**Appendix 1**: BMPPS model for the assessment of behaviours that challenge.

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| **Behaviour (B)** | A list and clear description of the target behaviour(s) to be addressed |
| The type and the nature of the behaviour(s) |
| Past history of similar behaviour. |
| Baseline behaviour prior to the onset of current problem behaviour. |
| The onset of the behaviour(s) to describe whether they appeared gradually over time or relatively abruptly perhaps precipitated by an acute event. |
| The frequency, severity, and duration of the behaviour(s). |
| Reactions to the behaviour by the person/ others/ services |
| Associated behaviours (other relevant behaviour than the target behaviours) |
| The impact of the behaviour(s) on the person’s life, other’s life, and the environment. |
| Consequences of problem behaviour e.g., reduced quality of life for the individual and her/his caregivers; reduced access to services including education, day service, and employment opportunity and may lead to a threatened or actual loss of placement in a residential setting or day placement; reduced social activities including leisure activities, access to friends, etc.; physically restraint; medicated; in severe cases, hospitalised or prosecuted. |
| Assessment of risks of behaviour e.g., risk to others; risk to the individual; risk to the environment and other risks. |
| Previous risk assessment |
| Review of previous and current measures taken to reduce risks to assess their effectiveness |
| The function of the behaviour (what does the behaviour want to achieve?) |
| **Medical and Organic Factors (M)** | Physical symptoms (toothache, tummy ache, heartburn, headache etc.). |
| Acute or chronic physical /medical conditions (cardiovascular, respiratory, endocrine, gastrointestinal, musculoskeletal, dental, skin and genito-urinary). |
| Physical disabilities. |
| Problem with sleep, appetite, weight, bowel, bladder. |
| Epilepsy, and other neurological conditions (spasticity, movement disorders, multiple sclerosis, brain tumour etc.). |
| Genetic conditions (Lesch-Nyhan syndrome, Prader-Willi syndrome, Fragile X syndrome, Smith-Magenis syndrome etc.). |
| Sensory impairment. |
| Communication/speech problems. |
| Drug and alcohol related factors. |
| Current medication, previous medication, polypharmacy and high dose medication use, adverse effects including anticholinergic burden. |
| **Relevant histories (Person)** | Family, occupational, relationship. |
| Current accommodation, daytime occupation, leisure activities, family circumstances. |
| Patient’s interests, strengths-abilities, likes, dislikes and preferences and how they express these opportunities, impact of disabilities, needs (including mental and physical health), and service and resource gaps. |
| Their history-social, developmental, psychological and history of use of services |
| Difficulties in developing fulfilling relationships |
| Daily/ weekly diary. |
| **Psychological/ Psychiatric Factors (P)**  | Psychiatric Disorders: Psychoses, Bipolar disorders, dementia, Depressive disorders, and anxiety related disorders etc. |
| Psychological/ emotional issues (such as bereavement, recurrent stress and relationship difficulties leading to loss of self-esteem and isolation, abuse, etc.New/ ongoing/ recurrent stressDifficulty in developing fulfilling relationshipsDevelopmental disorders, like Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD), including impulsivity, Neuropsychological factors |
| Relevant history of psychological development |
| Psychological symptoms: depression, anxiety etc. |
| Personality traits. |
| Dysregulated arousal and affect. |
| **Social/environmental Factors (S)**  | Crowded/noisy/uncomfortable environment. |
| Demanding activities, lack of interesting activities, too many changes in the activities etc. |
| Personalities of other people/ staff and interactions with other people. |
| Change in the environment, activities of daily living at home (e.g. washing, cleaning), activities of daily living outside home (e.g. shopping), relationships, influence of life events, occupation and activities including leisure activities and financial situation, therapeutic interventions. |
| Under- or over-stimulating environment |
| Issues relating to integration within the wider society, stigmatisation and discrimination.  |
| Carer issues, including levels of stress and lack of support for carers. |
| Changes required in the level of supervision and support, major life events including abuse. |
| Adequate support for patients and also their caregivers (both family caregivers and paid care staff). |

**Appendix 2**: Recomendations for good practice perscribing for behaviour that challenge for people with intellectual disabilities.

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| * The prescriber needs to ensure that a thorough assessment using a bio-psycho-social approach has been conducted and recorded prior to initiating treatment.
* The prescriber should ensure that an appropriate formulation is carried out and a treatment plan drawn, prior to instigating any intervention.
* The prescriber needs to ensure that appropriate physical examinations and investigations have been carried out.
* The prescriber is responsible for assessing the person’s capacity to consent to treatment.
* The prescriber should discuss the formulation and treatment plan with the person and/ or their family or carers.
* The prescriber should allow the person and/ or their family or carers to influence the decisions that are made and included in the treatment plan.
* The prescriber should clarify to the person and/ or their family or carers if the medication is prescribed outside their licensed indication. If this is the case, they should be told about the type and quality of evidence that is available to demonstrate its effectiveness.
* Where possible, and when necessary, the prescriber should discuss the formulation and treatment plan with other relevant professionals.
* The treatment plan should be part of a broader care plan that takes a person-centred approach.
* The treatment plan must comply with the country’s legal framework, including the relevant Mental Health and Capacity Act.
* The formulation and treatment plan should be shared with all the relevant parties, including GPs, as soon as possible.
* The prescriber should identify a key person who will ensure that medication is administered appropriately and communicate all changes to the relevant parties.
* The consultation should take into account the communication needs of the person.
 | * The prescriber should provide the person and/ or their family or carers a written treatment plan at the time of prescribing.
* The method and timing of the assessment of treatment outcome should be set at the beginning of the treatment.
* As far as possible, there should be an objective way to assess outcomes (the use of standardised scales is recommended).
* The prescriber should ensure that follow-up assessments have taken place.
* As far as possible, one medication should be prescribed at a time.
* Start with a low dose and increase the dose gradually until improvement or appearance of the adverse effect.
* As a general rule, the medication should be used within the recommended dose range.
* Consideration for withdrawing medication and exploring non-medication management options should be ongoing.
* The prescriber should remember that medication might be used at the same time with non-medication management.
* The prescriber should document all appropriate information and share it with appropriate individuals when necessary.
* The prescriber should discuss with the person and/ or their family, carer or key person common and serious adverse events related to the treatment (where possible, they should provide accessible information in writing).
* The prescriber should advise what action to take if a serious adverse event takes place.
* When ‘as required’ medication is prescribed, the prescriber is responsible for providing as much information as possible about why and when the medication may be used and should monitor this regularly.
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