The Development of a Behaviour Management Workshop to Educate Clinical Staff in a Forensic Mental Health Setting

by

Stephanie Yarrow

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The procedures in this staff training workshop are meant to be used by agency staff, as part of the broader services they provide, or under supervision of agency staff.
ABSTRACT

Clients in forensic mental health settings often show high rates of challenging behaviour due to the nature of their illness and the setting they are in. Staff who work in these settings face many challenges when working with forensic clients, especially when developing interventions to decrease the challenging behaviour. The present study sought to develop a method of addressing challenges faced by staff by providing information about causes of behaviour and the process of behavioural assessment and intervention. A brief workshop format was selected to accommodate the needs of staff and to address the barriers to treatment identified by staff. The present project focused on the development and implementation of the workshop. Suggestions for future research are provided and discussed.
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CHAPTER I: INTRODUCTION

The forensic mental health system is a combination of inpatient and outpatient services for individuals with mental health issues who are in conflict with the law. Those residing in inpatient units are there either for assessment or rehabilitation; those there for rehabilitation have been found either Not Criminally Responsible on account of Mental Disorder (NCRMD) or Unfit to Stand Trial. A major problem in these settings is challenging behaviour displayed by the clients, such as verbal aggression, physical aggression, and drug and alcohol use.

Challenging behaviour is a growing concern in many clinical professions (Farrell & Salmon, 2009). Some individuals are more likely than others to exhibit challenging behaviours, due to individual skill deficits, and personal and social factors (Gottfredson, 1993), with individuals with intellectual disabilities showing a prevalence of challenging behaviours ranging from 7.8-12.1% (van Oorsouw, Embregts, Bosman, & Jahoda, 2010). Challenging behaviours can include anything from not complying with pharmacological treatment to acts of physical aggression. In a forensic mental health setting, all of the clients have some form of mental illness, with some of the clients being dually diagnosed; this means they are diagnosed with a psychiatric illness as well as an intellectual disability. Thus, the prevalence of challenging behaviour on the forensic unit of a mental health hospital can be quite significant.

Recent studies have examined challenging behaviour in mental health settings, and have suggested that the high prevalence is due to clinical staff’s limited understanding and knowledge of how to address challenging behaviour, or how it develops or is maintained. Because of this lack of knowledge, staff can inadvertently promote or reinforce challenging behaviours (Farrell & Salmon, 2009). Farrell and Salmon also speculate that part of the issue is whether nurses think that they have the ability to manage behaviour. This could result in a lack of confidence or lack of attempts, or successful attempts, to change or manage challenging behaviour. Therefore, if lack of knowledge is part of the problem, then it stands to reason that educating clinical staff would be an appropriate intervention.

Based on empirical research, the present study hypothesized that if clinical staff feel unprepared and not sufficiently educated to appropriately intervene with challenging behaviour, by providing them with some basic information on behaviour, assessment, and intervention, they will feel better equipped to react appropriately and facilitate more appropriate behaviour. One method that has been found to be effective in educating staff is the use of a workshop.

For the purposes of the present project, a brief workshop was used to educate staff on the topics of behaviour, behavioural assessment, behavioural intervention, and challenging behaviour that may be encountered in a forensic setting. A case example was used to provide a practical example for the staff. For the purposes of this workshop, brief means approximately 40 minutes; due to the time constraints and the limitations of staff, it was not practical to create a workshop of greater length, as many of the staff would then not be able to attend.

The purpose of this workshop was to provide education to the staff around behaviour, particularly challenging behaviour, and the process of assessment and intervention. At the time of this project, there was no basic education on the unit about behaviour and behavioural interventions, and many of the staff had daily difficulties with the behaviour displayed by some clients. Although there was no time to collect data and examine the effectiveness of the workshop, the workshop itself was developed for the staff on the ward. All staff have access to the workshop and can continue with implementation, as well as research to examine for efficacy if they so choose.
A review of existing literature is provided in the current project. Topics covered in this literature review include: an overview of forensic mental health, stigma and forensic mental health, staff assessment of challenges of behavioural interventions, a clear definition of behaviour and challenging behaviour, the effects of challenging behaviour on staff, the effect of staff attitudes and responses on challenging behaviour, and the outcomes of workshop interventions on staff. The method for the development of the workshop is outlined, and the final product is included. There was also a satisfaction survey administered at the end of the workshop sessions to assess the relevance of the workshop, and whether it was helpful to staff. Lastly, there is a discussion around strengths and limitations of the workshop, multilevel challenges, and recommendations for future research.
CHAPTER II: LITERATURE REVIEW

An Overview of Forensic Mental Health

Forensic mental health is a growing field that combines the mental health and legal systems (Livingston, 2006). Livingston (2006) defines clients of the forensic mental health field as those who have a diagnosed mental disorder who are in conflict with the law. When charged with or accused of a crime, clients can be sent to a forensic mental health facility to be assessed for fitness to stand trial, or for criminal responsibility. Those found Not Criminally Responsible on account of Mental Disorder (NCRMD) or Unfit to Stand Trial (unfit) are then admitted into forensic units for rehabilitation or to be made fit to stand trial where possible. According to Livingston, forensic mental health is currently the favoured terminology, as it implies not only psychology, but the many disciplines that are involved in the care and rehabilitation of clients. Nursing staff are often the ones with the most contact with forensic clients, as they are available on forensic units all of the time. Other disciplines that have regular contact with clients are psychology, psychiatry, social workers, and occupational therapists. All of these staff are committed to the treatment and rehabilitation of forensic clients, whether inpatient or outpatient.

While the past reputation of forensic services has been one of punishment and coerciveness, the present and future of forensic services is one of evidence-based treatment and service delivery (Sullivan & Mullen, 2006). Assessment and containment of clients is part of forensic mental health, but the multi-disciplinary involvement and evolvement of services allow for treatment and rehabilitation to be possible. While advances are being made, there are still many challenges to overcome when treating forensic clients.

Stigma and Forensic Mental Health

Stigma is a common challenge faced by many populations, but especially individuals with mental health issues. Horsfall, Cleary, and Hunt (2010) outline three parts to stigma: a mainstream negative stereotype (people who are mentally ill are dangerous, for example); signs that an individual is mentally ill (odd behaviour, a diagnosis, etc.); and avoidance or mistreatment against the individual. Stigma can have a significant negative impact on areas of daily life such as personal relationships, professional relationships, and even things like weekly shopping or socializing in public (Lyons, 1997, as cited in Lyons, Hopley, & Horrocks, 2009). Lyons (1997) also found that stigma can significantly decrease an individual’s confidence.

There are challenges when developing and implementing interventions within any population, but forensic clients often have amplified challenges due to the nature of their diagnoses, the setting they are in, and the stigma attached to their situations. Once sufficient rehabilitation has taken place, forensic clients frequently move into the community to continue rehabilitation and to attempt to regain normalcy in their lives. Often, though, despite efforts to educate the general public, stigmatization remains a problem, and can lead to the estrangement of forensic clients. Some of the effects of stigmatization for individuals with mental health issues include reduced self-esteem and social isolation (Lammie et al., 2010). However, it is not solely the general public that can present barriers to treatment for forensic clients. Many staff members, along with the general public, can also hold negative views of forensic clients, and often assign labels to the clients themselves, and their behaviour (Mason, Caulfield, Hall, & Melling, 2010). According to Mason et al. (2010), the label of “dangerousness” is often applied to forensic
clients, which has obvious implications to anyone who hears the label. Because of stigmatization and labels, forensic clients often have trouble finding housing and accommodations upon release, and other services often show reluctance in assisting in treatment (Sullivan & Mullen, 2006). These stigmas are often a result of limited knowledge of forensics and forensic clients, and so to attempt to reduce this stigma and provide a more nurturing environment for treatment and intervention, basic education should be provided to both staff and the general public.

**Challenges of Treatment with Forensic Clients**

When attempting to work with individuals with mental illness, treatment often aims to encourage the individuals to understand the limitations placed upon them by their illness and to work within those limitations to lead a satisfying, meaningful life (Anthony, 1993). This is often referred to as the recovery approach, and many mental health service providers are currently adapting this approach with their clients. However, Mezey, Kavuma, Turton, Demetriou, and Wright (2010) outline four major challenges of applying the recovery approach with forensic clients. First, forensic clients are often legally detained on a secure forensic unit, which places limitations on their ability to make choices about their treatment. This alone causes a discrepancy in treatment, as one of the main focuses is to motivate the individual to make their own choices about their treatment and recovery. When an individual is legally detained, they are often mandated to participate in certain aspects of treatment, which makes it difficult to instill hope and motivation. Second, the length of time an individual is legally detained on the forensic unit is often long, and individuals who are in this environment often lose hope and optimism. Individuals who are detained on a forensic unit for a long period of time lose motivation as well, and often it is difficult to foster independence and autonomy when there is little opportunity for the individual to use these skills. Third, the therapeutic approach with individuals in a forensic setting is often based on confronting and challenging maladaptive behaviours. This can create conflicts between staff and the individual, and the therapeutic relationship becomes complicated and strained. This is not conducive to fostering a supportive environment in which to work with the individual on promoting positive behaviour change and instilling hope. Finally, forensic patients are frequently considered dangerous, and a majority of treatment decisions are based on risk to the safety of the public. This places even more limitations on what is possible when providing treatment for forensic clients, as there are strict limits imposed on what the client can and cannot do. The wishes and choices of the patient often conflict with what is deemed appropriate in regards to managing risk. All of these challenges limit the opportunities forensic clients have to begin creating satisfying, meaningful lives for themselves, and when it is possible, the process is often slow. These challenges all reflect in daily interactions and treatment attempts with forensic clients, and frustrations often result in challenging behaviours of clients.

**Staff Assessment of Challenges of Behavioural Interventions**

Due to the high levels of challenging behaviour in forensic settings, staff are often attempting to implement behavioural interventions with the clients to reduce the challenging behaviour. While behavioural interventions can be successful in treating mentally ill adults, there are several barriers that can negatively impact the implementation of the interventions (Corrigan et al., 1994). One of the main factors expressed by staff as a barrier to treatment is limited staff with the training to successfully implement the behavioural programs (Corrigan et al., 1994).
Corrigan et al. conducted a needs assessment with staff of a psychiatric hospital and respondents listed what they thought were challenges of successful implementation of treatment in five separate areas: administrative, staff, patient, resource, and program levels. Of the issues with treatment listed that were associated with staff, the fact that staff lack knowledge of behavioural management was a common theme. On the program level, two of the issues listed were that new treatment interventions are implemented with a low degree of consistency, and that communication of appropriate and inappropriate behaviour is inconsistent. Upon further levels of analysis of the staff survey, the above issues were not ones that staff showed the most concern with, but from a practical standpoint they are issues that can pose barriers to treatment not only in an inpatient psychiatric setting, but in any setting where behavioural interventions are being implemented.

One of the downfalls of this study is that only staff members from one agency were surveyed. However, these issues and barriers are ones that can be found across many settings, particularly in the forensic unit where the current project was implemented. There are gaps in the literature addressing staff identified issues with treatment, but Corrigan et al. (1994) provided groundwork for future studies, and were able to identify issues that can impede the implementation of interventions in many different settings.

If issues such as staff having limited knowledge of behavioural management, low degree of consistency when implementing interventions, and inconsistent communication on what is considered appropriate behaviour versus inappropriate behaviour are putting up barriers to successful implementation of interventions, then increasing knowledge of behaviour and interventions and providing staff with a foundation for what is considered appropriate or inappropriate behaviour should increase consistency between staff and improve the quality of interventions being delivered.

Clear Definitions of Behaviour and Challenging Behaviour

Clearly defined expectations and standards for defining behaviour are solutions, or at least a step towards solutions, to some of these issues. Miltenberger (2008) outlines definitions of behaviour, examples of behaviour, and characteristics of behaviour modification. He defines behaviour as what people do and say; behaviour can have more than one dimension, it can be observed, described, and recorded, it can have an impact on the environment, is lawful, and may be both overt and covert. Behaviour can be considered challenging when it: (a) at some point caused injury to either the person exhibiting the behaviour, or others, which has required immediate medical attention, or destroyed something in the environment; (b) occurs at least once a week and requires more than one staff person to intervene, or causes more than one hour of disruption; or (c) occurs at least daily and causes more than a few minutes of disruption (Qureshi & Alborz, 1992, as cited in Bromley & Emerson, 1995). Some specific examples of challenging behaviour that are often found on forensic units are aggression, self-injury, disruption or screaming, and destructiveness (Bromley & Emerson, 1995). Differences among staff on what these behaviours entail can create additional challenges when attempting to come together to change the behaviour. By providing definitions and examples of challenging behaviour, a greater sense of understanding of challenging behaviour should be demonstrated by staff. This should also increase consistency between staff, both when conducting an assessment and gathering information.
The Effects of Challenging Behaviour on Staff

Challenging behaviour is a common struggle faced by staff, family, and caretakers of individuals who have mental illness in any setting. The added strains of being on a secure forensic unit can have a significant impact on the clients, often resulting in high levels of challenging behaviour. Furthermore, some of the clients can also have a dual diagnosis, which means that they have a mental illness as well as an intellectual disability. This can again accentuate and increase levels of challenging behaviour. Bromley and Emerson (1995) state that a relatively small amount of research has been conducted on the effects of challenging behaviour on care staff. However, the literature that does exist suggests that not only are there many negative effects of challenging behaviour and negative experiences on care staff, but also that care staff can inadvertently reinforce the challenging behaviour by not responding appropriately.

Jenkins, Rose, and Lovell (1997) studied the effects of challenging behaviour on staff and their results supported the hypothesis that staff who work with clients who display challenging behaviour experience high levels of stress, more so than other staff. Their study revealed that challenging behaviour and low levels of staff support were the variables that contributed the most to the stress levels. Jenkins et al. also reported that staff working with clients who display challenging behaviour were significantly more anxious, as demonstrated by scores on the Thoughts and Feelings Index, than staff working with clients labeled as not having significant levels of challenging behaviour.

Man Cheung and Harding (2009) also examined the idea of staff burnout when working with clients displaying challenging behaviour. The concept of burnout is different than stress, with burnout being defined by three components: emotional exhaustion, depersonalizing others (distancing oneself emotionally and cognitively from clients), and lessened feelings of accomplishment (Maslach et al., 2001, as cited in Man Cheung & Harding, 2009). While their findings failed to demonstrate a significant relationship between psychological well-being (levels of depression or anxiety) and challenging behaviour, they did find a significant correlation between burnout and challenging behaviour. These findings contradict the results of Jenkins et al., however both studies demonstrate that challenging behaviour can have serious negative health effects on care staff.

In order to address the discrepancies found between studies, more extensive research on the relationship between stress, burnout, and interactions of staff with challenging behaviour can be conducted in the future. These studies could address both stress and burnout, as well as levels of psychological wellbeing, in staff who have different levels of exposure and contact with clients who display challenging behaviour. It would also be beneficial to examine whether certain types of challenging behaviour, for example physical aggression or verbal outbursts, have different impacts on the psychological well-being of staff.

The Effect of Staff Attitudes and Responses on Challenging Behaviour

While challenging behaviour can have negative effects on staff, care staff can also have negative effects on challenging behaviour. Without realizing it, the way staff respond to challenging behaviour can inadvertently reinforce it, which in turn causes the behaviour to increase in frequency. Bromley and Emerson (1995) examined the beliefs and emotional reactions to challenging behaviour of clients displayed by staff. They studied emotional reactions of sadness, annoyance, despair, anger, fear, and disgust by asking staff what emotional response
the staff group as a whole displayed to clients’ challenging behaviour. They found that in response to aggression, staff most commonly displayed annoyance (41%), anger (24%), and fear (19%), and in response to self-injury, staff most commonly displayed sadness (38%), despair (32%), anger (15%), annoyance (15%), and disgust (15%). Bromley and Emerson hypothesized that these negative reactions can set the occasion for staff to avoid clients, avoid the situations or stimuli that elicit the behaviour or to attempt to stop the behaviour as quickly as possible.

This supports the concept that not only does challenging behaviour affect care staff, but that the relationship is cyclic in that staff can affect challenging behaviour in return. What the literature fails to provide information on is the exact effects that this interaction can have on clients, other than increasing challenging behaviour. There is minimal, if any, literature examining what the negative emotional reactions and attitudes of staff have on the emotions and psychological well-being of the clients. This would be an area of future research that could prove useful in developing a more positive environment for clients and staff alike, as well as increasing the success rate of attempted interventions.

**Outcomes of Staff Training and Workshop Interventions to Increase Knowledge**

Possible reasons for such high stress levels in staff who have to manage clients with challenging behaviours are that staff feel as though they do not have enough resources to properly manage the behaviour (Farrell & Salmon, 2009), or that they do not have enough knowledge about challenging behaviour (Dowey, Toogood, Hastings, & Nash, 2007; van Oorsouw et al., 2009). Van Oorsouw et al. (2009) hypothesized that increasing staff’s knowledge and understanding of challenging behaviour may help reduce incidents of challenging behaviour. It is also hypothesized that increasing knowledge and understanding will help staff feel more comfortable and confident in managing clients with challenging behaviour. If increasing knowledge and understanding of challenging behaviour is the ultimate goal, an effective way to do this is through the development and presentation of a workshop.

Many recent studies have examined the use of training methods to educate staff about challenging behaviour. Van Oorsouw et al. (2009) developed a training package for staff both to increase their knowledge about challenging behaviour, as well as to improve the quality of physical intervention techniques of the staff. Staff participated in a series of training sessions for both knowledge of challenging behaviour and physical intervention techniques. Training sessions conducted to increase knowledge consisted of small group exercises, discussions, and role plays. Results supported the hypothesis and an increase in knowledge about challenging behaviour from pre-intervention to post-intervention was demonstrated, but the knowledge that was obtained deteriorated at the 3-5 month follow up assessments. One of the suggestions made to assist in maintaining the gains made during intervention was to implement some further short courses. This could allow staff to refresh their knowledge of challenging behaviour that they learned during the main training sessions.

One shortcoming of this study is that training sessions were conducted over several sessions, which is very time consuming. Staff on the forensics unit of a mental health hospital have very limited time to spare away from the clients. It would be difficult to implement more than one session of training, making planning for anything more than that a large initiative that would involve the support of management or the board of directors. A workshop to educate the staff on a forensics unit would have to be brief, or an agency-wide initiative, so while a
significant increase in knowledge was demonstrated by these training sessions, an effective workshop would have to be adapted to accommodate the busy schedules of staff.

Dowey et al. (2007) conducted a study to examine whether a brief workshop intervention could increase staff understanding of challenging behaviours. Six brief training sessions were offered to staff, with each session being delivered on a single day. Staff were only required to attend one of the six sessions. Lectures, handouts, group exercises, and role play activities were used over the course of the training sessions. Case vignettes were given, and participants were asked to identify challenging behaviours, explain what made the behaviours challenging, and suggest possible causes of the behaviours. Data was collected pre- and post-intervention by administering a questionnaire that asked participants about possible causes of different challenging behaviours. The results of the study demonstrated that significant increases in the knowledge of staff can occur from brief training sessions about behaviour. Not only was there an increase in knowledge, but staff causal thinking about the behaviour changed as well. This provided insight into the reasons for the behaviour for the staff. The results of Dowey et al. demonstrated that not only can a workshop provide education about challenging behaviour, but a brief workshop intervention can have significant effects on staff knowledge.

When looking at the use of a workshop as an intervention tool, there was no literature found on the use of a workshop that took place in a shorter time frame than one day. Keeping the staff in a setting like forensic mental health for a long period of time is difficult, and so for the purpose of the present project, a brief workshop taking place for only one hour would be most effective due to staff time constraints. The difficulty is that there is no literature supporting the use of such a brief workshop, but in the case of the current project, that time frame is the only practical one in which to deliver the information to the staff.

**Summary**

In summary, the empirical research demonstrates that challenging behaviour is a significant concern in many people with mental illness, and that one of the common factors in attempting to decrease challenging behaviour is limited staff knowledge. While there are many challenges both for forensic clients themselves in regards to stigma (Sullivan & Mullen, 2006) and staff attitudes (Bromley & Emerson, 1995), there are also challenges for staff when attempting to implement behavioural interventions to manage the behaviour of clients. Research has shown that staff who are exposed to clients with challenging behaviour are at a greater risk for high levels of stress (Jenkins et al., 1997), as well as increased risk for burnout (Man Cheung & Harding, 2009). Furthermore, it has been demonstrated that the relationship between challenging behaviour, clients, and staff is cyclical, with each of these factors contributing to the others. An attempt must be made somewhere in the cycle to break the pattern and create a better environment for both staff and clients.

In response to the need to reduce the risks of stress and burnout on staff, research has been conducted into staff perceived barriers to treatment, as well as solutions to these barriers. Staff identified that limited staff knowledge of behavioural management, low degree of implementation consistency with interventions, and inconsistent communication on what is considered appropriate and inappropriate behaviour as issues impacting the quality of interventions (Corrigan et al., 1994). A common tool for addressing these perceived issues is the use of a workshop to increase knowledge of staff in the areas of applied behaviour analysis and behaviour modification.
The present workshop was developed to address these barriers to intervention implementation. The goal was to increase the knowledge of staff on a forensic unit about behaviour, particularly challenging behaviour. It was hypothesized that staff who participated in the brief workshop would increase their knowledge of behaviour, which would in turn increase consistency in implementation of interventions and in identifying what is and what is not considered challenging behaviour. Although this hypothesis could not be directly tested within the scope of this project, the materials for the workshop were created and the workshop was delivered to staff on the unit.
CHAPTER III: METHODOLOGY

Participants

This workshop is designed for individuals who are working in a forensic mental health setting. Participants are expected to have at least a basic knowledge of the forensic mental health system, and the types of clients encountered in this setting. Participants should be at least 18 years of age, and should have contact with clients on the unit. The workshop is designed for staff who work on the forensic unit of a psychiatric hospital, but could be provided to students and other clinical staff as well.

Participation in this workshop should be voluntary, so participants should have an interest in gaining more knowledge and understanding about behaviour and the process of assessment and intervention. Participants can be from any discipline who have contact with the clients, such as psychology, psychiatry, social work, and occupational therapy, but would be most beneficial to nursing staff, as they spend the most time with the clients. Nursing staff are often the ones who have to witness and react to the challenging behaviour of clients, and without a good understanding of behaviour and causes of behaviour, certain reactions, although they are not conscious reactions, can trigger more behaviour. For this reason, any staff who have contact with clients, particularly staff who have the most contact with clients, should be encouraged to participate.

For the purpose of this workshop, a total of 16 staff members participated. Of the 16 participants, four were male and twelve were female. Disciplines represented by the participants were psychiatry, psychology, social work, nursing, and occupational therapy.

Workshop Facilitator Characteristics

When delivering a workshop, it is important to outline specific criteria for the facilitator as well as the participants. The facilitator should have a degree or diploma in the behavioural sciences or in behavioural psychology, or equivalent, as to assure a solid understanding of the material being presented. He or she should also have a good understanding of the forensic mental health system as this is the type of agency for which the workshop is designed. The rationale for these criteria is that, while the general information in the presentation is basic information on behaviour, the case example is based on a forensic client. Therefore, some of the information presented is case-specific, and without solid background knowledge on the information, and the setting, the facilitator will not be able to properly convey the information or answer any questions that participants may have.

Design

This workshop was designed to provide an overview of behaviour and behavioural assessment and intervention. The facilitator presents the information to the participants, and provides a case example based on a forensic client to demonstrate practical application of the assessment and intervention techniques described. A workshop format was selected because of its ease of delivery and time constraints of staff at the agency. There are many limitations on time and funding for mental health workers, so often staff are not able to attend educational opportunities. A workshop not only provides the information in an easy format, but it can be delivered to multiple staff at one time, making it efficient for both the staff participating and for the facilitator.
This workshop was designed to be delivered in a forensic mental health setting. This is because in this setting, there is often a lack of basic knowledge of behaviour modification and applied behaviour analysis, and consistency between staff when addressing issues of challenging behaviour among clients. The staff are stationed on or around the unit within the agency, and so there is easy access to the staff when the workshop is delivered.

This workshop was designed to be administered in one session of approximately 1 hour in length. This length was selected based on the length of current educational initiatives within the agency, and the limited time available to staff to attend such educational initiatives. The method of delivery for the workshop consisted mostly of lecture and discussion, with the addition of handouts and a group exercise to keep the participants involved. The lecture was delivered by PowerPoint, although a paper copy of the slides (see Appendix A) was also provided to the participants along with the necessary handouts. The facilitator used a computer, as well as a projector and a screen on which to display the PowerPoint presentation.

Procedure

As the workshop was delivered in such a brief time frame, only five main sections were included as the focus. These include: an introduction, behaviour and definitions, behavioural assessment, generating hypotheses, and behavioural intervention. These sections are fairly broad and contain information on a few topics relevant to each section.

Throughout the development of the workshop, staff from the mental health agency were consulted. A basic understanding of behavioural principles was identified early on as something many of the staff were lacking, and a workshop was suggested as an effective means of delivering information to the staff on the ward. The staff of the agency all had a solid grasp of mental illness, but an understanding of behaviour management is often not part of their training or a requirement for the positions. However, due to the high levels of challenging behaviour experienced on the unit, it was suggested that this be a useful, as well as a required, initiative.

The workshop was divided into five main sections. The first section is the introduction, which gives the purpose for the workshop, and why it is important to conduct behavioural assessment and to create behavioural interventions. It was important for staff to understand the importance of behavioural assessment and collecting data to gain insight into an individual’s behaviour.

The next section was about behaviour. Many staff at the agency used the term behaviour, but there was a relatively minimal understanding that everything an individual does is considered behaviour. The distinction was made between behaviour in general, and challenging behaviour, and definitions were given for each. The concept of operational definitions was also introduced. The case study was introduced in this section, and using challenging behaviours common on the forensics unit, definitions were given and rationales were explained to the staff to provide a better understanding of the concepts.

The third section was about behavioural assessment. Again, the importance of conducting a behavioural assessment was explained to the staff. Many of the staff understood the importance of developing an intervention for their clients, but they minimized the role and the importance of conducting behavioural assessment first. Different types of assessment were explained, and antecedents and consequences were defined. A functional assessment flow chart (See Appendix B) adapted from Mueller, Jenson, Reavis, and Andrews (1997) was provided in the form of a handout, and was discussed as part of the presentation. The flow chart outlined all of the steps
one must take when conducting an assessment and developing an intervention. It also gave an overview of the type of information that should be gathered and considered. Participants were then introduced to an ABC chart, and an example was given relevant to the case example of how to fill out a chart. ABC charts were only explained, as staff in this setting already write chart notes on what happens with the clients. To write a separate chart would be redundant, but it was felt that it was important to introduce the concept of an ABC chart in order to outline the type of information that staff should be looking for when challenging behaviour occurs. At this point in the workshop, participants were encouraged to suggest what they think would go under each section of the ABC chart to measure their understanding. Part of the discussion during this section was also around the importance of documenting this information in nursing notes on the clients’ charts when incidents occur. This allows accurate information to be recorded for others to have in the future when trying to do assessments and interventions for the clients. Case examples of assessment techniques were explained in this section as well. The case example outlined assessments that were directed at a client on the unit. One of the assessments explained is a Functional Assessment Interview (FAI) (see Appendix D). This can be given as an interview or a questionnaire and can be filled out by anyone who has contact with a client.

The fourth section was about generating a hypothesis. The participants learned how to understand the information gathered in the assessment and generate a hypothesis about the cause of behaviour. It was also explained to participants that in the event that there is not yet enough information, they can make a recommendation to gather more information before generating a hypothesis. During this section, the participants also learned about checking their hypothesis. There was a slide included in the PowerPoint about the possible dangers of checking a hypothesis; if a behaviour is very severe or dangerous, it may not be safe to manipulate the environment to test the hypothesis. The case example was then discussed.

The final section in the workshop was about creating an intervention for the client. First, it was explained that not every intervention suggestion has to be behavioural. There are often medical, psychological, or other areas of concern that can be addressed as well as having a behavioural intervention plan. Here, it was explained to the participants the importance of working together for the client and having a collaborative approach, especially in a hospital setting. Next, behavioural interventions were broken down into antecedent-related and consequence-related interventions. The difference between the two was explained, and examples were given for both. This section was finished by introducing suggestions for interventions for the case example, a discussion was generated from the participants on their opinions based on what they had learned.

At the end of the workshop, participants were asked to fill out an evaluation form (See Appendix C) that asked if they felt the workshop was helpful, what they liked, and what they did not like. This information was used to change and improve the workshop as well as to provide feedback to both the facilitator and the agency.

Confidentiality/Informed Consent

The client(s) or the Substitute Decision Maker (SDM) for the client(s) used as a case example were notified that their information was to be discussed during the workshop, as per agency policy. A signed consent form was not needed in this case, as only staff and students already affiliated with the agency are eligible to be participants in the workshop; these individuals would have already signed a confidentiality agreement upon starting at the agency.
and thus the information discussed was considered common knowledge among the participants. Because no identifying information was used in this presentation, informed consent was not needed. All staff understood that they were bound by confidentiality, and the information discussed will remain confidential. At the beginning of the workshop, the participants were reminded that client information is to remain confidential.

**Evaluation**

While no data could be collected on this workshop due to time constraints, a basic evaluation form was created for participants to gain insight into whether they found the workshop helpful. Four questions were asked pertaining to the effectiveness of the workshop; whether participants found the information helpful, whether there was any information that was not included that could have been, and a space was left for general comments if the participants had anything additional to comment on. The data obtained from this survey will be used to help provide the facilitator with useful information to improve professionally both through the workshop itself and in delivery in the future.
CHAPTER IV: RESULTS

Workshop Materials

The results of the current project were a workshop in the form of a PowerPoint presentation, and a handout of an ABC chart as well as a flow chart outlining the process of behavioural assessment and the development of an intervention. These products present information on behaviour, challenging behaviour, assessment, generating a hypothesis, and behavioural interventions. In addition to these products, a satisfaction survey was given to the participants to assess the relevance of the workshop material.

Participation and Workshop Feedback

A total of 16 staff members and students at the agency participated in the workshop. There were participants from psychology, psychiatry, social work, both inpatient and outpatient nursing, and occupational therapy. Three students, from occupational health and nursing, also participated in the workshop. One of the agency’s challenges is having staff participate in voluntary educational opportunities. Therefore, in this setting, this number of participants is quite substantial, and many of the disciplines within the agency were represented.

Each participant was given a feedback form, and was asked to fill it out and give it back to the facilitator. Only 6 feedback forms were returned. Staff reported finding the workshop helpful and easy to understand. Aspects that participants liked or found helpful were the case study, the graph and tally chart, and the open format of the workshop which allowed for discussion and questions throughout. Only one participant made a comment about what could be changed; they suggested that, had there been time, information on the results of an intervention for the case study would have been helpful.

Overall, the workshop was well received by staff and participation was high. A copy of the feedback forms was left with the agency so that feedback can be incorporated into the workshop where appropriate.
CHAPTER V: DISCUSSION

The current project sought to develop a useful, realistic method to provide information to staff at a mental health services agency about the process and application of behavioural assessment and intervention techniques. As discussed in the literature review, there are many challenges to working with clients in the forensic mental health system (Mezey, Kavuma, Turton, Demetriou, & Wright, 2010). High rates of challenging behaviour are especially prevalent in forensic mental health settings, and the effects of challenging behaviour can have negative impacts on both staff (Jenkins, Rose, and Lovell, 1997; Man Cheung and Harding, 2009) and clients (Bromley and Emerson, 1995; Dowey, Toogood, Hastings, & Nash, 2007; van Oorsouw et al., 2009). Intervention efforts are often unsuccessful when staff attempt to decrease challenging behaviour. Low success rates are attributed to limited knowledge of staff about behaviour modification and intervention (Corrigan et al., 1994). Brief workshops have been used to successfully address the lack of knowledge of behaviour modification in staff (Dowey et al., 2007) and so it was thought that a workshop would be the most effective way to deliver information to staff. A workshop maximizes the number of participants reached at one time, and thus maximizes time and resources.

Ethical Considerations

Since there was no data collection and the participants of the workshop were staff who just received information, there was no need to obtain ethics approval. However, a client example was used throughout the workshop, and his SDM was notified of the use of his information. Informed consent was not needed for this, though, because there was no identifying information used in the written part of the presentation, it was only discussed in the presentation of the workshop. Since the workshop was delivered only to staff, the information discussed is considered common knowledge and all staff are bound by confidentiality. However, at the beginning of the workshop, participants are reminded of confidentiality.

Strengths and Limitations

Despite some challenges in the development of this project, it has many strengths. Primarily, it was developed in conjunction with staff at the agency, so it is appropriate for the population it is targeting. As well, it was created to address specific concerns and challenges of the agency it was developed for, so it should be a valuable support tool for the staff and the agency as a whole. Lastly, special attention was paid to the language and terminology used; it was created to be understood by those without a behavioural background in order to ensure that it is useful for participants.

However, even though this project was developed with careful consideration as a method to address a gap in knowledge of staff at the mental health services agency, there are some limitations to its effectiveness and implementation. First, there was insufficient time in the placement to get ethical consent to collect data. The agency had its own review board that would need to give consent along with the review board through the college, and the whole process would take longer than the placement itself, so no actual data were collected to assess for a change in knowledge in the participants. Second, the staff at the agency do not have a lot of time, given the high levels of attention that have to be paid to the clients, so the workshop could not be
any longer than one hour. This amount of time allowed for a basic discussion and presentation of behaviour, assessment, and intervention, but there was not enough time allotted to go into depth about these concepts. However, despite the limited amount of time, the discussion generated throughout the presentation and the interactive nature of the design allowed staff to grasp the concepts well. In the future, though, it is suggested that if possible, the workshop be made longer and more in depth to allow for better understanding of the concepts.

**Multi-Level Challenges to Service Implementation**

There are several challenges on different levels when implementing a workshop. On the client level, there are two main challenges. First, the participants may not feel as though they need to receive more training or education on a certain subject area as they are already employed by the agency. They see it as unnecessary as they believe they already know everything there is to know about their job and working with this population. Some participants may have been employed for many years. As a result, some staff members may not want to participate, and as this workshop is held on a voluntary basis, there may be a very small group of participants. A second challenge on the client level is that participants may become offended by having a student present a workshop of this kind if a student is used as a facilitator. Due to the fact that they are all employed and many have been working in this field for several years, they may feel as though a student would not have the expertise that they would. This may lead them to feel superior and this could create tension within the participant group and a student facilitator. To address these concerns, the approach taken with the workshop is one of presenting information, and not one of the facilitator possessing more knowledge.

A challenge at the program level was the challenge of conveying what could be a large amount of information in a relatively small time frame. Due to time constraints and limitations of the staff at the agency, no more than one hour at a time was possible for the staff to attend. Therefore, a workshop that could extend over one day or a few days was minimized and condensed into a brief, one-hour workshop. The challenge was to convey all of the important and relevant information in a timely manner so that the participants were actually able to learn something new or take something away from their participation in the workshop. Handouts were created and distributed to the participants at the beginning of the workshop. A paper copy of the presentation was provided to each participant and they were encouraged to take notes for themselves throughout the presentation. However, it is a difficult balance and more time would be beneficial if it were possible.

A challenge at the organizational level was the limited time available to present this type of workshop to staff. Nursing staff is especially pressed for time. This creates a challenge as it is nursing staff who spend the most time directly with clients and so they would often have most of the responsibility of carrying out behaviour treatment plans. The organization does not have the resources to pay for extra staff on any given day so that more staff could attend a workshop of this kind, so it is difficult to get enough participants out to present the information.

A challenge on the society level is that society as a whole can sometimes have a negative view of behaviour analysis. This can make it difficult to appeal to people to participate in a workshop, as there could be perceptions that these strategies are ineffective. Changing society’s way of thinking is difficult, but this workshop aimed to simplify some behavioural concepts and make it easier for staff at the agency to implement and create successful strategies and plans for their clients. It also aimed to demonstrate the importance of behaviour analysis and assessment in
the process of behaviour modification in an attempt to change the thoughts and opinions of participants and to validate the efficacy of these procedures.

**Implications for the Behavioural Psychology Field**

This project provides a brief workshop for clinical staff in a forensic mental health setting addressing the basics of behaviour, assessment, and intervention. The workshop included the process of defining behaviour, conducting assessments, generating hypotheses, and combining all of this information to develop an appropriate intervention. The workshop itself was designed for a forensic mental health setting, and provided examples relevant to this setting, but could easily be adjusted and tailored to many different settings. This workshop allowed participants to become more familiar with the purpose and value of behavioural assessment and intervention, increased their understanding of behavioural approaches to challenging behaviour, and provided insight into ways that all staff can participate in the process. It was an informative way to educate staff on the importance of the concepts discussed, and emphasized the value of behavioural approaches to challenging behaviour to disciplines where behavioural approaches may not be well understood or appreciated.

**Recommendations for Future Research**

This project provides a solid base for future research. Due to time constraints, no data collection took place, but in the future an evaluation method could be constructed in order to evaluate the efficacy of the workshop. Furthermore, data could be collected on whether the change in staff knowledge and understanding produces a change in the number of incidents of challenging behaviour on the unit. Future research could also build upon the brief workshop developed for this project and assess whether a longer workshop produces a larger change in staff’s knowledge and understanding of behaviour, assessment, and intervention. This information would be useful in determining whether this workshop is effective or whether changes should be made to maximize the benefits the workshop aims to provide for staff.

**Concluding Statements**

In summary, the current project is a valuable contribution to the staff at the mental health agency. Empirical evidence has outlined the many challenges that staff face when working with forensic mental health clients, as well as the practicality and efficacy of using a workshop to address gaps in knowledge of staff. This workshop, including the PowerPoint presentation and the handouts to accompany it, provides an empirically supported method of educating staff on behaviour, assessment, and intervention, and introduces staff to the importance and value of behavioural approaches to challenging behaviour.
CHAPTER V: REFERENCES


Literature Review Word Count: 3,526
Appendix A: PowerPoint Presentation Slides

An Overview of Behaviour, Assessment, and Intervention

Presented by:
Stephanie Yarrow
4th Year Student - B.A.A. Behavioural Psychology

Supervised by: Dr. Rebecca Douglas

Purpose
- To provide basic information on behavioural assessment and intervention
- To outline the process of conducting a behavioural assessment and then creating and implementing a behavioural intervention

Learning Goals
- Participants will become more familiar with the purpose and value of behavioural assessment and intervention
- Participants will have an increased understanding of behavioural approaches to challenging behaviour
- Participants will have an increased knowledge of how they can participate in behavioural assessment and intervention

Why is this Important?
- It is common to have differences in opinion about the behaviour of clients (i.e. cause, suggested approach, how much of a problem it is, etc.)
- Clients themselves may not understand or may not be able to communicate why they are engaging in certain behaviours
- Assessment is used to identify the “function” of a behaviour – why the client engages in a specific behaviour

Why is this Important?
- Collecting data gives a clear, unbiased picture of the behaviour itself as well as possible causes and maintaining factors
- Answers the what, why, where, how, and when of behaviour
- Is an evidence based approach that is considered best practice in various populations, including developmentally delayed
- It is important to have the whole team involved in the process

What is “Behaviour”?
- Behaviour:
  - is what people do and say
  - involves a person’s actions
  - can be observed, described, measured, and recorded
  - is influenced by both internal and external events
- Everything we do is "behaviour" – not just “intentional” acts or “personality disordered” behaviour
- Examples include: brushing your teeth, combing your hair, walking to work, reading a book, etc.
What is Challenging Behaviour?

> Behaviour can be considered challenging when it:
  > (a) at some point caused injury to either the person exhibiting the behaviour, or others, which has required immediate medical attention, or destroyed something in the environment;
  > (b) occurs at least once a week and requires more than one staff person to intervene, or causes more than one hour of disruption; or
  > (c) occurs at least daily and causes more than a few minutes of disruption.

> This also includes behaviours that are socially unacceptable, such as behaviour of an apparent sexual nature in public or toward an inappropriate target.

> Examples include: physical aggression, verbal aggression, non-compliance, screaming, etc.

> (Currelly & Albee, 1992, as cited in Connolly & Emerson, 1995).

Defining Behaviour

> When doing any type of behavioural assessment or intervention, it is important to operationally define the behaviour.

> This means you provide a specific definition about what the person does when the behaviour occurs.

> Give a complete description of what the behaviour sequence looks like – anyone reading the definition should be able to act out the behaviour.

Why is this Important?

> An operational definition should give an unbiased description of the behaviour – no assumptions about motivation or purpose should be included.

> Having a complete, descriptive definition of the behaviour allows others to observe and collect data on its occurrence.

> Example: "sexual touching": client touched the breast of a staff member with his hand while facing the staff member. It may not have a sexual motivation – it could simply be a case of sensory stimulation and certain body parts are easier to grab. The definition does not imply any motivation, it only describes what exactly happened.

Case Example - SW Definitions of Behaviour

> Masturbation in Public:
  > The client is said to engage in masturbation in public when he is touching his penis in a sexual manner either through his clothes, under his clothes, or outside of his clothes in a location that is anywhere but the bathroom or his bed.

> Verbal Aggression:
  > The client is said to engage in verbal aggression when he swears or has an angry tone in his voice when speaking. This can be to other patients or staff. Common phrases the client uses are "fuck off" or "fuck off bitch."

Case Example - SW Definitions of Behaviour

> Physical Aggression:
  > The client is said to engage in physical aggression when he makes contact with another person or object with the intent of causing physical harm. This can include hitting, punching, kicking, pinching, biting, spitting, or any other act to cause physical harm. This can also include picking up an object and throwing it or using it as a weapon with the intent to cause harm.

Behavioural Assessment - Functional Assessment

> Collecting unbiased, systematic data on the behaviours of the individual can be both direct and indirect.

> Direct: observing and recording the behaviour exactly as it occurs, when it occurs.

> Indirect: second-hand information (e.g. interviews, questionnaires, rating scales).

> Data collected helps develop and check hypotheses about behaviour.
**Direct Observation vs. Indirect Observation**

<table>
<thead>
<tr>
<th>Direct Observation</th>
<th>Indirect Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>more accurate</td>
<td>less accurate</td>
</tr>
<tr>
<td>must be done with the person themselves</td>
<td>can be done with the person or with those who know the person well</td>
</tr>
<tr>
<td>not always realistic or possible - time consuming</td>
<td>more easily conducted than direct observation</td>
</tr>
</tbody>
</table>

*The frequency of behaviour should be considered before choosing an observation method.*

**Case Example – SW**

<table>
<thead>
<tr>
<th>Direct Observation</th>
<th>Indirect Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuous Recording</td>
<td>Chart Review</td>
</tr>
<tr>
<td>Behaviour does not occur frequently enough to only observe behaviour at a certain time every day</td>
<td>Functional Assessment Interview</td>
</tr>
<tr>
<td>To produce enough data, the behaviour should be observed and recorded continuously when possible</td>
<td>Motivational Assessment Scale</td>
</tr>
</tbody>
</table>

**Areas to Cover in a Functional Assessment**

- A Functional Assessment attempts to determine:
  - (a) antecedents that trigger the behaviour: identifying common antecedents; how predictive are they of the behaviour
  - (b) the behaviour itself - description of behaviour
  - (c) the consequences that maintain the behaviour; is there a chain of sequences? what always happens after the behaviour occurs?

**Methods of Functional Assessment**

- Common functional assessment tools include a Functional Assessment Interview and an ABC Chart

- An FAI would cover topics like what the behaviour looks like, setting events, what happens before the behaviour (antecedents), what happens after the behaviour (consequences), what the individual finds reinforcing, and possible motivations for the behaviour

**ABC Chart**

<table>
<thead>
<tr>
<th>Antecedents</th>
<th>Behaviour</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Select one)</td>
<td>(Select one)</td>
<td>(Select one)</td>
</tr>
<tr>
<td>Start playing with a toy</td>
<td>Started lectures and sitting</td>
<td>Continued playing and getting upset</td>
</tr>
<tr>
<td>Start playing with a toy</td>
<td>Started lectures and sitting</td>
<td>Continued playing and getting upset</td>
</tr>
<tr>
<td>Started lectures and sitting</td>
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</tr>
<tr>
<td>Continued playing and getting upset</td>
<td>Started lectures and sitting</td>
<td>Continued playing and getting upset</td>
</tr>
</tbody>
</table>
Example of Type of Information Derived from a Functional Assessment

- A functional assessment should provide insight into:
  - The environment in which the behaviour takes place (i.e. on the ward)
  - What happens right before the behaviour occurs (i.e. other clients get upset, the client is denied something)
  - What the behaviour looks like (i.e. the client begins to swear and then approaches and pushes a staff member)
  - What happens right after the behaviour occurs (i.e. the client is sent to their room)
  - The client's reaction to the consequences (i.e. the client walks away)
  - Possible functions of the behaviour (i.e. to get a tangible, such as coffee, that is reinforcing)

Example of Type of Data Derived from a Functional Assessment

Generating A Hypothesis

- Once data is collected, it is important to analyze it and to generate a hypothesis about causes and maintenance of the behaviours
  - Note: You may not always be able to go right to a hypothesis - a recommendation could be made to gather more information
  - Once a hypothesis is created, you can manipulate certain things to test the hypothesis

- Examples:
  - The client sometimes engages in physical aggression when he is denied something he wants (i.e. coffee), so a hypothesis could suggest that he engages in the behaviour to obtain tangibles that he finds reinforcing
  - The client sometimes engages in physical aggression to escape from an upsetting situation (e.g., other patients yelling or aggressive)

*Caution: If the behaviour is severe this would not be a good idea to remove aggression

Intervention Procedures

- After you have conducted an assessment and generated a hypothesis, you must create a plan to address the behaviour; this is called intervention
  - Interventions and recommendations are not always behavioural – could also be:
    - Medical
    - Psychological
    - Ecological

Behavioural Intervention

- Behavioural intervention (or a "Behaviour Plan" / "Behaviour Modification Plan") examines all aspects of assessment and hypothesis, and attempts to create a plan to change behaviour
  - Behavioural intervention can focus on both antecedent and consequence strategies

Antecedent Strategies (Preventative)

- Involve manipulating an aspect of the physical or social environment
  - Mainly target setting events and triggers
  - Common antecedent strategies include:
    - Environmental Manipulation
    - Behavioural Skills Training
Environmental Manipulation

- Involves manipulating an aspect of the environment that could influence behaviours
- Example: Two clients in the same dorm do not get along, so you move them into separate dorms
- Example: The client sees extra coffee and tries to take some, so you remove the extra coffee from the client's sight

Behavioural Skills Training

- Involves either teaching a new skill or enhancing a skill that is already in the individual's repertoire
- Used when challenging behaviour is seen as a function of a skill deficit
- Ex.: client does not know how to communicate that a situation is aversive (or how to get out of the situation), so instead of becoming aggressive, staff can teach the client appropriate ways to escape (role play escape skills)

Consequence Strategies

- Focus on providing consequences to behaviour
- Mainly targets what results after the behaviour occurs
- Consequences can be desirable or undesirable
- It is important to consider the function targeted in the hypothesis when developing an intervention, as you might inadvertently increase challenging behaviours
- Example: If the client's aggression serves an escape function, by removing him every time he engages in the behaviour, his needs are met and the behaviour is more likely to occur in the future

Reinforcement and Punishment

- Reinforcement: anything that increases a behaviour
  - Ex.: The client gets a coffee every time he appropriately communicates that he needs to leave a situation, and the behaviour of appropriate communication increases - the coffee is a reinforcer
- Punishment: anything that decreases a behaviour
  - Ex.: The client is restricted from going to a group he enjoys when he engages in aggressive behaviour, and the aggressive behaviour decreases - the restriction from attending group serves as a punisher

Reinforcement and Punishment

- Positive - the addition of something
- Negative - the removal of something

"Think of the medical meaning of "positive" and "negative", not "good" and "bad"

Positive and Negative Punishment and Reinforcement

- Positive reinforcement: the addition of something that increases behaviour (giving a coffee for appropriate behaviour which results in an increase in behaviour)
- Negative reinforcement: the removal of something that increases behaviour (removing restrictions on privileges when he continues to exhibit appropriate behaviours that increases the occurrence of appropriate behaviours)
- Positive punishment: the addition of something that decreases behaviour (the use of restraints following aggressive behaviour that decreases the aggressive behaviour in the future)
- Negative punishment: the removal of something that decreases behaviour (providing a time out removal of staff attention) after aggressive behaviour that decreases the behaviour)
Positive and Negative
Punishment and Reinforcement
• Whether it is a punishment or reinforcement depends on the
outcome of the consequence
• Ex: The client is sent to his room when he gets upset around other
patients who are upset. If his behaviour increases over time in
similar situations, then being sent to his room is likely acting as a
(negative) reinforcer (escape from upsetting situation) and a
punishment

Token Economy
• An intervention where tokens are provided on the occurrence
of positive behaviours or the absence of challenging
behaviours
• Provides an immediate reinforcer (i.e. a token or a sticker)
that can later be exchanged for bigger, more reinforcing
things (i.e. an outing, an extra coffee)
• Can serve as reinforcement of alternate behaviours: not only
decreases inappropriate behaviours but increases appropriate
alternatives at the same time
• Ex: Giving a token or money every time the client effectively
communicates he needs to leave a situation, or every 10 day the client goes
without being verbally or physically aggressive - 5 tokens can be
exchanged for an extra coffee

Behavioural Contracts
• Incorporates both antecedent and consequence strategies
• Two parties mutually agree on what behaviours must be seen
from each party as an agreement
• Consequences of behaviour can be outlined in the contract as
well
• To the extent possible, it is important to involve the client in
developing the contract; this allows for their input and
hopefully their buy-in into the intervention
• Example: specifying that the client must ask for help every
time he needs to leave a situation that is too stressful, and
also specifies that the staff must provide the assistance
needed to help the client when he asks for it

• *Note: The use of a behavioural contract depends on the level of functioning of the
client

How to Integrate this
Information into Practice

References
• Bromley, J., & Emerson, E. (1995). Beliefs and
emotional reactions of care staff working with
people with challenging behaviour. Journal of
Retrieved from EBSCOHost

Modification: Principles and Procedures. California:
Wadsworth Cengage Learning.
Appendix C: Workshop Evaluation Form

Workshop Feedback Form

1. Did you find this workshop helpful?
   Yes  No

2. Was the information presented in a way that was easy to understand?
   Yes  No

3. What did you like most about the workshop?

4. What would you change about the workshop?

5. Do you have any additional comments?

*Thank you for taking the time to attend and fill out this form! ☺️*
Appendix D: Functional Assessment Interview

ADAPTED FUNCTIONAL ASSESSMENT INTERVIEW (FAI)

Client: _______________________________ Age: _____ Sex: M  F

Date of Interview: _________________________________

Respondent: _________________________________

A. DESCRIBE THE BEHAVIOURS

1. What are the behaviours of concern?
   a. ___________________________________
   b. ___________________________________
   c. ___________________________________
   d. ___________________________________
   e. ___________________________________
   f. ___________________________________

2. How frequently do each of these behaviours occur?
   a. ______ _____________________________
   b. ___________________________________
   c. ___________________________________
   d. ___________________________________
   e. ___________________________________
   f. ___________________________________

3. How long does it last when it occurs?
   a. ___________________________________
   b. ___________________________________
   c. ___________________________________
   d. ___________________________________
   e. ___________________________________
   f. ___________________________________

4. What is the intensity level of the behaviour? How damaging or destructive is it?
   a. ___________________________________
   b. ___________________________________
   c. ___________________________________
   d. ___________________________________
   e. ___________________________________
   f. ___________________________________

5. Are any of the behaviours mentioned above likely to occur together in some way? Do they occur at the same time? Or in a kind of sequence or chain?
B. ECOLOGICAL EVENTS THAT PREDICT THE BEHAVIOUR

1. Is the person taking medications? How do you believe these may affect his behaviour?

2. What medical or physical conditions does the person experience that may affect his behaviour? (eg. asthma, allergies, seizures, diabetes, etc?)

3. What are the person’s sleep habits like? How do you think this affects the person’s behaviour?

4. Describe the eating routines and diet of the person and the extent to which these may affect his or her behaviour.

5. What is a typical day like for the individual? How structured or predictable is the person’s day?

6. How many other people are typically around the individual in his daily environment? Does he typically seem bothered when there are more people around?

7. What is the pattern of staffing support that the person receives on the unit? Do you believe that the number of staff, the training of staff, or their social interactions with the person affect the problem behaviour?
C. ANTECEDENT EVENTS THAT PREDICT BEHAVIOURS

1. What times of day are the behaviours most likely to occur? Least likely?
Most likely: ____________________________________________________________
Least likely: ____________________________________________________________

2. Where are the behaviours most and least likely to occur?
Most likely: ____________________________________________________________
Least likely: ____________________________________________________________

3. With whom are the behaviours most and least likely to occur?
Most likely: ____________________________________________________________
Least likely: ____________________________________________________________

4. What activities are most and least likely to produce the behaviours?
Most likely: ____________________________________________________________
Least likely: ____________________________________________________________

5. Are there any situations that are not listed above that sometimes set off the behaviour? (eg. particular demands, noises, lights, etc?)

6. What would happen to the person’s behaviour if….
   a. You asked him to perform a difficult task?

   b. You interrupted a desired activity (eating, watching tv)?

   c. You unexpectedly changed his routine?

   d. He was not able to have access to something he wanted (food item, etc.?)

   e. You didn’t pay attention to the person or left him alone for a while?
D. CONSEQUENCES OR OUTCOMES OF BEHAVIOUR

1. When thinking about the behaviours listed above, what are some specific consequences you have observed in different situations? What does the person get as a result of the behaviours? What does the person avoid?
   a. .................................................................................................................................
   b. .................................................................................................................................
   c. .................................................................................................................................
   d. .................................................................................................................................
   e. .................................................................................................................................
   f. .................................................................................................................................

E. FUNCTIONAL ALTERNATIVES OF CHALLENGING BEHAVIOUR

1. What socially appropriate behaviours or skills can the person already perform that may generate the same outcomes or reinforcers produced by the problem behaviours?

F. WHAT IS REINFORCING

1. What are some food items that are reinforcing to the person?
   a. .................................................................................................................................
   b. .................................................................................................................................
   c. .................................................................................................................................
   d. .................................................................................................................................

2. What are some activities that are reinforcing?
   a. .................................................................................................................................
   b. .................................................................................................................................
   c. .................................................................................................................................
   d. .................................................................................................................................

3. What are some other items that are reinforcing?
   a. .................................................................................................................................
   b. .................................................................................................................................
   c. .................................................................................................................................
   d. .................................................................................................................................

G. HISTORY OF UNDESIRABLE BEHAVIOURS

1. Do you know of any strategies or programs that have been put in place in the past for some of these behaviours?

2. Were any of these successful? Why or why not?
3. Is there anything currently in place for any of the undesirable behaviours?

4. What techniques do you or other staff use when some of these behaviours occur?