to individuals with learning disabilities and challenging behaviour, highlights the evidence base for core components of PBS. These are as follows: functional assessment of behaviour; personalised intervention, based in behavioural principles; psychological interventions indicated before antipsychotic medication; restrictive interventions are used as the last resort; training for staff providing direct support in proactive interventions, in addition to high quality on-going supervision; and the use of routine outcome measures and periodic monitoring.

5. Positive Behaviour Support at The Children's Trust

Positive Behaviour Support within children and family services involves an individualised process of information gathering, formulation, intervention, monitoring and review. This is represented in the table below. The psychology team hold primary responsibility for developing a formulation around the behavioural needs of the young person alongside the inter-disciplinary team, young person and their family.

This pathway facilitates communication between all parties, and ensures that key elements of Positive Behaviour Support are undertaken from point of admission, throughout a young person's time at The Children's Trust to time of discharge or other provision.

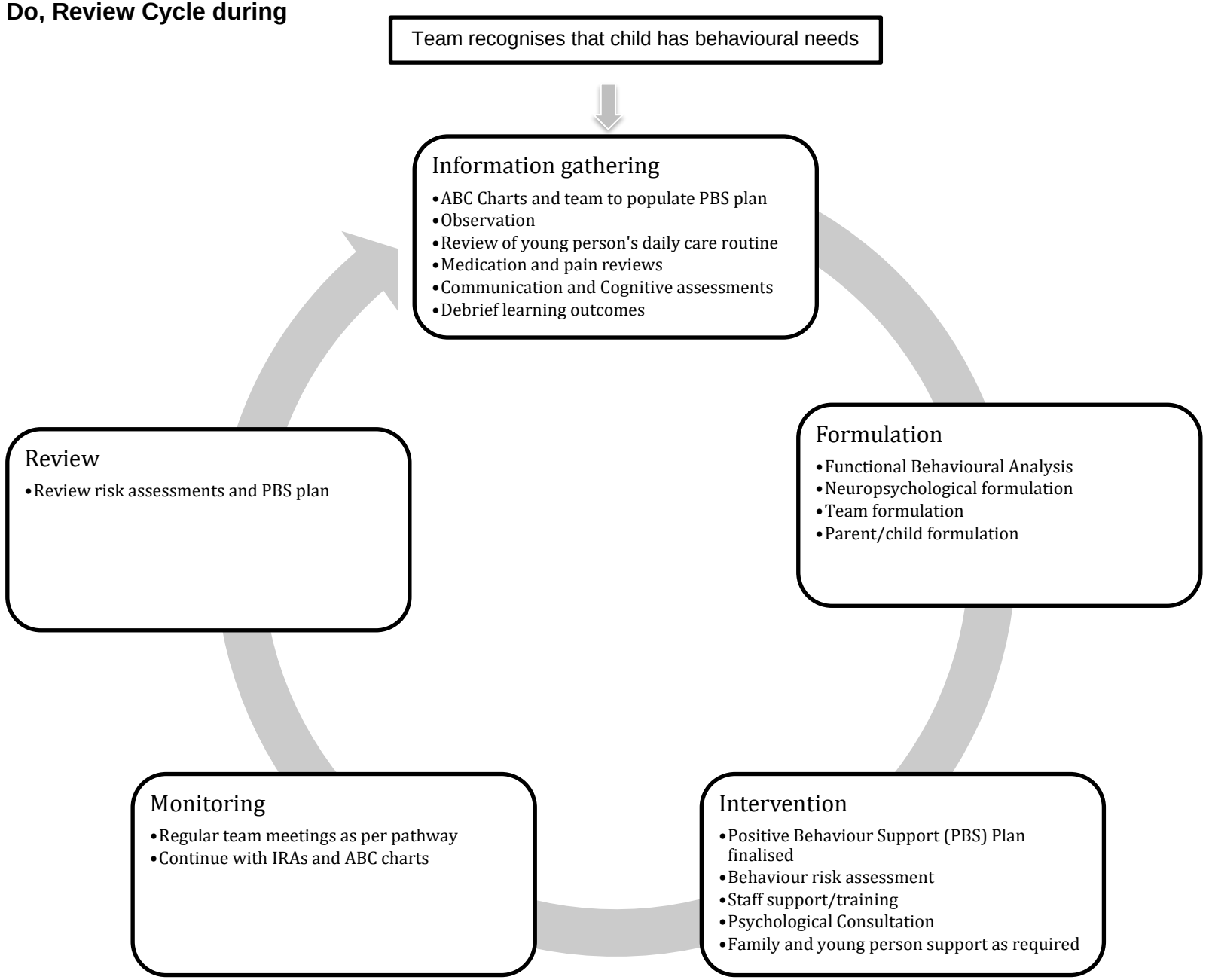
The PBS Pathway can be triggered prior to or during the young person's placement at The Children's Trust, depending on when the young person's behavioural needs emerge.

Staff will receive training on PBS approaches in the context of ABI and neurodisability. This will aim to develop a shared understanding of assessment, formulation, intervention and least restrictive practice.

PBS Rehabilitation Pathway	Red	Amber	Green
Admissions Panel	Significant emotional/behavioural concerns: Psychologist/senior Nurse to attend initial assessment. PBS (Positive Behaviour Support) Pathway triggered	Psychology/Nursing to contact ward and psychology team for further information	
Initial assessment	Psychology and Nursing to carry out joint assessment, formulate management plan and complete relevant risk assessments e.g. behaviour, self-harm, manual handling, fire evacuation. IF required request hospital team make CAMHS/Social care referrals pre-admission and coordinate admission date with Psychiatry clinic	Psychology and/or nursing to carry our joint PBS risk assessment alongside member of the MDT. Relevant risk assessments to be completed and outcomes shared at admissions panel	PBS risk assessment to be completed by assessors and outcomes shared at admissions panel. No further action at this stage.
Pre-admission: Neuropsychological case summary to be shared at meeting and session offered to named house team. Risk assessments to be reviewed and updated with any new information.	IF needs increased to Red pathway: Psychology and nursing to carry out further joint assessment and formulate management plan with relevant risk assessments e.g. behaviour, self-harm, manual handling, and fire evacuation. Psychology/Nursing to lead MDT in transition planning. Psychiatry consultation to be initiated as required.	IF needs appear to have increased to Amber: Psychology/Nursing initiate telephone consultation with hospital team and plan as appropriate for transition with MDT.	IF needs remain the same as initial assessment, continue with identified action and management plan. Transition to TCT in line with usual policy.
Admission: If PBS needs arise. Standard review schedule. Home and off-site visits to be discussed with the family and plan made in accordance with relevant risk assessments (PBS, Self-harm, Transport) and community teams e.g. social care	Weekly reviews of PBS plan and risk assessments	Fortnightly reviews of PBS plan until TAC (Week 3) and determine frequency thereafter.	Review PBS plan in line with team meetings
Transition: Home visits to be arranged in accordance with risk assessments, family and community counterparts.	Off site visits to be supported by at least two safety trained members of staff Home/School Visits: Member of staff to visit home/school to assess safety of environment, copies of risk assessments and PBS management plan to be shared with school. Plan to be agreed for safe access and exit plan. CAMHS and Social care referrals to be initiated at Week 3 if not already involved pre-admission. Local teams to be informed and aware of planning for community visits taking place. Emergency contact details to be shared with family/MDT members supporting visits.	Discussion with Family/School regarding safe access during visits. Risk assessments and PBS management plan to be shared with school. Plan to be agreed for safe access and exit plan.	MDT discussion with family/school regarding accessibility for home/school visits.
Any team member can identify need for review of the pathway (red, amber, green) as required			

PBS TCT School Pathway	**Red**	**Amber**	**Green**
Initial Assessment/Pre-admission to TCT School	Significant emotional/behavioural concerns detailed on EHCP/referral. Psychologist and Nurse to attend initial assessment with a member of the teaching team to carry out a joint assessment, formulate management plan and complete relevant risk assessments e.g. behaviour, self-harm, manual handling, fire evacuation. IF day placement: Request referrer also makes CAMHS/Psychiatry/Social care referrals in the community as required and consider coordinating admission date with Psychiatry clinic	Initial referral/EHCP suggests some possible behaviours that challenge. Psychology/Nursing/Behaviour Specialist Teacher to contact family, SEN Team/Allocated Educational Psychologist and current educational provision for further information Psychology/Behaviour Specialist and nursing to carry our joint PBS risk assessment alongside member of the IDT and teaching staff. Relevant risk assessments to be completed and outcomes shared at admissions panel	In line with the standard school admissions policy
School Placement: on school roll	Psychology team to offer fortnightly consultation to school/family/house and review PBS plan as required. Psychologist and Behaviour Specialist Teacher to work alongside class team in carrying out functional behavioural analysis and PERMA assessment. Contributions/reports to be provided at interim or planned annual reviews should updates to the EHCP and associated provision be required.	Psychology/Behaviour Specialist Teacher to attend initial reviews on admission and offer consultation and assessment as required to both school and house teams. Any PBS plan will be reviewed on a monthly basis.	PBS support at universal level, in line with school policy.
Transition to adult provision/other educational provision	Psychology and Behaviour Specialist Teacher to be involved in transition planning through attendance at 3-monthly meetings and annual reviews. PBS plan and any other risk assessments to be shared with new setting and handover of formulations and interventions to the new service. Community referrals for ongoing psychological input to be made as required.	Teachers/psychosocial/nursing team to share PBS plans in order to plan for transition and consult with new provision on application of interventions in their setting. TCT lead professional for PBS handover to be agreed at 3-monthly meeting.	PBS guidelines to be shared by teachers in line with school transition arrangements
Any team member can identify need for review of the pathway (red, amber, green) as required			

Assess, Plan, Do, Review Cycle during Placement:



The Children's Trust School: The PERMA model

The Children's Trust school has adopted the PERMA model (Seligman, 2018) to understand happiness and wellbeing of our children and young people. Seligman developed a five core model of psychological well-being and happiness believing that these five elements can help people work towards a life of fulfilment, happiness, and meaning.

We recognise that to provide a quality service, we need to ensure that our children and young people have opportunities for life enrichment/enhancement activities and experiences. As individuals we value different activities; the value of an activity is subjective. Activities may bring us enjoyment, satisfaction, pleasure, stimulation, relaxation, contentment or joy. Participation in such activities therefore improves our quality of life and promotes well-being.

Actively improving a person's quality of life is a key PBS intervention. Part of our role is to develop an understanding of the sort of lifestyle that is high quality for an individual and then help them to achieve it. In supporting our young people we need to look at life as a whole and try to gather information around the past and the present to guide and inform planning for the future.

Equally this reflective work allows us to:

- Provide support effectively, whilst encouraging greater independence and choice within the context of a strengths based approach
- Develop consistent practice and gives us structured information within which we can create a deeper understanding of each young person
- Promotes strategies that allow each young person to 'flourish' and ensure that we provide a range of opportunities to support the development of identity within meaningful lives.

This work informs any Positive Support planning around behaviour that is functional and communicating an unmet need for the young person, so that we can support them more effectively. Initially, it is suggested that we identify and summarise what is going on for the young person and look at what is providing elements of satisfaction, joy, pleasure, stimulation, relaxation and / or contentment at this time and to measure to what degree this is happening.

Having done that we may then proceed to plan what we would like to aim for over the coming months and how this fits into building a clearer set of goals towards improving Quality of Life (see appendix H).

Defusing and Debriefing post incidents

Effective post-incident debriefing aims to provide staff with the opportunity to:

- Explore and share emotions surrounding the incident
- Discuss feelings of safety in the workplace
- Prevent future incidents and promote learning
- Bring closure to the incident and ground staff members in systems of support
- Provide an opportunity to reflect upon the positive experiences from the incident and acknowledge factors that went well
- Prepare the staff member for returning to work

Defusing and debriefing sessions should be offered to the supporting team post 'Red level incidents' or when otherwise requested by the team. They should be jointly led by psychosocial and senior nursing team members.
It is recommended that wherever possible debriefing and defusing is convened prior to the end of a shift (preferably 90-minutes following the incident) and no later than 72-hours post incident.

Debriefs aim to explore in a non-judgemental way:

1. How is the staff member feeling? Are there considerations that need to be made to ensure a feeling of safety?
2. What was the young person/family/staff member trying to communicate during the incident?
3. How do we think they were feeling?
4. How is the young person/family feeling now?
5. How were the staff team feeling at the time of the incident?
6. How are the staff team feeling now?
7. Are there any factors that might have contributed to this incident? e.g. environment, noticeable triggers, relationships, activity, work related factors etc.
8. Have you ever experienced an incident like this before? How does this impact upon current thoughts and feelings?
9. What was done well? Are there things you would do again?
10. Are there any things that could have been done differently?
11. What have we learnt from this incident?
12. How might you feel/respond should you be faced with an incident like this in the future?
13. Are there any changes or actions that should be taken to minimise the likelihood of such an event in the future?
14. What do you think should happen next?
15. Are there any plans that need to be made in terms of additional staff support? Who else needs to be aware of the incident? What might support need to look like?

Incidents at The Children's Trust will be monitored and reviewed by psychology and nursing with quarterly audits reported at the Clinical Governance and Safeguarding Committee. This should ensure that learning and development is integrated with changes to systems and procedures as required.

Self-Harm and suicide behaviours

What do these terms mean?

The term self-harm is used in the NICE guidelines (Self harm in over 8s: short term and long term management, 2019) to refer to any act of self-poisoning or self-injury carried out by an individual whatever the reasons for this. This can involve self-poisoning with medication i.e. taking an "overdose" or self –injury by cutting. Children and young people can self-harm in different ways. There are several important exclusions that this term is not intended to cover. These include harm to the self-arising from excessive consumption of alcohol or recreational drugs, or from starvation arising from anorexia nervosa, or accidental harm to oneself.

Self-harm isn't usually a suicide attempt or a cry for attention. It is often a way for young people to release overwhelming emotions, it is a way of coping. It should always be taken seriously. The exact reasons a young person decides to hurt themselves aren't always easy to work out. Sometimes, they may not know exactly why they do it.

Young people often cannot explain why they self-harm, especially when the self-harm itself is a means of communicating what cannot easily be put into words or even into thoughts. There are links between depression and self-harm. A young person may self-harm to help them cope with negative feelings, to feel more in control or to punish themselves for something they have done/been accused of doing. It can be a way of relieving overwhelming feelings that build up inside when they feel sad, guilty, angry or desperate. Often, the physical pain of self-harm might feel easier to deal with than the emotional pain that's behind it.

Suicide is an intentional, self-inflicted, life threatening act resulting in death from a number of means. Suicidal Ideation (thoughts) means having thoughts about ending your life. These thoughts can be occasional, regular or frequent. The young person may also be thinking of a plan to complete suicide but not actually take steps to do so. (www.rethink.org).

Suicide is a leading cause of death globally in youths and suicidal behaviour and deliberate self-harm are major clinical concerns (Asarnow & Mehlum, 2019). Treatments and preventative interventions that address the psychological needs of young people while also enhancing the ability of trusted adults to protect and support them and strengthen protective processes in the environment yield the greatest benefits (Asarnow & Mehlum, 2019)

Talking about suicide:

Asking young people questions about suicide is safe. It is important for suicide prevention. Research has shown that asking young people about thoughts of suicide is not harmful and does not put thoughts into their head (National Institute of mental health).

Philosophy and Approach

These guidelines and the Self Harm Pathway have been based on research and on the recommendations made in the NICE guidelines (Self-Harm includes guidance for any child or young person over the age of 8 years old).

Emotional impact of their ABI

Children and young people with an acquired brain injury are often facing a number of emotional challenges. They may be experiencing a wide range of thoughts and feelings about what has happened to them. They may be struggling to emotionally adjust to their acquired needs which may lead to feelings of confusion, sadness, anxiety, frustration and anger. Children and young people will be coping with being away from home, school and their friends which can feel isolating. The way in which they sustained the brain injury may have been traumatic or violent in nature which can evoke fear around safety of self and the world. It should be considered that the young person may have experienced other losses e.g. the death of a family member or friend in a car accident.

Family and Developmental experiences

Children and young people come from a range of different backgrounds with a range of experiences. Some of the children and young people may have been facing emotional difficulties prior to their brain injury and some may have had psychological or mental health difficulties such as anxiety, depression or difficulties in their close family relationships. On occasion the child or young person might have attempted to cope with these emotional experiences by self-harming prior to their brain injury. Some of the young people we work with may have sustained their brain injury from a failed suicide attempt. Some children and young people are more vulnerable to self-harm following their brain injury due to their earlier experiences.

Neurological impact of the Child or Young Person's ABI

Children and young people's acquired cognitive and communication difficulties may also contribute to self-harming behaviours. Children and young people may find it harder to put into words how they are feeling due to communication difficulties and may act on these feelings instead. Acquired difficulties with, orientation, emotional regulation and difficulties with attention and impulsivity may also contribute to self-harming behaviours. Other cognitive and communication difficulties may mean that there appears to be a disconnection between a child or young person's thoughts and their feelings. This can mean that it is harder to predict how they will respond

General Guidance for supporting Self-harm behaviours

Positive Action	Challenges and ways to respond
Listen and take time to hear what the young person says	Recognise that young people may be taking an active choice to take these actions to communicate their feelings
Acknowledge the times when the young person isn't self-harming	Always talk with others and inform the young person that you need to do so
Understand that young people self-harm for various reasons and may have different feelings about their self-harm	Remain relaxed and supportive. Acknowledge that the young person has shown you how they feel and that you are present.
Offer sensitivity and empathy; take time to think about what you want to say	Ask for support/advice if you are uncertain how to respond
Be clear with the young person about boundaries to confidentiality and the need to maintain their wellbeing and safety. Inform them that you will need to share this information with the family, shift leader, social worker and psychologist	Be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgmental approach
Seek out support for yourself	
Recognise that self-harm is a coping mechanism which may take some time to be replaced by less harmful alternatives	
Listen to the young person and ask their thoughts on how they might be supported	
Always acknowledge and respond to these behaviours and the message communicated. Take action and inform family and team members	
Ensure that information about episodes of self-harm are communicated sensitively to family and team members	
Foster autonomy, decision making and independence wherever possible	

Self-harm and Suicide Ideation Pathway

Concerns about potential or actual self harm or suicidal ideation:

CYP indicates intention to self harm or has self harmed- when possible listen to the CYP and inform them of your duty to keep them safe

Immediate safety response:

1. Make the immediate environment safe- Prevent them from harming themselves e.g. MAPPA, removing an object, changing their position etc
2. Put CYP on Level 1 1:1 supervision. (This means that a member of staff must be within arms reach of a YP at all times)
3. If CYP is still unsafe or at risk escalate to 999

Report the incident:

1. Inform shift leader and psychology team, doctors and socical workers. If outside of hours inform On Call Manager.
2. Inform Parents
3. Record incident as a safeguarding IRAR

Immediate Risk assessments:

1. Psychologist and another senior member of the IDT will initiate a joint risk assessment immediately . (If out of hours this will be completed by the On Call Manager with the nurse in charge).
2. Risk Matrix **(Appendix I)** will be used to support this

Risk Management plan:

1. The risk assessment will guide the risk management plan that will be shared with the CYP, family and staff .
2. CYP to be supported to complete their own safety plan (appendix X), **risk management plan and emotional support guideline (Appendix H)**
3. Referral to psychiatry clinic will be completed
4. Risk management plan will be reviewed within an agreed time scale
5. Onward referrals to be made in preperation for discharge

Framework for 'My Safety Plan' **https://stayingsafe.net/ST/**

A self-harm safety plan can be an important tool for helping you get through some of your toughest times. Knowing how to spot that you've been triggered, thinking of things you can do to keep safe, and the places you can turn for support are useful in general too!

Date: (to be reviewed weekly or sooner if you need to)

What are the warning signs or feelings that I might self-harm? Are there any physical or mental things you're going through?	
Who can I speak to and ask for help right now? Who can I call that will be able to distract me? Friend: Teacher: Family member: Helpline:	
If your someone you care about was feeling like this, what would I say to them? Try and apply it to yourself now. Think of something positive you can tell yourself right now *("This feeling won't last forever, I've survived 100% of my bad days so far, I've got this - I can get through this")*	
What have you already learnt that helps you when you are feeling low or wanting to harm yourself? E.g distraction, grounding, relaxation, visualisation	
When you are feeling happy what are your three favourite things to do:	1. 2. 3.
How would I know that you were starting to feel low or like harming yourself? E.g quieter, stay in room, listen to sad music, cry, scream	
When you are feeling low what three things could we/parents do to help you? E.g sit with you, go for a walk, watch a movie, do some art, watch Harry Potter	1. – 2. – 3. –
What three things motivate you not to hurt yourself?	1. – 2. – 3. –
What is one thing that is important to you and worth living for right now?	
If we notice that you are already low who would you like us to contact for support?	

Table of Appendices

Version Control Schedule

Version Number	**Issue Date**	**Revisions from previous issue**	**Lead**
1	Jan 2018		
2	Dec 2020	**Integrated The Children's Trust PERMA model to PBS approach.** **Updated self-harm risk matrix** **Included safety plan template**	
2	Dec 2020	Addition of self-harm risk assessment	
2	Dec 2020	Framework for safety plan	
2	Dec 2020	Self-harm and suicide ideation flow chart added	

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Appendix A
Link to document: http://theloop/Interact/Pages/Content/Document.aspx?id=8133

Child's name: **DoB:** **House:**

TCT no: **NHS:** **Page no:**

The Children's Trust
For children with brain injury

ABC Chart – Targeted Behaviour

This document should be recorded in order for psychologists to monitor targeted behaviours and to inform positive behaviour support plans

Targeted Behaviours that challenge: .....

Date and Time	**Location** *Where were you? Who was present?*	**Antecedent** *What happened before? What had you/young person been doing? How was the environment e.g. loud/quiet/busy/limited activity/task or activity*	**Behaviour** *What did the young person do? What did the behaviour look like? e.g. hitting out, throwing, crying etc*	**Consequence** *What did you/others do in the response to behaviour? How did the young person respond? e.g. changed activity, reassurance given, humour, changed staff member*	**Documentation** Who completed the ABC and has information been handed over (if required)
					Staff Name: IRA Completed- Y/N Shift leader informed- Y/N Family Informed- Y/N Psychosocial Informed: Y/N
					Staff Name: IRA Completed- Y/N Shift leader informed- Y/N Family Informed- Y/N Psychosocial Informed: Y/N
					Staff Name: IRA Completed- Y/N Shift leader informed- Y/N Family Informed- Y/N Psychosocial Informed: Y/N
					Staff Name: IRA Completed- Y/N Shift leader informed- Y/N Family Informed- Y/N Psychosocial Informed: Y/N

This document should be recorded in order for psychologists to monitor targeted behaviours and to inform positive behaviour support plans

Appendix B
Link to document: http://theloop/Interact/Pages/Content/Document.aspx?id=8134

Child's name: **DoB:** **House:**

TCT no: **NHS:** **Page no:**

The Children's Trust
For children with brain injury

ABC Chart - Universal

This document should be recorded in order for psychologists to monitor behaviours, look for patterns/trends and to inform positive behaviour support plans. If starting ABC recording please notify the psychology team

Date and Time	**Location** *Where were you? Who was present?*	**Antecedent** *What happened before? What had you/young person been doing? How was the environment e.g. loud/quiet/busy/limited activity/task or activity*	**Behaviour** *What did the young person do? What did the behaviour look like? e.g. hitting out, throwing, crying etc*	**Consequence** *What did you/others do in the response to behaviour? How did the young person respond? e.g. changed activity, reassurance given, humour, changed staff member*	**Documentation** Who completed the ABC and has information been handed over (if required)
					Staff Name: IRA Completed- Y/N Shift leader informed- Y/N Family Informed- Y/N Psychosocial Informed: Y/N
					Staff Name: IRA Completed- Y/N Shift leader informed- Y/N Family Informed- Y/N Psychosocial Informed: Y/N
					Staff Name: IRA Completed- Y/N Shift leader informed- Y/N Family Informed- Y/N Psychosocial Informed: Y/N
					Staff Name: IRA Completed- Y/N Shift leader informed- Y/N Family Informed- Y/N Psychosocial Informed: Y/N

Appendix C
Link to document: http://theloop/Interact/Pages/Content/Document.aspx?id=8138

The Children's Trust
For children with brain injury

Behaviour: Risk Management Assessment

High Impact	High Impact and Low Frequency (Low ABI Vulnerability)	High Impact and Medium Frequency (Medium ABI Vulnerability)	High Impact and High Frequency (High ABI Vulnerability)
Medium Impact	Medium Impact and Low Frequency	Medium Impact and Medium Frequency	Medium Impact and High Frequency
Low Impact	Low Impact and Low Frequency	Low Impact and Medium Frequency	Low impact and High Frequency
Impact ↑ → Frequency	**Low Frequency (Rarely observed)**	**Medium Frequency (A few times a week)**	**High Frequency (Multiple/daily observations)**

	Low ABI Vulnerability	Medium ABI Vulnerability	High ABI Vulnerability
Key brain injury factors	• Young Person (YP) is orientated to time, place and person • YP is able to plan, problem solve and see consequences of behaviour • Low impulsivity • YP has insight into acquired needs • YP is able to regulate emotions • YP has cognitive skills and resources necessary to make positive choices • YP is able to clearly communicate their needs	• YP has some level of insight into acquired needs. • YP can be impulsive. • YP has some ability to regulate emotions • YP has some acquired cognitive deficits • YP may have difficulty in communicating their needs	• Post traumatic amnesia (PTA) • YP has emerging or minimal insight • YP is very impulsive • Impaired executive skills-difficulty with planning, seeing consequences of actions and problem solving • YP has significant cognitive deficits • YP has limited ability to self-manage mood state. • YP has significant difficulties in communicating their needs.
	Low Behaviour Risk	**Medium Behaviour Risk**	**High Behaviour Risk**
Key Behaviour related Factors	• Clear formulation of the function and purpose of behaviour • Young person (YP) has an understanding of what helps when experiencing triggers within their environment. • Young Person (YP) is orientated to time, place and person • YP is able to plan, problem solve and see consequences of behaviour • YP has cognitive skills and resources necessary to make positive choices • YP is able to clearly communicate their needs • YP is happy and feels safe within current setting, with minimal levels of adaptation required • YP pain/medication and physical health currently remains stable and well managed • Good sleep routine • Family appear to be accessing support network as required and currently presenting with minimal levels of distress	• Some understanding of the triggers and function of behaviour • YP has some ability to regulate emotions and apply coping strategies • YP has some acquired cognitive deficits • YP may have difficulty in communicating their needs • Some ability to provide an environment that feels safe and predictable • Partial effective management of pain/medication/physical health • Family experiencing some levels of distress but able to establish coping mechanisms and access appropriate support when required	• No clear indication of triggers/function of behaviour • Pre injury presentation of behaviours that challenge • YP has no current insight into emotional state or understanding of coping strategies. • YP has significant difficulties in communicating their needs. • Limited/minimal insight into behavioural incidents • Challenges maintaining safe environment for the YP e.g. noise/interactions with others, high levels of distractibility • Pain , medication and physical health unstable • Behaviour presents physical risk to self/others • Family experiencing high levels of distress which appears to be impacting on YP

Appendix D

Positive Behaviour Support: Out of hours guidance

In the event of immediate harm or danger to self or others that cannot be otherwise safely managed call 999 ask for police

During office hours (Mon-Fri 9-5)	Outside of office hours (Mon-Fri 5pm-9am) (5pm Friday-9am Monday)
Ensure young person and others around them are safe	Ensure young person and others around them are safe
Follow PBS (Positive Behaviour Support) Plan and refer to behaviour risk assessment	Follow PBS (Positive Behaviour Support) Plan and refer to behaviour risk assessment
Shift leader to contact Family and allocated Psychology, Social Worker, Doctor and team to inform them of incident	Shift leader to contact on-call clinical manager for advice and inform family if not present
Complete ABC chart and IRA	Refer to Safeguarding policy if necessary
Offer debrief for team members/young person and any others involved as appropriate	Complete ABC chart and IRA
Email team and "PBS Incident" to request a meeting to update PBS plan and risk assessments	Email team and "PBS Incident" for urgent review on the next working day
Nursing and Psychosocial review after a further 24-hours	Nursing and Psychosocial review after a further 24-hours

Appendix E
Link to document: http://theloop/Interact/Pages/Content/Document.aspx?id=8136

Child's name: **DoB:** **House:**

TCT no: **NHS:** **Page no:**

The Children's Trust
For children with brain injury

Positive Behaviour Support Plan

Behaviour Risk Assessment: High Medium Low (please select)

Completed by: ..... Date: .....

To be reviewed on: .....

External Triggers	**Internal Triggers**
Creating a Positive Environment:	

Child's name:	**DoB:**	**House:**	
TCT no:	**NHS:**	**Page no:**	

The Children's Trust
For children with brain injury

What does the behaviour look like? (Green, Amber and Red levels)

Signs of de-escalating behaviour:
(Blue font)

Support Plan

Green strategies: early signs of behaviour change in response to green behaviour
Amber strategies in response to Amber behaviours
Red strategies: include MAPA disengagement or low level holds (consult with Claire Seeruthun)
Call for assistance, create safe distance if possible, adopt supportive stance, MAPA disengagement skills, low level standing hold appropriate
Move to Amber level skills as soon as safe and complete IRA and ABC post incident
Debrief no sooner than 90-minutes post incident in order to repair working relationship, acknowledge triggers and feelings for X and reflect on what might help another time to prevent escalation

Child's name: **DoB:** **House:**

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The Children's Trust
For children with brain injury

To ensure all care is delivered in accordance with the Positive Behaviour Support plan all staff working on X House and MDT need to read the attached and sign below:

Name and role	Signature	Date

Appendix F
Link to Document: http://theloop/Interact/Pages/Content/Document.aspx?id=8329

The Children's Trust
For children with brain injury

Positive Behaviour Support Plan
Creating a Positive Environment - consider the following values

Primary Care and Protection	Making Close Relationships	Positive Self-Perception	Emotional Competence	Self-Management Skills	Resilience	A Sense of Belonging	Personal and Social Responsibility
Sensitivity to a child's basic needs shows the child that we care and they are important. (Maslow, 1971)	Secure attachment appears to act as a buffer against risks and acts as a protective mechanism. Ziegenhain (2004)	To allow the child to develop a positive self-image. Positive and negative statements have a powerful impact on self-perceptions. Burnett (1999)	This ability underpins the successful development of relationships outside the family and may moderate susceptibility to later mental health problems Saarni (1999)	Self-management is the insulation, which prevents inappropriate behaviour when enticing or compelling outside factors try to intrude. Lewis and Frydenberg (2002)	Resilient individuals seem to be able to understand what has happened to them in life (insight), develop understanding of others (empathy) and experience a good quality of life (achievement) Dent and Cameron (2003)	Research and theory in relationships have established human beings as fundamentally social and highlighted the need to belong. Baumeister (2005)	Personal and social responsibility means being able to coordinate one's own perspective with the help of others and developing personal views of fairness and reciprocity. Carpendale and Lewis (2006)
Primary Care and Protection Support	**Making Close Relationships Support**	**Positive Self-Perception Support**	**Emotional Competence Support**	**Self-Management Skills Support**	**Resilience Support**	**A Sense of Belonging Support**	**Personal and Social Responsibility Support**
Monitor fatigue, pain, hunger, personal care etc. to ensure that basic needs are met. Celebrate the young person's	Find out about the young person's likes and interests. Engage in play/leisure activities with	Celebrate the young person's successes e.g. successes from their sessions.	Explain why you want the young person to do something. Talk the young person through any care/procedure you	Use visual timetables and orientate to day. Make use of metacognitive approaches (see crib sheet	Where possible support access to family/peers e.g. supporting home visits, Facetime calls etc. Promote friendships with	Provide a good transition onto house e.g. key worker welcoming them, introducing them to others, showing them round etc.	Model considerate behaviour to other staff members and young people. Model honesty and openness.

successes e.g. successes from their sessions. Engage the young person in games/activities that they can experience success in / they are good at. Attend to young person's appearance so they look and feel their best.	the young person. Encourage the young person to explore new things / engage in new opportunities.	Recognise and reward positive behaviour. Provide descriptive praise (see crib sheet on descriptive praise). Set reasonable boundaries for behaviour.	are providing for them. Recognise and name the young person's emotions (see wondering aloud crib sheet). Teach empathy e.g. how do you think that X feels now? Look out for the needs of others (young people and colleagues) and articulate what you are doing.	on metacognition). Encourage self-reflection.	other young people. Ensure continuity and stability in care e.g. having a keyworker the young person can build a trusting relationship with.	Personalise the young person's bedroom e.g. through having things from home in their room. Try and create a home from home environment. Value the family's cultural customs.	Support the young person to help others, do something nice for someone else etc. Consider roles of responsibility/interest on house. Help young people to think about future aspirations.

Adapted from Sean Cameron and Colin Maginn (2008)
To ensure all care is delivered in accordance with the Positive Behaviour Support plan all staff working on X House and all members of the

Child's name: **DoB:** **House:**

TCT no: **NHS:** **Page no:**

The Children's Trust
For children with brain injury

Positive Behaviour Support Plan

Behaviour Risk Assessment: High

Completed by: …… Date: ……

To be reviewed on: ……

External Triggers	Internal Triggers
- Noise (by others) - Busy environment- dining room - Being told no - Inconsistency - Medication being given - School- not looking like typical school - Being at TCT - Maternal anxiety - Washing and dressing - Being woken up	- Fatigue: pre lunch, end of day, after physio - Traumatic memories: procedures and operations, going in the ambulance to hospital - Fear of dying - Worries about seizures - Thinking that people didn't like him - Knowing that others seemed scared of him - Missing friends and family - Wanting to be at home - Loss of independence - Fear on waking

Creating a Positive Environment:

- Mealtimes to be offered in quiet space e.g. bedroom, teenage room, side room
- Arrange for X to be off house when large groups are timetabled
- Consider environment for sessions e.g. offer outside space; soft play, be mindful of noise of others
- Medication- preparation and offer roles within procedures to enable some level of control for X and provide reassurance
- Fatigue management- offer regular naps, not to be woken for sessions if still asleep
- Use visual timetable and orientate to day
- Maintain positive communication that acknowledges how X is feeling
- Parents manage personal care, when involved discuss role with X prior to starting
- Access to home visits, having things from home in his room, Facetime family and allow time with staff after when feeling sad

Child's name: **DoB:** **House:**

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The Children's Trust
For children with brain injury

<u>What does the behaviour look like?</u> (Green, Amber and Red levels)

Cover his ears; Ask to leave; Tell you to go away; seek cuddles with Mum
I'm going to hit you; Raised voice; Standing up; Pacing; Complaining about noise
Shouting; Face to face; punch; hair pull; kick; grab clothes and limbs

Signs of de-escalating behaviour:
Tearful; Fatigue and sleep; tried to repair relationships with humour or apologies, Hug mum, affectionate towards family

<u>Support Plan</u>

Green strategies: early signs of behaviour change in response to green behaviour
Amber strategies in response to Amber behaviours
Red strategies: include MAPA disengagement or low level holds (consult with Claire Seeruthun)
Call for assistance, create safe distance if possible, adopt supportive stance, MAPA disengagement skills, low level standing hold appropriate
Move to Amber level skills as soon as safe and complete IRA and ABC post incident
Debrief no sooner than 90-minutes post incident in order to repair working relationship, acknowledge triggers and feelings for X and reflect on what might help another time to prevent escalation

The Children's Trust
For children with brain injury

Psychology Team: Neuropsychological Case Summaries

Neuropsychological case summaries aim to share relevant pre-injury information with the supporting team. The psychologists apply their knowledge to describe the nature of the young person's acquired brain injury and think about the potential implications for skills, needs and psychosocial functioning.

The pre-admission consultation provides an opportunity to discuss the presented case summary as a team. The aim is to explore the potential implications for approaches to rehabilitation and to collaboratively produce a rehabilitation plan.

Psychology team members who complete case summaries: Laura Carroll, Liz Roberts, Birgitta Norton, Amanda Davies, Gemma Costello, Louise Owen, Jenny Jim and Alison Perkins

Pathway at admission	Neuropsychological case summary timeline
For young people entering The Children's Trust on a Red 'positive behaviour support pathway' or 'self harm pathway'	Extended pre-admission meeting (additional 45-minutes). Aims: Psychologist to share the case summary and jointly develop a formulation and rehabilitation plan with the team. Case summary will also be shared and consultation provided to the house team.
Amber positive behaviour support pathway	As above: The case summary will be shared in an extended pre-admission meeting. The case summary will also be shared and consultation offered to the house team.
Green pathway	Neuropsychological case summary to be shared with house team and MDT at TAC meeting.

Appendix H: The Children's Trust PERMA Model Assessment and Plan

Young Person's Name: Completed by: Date:

Summary of current situation / background:

How are we currently supporting development and expansion of Relationships?	What might be the next step?

How are we currently supporting the young person to achieve an increasing Sense of health, Safety and well-being?	What might be the next step?

How are we supporting the young person to have more fun and enjoyment in everyday places?	What might be the next step?

How are we promoting a sense of power, choice and control at any level and an opportunity to make a contribution to others? (Engagement)	What might be the next step?

How are we supporting the young person to develop a greater sense of value and self-worth? (meaning and achievement)	What might be the next step?

How are we supporting the young person to learn important, valued and relevant skills? (meaning and achievement)	What might be the next step?

How are we supporting those working with the young person?	What might be the next step?

Completing the next part of this tool aims to identify and evaluate:

- The value and frequency of activities that the person is *currently* involved in.
- Where the frequency of high value (low financial or resource cost) the activities can be increased.
- Activities that may promote health (and are valued to an extent) that can be increased.
- High cost activities that are not highly valued – could be removed or reduced.
- Activities not currently involved in that the person may want to begin.

This is about identifying what people *want* to do rather than what they *need* to do as part of everyday life, so cleaning, cooking and exercises *are* included in the tool because some people actively enjoy them. Supporting people with activities of daily living is also important but we're focussing on life enrichment / enhancement activities and experiences that improve quality of life.
Wherever possible the person should complete the measure themselves and / or be supported as necessary to be as involved as possible in completing it. It may be useful to ask different people involved in the person's life, including a range of staff and family members, to complete the measure in order to compare views of what the person values.
Please indicate how often the person does any of the following activities (frequency).
Then rate how much

- enjoyment
- satisfaction
- pleasure
- stimulation
- relaxation
- contentment

The person gets from the activity, relative to other activities. This is a measure of how important the activity is, or appears to be, for the person **(value).**
*It is important to remember that the **value** rating needs to be based on observed behaviour or what the person says. How important it is, means – the importance to the person themselves; NOT how important OTHERS think it is that the person does the activity OR how 'GOOD' others think it is for them.*

Frequency	Value
0 = Never **1 = Less than every 3 months** **2 = At least every 3 months** **3 = Monthly or more frequent** **4 = Weekly or more frequently** **5 = Daily or more frequently**	**A = High pleasure / satisfaction etc. & importance = Some pleasure / satisfaction etc. & important** **B = Some pleasure / satisfaction etc. & important** **C = Not important, no / low value but not disliked** **D = Disliked or detrimental** ***Of not known, mark with a dash***

'Influenced by the Guernsey Community Participation and Leisure Assessment: Baker, Taylor-Roberts and Jones 2015'
What is the young person currently doing that they enjoy, how often and how much do they enjoy it? If they are not doing it at all – we can note this and suggest (if possible – this becomes part of our plan for the future

Activity	Frequency	Value	Details
Seeing my family and friends			
Hearing from my family and friends on the phone			
Play computer games			
Watching TV / films			
Having someone with me talking to me and spending time with me (intensive interaction)			
Taking part in sensory activities			
Doing creative things			
Listening to music			
Coloured lights that change			
Having time out of my chair on a wedge / acheeva			
Having things that other young people would have (age respectful)			
Being sung to			
Putting my hands / feet in squelchy things (warm / cold)			
Going to youth club			
Swimming			
Playing other sports like football / climbing / swinging /			
Cooking or baking			
Sitting in my comfy chair			
Going out for a drive			
Going outside – fresh air			
Being outside when it is windy			
Being outside in the sunshine			
Going shopping			

Being involved in performing arts or music activities			
Spending time with my friends			
Having a bath or shower			
Having my hair done			
Going to the beach			
Football			
Massage and complementary therapies			
Having my nails done			
Eating or tasting my favourite foods			
Going out to the theatre / cinema			
Going to a disco			
Going to a place of worship			
Going to the pub			
Going out with my family or friends to a restaurant			
Growing things in the garden			
Going really fast			
Seeing and touching different animals			
Horse riding			
Cycling			
Going on holiday			
Going to the beach			
Watching live sports			
Going on a boat			
Going to a funfair / theme park			

Going Bowling			
Travelling by boat / train / plane			
Going out into the countryside			
Helping out at home – tidying up or sorting things			

Recommendations / Suggestions / Resources / Support

	Ideas / goals towards improving well-being	**RAG rating**	**Evidence / How did we know?**
Positive emotion: Which includes happiness and life satisfaction			
Engagement: Activities that absorb a young person – that gives a sense of fun			
Relationships: With any young people or other adults			
Meaning: Belonging to and being a part of something bigger than oneself (part of community / relevant participation)			

Achievement: Accomplishments (however small, pursued for their own sake)			

Appendix I Link to document: http://theloop/Interact/Pages/Content/Document.aspx?id=8140

The Children's Trust
For children with brain injury

Self-harm Risk Management Assessment

High risk	High Self-harm Risk and Low ABI vulnerability	High Self-harm Risk and Medium ABI vulnerability	High Self-harm Risk and High ABI vulnerability
Medium risk	Medium Self-harm risk and Low ABI vulnerability	Medium Self-harm risk and Medium ABI vulnerability	Medium Self-harm risk and High ABI vulnerability
Low risk	Low self-harm risk and Low ABI vulnerability	Low self-harm risk and Medium ABI vulnerability	Low self-harm risk and High ABI vulnerability
Self-Harm risk ↑ → **ABI vulnerability**	**Low ABI vulnerability**	**Medium ABI vulnerability**	**High ABI vulnerability**

Appendix I

	Low Risk	Medium Risk	High Risk
Mental health/Emotional wellbeing risk and protective factors	• Mental health problems may be present but person has no immediate thoughts of plans regarding harm to self • Fleeting thoughts of suicide which were soon dismissed. No plan relating to thoughts of self harming behaviour. • No evidence of immediate or short-term risk or vulnerability • Protective factors evident including; support networks, sense of personal control, ability to maintain own safety emotional wellbeing, ability to understand, think clearly and interact socially. • May be showing a little distress/anxiety	• Mental health problems present. • Non-specific thoughts regarding harm to self or suicide • No specific plan to act on suicidal or self-harming thoughts. • Frequent suicidal thoughts are context driven-young person may be more vulnerable in certain circumstances • Showing some distress/anxiety. • May be behaving differently • Self-harm behaviour **Medium/High: No plan immediate but may have considered methods.**	• Serious mental health problems present • May have definte plans to enagage in further self-harming beahvour. • Has clearly identifiable risk charateristics –thoughts or plans relting to self-harm or suicide. • Clear, consistent immediate risk irrespective of context. • May have already engaged in self-harming behaviour. • Young person is likely to act upon thoughts of self-harm/suicide at earliest opportunity. • Mental state likely to detriote withour intervention.
	Low ABI Vulnerability	**Medium ABI Vulnerability**	**High ABI Vulnerability**
Brain injury risk and protective factors	• Young Person (YP) is orientated to time, place and person. • YP is able to plan, problem solve and see consequences of behaviour • Low impulsivity • YP has insight into acquired needs. • YP is able to regulate emotions	• YP has some level insight into acquired difficulties. • YP can be impulsive. • YP has some ability to regulate emotions. • YP has some acquired cognitive deficits. • YP may have difficulty in communicating their needs.	• Post traumatic amnesia (PTA). • YP has emerging insight • YP is very impulsive • Impaired executive skills-difficulty with planning, seeing consequences of actions and problem solving • YP has significant cognitive deficits • YP has limited ability to self-manage mood state.

	• YP has cognitive skills and resources necessary to make healthy choices. • YP is able to clearly communicate their needs.		• YP has significant difficulties in communicating their needs.
Actions in- hours	• Continue to support and monitor young person's emotional wellbeing.	• Overnight observation • 1:1 staffing-(within eye sight) time limited? • Safety plan to be put in place with YP and family (Appendix X) • Ongoing risk assessment and mood monitoring (if appropriate) • Start ABC charts	• 1:1 staffing 24 hours (within arm's reach) at all times • Room sweep (refer to sweep list, Appendix X) • If YP has lanyard for this to be removed • Safety plan to be put in place with YP and family • Referral to CAMHS • Refrreral to psychiatry • Professional only meeting to be organised • If in doubt, contact emergency services on 999 • Start ABC charts
Actions out of hours	• Continue to support and monitor young person's emotional wellbeing. • Access to psychosocial support and nursing/care	• Overnight observation • 1:1 staffing-(within eye sight) time limited? • Safety plan to be put in place with YP, family, shift leader and on call manager (Appendix X) • Notify psychosocial team for in-hours follow up. • Start ABC charts	• 1:1 staffing 24 hours (within arm's reach) at all times • Room sweep (refer to sweep list, Appendix X) • If YP has lanyard for this to be removed • Safety plan to be put in place with YP and family, shift leader and on call manager • If in doubt, contact emergency services on 999 • Inform psychosocial service for in-hours follow up.

Appendix J

Child's name:	**DoB:**	**House:**
TCT no:	**NHS:**	**Page no:**

The Children's Trust
For children with brain injury

Self-harm Risk Assessment and Emotional Support Plan

Behaviour Risk Assessment: High Medium Low (please select)
High Risk (Clear, consistent immediate risk irrespective of context)
Medium Risk (Fleeting, frequent risk which is more context driven)
Low Risk (No actual intent to end life, no future plans)

Completed by: ..... Date: .....

To be reviewed on: .....

External Triggers/Risk factors:	**Internal Triggers/Risk factors:**
Protective/Resiliency Factors:	**What do risk taking behaviours look like? (Amber and Red fonts- red indicate highest level of risk taking behaviours)**

Child's name: **DoB:** **House:**

TCT no: **NHS:** **Page no:**

Creating a safe environment: (Blue font)	Action plan	Who will action/by when	Review date

Emotional Support Plan:

Green strategies: early signs of behaviour change in response to green behaviour
Amber strategies in response to Amber behaviours
Red strategies: include MAPA disengagement or low level holds (consult with Claire Seeruthun)
Call for assistance, create safe environment wherever possible, adopt supportive stance, MAPA disengagement skills, low level standing hold appropriate
Move to Amber level skills as soon as safe and complete IRA and ABC post incident
Debrief no sooner than 90-minutes post incident in order to reflect, explore triggers and feelings for X and explore ways of restoring sense of safety.
Arrange staff debriefing with nursing and psychology

Child's name: **DoB:** **House:**

TCT no: **NHS:** **Page no:**

The Children's Trust
For children with brain injury

To ensure all care is delivered in accordance with the Self Harm support and risk management plan all staff working on X House and MDT need to read the attached and sign below:

Name and role	Signature	Date

Appendix K: Psychology Risk Assessment and Safety Planning

To be completed with the young person, include the parent/guardian if possible. The YP may not wish to have a parent present for the risk assessment. In this case, meet with parent afterwards to carry out risk assessment. If the YP is over 16 and is deemed to have mental capacity ask their permission for parent to join.

- Name:
- Date of Birth:
- GP:
- Who does the child live with/who has Parental Responsibility:
- Date of incident/disclosure and time:
- Date of risk assessment and details of who was present:
- Who witnessed act/disclosure made to (Name and profession):

Brief description of disclosure/behaviour by YP

e.g. I want to kill myself *e.g. I want to cut my arm to stop feeling this way* *e.g YP has made an attempt to harm themselves, cutting; head banging; scratching self etc.*

Baseline Risk Assessment

Aim is to establish the level of presenting risk and to ascertain what action is required.

Frequency:

- What makes them have these thoughts (of suicide or self-harm) e.g. sensation seeking; self-punishment escape; mood; conflict)
- How long have they been having these thoughts
- When did they last have these thoughts
- Frequency of thoughts (one time-a few times-a lot-all the time-DK)
- Have they had thoughts about being dead/not being alive anymore

Past behaviour:

- Have they ever tried to harm themselves
- Have they ever engaged in any form of self-injurious behaviour
- Have they ever tried to kill themselves (method)

Ideation

- *Active suicidal ideation with any method (not plan) without intent to act*

Have they thought of how they may harm themselves/kill themselves-what did they think about?

- *Active suicidal ideation with some intent to act, without specific plan*

When they had the thought about killing themselves, did they think this was something they may actually do? (This is different from having the thoughts but knowing you wouldn't do anything about it)

- *Active suicidal ideation with intent to act and specific plan*

Have they decided when they may kill themselves? Have they planned when they would do it? What is the plan? Likelihood of them carrying out this plan.
Intensity of ideation (one time-a few times-a lot-all the time-DK)

Plan

- Have they got access to these means (e.g. tablets, weapons)
- If no plan the have they got an idea about how they would do this
- Does anyone else know about these thoughts/plans

Emotional wellbeing/symptoms

- Ask about mood; anhedonia; anxiety; recklessness; hopelessness; isolation; sleep pattern; appetite; substance misuse.
- PTSD
- Psychosis

Social Support and Stressors

- Are they getting support for their feelings from anyone (friend, family, professional)
- Family situation (conflicts at home?)
- School functioning
- Do they think they need help to keep themself safe
- What stops them acting on these thoughts/having these thoughts 'reasons for living'
- What helps them to stop the self-harming behaviour from getting worse
- Are they at risk of harm from others (family,friends,professionals)
- What do they think needs to happen to help them feel better

Acquired Brain Injury Factors

- Consider hot and cool executive skills
- Impulse Control
- Level of Insight
- Emotional dysregulation
- Disinhibition
- Emotional lability
- Ability to plan/goal directed behaviour
- Cognitive factors (e.g. misperceptions; disorientation)
- Perseverance
- Post traumatic amnesia
- Pain
- Communication difficulties

Risk and protective factors

Protective Factors/factors that reduce risk (social, psychological, pharmacological and motivational)	
Positive attitude /sense of personal control	
Ability to understand, think clearly and interact socially	
Emotional well-being evident: self-esteem/self-worth/confidence/hopefulness/ optimism/ sense of belonging	
Good communication skills	
Having close friends	
Belief in own/parents capabilities and self determination to help oneself	
Belief in parents/carers capabilities and self determination to help them	
Cognitive skills and resources to make healthy choices	
Significant relationships that may be supportive	
Parental motivation to intervene	
Parental response to distress managed well	
Parents in touch with child's emotional state	
Connected to values/beliefs e.g. religions practices, social practice	
Having a valued role, sense of belonging, feeling involved	
Reasons to stay alive identified	
Supportive school environment	
Permanent home base	
Access to leisure and social amenities	
Low crime area/low drug use in community	

Risk Factors	
Previous self-harm/suicidal thoughts/suicide attempts	
Is there a known mental health problem • Depressive symptoms/hopelessness • Psychosis/neurosis symptoms • Anxiety	
• Low self esteem • Trauma history • Fear of failure • Attachment difficulties	
Recent bereavement or relationship break up	
Relationship problems with friends or family	
Current stress in young person's life (including ABI) Previous stressors in YP's life	
Family history of self-harm/suicide Family psychiatric history	
Any issues around gender and sexual orientation/gender identity	
History/current bullying	
Risk taking behaviours by young person	

Poor social connectedness	
Non-verbal warning signs: • Withdrawal/isolation • Signs of depression • Making a will/giving away possessions • Weight loss • Fascination with death	
Parental risk factors • Conflict and violence • Low warmth interaction/critical • Neglect of child's needs • Excessively high/low goals for child • Parental MH /substance misuse.	
Environmental risk factors: School (demands placed on child; bullying;ignoring special needs) Housing and community: homelessness; high fear of crime/drugs	
Brain Injury related risk factors-refer to risk matrix	

Other agencies involved, please circle

CAMHS/CMHT Social Services Police
Educational Psychology Youth Justice Other

Level of risk (refer to risk matrix)

High risk **Medium Risk** **Low risk**

Actions:

Formulation of risk with team, YP and family. Use risk Matrix. Decision regarding level of risk	
Risk management Plan-monitor and provide additional support within setting. Circulate to team and share with shift leader, YP and family.	
YP to be supported to create their own risk management plan/safety plan	
Provide parents and YP with resource list-contact numbers and APPS	
Referral to psychiatry clinic	
Planning for home visits and off site trips	
Liaise with community CAMHS for ongoing referral	

Assessors: **Date/Time:**

Appendix L

ABC Chart Audit	
House	
How are they being used? Universal/Targeted Are all sections completed?	
Sex, Age, Ethnicity, Type of injury, Socioeconomic status	
Parents Informed/IRAR Completed	
Content/Themes in ABC chart recording	
Incidents per week	
Safety training technique been used/IRAR Completed	
Are they under section 9 in the Care Plan	
Who recorded the incident: Nursing Parent Therapists Psychosocial team member Surrey Teaching Centre	
Parent ABC chart pack	
Any use of restraint/deprivation of liberty	
Debrief recorded	

PBS Plan Audit	
House	
Type of injury	
Behaviours of concern	
Produced with: Nursing, Therapy, School, Parents, Child/young person	
Sex, Age, Ethnicity, Type of injury, Socioeconomic status	
Pre injury history of positive behaviour support needs	
Plan level: Red, Amber, Green	
Types of intervention e.g. environment, orientation, self-regulation, wondering aloud, safety technique	
Frequency of review	Red: weekly Amber: fortnightly Green: at MDT team meeting
Signature of team, parent and young person	
Are they under section 9 in the Care Plan	

Nursing care plan states PBS plan in place with level	
Any use of restraint/deprivation of liberty	
Consultation offered	
On call used	
Safety technique used	
Change in level	
Debrief	

Emotional support plan Audit	
Type of injury	
Behaviours of concern	
Pre-injury history of mental health	
Pre-injury CAMHS involvement	
Produced with: Nursing, Therapy, School, Parents, Child/young person	
Documentation of actions- checklist completed	
Sex, Age, Ethnicity, Type of injury, Socioeconomic status	
Who assessed the risk	
Level of risk: High, Medium, Low	
Plan shared with family, young person	
Materials used to assess the risk	
Type of harm	
Types of intervention	
Communication with those who have parental responsibility	
Mental Capacity- 16+	
Psychiatry involvement	
Frequency of review	High: weekly Medium: fortnightly Low: at MDT team meeting
Signature of team	
Are they under section 9 in the Care Plan	
External triggers, environmental factors discussed	
Any use of restraint/deprivation of liberty	
Safety technique Used	
Consultation offered	
On call used	
Debrief	

Behaviour Incidents:	
When did they occur	
Where did they occur	
Allocated house	
Nature of incident	
Trips and falls	
Risk- input	
Risk- closed	
Safeguarding- yes/no	

ABC log completed	
PBS/Self-harm plan yes/no	
Themes of incident	
Any use of restraint/deprivation of liberty	
Actions taken	
Was further information required	
Safety technique- disengagement/holding skills	
Learning identified in reflection	
Debrief recorded	