Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Training Needs Analysis Report

Method and results of an analysis of learning disability clustering data on behalf of H.E.E.

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September 2015

Shining a light on the future

Contents Page

Background

Since 2012, 18 Trusts have been involved in a project to extend the needs-led classification system mandated for use in specialist mental health services. The aim has been to capture and describe the additional needs commonly experienced by people treated within secondary care and acute inpatient specialist learning disability services. (See the full report here).

A data-driven approach has been adopted which combined statistical cluster analysis with the views of multi-disciplinary groups of staff as well as users and carers to develop a set of six needs groupings/clusters which describe people with a varying degree of behaviours that challenge. Each cluster also has a different combination of co-morbidities which include the social communication difficulties frequently associated with autism. There are also three clusters which describe people with a primary physical health need that is complicated / associated with their learning disability.

These nine 'learning disability' clusters have been integrated with the existing mental health clusters to create a way of grouping people with learning disability according to shared characteristics and needs Importantly the taxonomy is independent of treatment setting and organisational boundaries, thus avoiding reliance on any particular service model / local commissioning arrangement.

After the initial validation phase, six Trusts have been collecting clustering data since 2014 and submitting it to Northumberland Tyne and Wear NHS Foundation Trust (NTW) for central analysis and further validity checks in collaboration with Warwick University. The data set is relatively broad and contains a significant number of data items. The items of most relevance to this report are:

- The needs-led cluster that people referred into specialist learning disability services have been allocated to by staff (appendix 1).
- The ratings staff have made on each 5-point scale of a standardised 23 item rating scale (appendix 2).

Participation in this phase of the project has been voluntary and hence organisations have been able to commit different levels of investment in staff training and IT developments. As a result, even though 2312 cases were assessed, the sample of patients cannot be seen as representative of any one organisation, or even the secondary care learning disability population as a whole. The data set does though provide a hugely valuable insight into the needs of this patient population with data items that are not yet available through other regional or national datasets.

Health Education England's Requirements

Under the Transforming Care Programme Health Education England has been tasked to lead the development of the workforce required to work in a radically new configuration of services with a reduced reliance on inappropriate inpatient care and the development of high quality, local community based services supported by the staff with skills to meet their caseload's individualised profile of needs. HEE are therefore required to produce a training needs analysis and delivery plan for secondary care staff working with people who have a learning disability. There is a clear idea about the training areas that are required but, as yet, no easy way to quantify demand for each type of course (which is likely to vary depending on the profile of need in the population served). This information will be essential to ensure sufficient training capacity is developed.

The broad training topics identified by HEE are:

- Mental health
- Physical health
- Challenging behaviour
- Autism spectrum disorder

The clustering dataset described earlier contains potential flags for each of these training areas and has the added advantage of being currently considered for mandatory use in the Transforming Care Fast Track sites (which would rapidly increase uptake and coverage).

As a result, NTW (the host of the data) has been tasked by HEE to identify how the available data could be used to quantify demand for each training area. Given the earlier caveats regarding the non-representative sample it is important to recognise that the intention of this work is to provide proof of concept rather than true estimates of demand i.e. a method that could be used initially by Trusts, and then nationally as and when these data items are mandated for submission to the Health and Social Care Information Centre (early planning for which has already commenced).

Method

The following method has been agreed by NTW and HEE clinicians as the most appropriate way to identify numbers of patients whose needs should be met by staff with each type of training from the dataset.

It is important to recognise that many people in specialist learning disability services have multiple needs and hence, whilst need-led cluster allocation provides a good indication of the primary knowledge and skills areas that their treatment team should possess, their use alone could miss important co-morbidities (and their associated training requirements). For example, a single patient may require their care team to possess multiple skill sets/competencies in order to meet their needs. As a result a second level of analysis has been undertaken which utilises the individual clustering tool scale ratings to identify significant, secondary needs.

When interpreting this second, more refined analysis it is important to note that ratings of 0-1 on scales in the clustering tool have been seen as too low to trigger a training need as they are deemed to be minor problem "requiring no action". In contrast ratings of 2-4 represent differing severities of problem from moderate through severe to very severe and so have all been treated as triggers.

No distinction has been made between the ratings of 2, 3 and 4 for a number of reasons. Firstly the levels of knowledge/skills and hence training have yet to be agreed. As a result no mapping could be produced between severity of need and level of training. More importantly severity does not in itself dictate skill level for interventions as complexity is arguably a more significant factor. For example, multiple low level needs may actually be harder to treat than a single but very severe issue. Further work would be possible in this area but it would require the capture of concurrent data designed specifically to elicit this relationship.

All analysis was carried out using a statistical package (SPSS) however trusts would easily be able to undertake the required stratifications using excel or SQL.

The following criteria were used to identify primary need and secondary need. These do not necessarily result in mutually exclusive groupings; however, as alluded to previously this is appropriate as one person can have multiple needs which require multiple competencies and hence multiple training packages.

Training topic	Primary Group	Secondary group
Mental Health Training	Allocated to clusters: 1-8 OR 10-21	Allocated to clusters 9a-f or 22-24 AND scores 2-4 on scale 4 AND scores 2-4 on either scale 2/6/7/8/13
ASD training	Allocated to clusters 9d-9f	Allocated to any other cluster AND scores 2-4 on scale I
Challenging behaviour training	Allocated to clusters 9b-9f	Allocated to any other cluster AND scores 2-4 on scale 4 AND scores 2-4 on either scale 30/A/I
Physical health training	Allocated to clusters 22-24	Allocated to any other cluster AND scores 2-4 on either scale 5/31/K

NB. It is possible that there are additional needs present within the cohort which are not covered by the four main HEE training themes. An additional exploratory analysis could be undertaken to understand the nature of other unmet needs within the cohort that could necessitate staff training. Given the quantities of data that may be collected from Fast Track sites, this could be achieved by exploring additional clinical data e.g. demographics (where available) in relation to the main themes identified in this report. This would be particularly relevant to cluster 9a which is currently thought to contain a diverse group of people with a heterogeneous but generally low level set of needs.

Results:

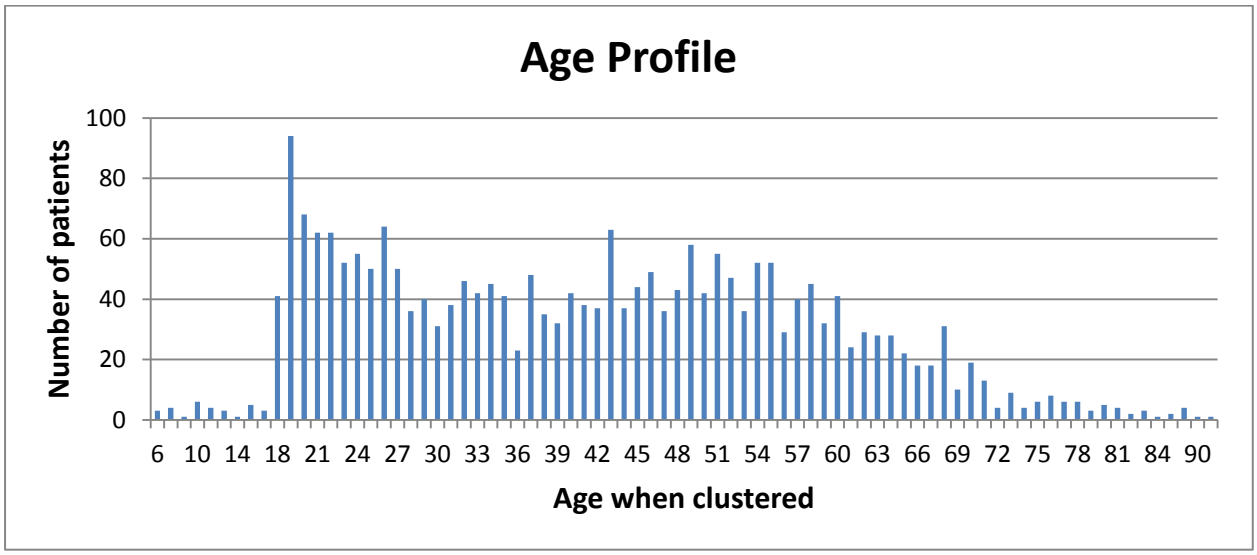
Demographics:

As stressed earlier in this report, due to the method of data collection there can be no guarantees that the data is representative of the entire learning disability population, or even the sub-set that access secondary care. However, the dataset is significant in containing over 2300 records. The following demographic information is provided to allow any crude comparisons to nationally published incidence and prevalence figures that may be helpful.

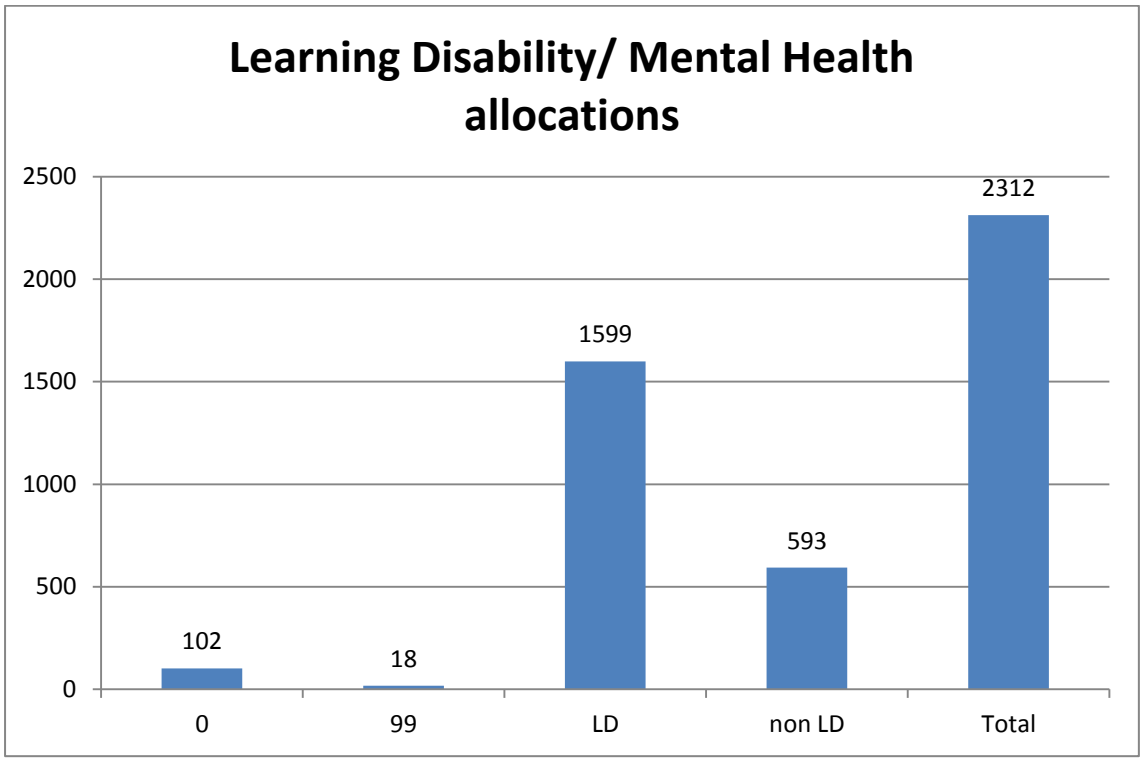
The table below shows the number of records submitted by each organisation.

Records per trust	
1	159
2	462
3	137
4	105
5	689
6	760
Total	2312

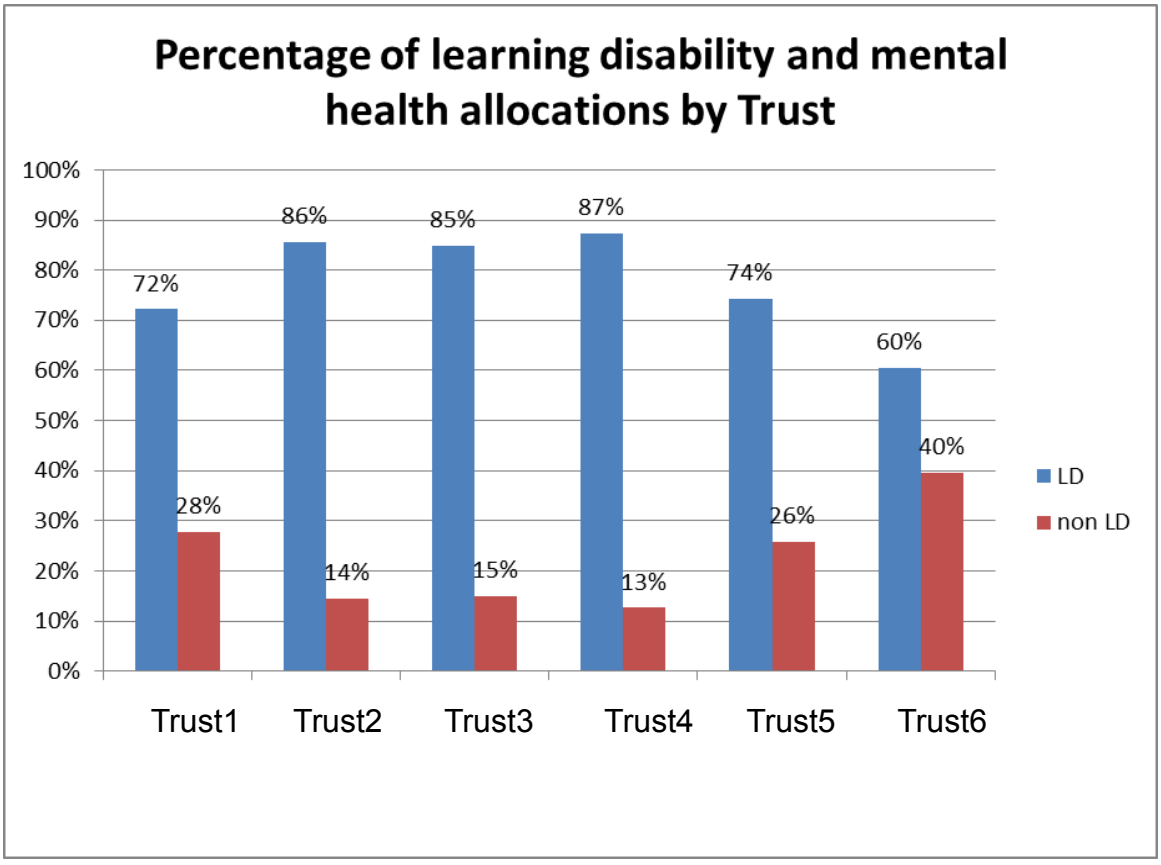
55% of the cases were male and 45% female. 5% were inpatients at the time of admission, the majority of these admissions were under the mental health act. The median age was 41 years of age, distributed as shown.



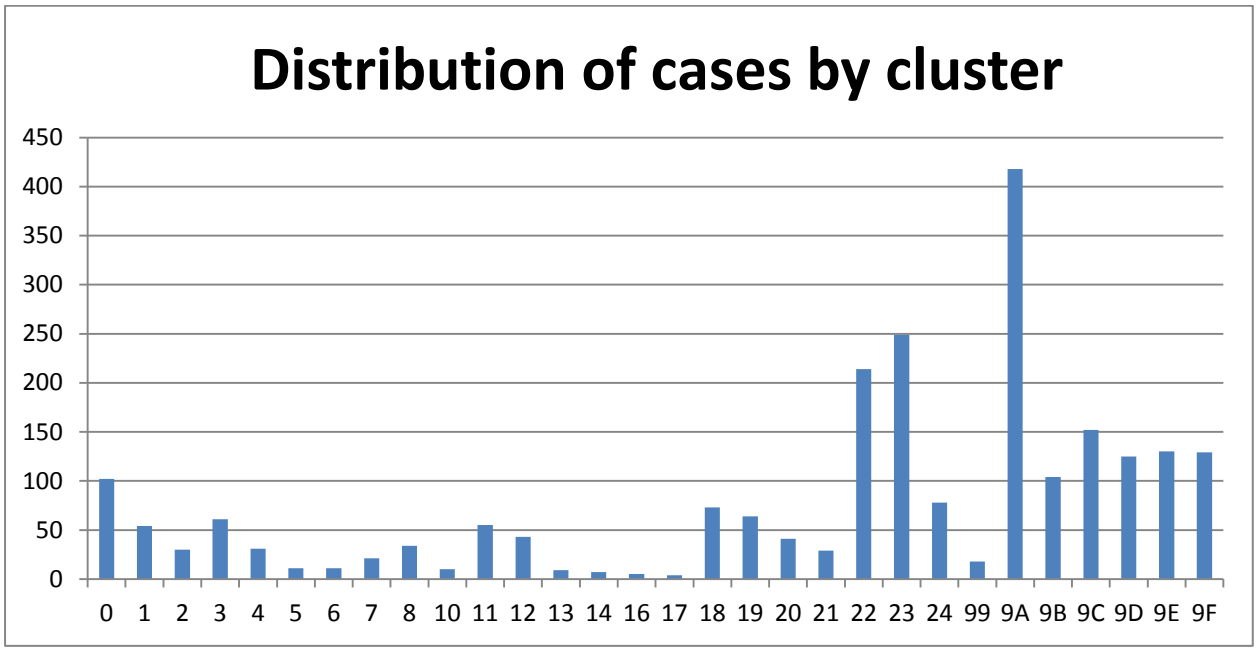
In broad terms over two-thirds of cases were allocated to a cluster most closely associated with learning disability-associated needs whilst over a quarter were allocated to a mental health-related cluster. The remainder (4%) were allocated to cluster 0 (indicating a definite requirement for treatment but that no cluster adequately describe the individual's profile of needs). There were also a small number ofmissing values (labeled as cluster 99)This coverage/variance rate is comprable with previous cluster developments.



These proportions were similar for each Trust.



More specifically the cases were distributed across the clusters as shown below.
N.B. Clusters 9a-9f are the new clusters associated with varying levels of challenging behaviour and 22-24 are the new physical health clusters generated from data collected by secondary care specialist learning disability services.

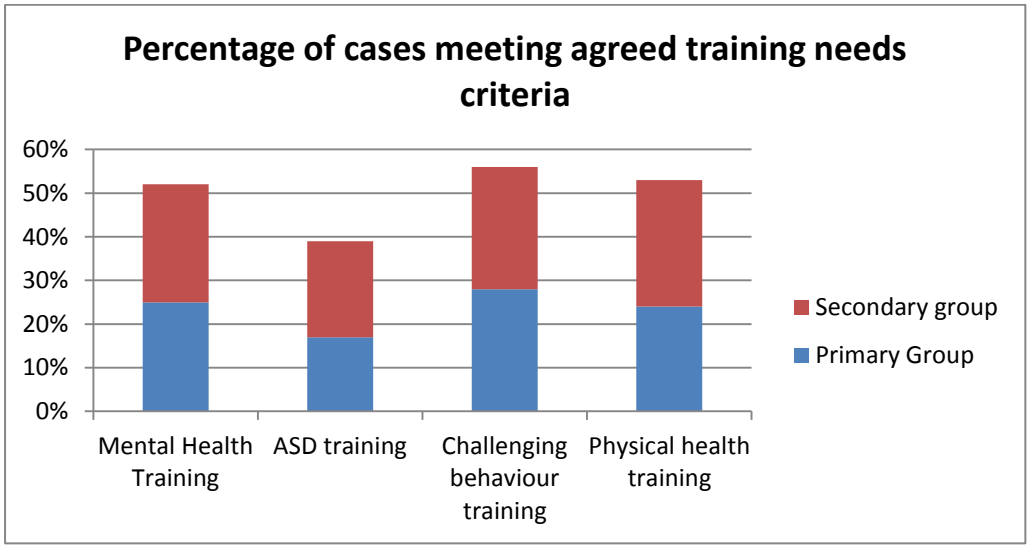


Training needs analysis:

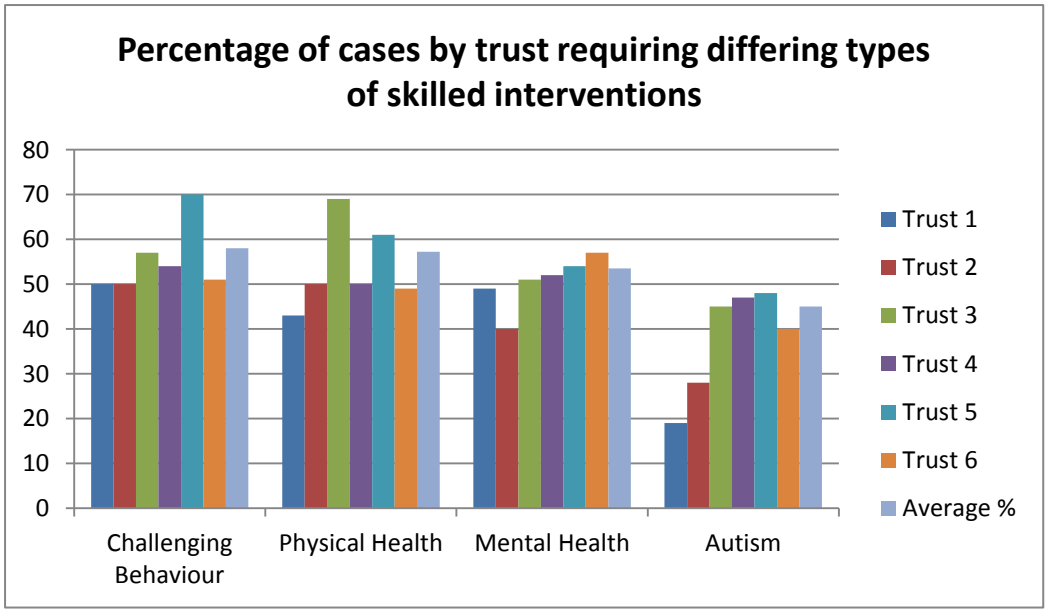
The agreed criteria were applied to the assessment data that had been gathered for each case. Again it should be noed that one patient could trigger multiple training needs, hence totals may vary. The overall results are shown in the tables and graph below.

Number of times agreed training needs criteria were met			
Training type	**Primary Group**	**Secondary group**	**Combined**
Mental Health Training	505	550	1055
ASD training	345	457	802
Challenging behaviour training	580	580	1160
Physical health training	501	600	1101

Percentage of cases meeting agreed training needs criteria			
Training type	**Primary Group**	**Secondary group**	**Combined**
Mental Health Training	25%	27%	51%
ASD training	17%	22%	39%
Challenging behaviour training	28%	28%	56%
Physical health training	24%	29%	53%



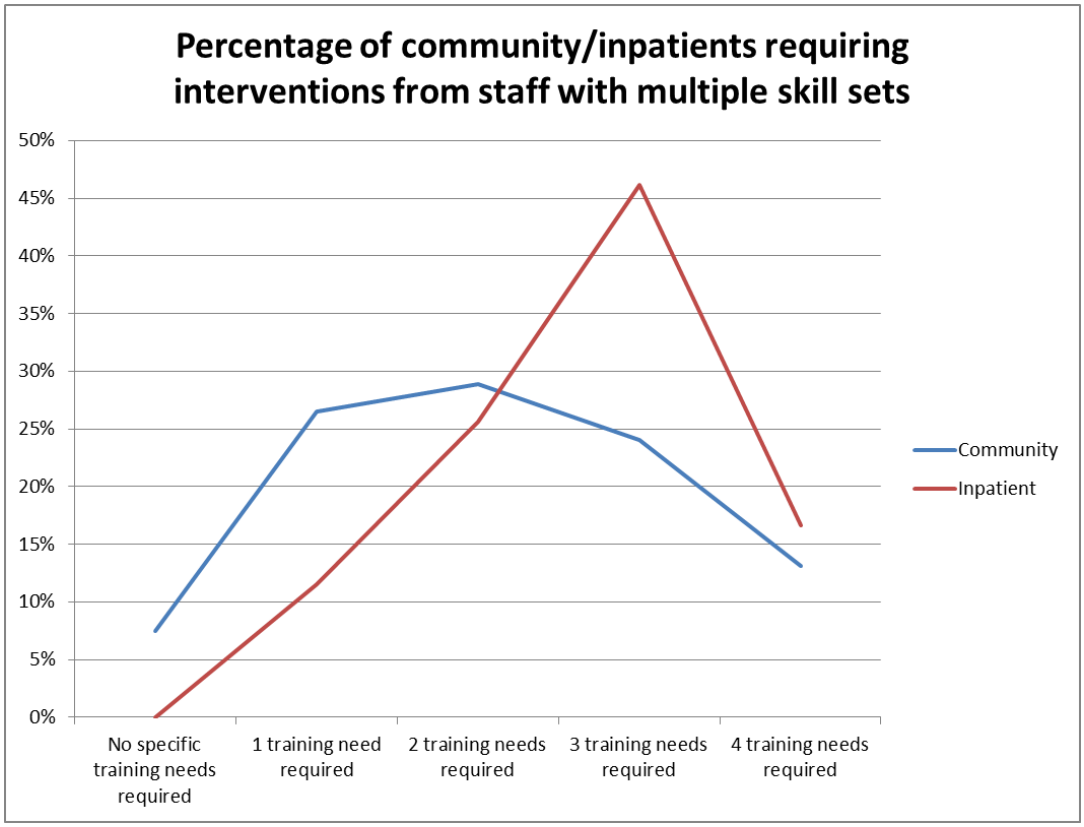
Again, when broken down by trust, the combined figures (primary and secondary) showed a degree of consistency:



NB the outlying trust in terms of autism training needs is likely to be as a result of missing data on key scales.

In addition to overall training requirements, inpatients were separated from community patients and the number of staff training needs triggered by each patient were calculated. These are set out below.

Multiple training needs by setting						
	Training needs not identified within criteria	**1 training need required**	**2 training needs required**	**3 training needs required**	**4 training needs required**	**Grand Total**
Community	7%	26%	29%	24%	13%	100%
Inpatient	0%	12%	26%	46%	17%	100%



The mean number of skill sets required per inpatient was 2.7 (S.D. 0.89) whilst for community cases it was 2.1 (S.D. 1.15). The maximum number of skills sets a single person could trigger was 4 whilst a small number of community cases (in clusters 9a and 0) did not meet the threshold to trigger any of the 4 training themes). These results clearly show that inpatients are more likely to have multiple needs, and that the number of skill sets required to treat them effectively is higher.

Discussion:

The caveats to the results of this analysis have been outlined earlier and this report should primarily been seen as a proof of concept. The proportion of needs identified within the dataset compares favourably to prevalence rates within the learning disability population. For example, the proportion of people with a learning disability who display behaviour that challenges is aproximately 5-15%; however, this may rise to 40% within institutional settings (NICE, 2015). The proportion of people with a learning disability who have a co-morbid mental health condition is approximately 35-40%, (Cooper et al., 2007). The prevalence of autism in the learning disability population is approximately 20-30% (Emerson & Baines, 2010). Also the comparison of co-morbidities in community patients versus inpatients has face validity.

The analysis has been undertaken to identify the demand for four broad types of training that have already been identified by HEE. It should be noted that by collecting and analysing clustering data there is also the potential for organisations to identify other training requirements arising from clinical need.

Furthermore it will be possible to sub-divide the four broad areas to help inform the content of the courses. For example, the allocations to the mandated mental health clusters could be used to subdivide the broad area of mental health into psychosis, non-psychosis and dementia or even to a more specific level where the prevelance of different non-psychotic conditions (OCD, eating disorder, PTSD etc) are quantified.

Conclusion:

The criteria proposed have clinical face validity, are easy to apply locally, regionally or nationally and produce results which also have face validity. As a result, if replicated on a representative sample at Team, Trust, Fast Track or National level it would seem that it would be possible to predict training needs requirements with a reasonable level of confidence. It would also be viable to prioritise the 25,000 cases thought to be at risk of admission to better understand their needs and the training requirements of the staff supporting them. In this way more effective interventions could be provided in order to reduce the liklihood of admission.

Simple ‘rules of thumb’ could be created which, for this dataset would be that:

- Half of the caseload of specialist secondary care leaqrning disability services will require interventions from staff skilled in the **positive behavioural support.**
- Half will need staff suitable skilled in **physical health interventions**.
- Half will need staff able to deliver interventions to address **mental health conditions.**
- Around 40% will require staff to be proficient in delivering services to people with **Autistic Spectrum Disorders** (though this may be an underestimate resulting from missing data).

References

Cooper, S., Smiley, E., Morrison, J., Williamson, A., & Allan, L (2006). Mental ill-health in adults with intellectual disabilities: prevalence and associated factors. *The British Journal of Psychiatry*, 190, 27-35

NICE (2015). Challenigng behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges. Retrieved from: https://www.nice.org.uk/guidance/ng11

Emerson, E. & Baines, S. (2010). *The estimated prevalence of autism among adutls with learning disabilities in England*. Retrieved from: http://www.improvinghealthandlives.org.uk/uploads/doc/vid_8731_IHAL2010-05Autism.pdf

Appendix 1 – Clusters

No	Title
1	Common Mental Health Problems (Low Severity)
2	Common Mental Health Problems (Low Severity with Greater Need)
3	Non-Psychotic (Moderate Severity)
4	Non-Psychotic (Severe)
5	Non-Psychotic Disorders (Very Severe)
6	Non-Psychotic Disorder of Over-Valued Ideas
7	Enduring Non-Psychotic Disorders (High Disability)
8	Non-Psychotic Chaotic and Challenging Disorders
9a	Maintenance, Engagement & Minor Support Needs, complicated by LD
9b	Risk To Self, complicated by LD
9c	Risk to others, complicated by LD
9d	Risk to others, complicated by mild LD & ASD
9e	Risk to others, complicated by moderate - profound LD & ASD
9f	Risk to others & self, complicated by moderate - profound LD & ASD
10	First Episode Psychosis (with/without manic features)
11	Ongoing Recurrent Psychosis (Low Symptoms)
12	Ongoing or Recurrent Psychosis (High Disability)
13	Ongoing or Recurrent Psychosis (High Symptom & Disability)
14	Psychotic Crisis
15	Severe Psychotic Depression
16	Psychosis & Affective Disorder (High Substance Misuse & Engagement)
17	Psychosis and Affective Disorder – Difficult to Engage
18	Cognitive Impairment (Low Need)
19	Cognitive Impairment or Dementia Complicated (Moderate Need)
20	Cognitive Impairment or Dementia Complicated (High Need)
21	Cognitive Impairment or Dementia (High Physical or Engagement)
22	Cognitive impairment or Dementia (High physical or engagement needs)
23	Physical health, complicated by mild LD
24	Physical health, complicated by moderate - profound LD

Key:
Original clusters generated from the mental health project
New clusters generated from the learning disability project

Appendix 2 –Clustering Tool Scales

Summary of rating information

- **Rate each scale in order. NB Numbers and letters may not be sequential to align with other versions of the tool.**
- **For the first 12 scales, do not include information rated in an earlier scale except for scale 10 which is an overall rating.**
- **Rate the MOST SEVERE problem that occurred in the rating period**
- **All scales follow the format:**
  0 = no problem
  1 = minor problem requiring no action **3 = moderately severe problem**
  2 = mild problem but definitely present **4 = severe to very severe problem**

PART 1: Current Ratings

For the numbered scales, rate the most severe occurrence in the <u>previous two weeks</u>

1. Overactive, aggressive, disruptive or agitated behaviour (current)					
	0	**1**	**2**	**3**	**4**
• *Include such behaviour due to any cause (e.g. drugs, alcohol, dementia, psychosis, depression, etc.)* • *Do not include bizarre behaviour rated at Scale 6.*	No problem of this kind during the period rated.	Irritability, quarrels, restlessness etc. not requiring action.	Includes aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (e.g. broken cup, window); marked over-activity or agitation.	Physically aggressive to others or animals (short of rating 4); threatening manner; more serious over-activity or destruction of property.	At least one serious physical attack on others or on animals; destructive of property (e.g. fire-setting); serious intimidation or obscene behaviour. ***Rate 9 if not known***
2. Non-accidental self-injury (current)					
	0	**1**	**2**	**3**	**4**
• *Do not include accidental self-injury (due e.g. to dementia or severe learning disability); the cognitive problem is rated at Scale 4 and the injury at Scale 5.* • *Do not include illness or injury as a direct consequence of drug/alcohol use rated at Scale 3 (e.g. cirrhosis of the liver) or injury resulting from drink driving which are rated at Scale 5).*	No problem of this kind during the period rated.	Fleeting thoughts about ending it all but little risk during the period rated; no self-harm.	Mild risk during the period rated; includes non-hazardous self-harm (e.g. wrist-scratching).	Moderate to serious risk of deliberate self-harm during the period rated; includes preparatory acts (e.g. collecting tablets).	Serious suicidal attempt and/or serious deliberate self-injury during the period rated. ***Rate 9 if Not Known***
3. Problem-drinking or drug-taking (current)					
	0	**1**	**2**	**3**	**4**
• *Do not include aggressive/destructive behaviour due to alcohol or drug use, rated at Scale 1.* • *Do not include Physical Illness or disability problems or disability due to alcohol or drug use, rated at Scale 5.*	No problem of this kind during the period rated.	Some over-indulgence but within social norm.	Loss of control of drinking or drug-taking, but not seriously addicted.	Marked craving or dependence on alcohol or drugs with frequent loss of control; risk taking under the influence.	Incapacitated by alcohol/drug problem. ***Rate 9 if Not Known***

4. Cognitive problems (current)					
	0	**1**	**2**	**3**	**4**
• *Include problems of memory, orientation and understanding associated with any disorder: learning disability, dementia, schizophrenia, etc.* • *Do not include temporary problems (e.g. hangovers) resulting from drug/alcohol use, rated at Scale 3.*	No problem of this kind during the period rated.	Minor problems with memory or understanding (e.g. forgets names occasionally).	Mild but definite problems (e.g. has lost the way in a familiar place or failed to recognise a familiar person); sometimes mixed up about simple decisions.	Marked disorientation in time, place or person; bewildered by everyday events; speech is sometimes incoherent; mental slowing.	Severe disorientation (e.g. unable to recognise relatives); at risk of accidents; speech incomprehensible; clouding or stupor. ***Rate 9 if Not Known***
5. Physical Illness or disability problems (current)					
	0	**1**	**2**	**3**	**4**
• *Include illness or disability from any cause that limits or prevents movement, or impairs sight or hearing, or otherwise interferes with personal functioning.* • *Include side-effects from medication; effects of drug/alcohol use; physical disabilities resulting from accidents or self-harm associated with cognitive problems, drink-driving, etc.* • *Do not include mental/behavioural problems rated at Scale 4.*	No physical health problem during the period rated.	Minor health problems during the period (e.g. cold, non-serious fall, etc.)	Physical health problem imposes mild restriction on mobility and activity.	Moderate degree of restriction on activity due to physical health problem.	Severe or complete incapacity due to physical health problem. ***Rate 9 if Not Known***
6. Problems associated with hallucinations and delusions (current)					
	0	**1**	**2**	**3**	**4**
• *Include hallucinations and delusions irrespective of diagnosis.* • *Include odd and bizarre behaviour associated with hallucinations or delusions.* • *Do not include aggressive, destructive or overactive behaviours attributed to hallucinations or delusions, rated at Scale 1.*	No evidence of hallucinations or delusions during the period rated.	Somewhat odd or eccentric beliefs not in keeping with cultural norms.	Delusions or hallucinations (e.g. voices, visions) are present, but there is little distress to patient or manifestation in bizarre behaviour, i.e. clinically present but mild.	Marked preoccupation with delusions or hallucinations, causing much distress and/or manifested in obviously bizarre behaviour, i.e. moderately severe clinical problem.	Mental state and behaviour is seriously and adversely affected by delusions or hallucinations, with severe impact on patient. ***Rate 9 if Not Known***
7. Problems with depressed mood (current)					
	0	**1**	**2**	**3**	**4**
• *Do not include over-activity or agitation, rated at Scale 1.* • *Do not include suicidal ideation or attempts, rated at Scale 2.* • *Do not include delusions or hallucinations, rated at Scale 6.*	No problem associated with depressed mood during the period rated.	Gloomy; or minor changes in mood.	Mild but definite depression and distress (e.g. feelings of guilt; loss of self-esteem).	Depression with inappropriate self-blame; preoccupied with feelings of guilt.	Severe or very severe depression, with guilt or self-accusation. ***Rate 9 if Not Known***

8. Other mental and behavioural problems (current)					
	0	**1**	**2**	**3**	**4**
• *Rate only the most severe clinical problem not considered at scales 6 and 7 as follows.* • *Specify the type of problem by entering the appropriate letter: A phobic; B anxiety; C obsessive-compulsive; D mental strain/tension; E dissociative; F somatoform; G eating; H sleep; I sexual; J other, specify.*	No evidence of any of these problems during period rated.	Minor problems only.	A problem is clinically present at a mild level (e.g. patient has a degree of control).	Occasional severe attack or distress, with loss of control (e.g. has to avoid anxiety provoking situations altogether, call in a neighbour to help, etc.) i.e. moderately severe level of problem.	Severe problem dominates most activities. ***Rate 9 if Not Known***
9. Problems with relationships (current)					
	0	**1**	**2**	**3**	**4**
• *Rate the patient's most severe problem associated with active or passive withdrawal from social relationships, and/or non-supportive, destructive or self-damaging relationships.*	No significant problem during the period.	Minor non-clinical problems.	Definite problem in making or sustaining supportive relationships; patient complains and/or problems are evident to others.	Persisting major problem due to active or passive withdrawal from social relationships and/or to relationships that provide little or no comfort or support.	Severe and distressing social isolation due to inability to communicate socially and/or withdrawal from social relationships. ***Rate 9 if Not Known***
10. Problems with activities of daily living (current)					
	0	**1**	**2**	**3**	**4**
• *Rate the overall level of functioning in activities of daily living (ADL) (e.g. problems with basic activities of self-care such as eating, washing, dressing, toilet; also complex skills such as budgeting, organising where to live, occupation and recreation, mobility and use of transport, shopping, self-development, etc.).* • *Include any lack of motivation for using self-help opportunities, since this contributes to a lower overall level of functioning.* • *Do not include lack of opportunities for exercising intact abilities and skills, rated at Scales 11-12.*	No problem during period rated; good ability to function in all areas.	Minor problems only (e.g. untidy, disorganised).	Self-care adequate, but major lack of performance of one or more complex skills (see above).	Major problem in one or more areas of self-care (eating, washing, dressing, toilet) as well as major inability to perform several complex skills.	Severe disability or incapacity in all or nearly all areas of self-care and complex skills. ***Rate 9 if Not Known***

11. Problems with living conditions (current)					
	0	**1**	**2**	**3**	**4**
• *Rate the overall severity of problems with the quality of living conditions and daily domestic routine. Are the basic necessities met (heat, light, hygiene)? If so, is there help to cope with disabilities and a choice of opportunities to use skills and develop new ones?* • *Do not rate the level of functional disability itself, rated at Scale 10.* **NB: Rate patient's usual situation. If in acute ward, rate activities during period before admission. If information not available, rate 9.**	Accommodation and living conditions are acceptable; helpful in keeping any disability rated at Scale 10 to the lowest level possible, and supportive of self-help.	Accommodation is reasonably acceptable although there are minor or transient problems (e.g. not ideal location, not preferred option, doesn't like the food, etc.)	Significant problem with one or more aspects of the accommodation and/or regime (e.g. restricted choice; staff or household have little understanding of how to limit disability or how to help use or develop new or intact skills).	Distressing multiple problems with accommodation (e.g. some basic necessities absent); housing environment has minimal or no facilities to improve patient's independence.	Accommodation is unacceptable (e.g. lack of basic necessities, patient is at risk of eviction, or 'roofless', or living conditions are otherwise intolerable) making patient's problems worse. ***Rate 9 if Not Known***

12. Problems with occupation and activities (current)					
	0	**1**	**2**	**3**	**4**
• *Rate the overall level of problems with quality of day-time environment. Is there help to cope with disabilities, and opportunities for maintaining or improving occupational and recreational skills and activities? Consider factors such as stigma, lack of qualified staff, access to supportive facilities e.g. staffing and equipment of day centres, workshops, social clubs, etc.* • *Do not rate the level of functional disability itself, rated at Scale 10.* **NB: Rate patient's usual situation. If in acute ward, rate activities during period before admission. If information not available, rate 9.**	Patient's day-time environment is acceptable: helpful in keeping any disability rated at Scale 10 to the lowest level possible, and supportive of self-help.	Minor or temporary problems (e.g. late giro cheques): reasonable facilities available but not always at desired times, etc.	Limited choice of activities; lack of reasonable tolerance (e.g. unfairly refused entry to public library or baths, etc.); handicapped by lack of a permanent address; insufficient carer or professional support; helpful day setting available but for very limited hours.	Marked deficiency in skilled services available to help minimise level of existing disability; no opportunities to use intact skills or add new ones; unskilled care difficult to access.	Lack of any opportunity for daytime activities makes patient's problems worse. ***Rate 9 if Not Known***

13. Strong unreasonable beliefs that are <u>not</u> psychotic in origin (current)					
	0	**1**	**2**	**3**	**4**
• *Rate any apparent strong unreasonable beliefs (found in **some** people with disorders such as Obsessive Compulsive Disorder, Anorexia Nervosa, personality disorder, morbid jealousy etc.)* • *Do not include Delusions rated at scale 6.* • *Do not include Severity of disorders listed above where strong unreasonable beliefs are not present – rated at Scale 8.* • *Do not include Beliefs/behaviours consistent with a person's culture.*	No Strong unreasonable beliefs evident.	Holds illogical or unreasonable belief(s) but has insight into their lack of logic or reasonableness and can challenge them most of the time and they have only a minor impact on the individual's life.	Holds illogical or unreasonable belief(s) but individual has insight into their lack of logic or reasonableness. Belief(s) can be successfully challenged by individual on occasions. Beliefs have a mild impact on the person's life.	Holds strong illogical and unreasonable belief(s) but has some insight into the relationship between the beliefs and the disorder. Belief(s) can be 'shaken' by rational argument. Tries to resist belief but with little effect. Has a significant negative impact on person's life. The disorder makes treatment more difficult than usual.	Holds strong illogical or unreasonable belief(s) with little or no insight in the relationship between the belief and the disorder. Belief(s) cannot be 'shaken' by rational argument. Does not attempt to resist belief(s). Has a significant negative impact on the person's life or other people's lives and the disorder is very resistant to treatment. ***Rate 9 if not known***

30. Non-accidental self-injury (associated with cognitive impairment)					
	0	**1**	**2**	**3**	**4**
• *Include all forms of self-injurious behaviour associated with cognitive impairment. Do not include behaviour directed towards others (Scale 1).*	No problem of this kind during the period rated.	Occasional or mild self-injurious behaviour	Frequent self-injurious behaviour not resulting in tissue damage (e.g. redness, soreness, wrist scratching)	Risk or occurrence of self-injurious behaviour resulting in reversible tissue damage and no loss of function (e.g. cuts, bruises, hair loss)	Risk or occurrence of self-injurious behaviour resulting in irreversible tissue damage and permanent loss of functions (e.g. limb contractures, impairment of vision, permanent facial scarring). ***Rate 9 if Not Known***
31. Physical Problems with eating and drinking					
	0	**1**	**2**	**3**	**4**
• *Include both increase and decrease in weight. People with severe physical disability and related eating and drinking problems should be included in this scale.* • *Do not rate pica — which should be rated in Scale 8.*	No problem with appetite during the period rated or no signs of problems swallowing. No prior choking incidents.	Slight alteration to appetite or occasional coughing when eating and/or drinking, no chest infections weight loss that does not require assistance. May have slight difficulties manipulating utensils.	Severe alteration in appetite with no significant weight change. As above plus needs monitoring to ensure adequate food and fluid intake. Some modifications made to food and/or drink e.g. hard foods avoided. Close supervision required. May have experienced occasional chest infections and/or recent choking incident(s).	Severe disturbance with some weight change during the period rated or coughing with food and/or drinks, choking episodes, distress/discomfort when eating/drinking, frequent chest infections, possible hospital admission. Significant modifications required to food and drink. Meals are effortful and close supervision required.	Very severe disturbance with significant weight change during the period rated. Alternative methods of feeding are being explored, are in place or have been considered not appropriate. Possible use of tasters. Food and drinks are significantly modified. Full support is required. Mealtimes often distressing or stressful for client/carer. ***Rate 9 if not known***

PART 2: Historical Ratings

Scales with letters rate problems that occur in an episodic or unpredictable way. Include any event that remains relevant to the current plan of care.
Whilst there may or may not be any direct observation or report of a manifestation during the last two weeks, the evidence and clinical judgement would suggest that there is still a cause for concern that cannot be disregarded (i.e. no evidence to suggest that the person has changed since the last occurrence either as a result of time, therapy, medication or environment etc.)

A. Agitated behaviour/expansive mood (historical)					
	0	**1**	**2**	**3**	**4**
• *Rate agitation and overactive behaviour causing disruption to social role functioning. Behaviour causing concern or harm to others.* • *Elevated mood that is out of proportion to circumstances.* • *Include such behaviour due to any cause (e.g. drugs, alcohol, dementia, psychosis, depression etc.)* • *Excessive irritability, restlessness, intimidation, obscene behaviour and aggression to people animals or property.* • *Do not include odd or bizarre behaviour to be rated at Scale 6.*	No needs in this area.	Presents as irritable, argumentative with some agitation. Some signs of elevated mood or agitation not causing disruption to functioning.	Makes verbal/gestural threats. Pushes/pesters but no evidence of intent to cause serious harm. Causes minor damage to property (e.g. glass or crockery). Is obviously over-active or agitated.	Agitation or threatening manner causing fear in others. Physical aggression to people or animals. Property destruction. Serious levels of elevated mood, agitation, restlessness causing significant disruption to functioning.	Serious physical harm caused to persons/animals. Major destruction of property. Seriously intimidating others or exhibiting highly obscene behaviour. Elevated mood, agitation, restlessness causing complete disruption. ***Rate 9 if not known***
B. Repeat self-harm (historical)					
	0	**1**	**2**	**3**	**4**
• *Rate repeat acts of self-harm with the intention of managing people, stressful situations, emotions or to produce mutilation for any reason.* • *Include self-cutting, biting, striking, burning, breaking bones or taking poisonous substances etc.* • *Do not include accidental self-injury (due e.g. to learning disability or cognitive impairment); the cognitive problem is rated at Scale 4 and the injury at Scale 5.* • *Do not include harm as a direct consequence of drug/alcohol use (e.g. liver damage) to be rated at Scale 3. Injury sustained whilst intoxicated to be rated at Scale 5.* • *Do not include harm with intention of killing self (rated at Scale 2).*	No problem of this kind.	Superficial scratching or non-hazardous doses of drugs.	Superficial cutting, biting, bruising etc. or small ingestions of hazardous substances unlikely to lead to significant harm even if hospital treatment not sought.	Repeat self-injury requiring hospital treatment. Possible dangers if hospital treatment not sought. However, unlikely to leave lasting severe damage even if behaviour continues providing hospital treatment sought.	Repeat serious self-injury requiring hospital treatment and likely to leave lasting severe damage if behaviour continues (i.e. severe scarring, crippling or damage to internal organ) and possibly to death. ***Rate 9 if not known***

C. Safeguarding other children & vulnerable adults (historical)					
	0	**1**	**2**	**3**	**4**
• *Rate the potential or actual impact of the patient's mental illness, or behaviour, on the safety and well-being of vulnerable people of any age.* • *Include any patient who has substantial access and contact with children or other vulnerable persons.* • *Do not include risk to wider population covered at scale A.* • *Do not include challenge to relationships covered in scale 9.*	No obvious impact of the individual's illness or behaviour on the safety or well-being of vulnerable persons.	Mild concerns about the impact of the individual's illness or behaviour on the safety or well-being of vulnerable persons.	Illness or behaviour has an impact on the safety or well-being of vulnerable persons. The individual is aware of the potential impact but is supported and is able to make adequate arrangements.	Illness or behaviour has an impact on the safety or well-being of vulnerable persons but does not meet the criteria to rate 4. There may be delusions, non-accidental self-injury risk or self-harm. However, the individual has insight, can take action to significantly reduce the impact of their behaviour on the children and is adequately supported.	Without action the illness or behaviour is likely to have direct or indirect significant impact on the safety or well-being of vulnerable persons. Problems such as delusions, severe non-accidental self-injury risk or problems of impulse control may be present. There may be lack of insight, an inability or unwillingness to take precautions to protect vulnerable persons and/or lack of adequate support and protection for vulnerable persons. ***Rate 9 if not known***
D. Engagement (historical)					
	0	**1**	**2**	**3**	**4**
• *Rate the individual's motivation and understanding of their problems, acceptance of their care/treatment and ability to relate to care staff.* • *Include the ability, willingness or motivation to engage in their care/ treatment appropriately, agreeing personal goals, attending appointments. Dependency issues.* • *Do not include Cognitive issues as in scale 4, severity of illness or failure to comply due to practical reasons.*	Has ability to engage/disengage appropriately with services. Has good understanding of problems and care plan.	Some reluctance to engage or slight risk of dependency. Has understanding of own problems.	Occasional difficulties in engagement, i.e. missed appointments or contacting services between appointments inappropriately. Some understanding of own problems.	Contacts services inappropriately. Has little understanding of own problems. Unreliable attendance at appointments. Or attendance depends on prompting or support.	Contacts multiple agencies, i.e. GP, A & E etc. constantly. Little or no understanding of own problems. Fails to comply with planned care. Rarely attends appointments. Refuses service input. Or Attendance and compliance dependent on intensive prompting and support. ***Rate 9 if not known***

E. Vulnerability (historical)					
	0	**1**	**2**	**3**	**4**
• *Rate failure of an individual to protect themselves from risk of harm to their health and safety or well-being.* • *Include physical, sexual, emotional and financial exploitation or harm/harassment* • *Do not include problems of engagement rated at scale D.*	No vulnerability evident.	No significant impact on person's health, safety or well-being.	Concern about the individual's ability to protect their health, safety or well-being requiring support or removal of existing support would increase concern.	Clear evidence of significant vulnerability affecting the individual's ability to protect their health and safety or well-being that requires support (but not as severe as a rating of 4). Or removal of existing support would increase risk.	Severe vulnerability – total breakdown in individual's ability to protect themselves resulting in major risk to the individual's health, safety or well-being. ***Rate 9 if not known***
I. Social communication & interaction difficulties (historical)					
	0	**1**	**2**	**3**	**4**
• *Rate the individuals behaviour in a range of settings* • *Include onset in early childhood* • *Do not include ratings accounted for by delayed developmental level.*	No significant problem	Social communication and interaction is slightly unusual, (e.g. over familiar) or inappropriate but not of such a level that it prevents interactions.	Social communication and interaction is obviously unusual, (e.g. inappropriate physical proximity, difficulties listening to others) observing appropriate rules in conversation is odd, (e.g. not participating or not taking turns, repetitive questioning, poor topic focus) and a tendency to display repetitive patterns or ritualistic behaviours. Difficulties are starting to impact on social opportunities.	Qualitative impairment in social communication and interaction (e.g. poor turn taking) accompanied by restricted repetitive patterns of behaviour (e.g. inflexible, non functional routines or rituals) in relation to developmental level having moderate impacts on quality of life and everyday functioning (e.g. requiring some, infrequent support and/or supervision).	Severe qualitative impairment in social communication and interaction (e.g. lack of social reciprocity) accompanied by restricted repetitive and stereotyped patterns of behaviour (e.g. inflexible adherence to specific, non-functional routines or rituals) in relation to developmental level leading to severe impacts on quality of life and everyday functioning (e.g. requiring high levels of daily support). ***Rate 9 if not known***