Conscious Care and Support

Demonstration Project

FINAL REPORT

Submitted to:
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A. Introduction

In October 2016, Community Living Windsor in partnership with A Centre for Conscious Care began an eighteen month demonstration project with six developmental service organizations throughout Ontario.

The project aimed to develop the capacity and resources to deliver the Conscious Care and Support (CCS) program to the employees of the organizations, the people they support, family members and other community partners by way of the following objectives:

a) introducing and delivering the Conscious Care and Support program to the six developmental service organizations in Ontario, their employees and family members;
b) introducing and delivering the Conscious Care and Support program to teams of six people who have an intellectual disability who use a behavioural support plan within six developmental service organizations and offer strategies that will enhance their quality-of-life and reduce their anxiety and aggression;
c) introducing the Conscious Care and Support program to community partners outside of the developmental services sector within the respective communities of the participating agencies;
d) evaluating the qualitative and quantitative outcomes of the implementation of Conscious Care and Support by an independent researcher as identified in the research methodology.

This demonstration project was unique in that the teams of the individuals with complex needs who were identified to participate in the CCS program were teams who support individuals with the most complex needs including ongoing incidents of serious anxiety, self-injurious behaviours and aggression towards others. The learnings of the CCS program and the follow up support from the lead consultant positioned the supporters to collectively create, implement, follow and evaluate a much more comprehensive support and wellness plan for those they support. The CCS program is also recognized as a certified program through the University of Toronto's Continuing Studies Program.

Research and evaluation of the demonstration project was conducted by Dr. Vera Azah, an independent researcher affiliated with Leithwood and Associates located in Toronto, ON.

B. Conscious Care and Support - A Brief Overview

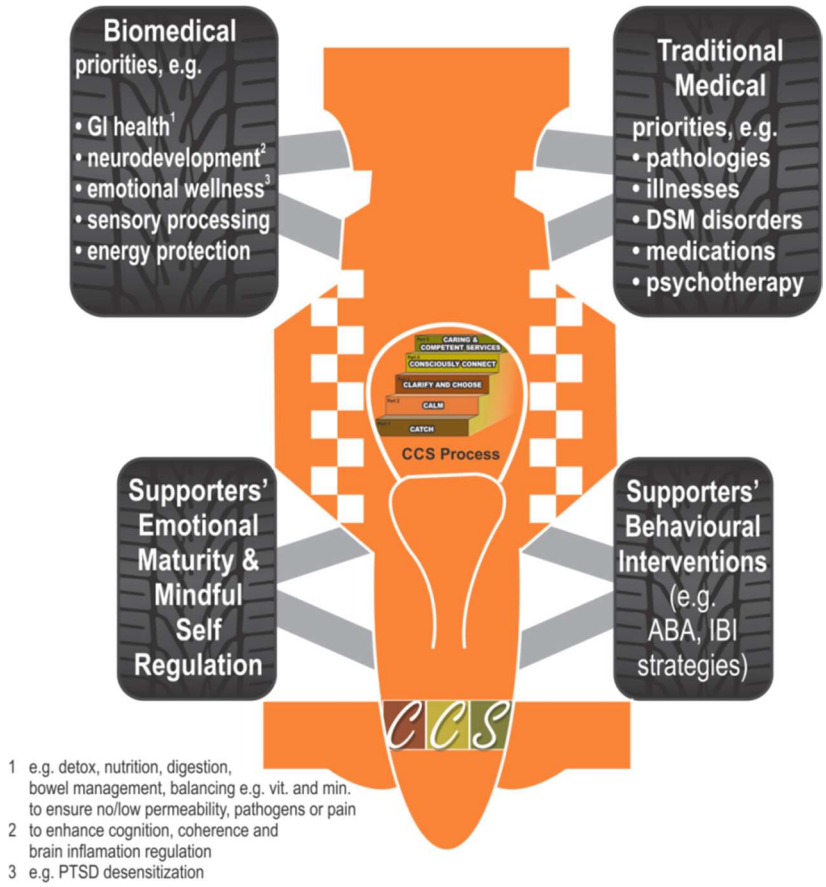
The need to identify upstream causes of anxiety, agitation and aggression is vital for anyone including individuals who have an intellectual disability to live meaningful, inclusive lives.

Conscious Care and Support features the learning of over twenty-five specific strategies and tools that have a proven record of decreasing anxiety and aggressive behaviour, as well as fostering positive behaviours in many people who have an intellectual disability. In combination with mental health, traditional medicine and behavioural techniques, the learnings include relevant applications from the disciplines of biomedicine, mindfulness, social neurobiology, bilateral and bio-meridian activation, gastrointestinal health, sensory integration, brain coherence, and neurofeedback. Most organizations and families are not aware of, or implementing any of these Conscious Care and Support strategies and tools.

Secondly, CCS provides supporters with the know how to enhance their effectiveness by helping them to develop their emotional maturity and mindful self-regulation skills so that they can consistently bring their "A-Game" to all support situations. Through the development of these key intra-personal skills, supporters can provide support that is authentically compassionate to ensure that supports and services are offered in a sincere and meaningful way.

These strategies and tools are intended to complete the services that are currently offered with traditional medical, mental health, behavioural, and other specialized support services typically available through local service delivery networks and the Community Networks of Specialized Care.

CCS Model of Complete and Optimal Supports



C. Project Outcomes – Executive Summary

Overall Conclusions

The findings from the research strongly conclude that the CCS program has significant influences on people who have autism or other developmental disabilities. Through the strategies and techniques garnered from the CCS program, supporters can significantly influence individuals with challenging behaviours through prevention, reduction and management of agitation, anger and aggression to become calmer and focused with overall improvement in their quality of life.

The evidence presented in the research demonstrates highly positive results. Almost all six agencies reported significant improvements in their knowledge, skills and dispositions to effectively de-escalate challenging behaviour and work effectively with individuals with challenging behaviours to improve their quality of life. Most of the participants in five of the six agencies had successfully implemented learnings from the CCS program and experienced a decrease in the number of actual assault cases by the persons they supported.

The research evidence clearly illustrated how the CCS program has indirectly benefited an individual with challenging behaviour who was not included in the project as well as those who were not participants of the training. What this tells us is that the training is transferable and can make a greater impact on Ontario in general.

Key Findings from Pre-Post Surveys and Focus Groups

As a result of CCS training, findings of the research study conducted by independent researcher Vera Azad, Ph.D. (*see Appendix II – Final Research Findings for Conscious Care and Support Demonstration Project*) confirmed the following significant changes in individuals with a disability and their supporters who participated in the CCS program:

a) Decreased number of assault cases by persons with challenging behaviour.

Most of the participants in five of the six agencies indicated a decrease in the number of actual assault cases (e.g. flipping chairs, hitting people, aggressing towards staff etc.) by the persons they support.

Amongst other things, the following were associated with the decrease in actual assaults:

i. Supporters' implementation of techniques to limit environmental toxins (e.g. limiting use of electronic devices);
ii. Medication for mental health (e.g. a medical prescription to manage bi-polar disorder);
iii. Dietary changes for the person supported (e.g. lowering the amount of sugar intake);
iv. Supporters recognizing triggers more easily and faster and giving persons supported what they need in order to reduce their anxiety; and
v. Increased self-confidence for supporters in meeting the needs of people with challenging behaviour.

Quotes from Focus Group Discussions:

"I find that I actually got hit physically less. Personally, I used to get hit a lot. And I don't think I've been hit, maybe once or twice since the training. And normally it'll have been at least once, twice a week or a few times."

"She hasn't assaulted herself. I don't know if it's based on familiarity of staff is not changing all the time… The threats aren't there. They haven't been there for the last I would say since significantly since Conscious Care she hasn't threatened in that way at all."

b) Participants learned a lot of things that were not taught in school (college) or not offered in other professional training sessions (e.g. mindfulness, how the brain and stomach interact differently, electromagnetic fields, etc.).

Mindfulness has been shown in this study to help supporters to:

i. Be aware of themselves and the moment, calm themselves and give persons supported the time to process information in order to limit aggressive behaviour;
ii. Change their perspective and the way they respond to what's going on as opposed to changing what is going on in order to give persons supported a better opportunity for a better life;
iii. Have a compassionate approach to letting persons supported know they can feel free to talk or cry; and
iv. Catch triggers of anxiety and address them before people they support become aggressive or self-abusive.

Quotes from Focus Group Discussions:

"I think people are recognizing now whereas before things would have blown up. I think there's been quite a few incidences with [name] that things could have escalated but the team's mindfulness has helped keep it here. As well as their ability to recognize her triggers has helped it to not escalate."

"Just the compassionate approach…letting them know that you're here to listen to them whether they want to talk, cry, you're just there to help them though whatever it is they need. I think it's helped me with a relationship with a lady and like we have a really good report as well as you know like um I just think they're is a more personal connection sometimes now that we are really looking in depth and trying to get to the bottom of a lot of things, help."

c) Mindfulness and faulty filters are the most significant benefit of CCS training on the supporters' ability to support people with challenging behaviours.

Survey data revealed that there was remarkable improvement in supporters' states of awareness, emotional competence and emotional self-regulation across all six agencies. This has proven to be essential for effectively de-escalating and managing individuals with challenging behaviours as espoused in focused group interviews.

Quotes from Focus Group Discussions:

"I think the difference that the training has made to the people that we support is it's helped us as support workers to be more understanding. To be more thoughtful and realize that people don't choose to have difficult days or difficult moments that there's something else going on. So it's helped us to be more understanding and compassionate and to think about how that person must feel…"

"I think increase in the meditation and the calming yourself you know what you take into your home. We had an opportunity to share it with all of the support workers at [name of support location] and we've implemented before our team meeting, we do a mindfulness exercise and you know I was very excited to take it home and share some of the information with my family…"

d) Nutrition (with dietary changes e.g. lowering sugar intake, lowering gluten intake and adding supplements) and exercise (e.g. walking) have significant impact on persons supported.

Most of the primary individuals in each agency have become calmer and more focused since anxiety had decreased following changes in diet.

Quotes from Focus Group Discussions:

"He, we went from using a suppository every day to every other day. And prior to the changes in food, we did not see results on the days he did not receive the suppository. Once we like I said we've slowly introduced these things, on two occasions out of a month, he has gone on

his own without the suppository. It is an improvement. It's only twice but it is an improvement."

"[Name], because of Conscious Care now sees a naturopath and our first couple of visits she had some pretty big concerns, one being some pretty severe sensitivities to foods that we might not have thought about; tomatoes being one of them. Also he needed a liver detox and a few things that were rating pretty high so he was on some stuff for those things and I think I've noticed. I did notice so we went to the naturopath and he had dinner and put ketchup all over it and right after that, he had severe anxiety. So that was before we implemented it and right after we found out that ok I'm seeing this, this is real… I see a difference when he eats them. That's all I can say for sure… I know he hasn't complained or asked to vomit in the toilet like he had been before so that's something that we see that's concrete, which is good."

e) Overall improvement in the quality of life of most of the persons supported.

The following changes in people with challenging behaviours were identified in the focus groups:

i. Communicating better and clearer;
ii. Sleeping better;
iii. Walking (going out for walks);
iv. Being calm, focused and happy;
v. Interacting more with supporters (staff) and people (e.g. strangers in one case) within the community; and
vi. In the case of one supporter, opening their eyes as opposed to walking with closed eyes in the past and bumping unintentionally into staff.

Quotes from Focus Group Discussions:

"Well [name] typically engages in a lot of self-injurious behaviour. When he first came, that involved him throwing himself on the floor, hitting himself in head and his body, biting himself really bad and he was bleeding. We've noticed that although the amount of incidents haven't decreased hugely, the duration of them have decreased quite a bit and the intensity have decreased quite a bit. So now if he bites he very rarely breaks his skin. He's not jumping to the floor hardly at all and his incidences turn to be more like here [reference location], where before it'll be like all over the place."

"Us being more calm as well has improved their quality of life because they're not getting as anxious as they were before so it's kind've like were rubbing off on them…Increase in their quality of life…The people have more control over their lives because we're not trying to set it we're trying to understand what they want and put things in place that we see that their wishes are being met."

"I find that the quality of his life has improved, like he's interacting more with social activities… and initiating them…Yeah, before he never used to do that…He was somebody that we thought you know this is gonna be the way he's going to be for the rest of his life but then it's like wow he's a different person…Because how many different things did we try with the same end result, until this [CCS] came along."

The outcomes of this evaluation begin to provide and measure a more accurate understanding and application of evidence-based practices that will both enhance the actual quality and quantity of services and treatments. While the process of Quality Assurance Measures (QAM) successfully evaluates implementation of service systems within service providers across Ontario, given that there is virtually no independent research to validate the current models of support services and treatment, the outcomes garnered from this research are considered to be quite significant and important.

D. Goals Outcomes

The demonstration project has successfully achieved its objectives, namely:

Goal #1: ***To introduce and deliver the Conscious Care and Support program to six developmental service organizations in Ontario, their employees and family members.***

The following organizations participated in the demonstration project:

- Community Living Chatham-Kent;
- Community Living St. Marys & Area;
- Community Living Stratford & Area;
- Ongwanada;
- Community Living Kingston & District;
- Community Living Prince Edward.

All of the organizations hosted and participated in the Introductory Workshop, the 5-week CCS Course and the Situational Leadership Training. The demonstration project has enabled the learnings of CCS to reach 400 people including employees of various organizations, family members and various community practitioners and professionals (including naturopaths, dieticians, registered holistic nutritionists, psychiatrists, behavioural therapists, occupational therapists, independent planning facilitators, college professors, elementary school teachers and educational assistants within the local school boards).

Across all of the organizations, 160 supporters have received the more in-depth 5-Week CCS course which upon successful completion of an assignment, participants were deemed eligible for a certificate of completion through the Continuing Studies Program at the University of Toronto.

From the various organizations, 122 employees (including members of the senior leadership teams, managers, coordinators and facilitators) participated in the Situational Leadership Training.

Lastly, the demonstration project has directly impacted the supports and services offered to 29 people with very complex needs who receive supports provided by the participating organizations.

Organization	Introductory Workshop	5-week CCS Course	Situational Leadership Training	People Supported directly through the demonstration project
Community Living Chatham-Kent	48 participants	27 participants	14 participants	5 participants
Community Living St. Marys & Area	67 participants	21 participants	12 participants	5 participants
Community Living Stratford & Area	69 participants	26 participants	25 participants	5 participants
Ongwanada	67 participants	29 participants	35 participants	4 participants
Community Living Kingston & District	83 participants	27 participants	25 participants	5 participants
Community Living Prince Edward	66 participants	30 participants	11 participants	5 participants
TOTAL PARTICIPANTS	**400**	**160**	**122**	**29**

Goal #2:	***To introduce and deliver the Conscious Care and Support program to support teams of six people who have an intellectual disability who use a behavioural support plan within six developmental services organizations and offer strategies that will enhance their quality-of-life and reduce their anxiety and aggression. Support will also be provided to each of the individual support teams.***

Six people and their support teams were chosen as primary participants within the demonstration project; one person and one team from each of the participating organizations.

As part of the demonstration project, consultations were provided by the lead consultant to each of the primary people supported. Consultations included a thorough review of information pertaining to various areas of wellness including but not limited to a review of their likes and dislikes, medications, nutrition and diet plans, biomedical supplements, behavioural support plans or other behavioural interventions, interventions to enhance or stabilize mental health, dynamics of social connection including family, friends and vocational/volunteerism and a review of their living and support arrangements. A brief longer term history, a review of their gifts and talents and a listing of current support challenges were gathered through a face to face meeting with family members and/or primary supporters.

Each primary participant was met by the lead consultant in a seemingly less formal consultation in the comfort of their own home. The lead consultant also met with various professionals and practitioners providing support to each primary person including primary care physicians, psychiatrists, nurses, dieticians, naturopathic doctors, behavioural therapists, teachers and educational assistants.

Goal #3:	***To introduce the Conscious Care and Support program to community partners outside of the developmental services sector within the respective communities of the participating agencies.***

The CCS program was introduced to various community practitioners and professionals including naturopaths, dieticians, registered holistic nutritionists, psychiatrists, behavioural therapists, occupational therapists, independent planning facilitators, college professors, elementary school teachers and educational assistants within the local school boards.

Along with traditional medical and behavioural clinicians, all of the organizations and support teams involved within the project have been able to consult with various practitioners to assist in implementing an optimal, comprehensive plan of wellness for the person they support. Consultations included but weren't limited to the practitioners and clinicians listed above. Many of the agencies have continued building their relationship with these practitioners in anticipation to bring a more comprehensive plan of wellness to the people they support.

Goal #4:	***To evaluate the qualitative and quantitative outcomes of the implementation of Conscious Care and Support by an independent researcher as identified in the research methodology.***

The evaluation of this demonstration project included measurements of quantitative and qualitative data for both the at-risk individual (person supported) and their supporters.

The following is a brief overview that highlights the main areas of investigation along with the methods of data collection. The evaluation was completed in accordance with the proposed project implementation plan (*see Appendix I - Example of CCS Implementation over Six Months*) with the post surveys and interviews completed within each agency approximately 2 months after their last training session.
For a more complete review of the research methodology and demographics, please refer to *Appendix II – Final Research Findings for Conscious Care and Support Demonstration Project.*

Outcomes for At-Risk Individual (Person Supported)		
	Outcome to Evaluate	**Method of Data Collection**
Quantitative Measurement	Is there a decrease in the amount of physical expressions of agitation, anger and aggression (AAA) or other concerns because of Conscious Care and Support (CCS) interventions?	1. Tracking logged by support team including but not limited to: • the frequency and intensity of incidents of aggression experienced; • the frequency and intensity of incidents of notable anxiety; • the frequency and intensity of self-injurious behaviour; • the number of administered PRN medications for pain or challenging behaviour; • the frequency of bowel movements; • the frequency and duration of activities (inside and outside of the home);and • the frequency of social engagement and communication. 2. Reported on pre and post survey.
Qualitative Measurement	Is there an increase in the quality of life and emotional self-regulation skills because of Conscious Care and Support (CCS) interventions?	1. The person supported indicates measurable decreases in stress, increases in self-calming, increases in flexibility, increase in initiating activities and personal interactions. 2. Logged by the support team, reported on pre and post survey and through the focus group discussion.
Outcomes for Supporters		
Quantitative Measurement	Is there a decrease in the amount of days off of work/ recovery time for staff because of Conscious Care and Support (CCS) interventions?	1. Calculate amount of injuries incurred, sick days used, personal paid holidays, times late, stress leave, WSIB claims, etc.[1]
Qualitative Measurement	Is there an increase in job satisfaction, job performance, safety, perceived emotional and physical security and overall quality of life because of Conscious Care and Support (CCS) interventions?	1. Self-rating of job satisfaction, job performance and overall quality of life factors to consider include resiliency, ability to emotionally self-regulate in times of crisis, interpersonal connection, collaboration, decision making, wellbeing, emotional maturity, safety, compassion, personal growth, etc. 2. Reported on pre and post survey and through the focus group discussion.

[1] This variable of investigation was omitted at this stage as the length and structure of the demonstration project could not accurately assess this evaluation.

E. Individual Case Studies - Overview

Six people who were deemed to be at-risk and their support teams were chosen as primary participants within the demonstration project (*see Appendix III - Criteria for At-Risk Individuals*).

The chart below highlights some characteristics of each of the primary participants including their gender, age, diagnoses, concerns of at-risk behaviour, CCS implementations and the number of supporters involved in consultations who have taken the CCS program (please note names have been changed).

For a detailed overview of pre and post implementation for each case study, see *Appendix IV - Overview of Pre and Post Implementation of Comprehensive Wellness Plans for People Supported.*

Name	Gary	Alex	Michael	Deanna	Chris	Kimberley
Gender	Male	Male	Male	Female	Male	Female
Age	44	23	26	28	36	32
Diagnoses	Autism/ OCD	Childhood disintegrative disorder	Autism, obsessive compulsive disorder, epilepsy and lead poisoning.	Autism spectrum disorder, pervasive developmental delay.	Autism spectrum disorder, behaviour disorder, epilepsy, tuberous sclerosis.	10 P Syndrome, scoliosis, sleep apnea, hearing loss in both ears.
Concerns of At-Risk Behaviour	Aggression towards self and others; destruction of property; limited social engagement & communication.	Aggression towards self and others; verbal threats.	Aggression towards self and others; destruction of property; limited social engagement & communication.	Aggression towards self and others; destruction of property; verbal threats.	Aggression towards self and others; destruction of property; & communication.	Aggression towards and others; negative self-talk; verbal threats.
CCS Implementations	Full medication review from an independent pharmacist to ensure medications were fully meeting his medical needs. Diet modifications. Changed lighting in day support program from fluorescent to	Full medication review from an independent pharmacist to ensure medications were fully meeting his medical needs. Diet modifications. Involvement of a Naturopath. Minimizing	Full medication review from an independent pharmacist to ensure medications were fully meeting his medical needs. Diet modifications. Involvement of a Naturopath. Daily	Diet modifications. Developing her own skills of self-regulation through the practice of meditation. Enhanced the development of supporters to become more mindful, emotionally self-regulated as they provide support.	Diet modifications. Involvement of a Registered Holistic Nutritionist. BB-ABC Exercises (Bilateral, Bio meridian Awareness Based Calming). Minimizing the exposure of EMF through the	Diet modifications. BB-ABC Exercises (Bilateral, Bio meridian Awareness Based Calming). Daily rebounding and cardio exercise. Enhanced the development of supporters to become more mindful,

Name	Gary	Alex	Michael	Deanna	Chris	Kimberley
CCS Implementations Con't	incandescent. Rebounding exercises and daily cardio. BB-ABC Exercises (Bilateral, Bio meridian Awareness Based Calming). Minimizing the exposure of EMF through the installation of dirty electricity filters. Involvement of a Naturopath. Enhanced the development of supporters to become more mindful, emotionally self-regulated as they provide support. Exploring meaningful activities to contribute to others. Still to connect with an Occupational Therapist trained in sensory integration/ processing.	the exposure of EMF through the installation of dirty electricity filters and grounding mat. Enhanced the development of supporters to become more mindful, emotionally self-regulated as they provide support. Exploring meaningful activities to contribute to others. Still to connect with an Occupational Therapist trained in sensory integration/ processing.	rebounding and cardio exercise. Minimizing the exposure of EMF through the installation of a harmonic panel filter. Enhanced the development of supporters to become more mindful, emotionally self-regulated as they provide support. Exploring meaningful activities to contribute to others. Still to connect with an Occupational Therapist trained in sensory integration/ processing.	Exploring meaningful activities to contribute to others.	installation of dirty electricity filters. Enhanced the development of supporters to become more mindful, emotionally self-regulated as they provide support. Exploring meaningful activities to contribute to others. Still to connect with an Occupational Therapist trained in sensory integration/ processing.	emotionally self-regulated as they provide support. Still to connect with a Registered Holistic Nutritionist. Still to connect with an Occupational Therapist trained in sensory integration/ processing.

Name	Gary	Alex	Michael	Deanna	Chris	Kimberley
# of Direct CCS Supporters Involved in Consultation	4 FT 1 PT 2 Managers	2 FT 4 PT 1 Manager	2 FT 1 Manager	3 FT 2 PT 1 Manager	4 FT 2 PT 1 Manager	2 FT 2 PT 1 Manager

F. Recommendations from CCS Project Leads

1. The nature of the project design did not allow for a more long-term evaluation of outcomes of interventions.

   It is recommended that future commitment to CCS evaluation be made in order to evaluate outcomes on a more long-term basis.

2. In every site in which the CCS program was delivered, the lead consultant would have to turn down families who would ask for consultation as there wasn't enough time to connect with every team who expressed interest in having consultation.

   It is recommended that future commitment be made to develop more consultants in Conscious Care and Support.

3. In some circumstances, the lack of or delay of connection with interdisciplinary clinicians affected the outcomes of a comprehensive model of support. When there was a lack of interdisciplinary clinicians working together, time would be spent educating the clinicians on the CCS model. Some were receptive of a comprehensive model, while others were not. When there was a delay of connection between existing interdisciplinary clinicians, the person supported would often wait months, with obvious signs of suffering, to receive additional interventions to complete a more comprehensive plan.

   It is recommended that future investment be made into CCS to educate additional clinicians, potentially with the Community Networks of Specialized Care, to integrate a more comprehensive model of support.

4. The 18 month timeline of the demonstration project limited the depth of integration of CCS into each agency.

   It is recommended that future opportunities be offered to assist the agencies in the demonstration project to implement CCS more deeply beyond the CCS course and consultation with six teams.

5. The timeline of the project only allowed for the delivery of the CCS program and consultation with six agencies. The evaluation of the demonstration project clearly illustrates that the CCS program can improve the supporter's states of awareness, emotional competence and emotional self-regulation. Supporters reported an increase in confidence in the work they do in turn, enabling them to feel better equipped to do their job. Supporters indicated that they were also more able to implement best practices to support the special needs of people they served.

   It is recommended that future opportunities be made available to assist more organizations to invest in CCS as an integral element of staff development to ensure that their employees are best equipped for the support that they provide to others.

6. As each organization also received training on situational leadership, it was noted that there is great need for situational leadership training in the developmental service sector for leaders and managers of service provider agencies.

   It is recommended that investment be made to ensure agencies are equipped with a model of leadership that uses a strength-based approach, mentors accountability and that promotes mindful, emotional self-regulation

G. Knowledge Sharing

2016	
November	*CCS Introductory Workshop, Chatham, ON.*
2017	
January	*CCS Introductory Workshop, St. Marys, ON.*
March	*CCS Introductory Workshop, Stratford, ON.*
April	*CCS Introductory Workshop, Kingston, ON.*
	Modified CCS Introductory Workshop, Kingston, ON.
June	*Presentation at Beyond Quality Outcomes: The Conference on Outcomes Measurement Systems and Strategies, Kingston, ON.*
	CCS Introductory Workshop, Kingston, ON.
September	*Scheduled presentation at Provincial Executive Director's Group Annual Meeting, Niagara Falls, ON.*
	Scheduled presentation at Annual Community Living Ontario Conference Niagara Falls, ON.
	CCS Introductory Workshop, Picton, ON.
October	*Modified CCS Introductory Workshop for Family Engagement Network, Picton, ON.*
November	*Scheduled workshop at Annual Health and Wellbeing in Developmental Disabilities Conference, Toronto, ON.*
December	*CCS Introductory Workshop, Welland, ON.*
	CCS Introductory Workshop, Peterborough, ON.
2018	
February	*CCS Presentation at Regional Support Associates, Woodstock, ON*

Appendix I- Example of CCS Implementation Over Six Months at Each Agency

MONTH	WEEK	ACTIVITY OF IMPLEMENTATION	INVOLVED
Month One	Week 1	Facilitation of Introductory Workshop for 50-90 in attendance.	Employees of organization, family members, community practitioners, community partners, Project Lead, Project Coordinator.
		Meeting with family of person supported who was selected as main participant in project.	Family members, members of support team, Project Lead, Project Coordinator.
		Meeting with person supported who was selected as main participant in project.	Person supported, members of support team, Project Lead, Project Coordinator.
		Meeting with team of person supported who was selected as main participant in project.	Members of support team, members of leadership team, Project Lead, Project Coordinator.
		Administration of pre CCS survey for supporters participating in project.	Participants of CCS course, Researcher, Project Coordinator.
	Week 2	Facilitation of Conscious Care and Support Class (1).	Participants of CCS Course, Project Lead, Project Coordinator.
		Meeting with Supervisors and Managers of each of the 4 - 5 teams participating in the CCS course to discuss leadership.	Members of leadership team, Project Lead, Project Coordinator.
	Week 3	Facilitation of Conscious Care and Support Class (2).	Participants of CCS Course, Project Lead, Project Coordinator.
		Meeting with each of the 4 - 5 teams participating in the CCS course to discuss the person they support and any challenges they may experience.	Members of support teams, members of leadership team, Project Lead, Project Coordinator.
		Reviewing and commenting on learning logs from Conscious Care and Support Class (2).	Project Lead.
	Week 4	Facilitation of Conscious Care and Support Class (3).	Participants of CCS Course, Project Lead, Project Coordinator.
		Meeting with person supported who was selected as main participant in project, if needed.	Person supported, members of support team, Project Lead, Project Coordinator.
		Reviewing and commenting on learning logs from Conscious Care and Support Class (3).	Project Lead.

Month Two	Week 5	Facilitation of Conscious Care and Support Class (4).	Participants of CCS Course, Project Lead, Project Coordinator.
		Meeting with each of the 4 - 5 teams participating in the CCS course to discuss the CCS plans of implementation.	Members of support teams, members of leadership team, Project Lead, Project Coordinator.
		Reviewing and commenting on learning logs from Conscious Care and Support Class (4).	Project Lead.
	Week 6	Facilitation of Situational Leadership training to management team and key supporters in leadership roles.	Members of leadership team, Project Lead, Project Coordinator.
		Reviewing and commenting on learning logs from Conscious Care and Support Class (5).	Project Lead.
		Administration of post CCS survey for supporters participating in project.	Participants of CCS course, Researcher, Project Coordinator.
Month Three	Week 10	Submission and review of CCS final assignments for possible certificate of completion from University of Toronto.	Participants of CCS Course, Project Lead, Project Coordinator.
	Week 11	Meeting with each of the 4 - 5 teams participating in the CCS course to discuss the CCS plans of implementation.	Members of support teams, members of leadership team, Project Lead, Project Coordinator.
Month Five	Week 18	Meeting with each of the 4 - 5 teams participating in the CCS course to discuss the CCS plans of implementation.	Members of support teams, members of leadership team, Project Lead, Project Coordinator.
Month Six	Week 24	Meeting with each of the 4 - 5 teams participating in the CCS course to discuss the CCS plans of implementation.	Members of support teams, members of leadership team, Project Lead, Project Coordinator.
		Facilitation of group interviews of supporters participating in project.	Participants of CCS course, Researcher, Project Coordinator.

Additional meetings would also include:

- Person supported and/or their support team meeting with Family Physician, Psychiatrist, Behavioural Therapist or other practitioners along with Project Lead and Project Coordinator;
- Project Lead and Project Coordinator meeting with various practitioners (i.e. Naturopaths, Registered Dieticians, Registered Holistic Nutritionists, Occupational Therapists and Pharmacists) in each respective community;
- Continual correspondence with members of support team, members of leadership team, family members with Project Lead and Project Coordinator to address any concerns with CCS implementation.

Appendix II- Final Research Findings for Conscious Care and Support Demonstration Project

The report below by independent researcher Vera Azah, Ph.D. contains the research findings from the 18 month Conscious Care and Support demonstration project. The outcomes of this evaluation begin to provide and measure a more accurate understanding and application of evidence-based practices that will both enhance the actual quality and quantity of services and treatments.

Conscious Care and Support (CCS) Survey

**Community Living Chatham-Kent, Community Living Kingston & District,
Ongwanada, Community Living Prince Edward,
Community Living St. Marys & Area and Community Stratford & Area Agencies**

Objective of Research: To evaluate the qualitative and quantitative outcomes of the implementation of Conscious Care and Support.

The following four research questions guided the development of the instruments for evaluation of the Conscious Care and Support project;

Research Questions (RQ):

1. Is there a decrease in the amount of physical expressions of agitation, anger and aggression (AAA) or other concerns because of CCS interventions?
2. Is there an increase in quality of life because of CCS interventions?
3. Is there a decrease in the amount of days off of work/recovery time for staff because of Conscious Care and Support Interventions?[2]
4. Is there an increase in job satisfaction, job performance, safety, perceived emotional security and overall quality of life because of CCS interventions?

The first two research questions (RQ1 and RQ2) are related to outcomes for persons with disabilities supported and the last two questions (RQ3 and RQ4) are related to outcomes for direct supporters.

This report is divided into three parts: Part A describes the demographics of the participants. Part B illustrates survey results of participants' knowledge, skills and practices before and after the CCS training and Part C describes findings and discussion of focus group, conclusions and recommendations.

[2] This variable of investigation was omitted at this stage as the length and structure of the demonstration project could not accurately assess this evaluation.

Part A. Research Methodology and Demographics of Participants Research Methodology

Sampling Method: Purposive sampling technique was used to identify six community living agencies in Ontario (Community Living Chatham-Kent, Community Living Kingston & District, Ongwanada, Community Living Prince Edward, Community Living St. Marys & Area and Community Living Stratford & Area) to participate in the demonstration project. From these six agencies, 29 individuals supported (including six individuals who were deemed as either medium or high risk and supported by a behaviour support plan), 120 direct supporters (including family members, direct support professionals, facilitators, team leaders, behaviour therapists and a treatment counsellor) and 40 supporters in positions of leadership or administration (including chief officers, directors, managers, supervisors, a board member and an executive assistant) participated within the demonstration project.

Research Methods/Design/Data Collection

Both quantitative and qualitative data collection methods were used to show the connection between CCS training and improved trainees' knowledge and skills and improved quality of life for people with challenging behaviours.

Quantitatively, two separate surveys (pre-training and post-training) were conducted for each of the six agencies beginning 2016 and ending 2017. Both surveys were designed and administered via SurveyMonkey. The pre-training survey was administered in each of the six agencies to assess the knowledge and skills of supporters prior to their CCS training sessions and the post-training survey was administered to each of the six agencies immediately after their respective completion of the CCS training sessions.

Qualitative data was collected throughout the training program using multiple sources of evidence: focus groups, participants' learning records, participants' written outcomes and documentation. The qualitative data provides in-depth knowledge of what the supporters have learned through the CCS program, any changes in their knowledge, skills and practices; observable changes in behaviour of persons supported with challenging behaviour.

Analysis Procedure: Descriptive statistics and t-tests were used to analyze the quantitative data and the qualitative data was analyzed using common themes and outliers derived from the focus groups.

Confidentiality and Anonymity: For confidentiality and anonymity purposes, participants were informed prior to the study that their names would not be recorded during the evaluation process but relevant background information such as name of agency, names of persons supported and position of supporters will be collected for identification and comparison where necessary. Data collected from the surveys and case studies will be kept under lock and key at the office of the researcher and discarded after 5 years following the research.

Demographics of Participants

The survey was administered at each of the six agencies on two occasions: before and after the CCS training. The sample sizes of respondents in each location are displayed in Table 1. As can be seen from this table, the number of respondents to the questionnaire after the training was smaller than the number of respondents before the training in each of the six locations.

Table 1. Sample Size of Survey Participants

Location	Pre-training	Post-training
Kingston	26	13
Ongwanada	27	12
St. Marys	21	19
Stratford	22	17
Prince Edward	31	27
Chatham-Kent	24	23
Total	151	111

Figure 1: Current Role in Organization Pre-Training

In all six agencies, over half of the CCS training participants were direct support professionals. Managers were represented across all six agencies. Other than in one agency (Community Living Chatham-Kent), supervisors were also represented in all other five agencies. Even though there is only family representation from Community Living Prince Edward illustrated through the data collection of the survey (shown on Figure 1), there was family representation at various trainings: one family supporter from Community Living St. Marys & Area, one family supporter from Community Living Stratford & Area, one family supporter from Community Living Kingston & District and three family supporters from Community Living Prince Edward. In five of the six agencies (except Community Living Stratford & Area), participants identified "other" positions in their organization to include: house/residential/day program facilitator, behaviour therapist, treatment counsellor, chief clinical and planning officer, director, youth facilitator, planning facilitator and team lead.

Figure 2: Current Role in Organization Post-Training

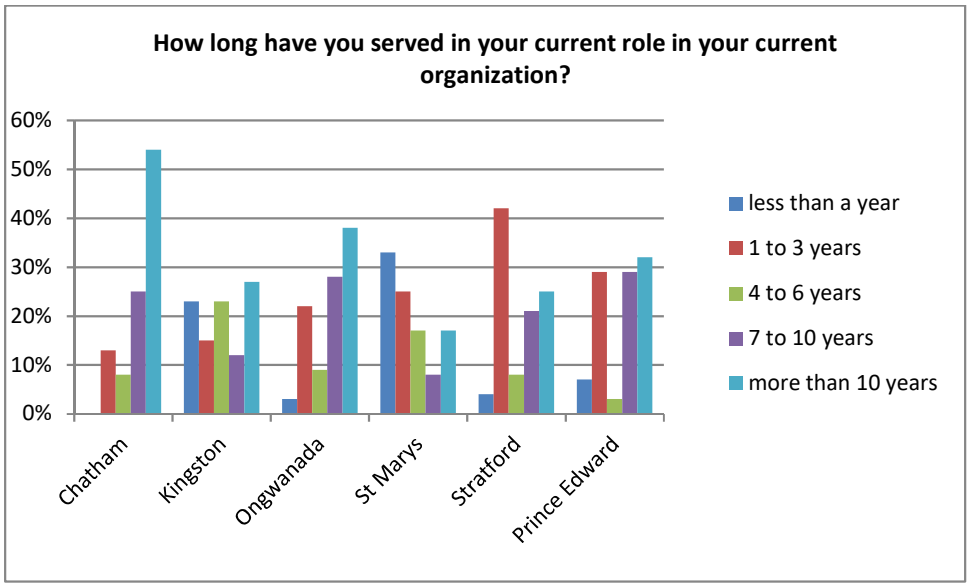
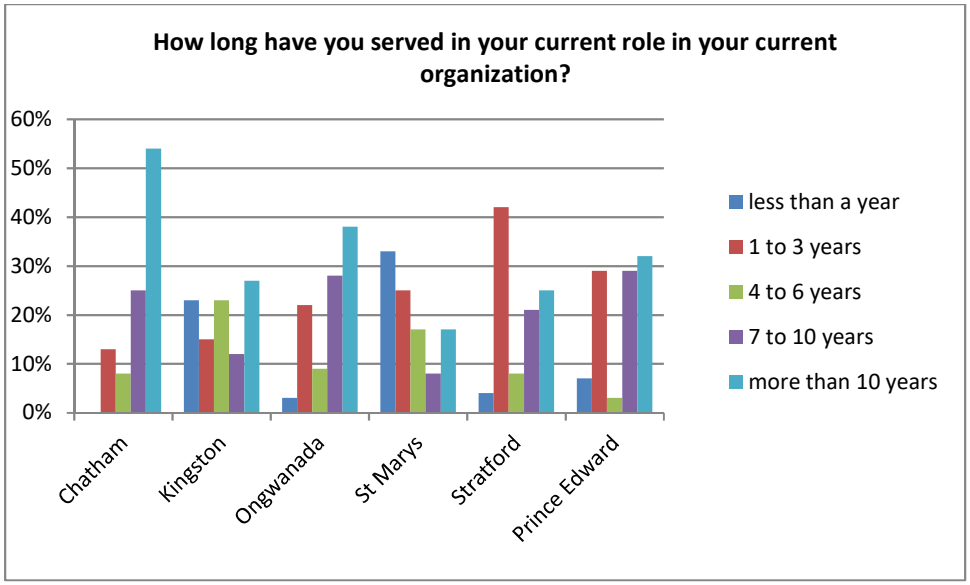
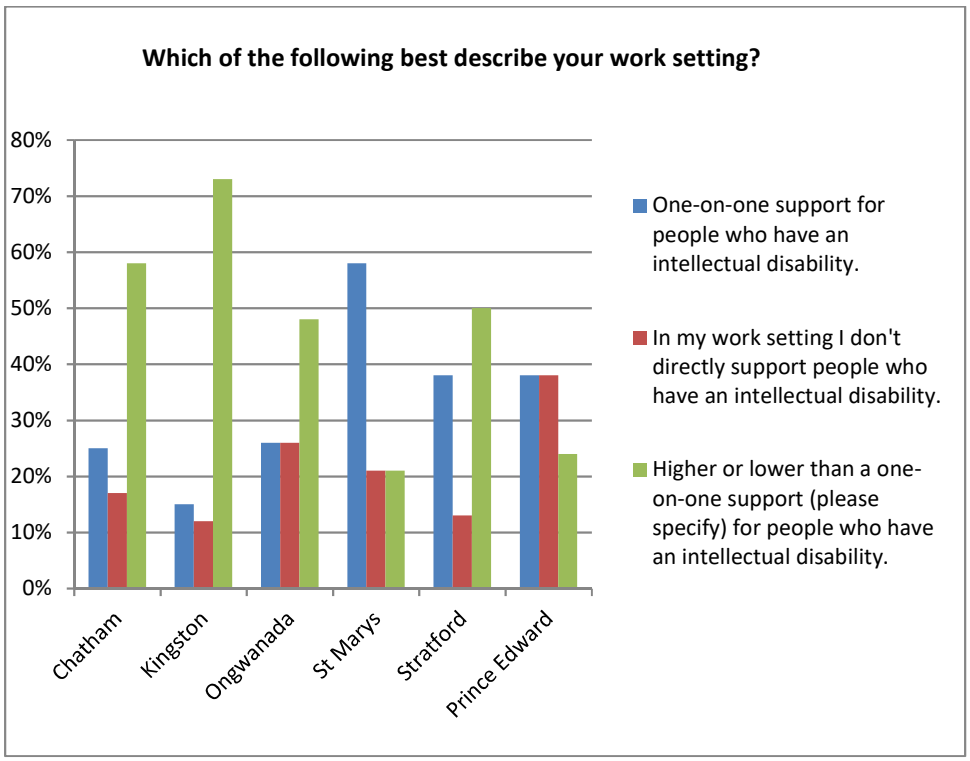


Figure 3: Number of Years Served in Current Role in Organization



As shown in Figures 2 and 3, other than Community Living Chatham-Kent which didn't have participants who had served in their role at their current organization for less than a year, participants of the training in all other five agencies had served in their role at their current organization from less than a year to more than 10 years. A majority of participants had served in their current role for over 10 years showing historical ties to their organization and to some extent experience supporting persons with disabilities.

Figure 4: Description of Work Setting



Other than Community Living St. Marys & Area with the majority (over 50%) of its participants indicating that they were in a one-on-one support setting for people who have an intellectual disability, most (over 45%) participants in the four agencies (Community Living Chatham-Kent, Community Living Kingston & District, Ongwanada and Community Living Stratford & Area) identified with work settings higher or lower than a one-on-one support for people who have an intellectual disability. Community Living Prince Edward on the other hand had only a small amount of participants (less than 25%) who identified with work settings higher or lower than a one-on-one support setting and over 35% of their participants were in a one-on-one support setting or a work setting where they didn't directly support people who have an intellectual disability. Higher than a one-on-one setting included a two-to-one staff to person supported ratio (two support professionals to one individual with a disability) while in most lower than one-on-one cases noted, there were one-to-six staff to person supported ratio (one support professional to six individuals with a disability, or groups). Given that all six agencies had at least one management staff (i.e. supervisor, manager or director) participate in the survey, some participants identified with a work setting in which they didn't directly support people who have intellectual disability.

Figure 5: Number of People with an Intellectual Disability Supported

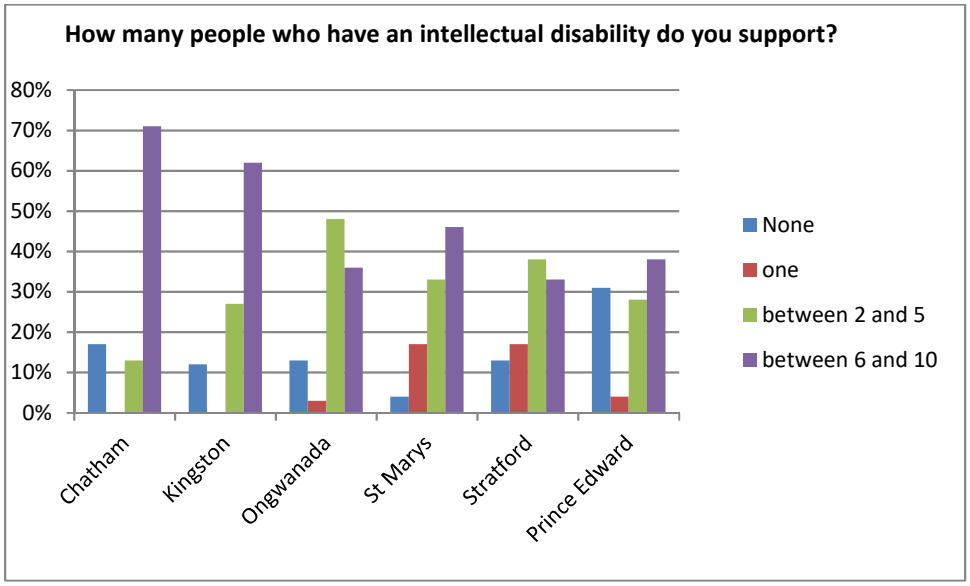
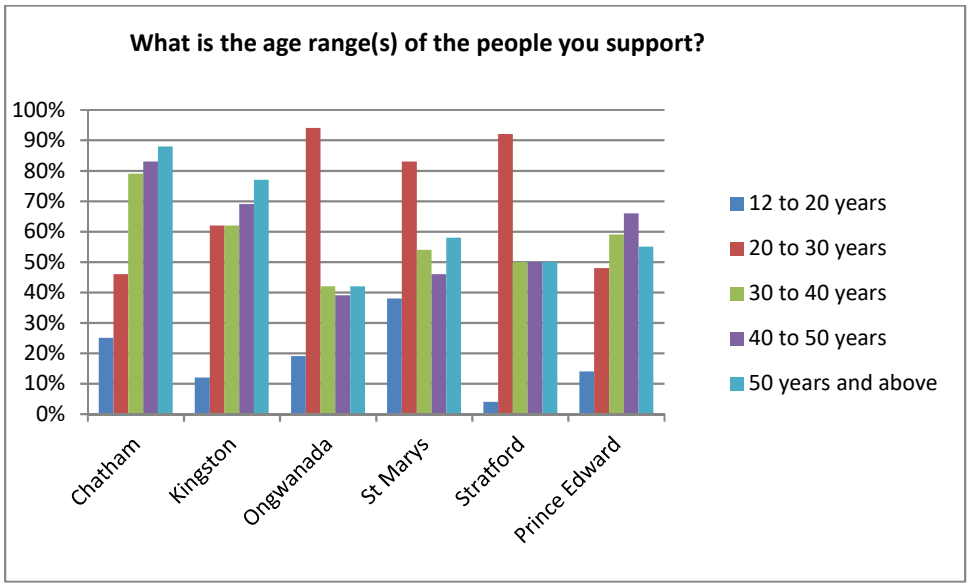


Figure 5 further breaks down the working relationships described in Figure 4. As the chart illustrates, most participants supported between 6 and 10 individuals with an intellectual disability followed by the support of between two and five individuals with an intellectual disability. Less than 20% of participants in each agency indicated that they did not support any individual with intellectual disability. However, in Community Living Prince Edward over 30% of its participants reported that they did not support any individual with intellectual disability.

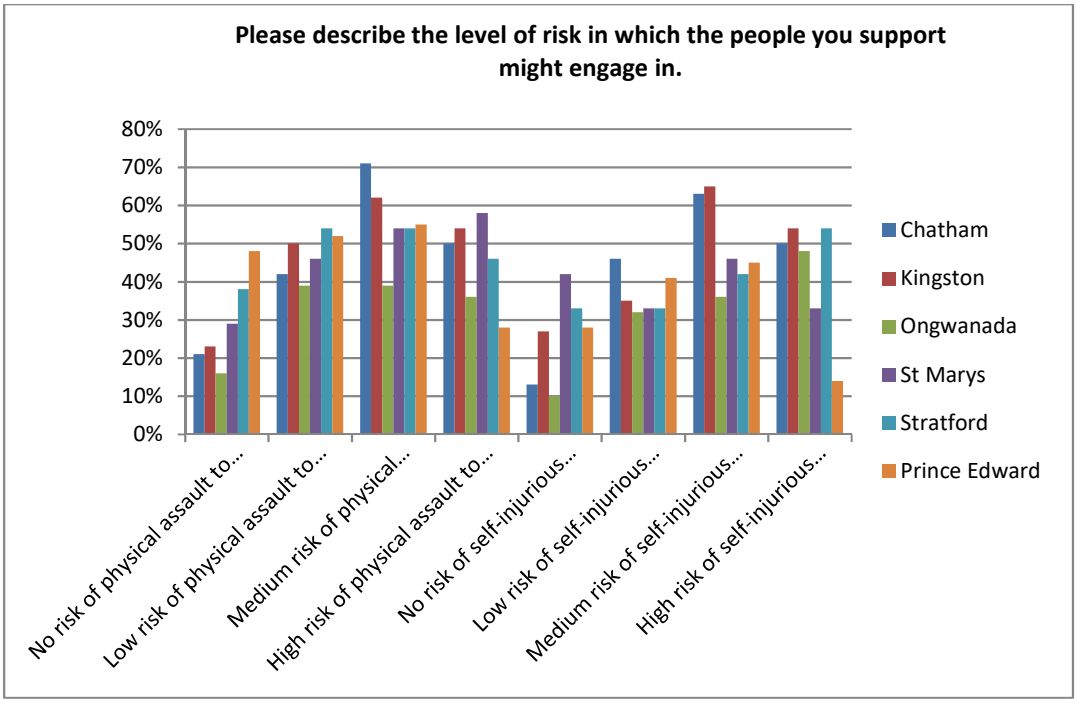
Figure 6: Age Range of Individuals with an Intellectual Disability Supported



In three agencies (Ongwanada, Community Living St. Marys & Area and Community Living Stratford & Area), majority (over 80%) of the participants supported people who were between 20 to 30 years while at Community Living Chatham-Kent and Community Living Kingston & District most (over 75%) of the participants supported people who were 50 years and above. Overall, in all six agencies, participants

supported people who were between 12 to 20 years and 50 and above. However, over 50% of participants from Community Living Prince Edward supported people who were 30 years and above with less than 20% in the 12 to 20 age range. This shows the maturity in age of the people being supported across the six agencies but does not necessarily determine a correlational level of support (i.e. the greater the maturity in age does not necessarily mean a lessened level of support.)

Figure 7: Level of Risk in Which Individuals with an Intellectual Disability Might Engage



As shown in Figure 7, participants in all six agencies noted that individuals with intellectual disability engaged in a range of risks from no-risk to high-risk of both physical assault to supporters and of self-injurious behaviour. High-risk of self-injurious behaviour was reported for the most part by participants from Community Living Stratford & Area, closely followed by Community Living Kingston & District, then Community Living Chatham-Kent, Ongwanada, Community Living St. Marys & Area reported by less than 25% and Community Living Prince Edward reported by only 14%.

Interestingly, high risk of physical assault to supporters was highly reported by participants from Community Living St. Marys & Area (over 55%), followed by participants from Community Living Kingston & District, Community Living Chatham-Kent, Community Living Stratford & Area, Ongwanada and Community Living Prince Edward respectively. From Community Living Chatham-Kent came the highest responses (over 70%) related to medium-risk of assault to supporters. As relates to physical assault to supporters, over half of the respondents from Community Living Stratford & Area and Community Living Prince Edward identified with people who engaged in low-risk; over half of the respondents from Community Living Chatham-Kent, Community Living Kingston & District, Community Living St. Marys & Area, Community Living Stratford & Area and Community Living Prince Edward with medium-risk; and over half of the respondents from Community Living St. Marys & Area and Community Living Kingston & District with high risk of physical assault to supporters. With respect to self-injurious behaviour on the other hand, over half the participants from Community Living Kingston & District and Community Living Chatham-Kent reported medium risk while over half of participants from Community Living Stratford & Area and Community Living Kingston & District reported high risks.

Participants from Community Living Kingston & District seemed to be at more risk as they were the only participants who were exposed to both medium and high risks of physical assault and the people they support engaged in both medium to high risks of self-injurious behaviours.

Part B. Survey Results of Participants Knowledge, Skills and Practices Before and After CCS Training

Preliminary Analysis

To investigate whether reliable scale scores can be computed for sections of the questionnaire, the internal consistency indices (Cronbach's alpha) were computed for each set of questions. The values of Cronbach's alpha greater or equal to .70 indicate reliable scales. The results of these analyses, presented in Table 2, suggest that reliable total scores can be computed for most sections of the survey.

The section on assault and vulnerability (questions 13 to 16 in pre-training survey and questions 10 to 14 in post-training survey) could not be analyzed for Community Living Chatham-Kent, Community Living Stratford & Area, Ongwanada and Community Living St. Marys & Area samples, as these questions had errors in the survey design in SurveyMonkey for post-training survey and as such, the data could not be extracted. Therefore, these questions were analyzed only from the Community Living Kingston & District and Community Living Prince Edward samples.

Table 2. Internal Consistency Index for Sections of the Survey

Survey	Section	Question	Number of items	Cronbach's alpha
Pre	Agitation, anger and aggression	8	8	.83
	Best practices	9	10	.91
	Confidence	12	8	.91
	Verbal and behavioral	18	5	.88
	Behaviour Support Plan	20	11	.96
Post	Agitation, anger and aggression (retrospective pre-training)	2	8	.87
	Agitation, anger and aggression	3	8	.85
	Best practices (retrospective pre-training)	4	10	.90
	Best practices	5	10	.94
	Confidence (retrospective pre-training)	8	8	.93
	Confidence	9	8	.90
	Verbal and behavioral (retrospective pre-training)	17	5	.97
	Verbal and behavioral	18	5	.99
	Behaviour Support Plan	20	11	.98
	Improvement	21	9	.93
	Abilities (retrospective pre-training)	22	10	.98
	Abilities	23	10	.99

The total scores for each scale were computed by taking an average across all items in the scale. The distributions of total scores were examined and found to be skewed for most scale scores. Therefore, main analyses were performed with bootstrapping to produce robust estimates that are not sensitive to the violation of the normality assumption. All analyses were performed with SPSS software.

Main analyses:

To investigate whether the average scores on the scales computed in the preliminary analyses have changed as a result of the CCS training, a series of one-sample t-tests were conducted. The means of the scale scores from the pre-training questionnaire were used as reference points in one-sample t-tests. The descriptive statistics for each scale, as well as the results of the t-tests for each of the six agencies are presented in Table 3.

As can be seen from Table 3, the scores on the agitation, anger and aggression scale significantly increased after the training across five agencies (except Community Living Chatham-Kent), indicating that the respondents felt more confident and able to support the needs of the people they support related to these emotional states. Similarly, in all six locations the respondents indicated that after the training they were more able to implement best practices to support the special needs of people they served. The confidence level and the verbal and behavioral scale scores of the training participants significantly increased as a result of the training in five agencies (except Community Living Kingston & District). However, their agreement with the statements related to the Behavior Support Plan did not change significantly in any of the six agencies.

Overall, across the six locations, though, the scores on all five scales reported in Table 3, have increased significantly. However, the increase in the Behavior Support Plan scores was marginal.

Table 3. Scale Scores Before and After the CCS Training

	Scale	**N**	**Pre**		**Post**		**T**	**p-value**
			Mean	***SD***	***Mean***	***SD***		
Kingston	Agitation, anger and aggression		3.23	0.32	3.50	0.37	2.64	.032
	Best practices		2.27	0.37	2.77	0.55	3.27	.039
	Confidence		3.43	0.68	3.91	0.77	2.25	.060
	Verbal and behavioral		2.73	0.51	3.09	0.67	1.80	.112
	Behaviour Support Plan		2.23	0.55	2.72	0.69	2.47	.052
Ongwanada	Agitation, anger and aggression		3.10	0.46	3.41	0.43	2.45	.032
	Best practices		2.35	0.49	3.04	0.50	4.80	.001
	Confidence		3.57	0.67	4.17	0.62	3.37	.013
	Verbal and behavioral		2.82	0.40	3.33	0.54	3.28	.029

	Scale	N	Pre		Post		T	p-value
			Mean	*SD*	*Mean*	*SD*		
	Behaviour Support Plan		2.37	0.54	2.68	0.68	1.57	.155
St. Marys	Agitation, anger and aggression		2.94	0.48	3.45	0.41	5.43	.002
	Best practices		2.13	0.70	3.04	0.65	6.07	.001
	Confidence		3.06	0.78	4.33	0.54	10.18	.001
	Verbal and behavioral		2.63	0.47	3.56	0.49	8.21	.002
	Behaviour Support Plan		2.10	0.80	2.56	0.90	2.24	.054
Stratford	Agitation, anger and aggression		3.15	0.33	3.62	0.25	7.97	.001
	Best practices		2.64	0.67	3.22	0.50	4.76	.001
	Confidence		3.51	0.84	4.13	0.46	5.52	.002
	Verbal and behavioral		2.87	0.73	3.40	.48	3.96	.008
	Behaviour Support Plan		2.68	0.83	2.49	0.66	-1.11	.275
Prince Edward	Agitation, anger and aggression		2.93	0.71	3.38	0.50	4.44	.001
	Best practices		2.32	0.75	3.16	0.64	5.57	.002
	Confidence		3.09	1.06	3.99	0.97	3.95	.001
	Verbal and behavioral		2.17	0.88	4.17	1.15	7.36	.001

	Scale	N	Pre		Post		T	p-value
			Mean	***SD***	***Mean***	***SD***		
	Behaviour Support Plan		2.00	0.95	2.12	1.27	0.42	.679
Chatham-Kent	Agitation, anger and aggression		3.23	0.38	3.40	0.49	1.77	.129
	Best practices		2.39	0.40	3.03	0.79	3.68	.005
	Confidence		3.64	0.64	4.30	0.72	4.19	.003
	Verbal and behavioral		2.99	0.67	4.38	1.13	5.65	.002
	Behaviour Support Plan		2.86	0.71	2.69	0.90	-0.81	.446
All locations	Agitation, anger and aggression		3.06	0.51	3.45	0.43	9.59	.001
	Best practices		2.29	0.60	3.05	0.63	12.12	.001
	Confidence		3.40	0.80	4.16	0.70	10.76	.001
	Verbal and behavioral		2.57	0.78	4.18	0.91	17.57	.001
	Behaviour Support Plan		2.34	0.76	2.53	0.91	2.03	.047

In the post-training survey, the respondents were asked questions retrospectively about their pre-training perceptions and also about their post-training perceptions. These scores were compared using the paired-samples t-tests. The results are presented in Table 4. As can be seen from this table, the participants' ratings were significantly higher for agitation, anger and aggression, best practices, confidence and abilities scales within each of the six locations and for the entire sample. The average scores for the verbal and behavioral scale have increased significantly within four of the six locations (except Community Living Kingston & District and Community Living Chatham-Kent) and across the six locations together. Again, this indicates that the respondents felt more confident and able to support the needs of the people they support related to these emotional states and that after the training, respondents were more able to implement best practices to support the special needs of people they served.

Table 4. Scale Scores Before and After the CCS Training

	Scale	Post (retrospective about pre-training)		Post		*T*	*p*-value
		Mean	***SD***	***Mean***	***SD***		
Kingston	Agitation, anger and aggression	2.94	0.32	3.46	0.38	-6.15	.001
	Best practices	1.89	.39	2.69	0.56	-5.30	.001
	Confidence	3.19	0.46	3.90	0.78	-3.34	.012
	Verbal and behavioral	2.95	0.37	3.10	0.67	-0.71	.481
	Abilities	3.41	0.76	3.97	0.53	-3.05	.034
Ongwanada	Agitation, anger and aggression	2.85	0.50	3.40	0.43	-5.10	.004
	Best practices	2.00	0.54	3.03	0.50	-7.80	.001
	Confidence	3.27	0.73	4.17	0.62	-5.28	.001
	Verbal and behavioral	2.75	0.68	3.33	0.54	-4.29	.004
	Abilities	3.67	0.82	4.29	0.59	-3.12	.022
St. Marys	Agitation, anger and aggression	2.78	0.49	3.45	0.41	-5.83	.001
	Best practices	2.01	0.45	3.04	0.65	-7.97	.001
	Confidence	3.03	0.83	4.32	0.54	-8.08	.001
	Verbal and behavioral	2.71	0.65	3.56	0.49	-5.32	.001
	Abilities	3.00	0.79	4.24	0.78	-6.05	.001
Stratford	Agitation, anger and aggression	2.91	0.42	3.64	0.25	-7.20	.001
	Best practices	2.27	0.49	3.26	0.50	-7.69	.001

	Scale	Post (retrospective about pre-training)		Post		*T*	*p*-value
		Mean	***SD***	***Mean***	***SD***		
	Confidence	3.20	0.60	4.13	0.48	-7.32	.001
	Verbal and behavioral	2.86	0.55	3.42	0.48	-5.27	.003
	Abilities	3.62	0.79	4.29	0.50	-5.82	.001
Prince Edward	Agitation, anger and aggression	2.58	0.70	3.45	0.51	-4.79	.001
	Best practices	1.81	0.51	3.16	0.64	-7.08	.001
	Confidence	2.84	1.25	3.99	0.97	-5.03	.001
	Verbal and behavioral	2.28	1.22	2.84	1.37	-3.35	.013
	Abilities	2.58	1.36	3.58	1.43	-3.93	.005
Chatham-Kent	Agitation, anger and aggression	2.68	0.53	3.36	0.48	-6.85	.001
	Best practices	1.81	0.53	3.01	0.81	-9.03	.001
	Confidence	3.21	0.74	4.27	0.73	-7.77	.001
	Verbal and behavioral	2.66	0.75	3.15	1.16	-2.27	.096
	Abilities	3.42	0.95	4.11	1.13	-5.02	.001
All locations	Agitation, anger and aggression	2.77	0.52	3.46	0.43	-13.30	.001
	Best practices	1.96	0.51	3.05	0.64	-17.63	.001
	Confidence	3.11	0.83	4.15	0.71	-14.41	.001
	Verbal and behavioral	2.68	0.79	3.24	0.91	-7.68	.001
	Abilities	3.24	1.01	4.07	0.96	-10.3	.001

Finally, responses in four areas related to feeling vulnerable and being satisfied with physical safety and emotional well-being were compared using the paired-samples t-test. The results of these analyses varied across the six locations as shown on Table 5.

The participants from Community Living Kingston & District had significantly higher satisfaction with their physical safety and emotional well-being after the training, but their average scores on the other two items had not changed compared to the pre-training scores. The participants from Ongwanada had higher satisfaction only with their sense of physical safety after the training, while the participants from Community Living Stratford & Area reported only better emotional well-being after the training. For the participants from Community Living St. Marys & Area, significant changes were observed for all four items: they felt less vulnerable both physically and emotionally, and felt better physical safety and emotional well-being. The participants from Community Living Chatham-Kent felt less physically vulnerable, but the rest of the scores did not change in this sample. The participants from Community Living Prince Edward felt physically and emotionally vulnerable with a significant improvement in their emotional wellbeing.

On average across all six locations, though, the scores on all four scales have changed significantly. Specifically, the participants felt less physically and emotionally vulnerable and their physical safety and emotional wellbeing improved.

Table 5. Item Scores Before and After the CCS Training

	Item	**Pre**		**Post**		**T**	**p-value**
		Mean	***SD***	***Mean***	***SD***		
Kingston	Feeling physically vulnerable	3.14	1.13	2.77	1.42	-0.94	.366
	Feeling emotionally vulnerable	2.95	1.17	2.62	1.26	-0.96	.358
	Satisfaction with physical safety	3.50	1.01	4.18	0.75	3.01	.013
	Emotional wellbeing	3.32	0.95	4.09	0.83	3.08	.022
Ongwanada	Feeling physically vulnerable	2.43	0.66	2.50	1.00	0.24	.843
	Feeling emotionally vulnerable	2.35	0.83	2.55	0.69	0.94	.349
	Satisfaction with physical safety	3.43	0.95	4.08	0.67	3.39	.009
	Emotional wellbeing	3.43	1.20	3.83	1.12	1.25	.236
St. Marys	Feeling physically vulnerable	3.16	1.17	2.32	1.11	-3.32	.014
	Feeling emotionally vulnerable	3.11	0.94	2.56	0.98	-2.39	.037
	Satisfaction with physical safety	3.16	1.21	3.95	0.97	3.58	.002

	Item	Pre		Post		T	p-value
		Mean	***SD***	***Mean***	***SD***		
	Emotional wellbeing	3.05	1.18	4.11	0.81	5.68	.001
Stratford	Feeling physically vulnerable	2.55	0.86	2.24	0.90	-1.44	.219
	Feeling emotionally vulnerable	2.55	0.91	2.35	0.70	-1.16	.264
	Satisfaction with physical safety	4.23	0.61	4.35	0.61	0.84	.425
	Emotional wellbeing	3.64	0.58	4.29	0.47	5.74	.001
Prince Edward	Feeling physically vulnerable	2.63	1.31	1.93	0.62	-4.26	.001
	Feeling emotionally vulnerable	2.83	1.24	2.31	0.86	-2.20	.044
	Satisfaction with physical safety	3.38	1.10	4.17	1.15	0.79	.073
	Emotional wellbeing	2.88	1.04	4.17	1.20	4.55	.008
Chatham-Kent	Feeling physically vulnerable	2.67	0.77	1.95	0.74	-4.44	.001
	Feeling emotionally vulnerable	2.50	0.71	2.10	0.89	-2.09	.050
	Satisfaction with physical safety	3.83	0.62	4.43	1.12	2.45	.143
	Emotional wellbeing	3.61	0.98	4.33	1.16	2.87	.057
All locations	Feeling physically vulnerable	2.75	1.04	2.25	1.00	-4.93	.001
	Feeling emotionally vulnerable	2.71	1.01	2.39	0.91	-3.43	.004
	Satisfaction with physical safety	3.59	0.99	4.20	0.93	6.54	.001
	Emotional wellbeing	3.31	1.03	4.16	0.96	8.80	.001

These survey results have shown significant positive changes in participants' knowledge and skills as a result of the CCS program. These significant changes have overall positive implications for supporters in preventing and de-escalating challenging behaviours in the individuals they support who have an intellectual disability in all six agencies.

Questions about the frequency of verbal and physical abuse before and after the training could be addressed only with the Community Living Kingston & District and Community Living Prince Edward samples as the error in the survey design did not allow for collection of the data for these questions across the other four locations. However, only 22 respondents had valid responses to the questions about physical abuse and only 18 respondents had valid data for physical abuse across these two locations. Therefore, significance testing could not be performed to investigate whether the frequency of verbal and physical abuse has changed after the training. However, descriptively, it can be seen that for majority of respondents (19/22) the frequency of verbal abuse did not change. Similarly, for 67% of respondents the frequency of physical abuse did not change, but it had reduced for the other 33%. With the constraint from the design of the questions pertaining to verbal and physical assault scales in the other four locations, these results would probably have been different if an analysis was done on all six agencies.
Fortunately, the more in-depth data from focused group interviews shed more light on the positive accounts of reduction in challenging behaviour from majority of the respondents in all six agencies (see details in Section C).

Part C. Findings and Discussion by Research Questions, Conclusions and Recommendations

This section of the report combines the key findings from the survey results together with key evidence from focus group interviews and statements from participants' written description of their professional and personal learning outcomes. These statements are representative of comments from participants who participated in the demonstration project.

Three (RQ1, RQ2, and RQ4) of the following four research questions guiding this study are answered in this section of the report.

Research Questions (RQ):

1. Is there a decrease in the amount of physical expressions of agitation, anger and aggression (AAA) or other concerns because of CCS interventions?
2. Is there an increase in quality of life because of CCS interventions?
3. Is there decrease in the amount of days off of work/recovery time for staff because of Conscious Care and Support Interventions?[3]
4. Is there an increase in job satisfaction, job performance, safety, perceived emotional security and overall quality of life because of CCS interventions?

Research Question 1: Is there a decrease in the amount of physical expressions of agitation, anger and aggression (AAA) or other concerns because of CCS interventions?

Evidence from the surveys and focus groups show that there is a decrease in the amount of physical expressions of agitation, anger and aggression as a result of CCS interventions. The scores on the agitation, anger and aggression scales of the survey significantly increased after the training across five agencies (except Community Living Chatham-Kent), indicating that the respondents felt more confident and able to support the needs of the people they support in order to decrease agitation, anger and aggression. In support of this evidence, five agencies (except Community Living Chatham-Kent) in the focus groups indicated a decrease in actual assaults for the people they support.

[3] This variable of investigation was omitted at this stage as the length and structure of the demonstration project could not accurately assess this evaluation.

Participants of the survey were more aware and able to identify the special support needs of the people they support that contributed to their anger, agitation and aggression. In accordance, participants in one agency noted the decrease in AAA as follows:

> *"I previously did [name] and his home when I was first hired with the agency and we had had our fair share of physical aggressive incidents and I actually spent some time with [name], I think it was last week. I was going back to what [name] was saying, just being more mindful I didn't feel myself getting anxious around him and in that situation. And he was pretty agitated, there was a few of us in his house. He had been engaging in some head banging behaviour so he was a little more escalated in that situation but just practicing the mindfulness through that kind of time, I would say for me being the biggest thing because I don't do a lot of direct support. But when I do I try to be more mindful of those things."*

A second participant in the same agency added:

> *"I was gonna say some thoughts from reading physical aggression reports show it's [actual assaults] stabilized or have decreased a little bit but there seems to be a big spike in self-injurious behaviour with the head banging and more now. And that's just from what I see, I don't know."*

A third participant in the same agency noted:

> *"I find that I actually got hit physically less. Personally, I used to get hit a lot. And I don't think I've been hit, maybe once or twice since the training. And normally it'll have been at least once, twice a week or a few times."*

Other participants in the same agency went further to explain the CCS interventions implemented to address the triggers associated with the expression of physical assault:

> *"We've seen a decrease… I would like to think the environmental things we've implemented. So I would say the noise cancelling headphones, I would say for sure those have benefitted him."*

> *"I think limiting the [time of] electronics on with his anxiety has definitely decreased. He's not as before."*

One participant clearly associated the decrease in assault to the knowledge supporters garnered from CCS training:

> *"But for [name] I would say she is decreased in that because of our training with Conscious Care"*

In a second agency participants described how the persons supported expressed physical AAA prior to CCS training and the changes that occurred after CCS training following CCS intervention:

> *"I was the only person on [name]'s team who went through the CCS training and when we started this he was just moving out. And in the beginning we had a lot of… he would pull you, take your wrists and drag you to the door because he wants to go out. Or if he knows that if he gets his fingers like if he gets his nails in your hand, you're getting up because that hurts. And that was happening nightly multiple times a night. And it is I'm sure a lot of things it could be because there's more stuff to do at his house and he's more comfortable as well but we've seen those numbers decrease on his team I would say."*

> *"He's [name] is much different in intensity. He'll hold off from targeting people but he'll pick some person and just attack them to like going to…Last summer was much worse than this summer. And I'd say the time has decreased because he would go like from what seemed like for hours (eight hours) and now it's only ten minutes."*

"With us they've definitely decreased until this medical issue came up. It was the doctors, dentists and expert technicians that failed in their communication. But up until that, there was a major decrease… I think the diet getting her sugar levels under control accounts for that."

In yet another agency, participants showed how CCS training is indirectly benefiting other people with challenging behaviour who were not involved in the study by recognizing triggers and addressing them in order to decrease their expression of physical AAA:

"Yeah, we have another individual who's on [name of support location] who has greatly benefited indirectly from the staff having this training because they have started to recognize his triggers more and are giving him what he needs to be able to reduce his anxiety. So for him, even though he wasn't included in the project, he has not had any incidences."

"You're able to see her triggers… Just to add on to that, [name] you're right. I think people are recognizing now whereas before things would have blown up. I think there's been quite a few incidences with [name] that things could have escalated but the team's mindfulness has helped keep it here. As well as their ability to recognize her triggers has helped it to not escalate. So I would say yes there has been a decrease [in assault]."

Another participant in the same agency further described changes in actual numbers of assaults:

"Maybe fifty-five or something like it in a month…five to ten in a week. She was really struggling, she was struggling a lot. So I would say yeah within a month it would be between five and ten times and so that's what we're seeing over the last two months. I think maybe there was one time in those two months."

The team of supporters supporting a primary individual with medium to high risk concurred and associated the changes directly to CCS:

"She hasn't assaulted herself. I don't know if it's based on familiarity of staff is not changing all the time… The threats aren't there. They haven't been there for the last I would say since significantly since Conscious Care she hasn't threatened in that way at all."

Participants in another agency associated the change in behaviour to an increase in their confidence to identify and address the needs of the people they support:

"Well the incident reports have decreased so…They would be considered assault in the years but when he was screaming. So they've drastically decreased…Yes decreased…Maybe it comes back to the self-confidence because there's a couple of people here he had up against the wall and was very frustrated and strong and pulling them down the hall and bruising. So maybe it comes down to the confidence and just knowing what he wants and offering him."

Aligning with the evidence from participants in the agency which showed changes in duration of incidents of assault, team members of a primary individual in another agency expatiated on such changes as follows:

"Well [name] typically engages in a lot of self-injurious behaviour. When he first came that involved him throwing himself on the floor, hitting himself in head and his body, biting himself really bad and he was bleeding. We've noticed that although the amount of incidents haven't decreased hugely the duration of them have decreased quite a bit and the intensity have decreased quite a bit. So now if he bites he very rarely breaks his skin. He's not jumping to the floor hardly at all and his incidences turn to be more like here [reference location], where before it'll be like all over the place."

"And we hypothesized that it was pain triggered. And because the pain has been managed we think that that has helped a great deal. So now I think the self-injuries are more of frustrations and pissed off."

The survey evidence also portrayed that when participants became emotionally hi-jacked they were aware of the psychological triggers that contributed to that mood and the time when their mood, body sensations and thoughts were changing. This was supported by data from focus groups with one participant saying:

"Yes, yes [feeling physically and emotionally safe] because I think we're better equipped to read his triggers and read his…Intervene in earlier stages of his escalation. We notice more…We're catching things much quicker and we're also listening to him. Because before it was like yes ok fine but… and pushing him to the point where he was creating like he was going "come on" you guys. When you are non-verbal you can't say that. So yeah I but…we have to still remind ourselves that we always have to be safe right? That's that fine line right? 'Cause you can get too comfortable and I tend to do that sometimes and I don't mean to but I have to catch myself. And [my co-worker] helps me. And no it's good. It's a good team."

The evidence from surveys also indicated that supporters felt authentically kind and caring and respectful regardless of who they were supporting and regardless of their behaviour at the time. This evidence is corroborated by comments from participants in the focus groups.

The following participants in one agency noted:

"I think for me like another thing that is significant is like learning about post-traumatic stress and trauma especially with the woman that we provide support to because she has had some traumatic events that happened. Once we kind of started talking to the family a little bit more. So understanding and recognizing the triggers signs the symptoms of post-traumatic stress and how to help her throughout that in her everyday living…because she is non-verbal. Sometimes she wakes up and she is just very angry right off the bat so being compassionate showing her you're there, empathic you know that kind of stuff I thought was very useful."

"Just the compassionate approach…letting them know that you're here to listen to them whether they want to talk, cry, you're just there to help them through whatever it is they need. I think it's helped me with a relationship with a lady and like we have a really good report as well as you know like um I just think they're is a more personal connection sometimes now that we are really looking in depth and trying to get to the bottom of a lot of things, help."

In a different agency a participant described how the training caused them to be more understanding and compassionate:

"I think the difference that the training has made to the people that we support is it's helped us as support workers to be more understanding. To be more thoughtful and realize that people don't choose to have difficult days or difficult moments that there's something else going on. So it's helped us to be more understanding and compassionate and to think about how that person must feel."

Another participant from a team in the same agency supporting a medium to high risk individual described an incident where they were able to de-escalate challenging behaviour by being caring and having a conversation with the person supported:

"One morning, there was anxiety that was increasing and increasing and very quickly increasing quicker than I could actually get there. So once I was able to help her sitting down and eating breakfast so just give her a few minutes here to calm down a bit because she's eating. And then I went in and just sat with her and talked to her she's looking at me and I said I understand that this

is what I heard you saying. Why is it so upsetting to you? Why is it causing you so much anxiety? Talk to me. Tell me why. She looked at me like I was out of space. I said no come on talk to me, I said tell me. I said was sitting with her I was really open and she "haa" and started talking and told me what was going on, why she was having this anxiety, why it was upsetting her. I offered a suggestion on how to help and she said yes. I said okay I would go and do that for you right now I'll be right back. And as I walked away, she said thank you for listening right. I've always taken that as she saying her thank you for listening, right? That's not what she means she stands there looking at me she means thank you for listening to me. And I said you're very welcome and I will always listen to you and she just "haa." Like this and I went and did what I said I would do. I came back with all the information she was looking for and our day was wonderful for the rest of the day which normally, that would have turned very bad really quickly into the banging, the hitting, everything and not really knowing why."

As the evidence has shown, participants in this study were aware of their psychological triggers that contributed to their mood change when they felt emotionally hi-jacked. Additionally, they were aware and able to identify special support needs of the people they support that contributed to their agitation, anger and aggression. Finally CCS interventions were shown to decrease such expressions of physical agitation, anger and aggression.

Research Question 2: Is there an increase in quality of life because of CCS interventions?

Based on data from focus groups, yes there is an increase in quality of life of people supported due to CCS interventions. CCS provides strategies and techniques to support the improvement of quality of life for persons with challenging behaviour. A good number of participants identified overall improvement in the quality of life of most of the persons supported in majority of the agencies. The following observable changes in people with challenging behaviours were identified in the focus groups:

a) communicating better and clearer;
b) interacting more with supporters (staff) and people (e.g. strangers in one case) within the community;
c) overall improvement in quality of health (related to changes in nutrition and exercise);
d) sleeping better;
e) walking (going out for walks);
f) being calm, focused and happy; and
g) opening eyes (the case of one person supported) as opposed to walking with closed eyes in the past and bumping unintentionally into staff.

Three of these observable changes in behaviour (illustrating improvement in quality of life for persons supported) with data collected across multiple agencies involved in this study will be discussed further.

a) Communicating Better and Clearer:

One of the participants noted how CCS enabled a medium to high risk individual to communicate better and clearer:

"And so for me it's been really cool. And what I've noticed is I used to ask a lot of questions if he didn't respond I would just continue to ask him questions but then when I give him time to process I found that [name] would respond so in the mornings I'll ask [name] a question. [name] what kind of pants do you want? This time he was sitting on his bed reading his book. Before I would have continually asked him to answer me but three minutes later [name] puts the book down and then grabs two different pair of pants and then makes that decision. And then I realized that he was still processing that but he just needed time. Right now I have my book and then he puts the book

down then he went to the pants. This was a couple of weeks after the course [CCS training] and I was shocked like what you actually heard my question. You just needed the time to process it. So I have found that [name] is communicating lot more clearer and I find less confusion".

A second participant from the same agency added:

"It's also nice to see that we can actually, I see that he communicates better in a way. In my personal experience with him is that he used to always…I couldn't understand him but now I feel that he's actually a little bit better. Yeah, I agree. It's almost like he is more alert. Where before I always felt like I couldn't really understand him."

The reason associated with this change in behaviour as explained by other team members supporting the same medium to high risk individual supported was:

"Us being more calm as well has improved their quality of life because they're not getting as anxious as they were before so it's kind've like were rubbing off on them…Increase in their quality of life…The people have more control over their lives because we're not trying to set it we're trying to understand what they want and put things in place that we see that their wishes are being met."

Other participants in another agency supporting individuals with challenging behaviour corroborated this and went further to explain how those supported were feeding into their confidence hence building the confidence of persons supported:

"I find the individual she's speaking more, she's talking more, she's answering questions more, more social. Asking when you can see the anxiety building and sitting down and say ok tell me about this… I think it's made her more confident in verbalizing like she now has the confidence to as opposed to the banging or the threatening behaviour or the threatening words. So she can sort of see a difference and we don't say to her we're implementing this strategy here's what you do and this is how we're doing it and how do you feel about it? But she recognizes that change and again you can see the change in her and how she's building up her confidence off of our confidence."

As seen in the quote below, supporters took it a level higher to actually engage in teaching people who were non-verbal how to use sign language to improve on their communication, thereby, decreasing anxiety associated with the inability to express themselves:

"*We've been working with [name] to teach him some new sign language some new ways to communicate so he doesn't have to bite he doesn't have to always say: "break" but he's got a new toolbox to use to be able to tell us how he's feeling. And I think even the you know we were doing a very BSP driven way of doing it where we would say he'd have to do it 10 times or say if it were a chip, he'd have to sign chip and we'd give him a chip where even that we're starting to look at that a little bit differently that he's maybe learning better in a natural way. So we're teaching him emotions instead of making him sign them. I'm happy…oh [name], I'm happy today then you sign happy in the moment. So he's learning how to use it as he would need to not sitting across the table. I mean I'm not saying but I think just we've grown to understand that [name] learns in a different way as well and he is very smart. He's not a child so doing some of these things I think we've taken a different look at and a different approach that we need to just be more spontaneous and we need to be more in the moment and more natural in the way we're teaching him these things."*

Participants in two different agencies identified the ability of people with challenging behaviour to communicate as follows:

> *"Well he does communicate more for example today like [supporter name] right away, she recognized that he was struggling in the room he was in so [supporter name] like brought him to a different room and he ended up having break in my room and he was content. He didn't swear, he had two bottles of water…well one and a half and then but I mean he had a great break there was no profanity. He was interacting with the other people…a lady came up and rubbed his head and that you know he liked it and then it was fine. But he is communicating better, yes he still has his outbursts but he's communicating better."*

> *"I find the individual she's speaking more, she's talking more, she's answering questions more, more social. Asking when you can see the anxiety building and sitting down and say ok tell me about this… I think it's made her more confident in verbalizing like she now has the confidence to as opposed to the banging or the threatening behaviour or the threatening words. So she can sort of see a difference and we don't say to her we're implementing this strategy here's what you do and this is how we're doing it and how do you feel about it? But she recognizes that change and again you can see the change in her and how she's building up her confidence off of our confidence."*

When these individuals with challenging behaviour are communicating better, they can easily convey information to their supporters about their needs which if not known by supporters can be left unaddressed and in most cases lead to anxiety. However, better and clearer communication as seen in these quotes facilitates supporters' work and improves the quality of life of people supported.

b) Socially Interactive:

Based on the knowledge garnered from CCS training, participants were able to help to improve the quality of life of a medium to high risk individual as noted in the following quotes:

> *"With what [name] just said about getting the equipment and stuff by bringing that equipment into his room and him getting to use that he's now also allowing more stuff into his room. He had prior to us doing this training his room was basically a table and a chair like he didn't want anything in his room. He is now allowing cards lite-brights, puzzles, people. People is a big one so that's all been a major improvement on his quality of life."*

Another participant from the same team supporting the same individual with medium to high risk concurred by saying:

> *"I find that the quality of his life has improved, like he's interacting more with social activities… and initiating them…Yea, before he never used to do that…He was somebody that we thought you know this is gonna be the way he's going to be for the rest of his life but then it's like wow he's a different person…Because how many different things did we try with the same end result, until this [CCS] came along."*

Taking it to another level, participants in another agency added that as a result of CCS training [not explicit in quote] another person with medium to high risk supported by their team is going out of her way to interact with others:

> *"I just want to say that I noticed another change because she's opening up and that is her giving. She is far more open to she's talking about inviting people to go to the parade. Wanting to go out for supper with individuals. She's being more social with a wider range of people and that is very good to see. I think the more she gives, the more that it will benefit her. We've been trying to implement her making something to go to she goes out to dinner every week. And she never used to bring anything. So for her to make something from her own time and to take it there is*

very giving and I think that has really opened her up into letting other people into her life and asking for people to go to different places with her to dinner. She even mentioned she wanted [name] to go to the fair with her next year. She's talking more, she's open like that where she wants people into her life into her circle. Even with her food she's wanting to share that a lot more and that's huge. It is huge and I noticed it increasing and increasing."

"We have a Facebook page that one of our co-workers keeps current and the amount of outings and right away mom likes. She's watching and she's seeing exactly how active [name] is in his own community with a variety of people and also [name] has established friendships with peers throughout the agency which is very exciting. Because when he first came we weren't sure. He seemed rather anti-social which isn't the case at all. He's an amazing person and with the right situation and the right people he's extremely happy and extremely social and wants to interact. He loves going to [day support program] and he's established a friendship actually with someone [name of supporter] used to support; [name of friend]. They both love swimming and they [name of friend] is more verbal than [name] but not a whole lot. But they have a connection which they saw each other at the pool this week-end. [Name of friend] was like just thrilled."

c) Overall Improvement in Quality of Health (related to changes in nutrition and exercise):

Focus group data show overall improvement in the quality of health influenced in part by changes in nutrition, visits to experts and introduction of exercise in the routines of people supported with challenging behaviours due to CCS interventions.

With respect to nutrition, participants in the following quotes identified changes in diet which have resulted in better bowel movements:

"He, we went from using a suppository every day to every other day. And prior to the changes in food, we did not see results on the days he did not receive the suppository. Once we like I said we've slowly introduced these things, on two occasions out of a month, he has gone on his own without the suppository. It is an improvement. It's only twice but it is an improvement."

The next participant described concrete evidence of changes in behaviour as a result of changes in nutrition following exposure to expert advice:

"[Name], because of Conscious Care now sees a naturopath and our first couple of visits she had some pretty big concerns, one being some pretty severe sensitivities to foods that we might not have thought about; tomatoes being one of them. Also he needed a liver detox and a few things that were rating pretty high so he was on some stuff for those things and I think I've noticed. I did notice so we went to the naturopath and he had dinner and put ketchup all over it and right after that, he had severe anxiety. So that was before we implemented it and right after we found out that ok I'm seeing this, this is real… I see a difference when he eats them. That's all I can say for sure… I know he hasn't complained or asked to vomit in the toilet like he had been before so that's something that we see that's concrete, which is good."

A participant in another agency connected changes in nutrition to ability to exercise as follows:

"With [name] we cut out a lot of the sugars the cow's milk doing the gluten free, more whole wheat stuff too…"In the beginning it seemed his behaviours were decreased and stuff but and I don't find that he's yelling that he wants bread as much as he was before…"but he has lost the weight, it helps him to do the grounding exercises and so you know it's kind of all related."

Another participant concurred:

"The gastrointestinal. We've taken him to a naturopath. He's on a probiotic now and he's done those. Alot of testing to see what's going on with his gut. [Name] was very clear about how gut health is very high with autistic individuals and that's where a lot of the problems stem from so

we're really focusing on that through his family doctor as well as the naturopath. And he gets out twice a day most days for physical exercise whether it's for a walk or whether we go into groceries or go out and do a fair or a festival which is really huge because there was a stretch there were he wasn't…days on end where he wouldn't go anywhere. Yeah. He wouldn't leave the house…When he first came he wasn't going out at all and it was a struggle to get him out once or twice a week. And now he's going out generally speaking like twice a day so that's a huge change."

The changes in nutrition and ability to exercise resulted in overall improvement in health as seen in a participants' comment below:

"More energy. Not so sluggish. Not eating fast food…We were at the doctor's office and she had never seen [name] have perfect blood sugars and her average three month was 6.2 she was like we've never seen that. So that says a lot about changes…Healthier changes. She just had her medical report so a lot of good changes."

Prior to CCS training, the medium to high risk individuals exhibited challenging behaviours which were seen as impediments to them living better lives. As a result of CCS training, supporters were able to support these individuals to improve their quality of life. If CCS can make such a difference in the lives of most of the medium to high risk individuals, it is possible that with appropriate sharing of information garnered from the training, CCS could make a difference in the lives of all individuals with challenging behaviours in Ontario.

Research Question 4:	**Is there an increase in job satisfaction, job performance, safety, perceived emotional security and overall quality of life because of CCS interventions?**

The evidence from survey and focus groups indicate that there is an increase in job satisfaction, job performance, safety and perceived emotional security because of CCS interventions.

Safety and Perceived Emotional Security:

Evidence from both survey and focus group data indicate an increase in safety and perceived emotional security for supporters who participated in the study.

The participants from Community Living Kingston & District had significantly higher satisfaction with their physical safety and emotional well-being after the training, but their average scores on the other three items had not changed compared to the pre-training scores. Evidence from focus group aligned with survey findings. Participants noted that:

"I previously did [name] and his home when I was first hired with the agency and we had had our fair share of physical aggressive incidents and I actually spent some time with [name], I think it was last week. I was going back to what [name] was saying, just being more mindful I didn't feel myself getting anxious around him and in that situation. And he was pretty agitated, there was a few of us in his house. He had been engaging in some head banging behaviour so he was a little more escalated in that situation but just practicing the mindfulness through that kind of time, I would say for me being the biggest thing 'cause I don't do a lot of direct support. But when I do I try to be more mindful of those things."

"For me, I used to do a lot of mental preparation before I'd go in. I'd spend like twenty minutes in my car praying before I go in because I was usually so anxious and so nervous before I go in 'cause I'm gonna get hit today, I'm gonna get punched and I'm gonna get beat up. And I am being honest, I'd be in my car and I'd be like be calm. Most of the staff used to do that. You'd see them

in their car mentally and if you asked the staff they'd say they spent time mentally preparing themselves to go in. For me, that is something that has totally reduced. I get to a shift and I don't need to spend ten minutes in my car. I can just walk in and just be there and be present whereas after this course [CCS training] I think it's reduced my personal anxiety walking in. I'm less like oh I'm gonna get hit. And with that I actually did get hit a lot. The opening thing and it has to do with my own mindset change."

The Community Living Stratford & Area participants reported only better emotional well-being after the training. However, focus group data showed evidence of a sense of improvement of physical safety as opposed to emotional well-being. On physical safety, one of the participants noted that:

"I think it's helped a lot with preventative stuff. So I feel more safe with I don't think [name] is going to escalate as much as I did before. So I think that he is more in control of himself which has helped me to feel safe…I think he's feeling better physically too. I think he struggled with these headaches and he struggled with his stomach. He was fatigued probably because he felt crappy all the time so I think in us helping him to get to a better place physically I think it's given him some energy back and he just seems lighter. I don't know like he does. He seems happier. ..Yeah I feel a lot more confident with the knowledge I've learned therefore I feel safer."

Another participant from a different agency went further to explain how both support staff and the people they support felt safer due to CCS interventions:

"I think that though we feel safe but I also think that the person that we support also feels safer too. Well I know speaking from my little…we are open with what we're doing and keep him involved with all the steps too. And I think I can feel a little bit more confidence in him too that he's confident and people that are supporting him are there for him and can help him through whatever's going on... Well [name] talked about it earlier too about how people are recognizing better that people are going from 0 to 100 while a lot of times they are sitting at a little more higher level. I think we've got collectively more strategies to implement earlier as preventative and early supports so not looking not waiting till you've really seen things happening the more subtle things the more subtle stuff. We've got more tools now to provide support earlier."

For participants from Community Living St. Marys & Area, significant changes were observed for all four items: they felt less vulnerable both physically and emotionally, and felt better physical safety and emotional well-being. This evidence aligned well with evidence from focus groups.

On emotional well-being, one participant noted that:

"I think for emotional well-being you're able to separate what's happening isn't because of me, isn't directed at me it's just happening because something else is happening most of the time. So you don't feel upset or frustrated that oh they don't like me or something like that because there's other factors that are playing into somebody's outburst or their frustration."

A second participant added a change in their way of thinking which has helped in improving their emotional well-being:

"Sometimes I think I've changed the way that I think about it because sometimes people have high agitation or anxious or whatever. So if you walk in thinking oh my gosh they might bite me. I've changed the way that I think about that you know like hey how is it going? Because they tell you about the importance of touch, stimulating the cerebellum and all of that stuff. So you try that first if things are rocky you go sit somewhere else. But you've got to walk in with the approach that everything's gonna be ok. And I think I've tried to change the way that I to do it like that. And I think that's helped to reduce my stress anyway."

On physical safety, one of the participants indicated that:

> *"I personally feel safer walking with [name] like the one day I told her. She likes to hold your hand sometimes when she goes for a walk so I told her no I'm not holding your hand. The last time I held your hand you attacked me. Normally that wouldn't go well but she was like: "alright." I just feel like, I don't know safer."*

The participants from Ongwanada had higher satisfaction only with their sense of physical safety after the training. This was strongly corroborated with evidence from focus groups.

One participant simply noted:

> *"I feel safe working with him."*

Another participant added:

> *"It wasn't like he was aggressive but to him he was a big guy anyway right? But it sort of like maybe he wanted just to talk. He wanted to get in your space. He wanted to like [name of supporter] was saying, he reaches out to grab your hand and if you don't know that he just wants to grab your hand, then of course you would pull back or something like that right? But like [name of supporter] said he was very unpredictable so we not knowing him, him not knowing us, we not knowing what's triggering this kind of made you feel like oh ok, what is he doing? He's getting really close, he's yelling right here."*

A third participant identified CCS training as accounting for the change in behaviour and the result of supporters feeling safe. The participant said:

> *"He was threatening before. I mean when you see reports before, he was perceived to be threatening and more threatening, so the questions is was he more threatening prior to this training, have things changed?...Yeah because probably because we've changed too. Because we know now that that's why he's upset, so you can put a reason to why he is upset and be accepting of it…We approach things in different ways than what we did."*

In Community Living Prince Edward and Community Living Chatham-Kent locations the participants felt less physically vulnerable, but the rest of the scores did not change in this sample. Focus group data did not completely align with this as there were indications of decrease in physical vulnerability but also improvement in physical safety and emotional well-being.

One participant noted:

> *"I know for myself, I work at another location as well and there's one female you kinda get to know her signs so you know when to leave the room, like she's in an apartment by herself…um…she starts getting really repetitive and then you can see her eyes just start to go really big so you know you have to exit the room or she's going to target you, you're just kind of taking yourself out of the situation… I feel safer like you just give her a moment to calm you just set a timer for her, let her calm and then you can go into the room and speak with her and she's usually calm by then."*

Another participant added:

> *"I feel safer in a sense that I am catching behaviours almost before they start or at the very beginning. You know especially being in a vehicle with someone in close quarters …so I would say definitely in those type of situations. Yeah."*

A third participant concurred:

> *"Yeah so when I first started there'll be that wonder of what her day would look like. What's today gonna look like? Upon coming back from participating in Conscious Care, prior to being at the location, I had the mindset trying to implement the strategies going forward and being approached in a different way when arriving at the home. It was a difference…it wasn't what does today look like? I don't have that any more it's been positive greetings…"*

Emotionally speaking, a participant said:

> *"There is a better connection with all the staff. He's got a better emotionally connection with everybody because he pushed everybody away before and now he's accepting us….so it's more positive, just generally day to day it's more positive… because you can talk to him, before it was always no, no, no, now he'll actually look at you and he'll talk to you."*

Job Satisfaction and Job Performance:

Participants in the focus group provided positive responses to a question about how CCS has influenced their job satisfaction and job performance. Though not very explicit in the quotes below, the respondents indicated satisfaction with their job and success with their performance.

Participants working with a medium to high risk individual explained how CCS strategies have helped them to do their job better:

> *"I also think from a supporting a staff point of view it's been very helpful because you know within our agency our house has a tendency to be looked upon with fear because we're the treatment house. We have specialized walls and specialized windows and specialized med logs. And when we are training people there's an inherent fear as well because with [name] we wear bite jackets and bite sleeves. So I think that for the agency to be able to look at it differently, to look at [name] differently and his house differently and for staff who are coming in wearing the bite jackets, for them to have that mindfulness aspect and to be able to decrease their fear and their feelings of not being safe has really helped them and my ability to support him as well."*

Another participant from a different agency described how CCS was implemented at the workplace, the excitement and how they moved to sharing the information with family:

> *"I think increase in the meditation and the calming yourself you know what you take into your home. We had an opportunity to share it with all of the support workers at [name of support location] and we've implemented before our team meeting, we do a mindfulness exercise and you know I was very excited to take it home and share some of the information with my family and you know just giving hints about you know there were different sections different pages that I would mark and I would want my daughter to read this or my husband to see this I want you know just because it was so very good 'a-ha' moments, really."*

Two participants in the same agency noted how CCS has changed staff approach:

> *"It makes a difference how you respond to people at work whether it's with coworkers or with other individuals or high stress situations it don't matter. I just find myself, the way I respond to it is different than the way somebody else would respond to it."*

> *"I go in and I'm always bubbly to the ladies and put on some music and that's kind of how I start our shift every time…and it's just I think people are maybe more receptive and it's a good tone to start the shift with…and everybody's having a good time and I mean we've had so many new staff*

there too right…they're trying to get to know us so we're cohesive it's not newbies versus the oldies it's you know, so it's nice."

Finally, participants working in a team supporting a medium to high risk individual expressed their feeling of accomplishment and less stress after implementing CCS interventions and seeing the changes in those people they supported with challenging behaviours:

"I feel more accomplished."

"It's not as stressful."

With these feelings of accomplishment, comes the desire to want to share amongst colleagues as noted by the following participants:

"Successes are shared."

"I find I get a lot more, hey he did this today isn't that awesome [these stories are shared through] conversations, the communication book and phone calls."

"He was somebody that we thought you know this is gonna be the way he's going to be for the rest of his life but then it's like wow he's a different person…Because how many different things did we try with the same end result, until this [CCS] came along…Just like him initiating the walk the next day pretty much everybody knew…"

Overall, focus groups have shown an increase in job satisfaction, job performance, safety, and perceived emotional security due to CCS interventions.

Key Findings

As a result of CCS training, findings of the research study confirmed the following significant changes in individuals with disability and their support workers who participated in the training sessions:

a) Decreased number of assault cases by persons with challenging behaviour.

Most of the participants in five of the six agencies indicated a decrease in the number of actual assault cases (e.g. flipping chairs, hitting people, aggressing towards etc.) by the persons they support.

Amongst other things, the following were associated with the decrease in actual assaults:

i. Supporters' implementation of techniques to limit environmental toxins (e.g. limiting use of electronic devices);
ii. Medication for mental health (e.g. a medical prescription to manage bi-polar disorder);
iii. Dietary changes for the person supported (e.g. lowering the amount of sugar intake);
iv. Supporters recognizing triggers more easily and faster and giving persons supported what they need in order to reduce their anxiety; and
v. Increased self-confidence for supporters in meeting the needs of people with challenging behaviour.

b) Participants learned a lot of things that were not taught in school (college) or not offered in other professional training sessions (e.g. mindfulness, how the brain and stomach interact differently, electromagnetic fields, etc.).

Mindfulness has been shown in this study to help supporters to:

i. Be aware of themselves and the moment, calm themselves and give persons supported the time to process information in order to limit aggressive behaviour;
ii. Change their perspective and the way in which they respond to a situation as opposed to changing the situation in order to give persons supported a better opportunity for a better life;
iii. Have a compassionate approach letting persons supported know they can feel free to talk or cry; and
iv. Catch triggers of anxiety and address them before people they support become aggressive or self-abusive.

c) Mindfulness and faulty filters are the most significant benefit of CCS training on the supporters' ability to support people with challenging behaviours.

Survey data revealed that there was remarkable improvement in supporters' states of awareness, emotional competence and emotional self-regulation across all six agencies. This has proven to be essential for effectively de-escalating and managing individuals with challenging behaviours as espoused in focused group interviews.

d) Nutrition (with dietary changes e.g. lowering sugar intake, lowering gluten intake and adding supplements) and exercise (e.g. walking) have significant impact on persons supported.

Most of the primary individuals in each agency have become calmer and more focused since anxiety had decreased following changes in diet.

e) Overall improvement in the quality of life of most of the persons supported.

The following changes in people with challenging behaviours were identified in the focus groups:

i. Communicating better and clearer;
ii. Sleeping better;
iii. Walking (going out for walks);
iv. Being calm, focused and happy;
v. Interacting more with supporters (staff) and people (e.g. strangers in one case) within the community; and
vi. In the case of one supporter, opening their eyes as opposed to walking with closed eyes in the past and bumping unintentionally into staff.

Survey results showed significant enhancement of respondents' levels of confidence and efficacy of participants in supporting individuals with challenging behaviour (see Table 3 and 4) to live better lives.

Conclusions

CCS training has significant influences on people who have autism or other developmental disabilities, as well as their supporters.

Through the strategies and techniques garnered from CCS training, supporters can significantly influence individuals with challenging behaviours through prevention, reduction and management of agitation, anger and aggression to become calmer and focused with overall improvement in their quality of life.

The evidence presented in this report demonstrates highly positive results. Almost all six agencies reported significant improvements in their knowledge, skills and dispositions to effectively de-escalate challenging behaviour and work effectively with individuals with challenging behaviours to improve their quality of life. Most of the participants in five of the six agencies had successful implemented learnings from CCS training and experienced decrease in the number of actual assault cases by the persons they supported.

The research evidence clearly illustrated how CCS training has indirectly benefited an individual with challenging behaviour who was not included in the project as well as those who were not participants of the training. What this tells us is that the training is transferable and can make a greater impact on Ontario in general.

The research provides recommendations for future training, future research and to the Ministry of Community and Social Services.

Recommendations

Training

1. Provide training to everyone working with people with challenging behaviour. If this seems not to be feasible due to financial challenges, get training information to everyone involved in supporting people with challenging behaviours.
2. Create chapter summaries, videos to help participants share information from training with colleagues, parents and community members.
3. Connect stories to techniques on how they can be applied in the various homes.
4. Make timelines about the training clearer from the onset of the training.
5. Cost to be incurred by individuals with challenging behaviour selected to participate in the project should be specified prior to the beginning of the program for better planning.
6. Clarify from onset of training the expectations of the program – a clear plan or directive on how things will be happening.
7. Spread out the 8-hour training session over two or three days to reduce information overload and keep participants focused.
8. Develop a better approach in presenting the information on training from chapter to chapter. One chapter should be followed by evidence then transition to the next chapter.
9. Choose an appropriate time for the training – fall or winter when things are quieter is preferable.
10. Lead consultant should meet all people with challenging behavior involved in the study, not just the primary people.

Research

Focus group and follow-up should be done a bit longer after training (at least six months after training).

Ministry of Community and Social Services

The Ministry of Community and Social Services should change the ODSP plan to include supplements. This will reduce cost incurred by persons supported with challenging behaviour.

Appendix III - Criteria for At-Risk Individuals

Criteria for Designation of Medium At-Risk Individual*

- ❑ No history of use of mechanical restraints
- ❑ Support staff ratio 1 to 1 or less support
- ❑ Average reported behavioural incidents and serious occurrences approximately 4 per month
- ❑ No history of direct services from a Behavioural Consultant (beyond development of the Behaviour Support Plan if applicable)
- ❑ Average use of behavioural PRN medication approximately 4 per month or less
- ❑ No Dual Diagnosis
- ❑ Average use of physical restraint is bimonthly or less
- ❑ Average report of staff injury bimonthly or less
- ❑ Psychotropic medications stable for 3 months
- ❑ Support Team stable for 3 months
- ❑ No use of protective clothing or equipment worn by supported individual
- ❑ No use of protective clothing or equipment worn by supporters
- ❑ Current QAM status full compliance

Criteria for Designation of High At-Risk Individual

- ❑ No history of use of mechanical restraints for 3 months
- ❑ Support Staffing ratio 1-2 staff to 1 person supported
- ❑ Average number of reported behavioural incidents and serious occurrences unlimited.
- ❑ No direct services from a Behavioural Consultant (beyond development of the Behaviour Support Plan) for the past 3 months
- ❑ Use of Behavioural PRN medications unlimited
- ❑ Dual Diagnosis mandatory
- ❑ Use of physical restraints unlimited
- ❑ Reports of staff injury unlimited
- ❑ Psychotropic medications stable for 3 months (must also include use of one or more antipsychotic)
- ❑ Support Team stable for 3 months
- ❑ Possible use of protective clothing or equipment worn by supported individual
- ❑ Possible use of protective clothing or equipment worn by supporters
- ❑ Current QAM status full compliance

***General Guidelines**

Appendix IV- Overview of Pre and Post Implementation of CCS Comprehensive Wellness Plans for People Supported

Gary

A Bit About Gary:

Gary is a 44 year old man who has been long supported by an organization since he was young. He currently receives 24/7 support, shares his house with roommates and attends a program that offers support during day throughout the week. Generally, Gary enjoys going for walks, using litebrite and Lego, sorting, matching, crafts, listening to music and watching wrestling, sports or the weather on T.V.

Gary has a diagnosis of Autism/ Obsessive Compulsive Disorder. He does appear to enjoy being part of a group; however tends to remain on the outside observing. At times Gary can become quite agitated, anxious and aggressive. When he is anxious, Gary will bang his knuckles against his teeth, occasionally causing them to bleed. His voice levels will raise and "NO" is very emphatically spoken.

Gary also engages in excessive running/jumping, rocking, bouncing in chairs, wringing of hands, sweating profusely to also indicate his level of anxiety. There have been a few incidents of aggression i.e. - hitting or pushing support workers, destruction of property when Gary is anxious.

At times, he becomes so agitated to the point that he is inconsolable. Observable signs which indicate this is that his pupils dilate, he rocks vigorously, may remove his clothing, may bang his mouth with his knuckles, his skin becomes mottled, and his skin from mid chest up becomes extremely red. These episodes often last up to an hour.

Gary has been violent with others and does engage in self-injurious behaviours. He has a tendency to uncross another person's legs or arms, forcefully pull off their shoes or remove other articles of clothing without being invited to do so. This has become a concern for safety for others.

Overall, Gary has levels of anxiety, agitation and aggression that affect many aspects of his daily life. His anxiety and agitation has very much restricted him to one room during the day with the lights turned off and minimal people entering his space.

Additions Through CCS Towards A More Comprehensive Wellness Plan:

In addition to his current supports, the following additions were made to ensure the most optimal support was being offered to Gary:

1. Full medication review from an independent pharmacist to ensure medications were fully meeting his medical needs.
    a. Gary had a diagnosis of OCD but was lacking medication to specifically manage the manifestations from the diagnosis.
2. Changed lighting in day support program from fluorescent to incandescent.
3. Rebounding exercises and daily cardio.
4. BB-ABC Exercises (Bilateral, Bio-meridian Awareness Based Calming).
5. Modified Diet.
    a. More whole foods, low carb, low sugar, low grain, low dairy and casein modifications were made.
6. Involvement of a Naturopath.
    a. Introduction of omega 3 fatty acids, N-Acetylcysteine (NAC) and B50 Complex.

7. Enhanced the development of supporters to become more mindful, emotionally self-regulated as they provide support including:
    a. Gaining an understanding of behavioural contagion and entrainment as they engage in their role as a supporter and the ultimate effects that has on the level of anxiety of others;
    b. Identifying when they were getting into power struggles and being able to redefine negotiables vs. non-negotiables; and
    c. Identifying key intra-personal insights to bring a perspective of understanding and authentic compassion.

Gary's Comprehensive Wellness Plan:

Needs Area # 1
Environment Management, Skilled Advocacy and Competent and Compassionate Support from Mindful Emotional Self-Regulated Support Professionals:

Continue:

- Regulate heat in his room.

Stop:

- Overreacting to Gary;
- Using scented soaps and fabric softeners; and
- Using bleach in his laundry.

Start:

- Introduce increased presence by staff (which we previously considered to be intrusions), as well as increase in presenting activities;
- Lighting in his area of the day program has been changed; we encourage use of the "dimmer switch" when darker conditions are desired by Gary;
- Stabilization chair and rebounder obtained. I believe we are going to obtain a swing. His room has already had furniture moved out to accommodate this; and
- Replacing clothing/bedding with cotton materials.

Needs Area # 2
GI, Bowel and Digestive System Management and Holistic Treatment,Nutrition and Pain Management:

Continue:

- Avoiding processed foods/aspartame;
- Reviewing best practices;
- One menu for all men; and
- Encourage drinking water, eating fresh fruits and vegetables.

Stop:

- Any additional food intake that may interfere with his dietary restrictions;
- Stop/decrease coffee intake to 1 cup/day (half and half) at 1 tsp./cup, then decrease quantities to give him coffee flavor without the unpleasant side effects;
- Sugar substitutes;
- Gluten intake;
- Sugar in coffee; and
- Using processed foods.

Start:

- Increase reporting re: bowel habits;
- Measure water intake (provide water in a 500 ml. bottle--try not to offer in excess of 500 ml/hr.);
- Buy infuser for fruit drinks;
- Recording size and shape of B.M.s;
- Improved peri-care;
- Review Paleo diet (gluten free breads, dairy free);
- Change sugars in the house to stevia and use coconut sugar;

- Using almond milk; and
- Gardening in the summer.

Needs Area # 3
Brain Coherence Balancing, Inflammation Regulation and Mirror Neurodevelopment:

Continue:

- Cooking with onions, minced garlic and broccoli.

Stop:

- In reference to the chart submitted by [home location], Day Program would like to use another word besides "encourage" isolation. We do not encourage it, but we do respect it when he conveys it as his wishes;
- Obtaining meals from day program;
- Making/having people stop the stimulation; and
- Discouraging his rocking.

Start:

- Providing only what is sent to day program--no extras;
- Encourage use of rebounder/stabilization chair;
- Play catch, and "bounce and catch";
- Stabilization cushion;
- Rocking chair;
- Bring in balancing ball;
- Encourage eye contact;
- Encourage participation;
- Evening snack at table; and
- Steam vegetables.

Needs Area # 4
Human Energy System – Building, Balancing and Protection from Radiation and Electromagnetic Fields (EMF):

Continue:

- Use of Green Wave devices;
- Continue allowing bare feet; and
- Using direct wired computers.

Stop:

- Using walkie talkies routinely, and exposure to EMF from cell phones carried by staff;
- Carrying cellphone;
- Having music from the stereo playing while Zumba or Karaoke is going on to avoid overstimulation and anxiety; and
- Making people wear footwear (unless safety concern).

Start:

- Use of white noise machine;
- We investigated, but were unable to disconnect the outlets in his area in day program;
- Ask Gary if he wants his music off when he appears unsettled;
- Walk on concrete; and
- Turning routers down or off;
- Using electricity filters; and
- Looking into grounding mats and blankets.

Needs Area # 5
Sensory Integration and Processing:

Continue:

- Respecting his wish for solitude;
- Maintaining awareness of the impact some clothing has on Gary;
- Offering opportunities to go outdoors or on trips out of the program;
- Dancing in the mornings while waiting for the cab;
- Encouraging to assist with household chores (vacuuming, bringing garbage out);
- Encourage him to look at us; and
- Going up stairs to get him instead of calling him down.

Stop:

- Use of "direct approach" in interactions with Gary;
- Using raised voices;
- Encouraging isolation;
- Noises simultaneously from multiple sources (music in room as well as karaoke); and
- Unnecessary chatter from staff.

Start:

- Initiate jumping jacks;
- Complete (re-schedule) eye exam;
- Hand massages;
- Physical tasks and activities to improve motor skills;
- Offer opportunities to access different areas of the program;
- 20 mins. 4 times/week cardio;
- Encourage eye contact when giving an instruction;
- Bring him down for a snack and activity before going to bed; and
- 0800 hrs. wake ups.

Needs Area # 6
Trauma Desensitization and Mood Disorders Prevention and Treatment (e.g. PTSD, OCD):

Continue:

- Do not interrupt Gary's intentions (give freedom to complete his routines, make changes to the structure of his area, and "fix" things to his liking;
- Avoid power struggles;
- Allow him to have time alone; and
- Offering him choices (bath to help calm, calming teas).

Stop:

- Startle through voice tones or volume;
- Interrupt his movements or intended direction (actions);
- Having a power struggle about the hallway lights and the bathroom fan; and
- Forcing him to be in social situations that he is not comfortable with.

Start:

- Listen--encouraging him to use words, vocalizations or physically take you and show you if he cannot verbally indicate it;
- GIVE GARY INCREASED CONTROL;
- Put the lights in rooms that he uses on dimmer switches or replace with fans that allow light to dim; and
- Change light fixture or bulbs in his bedroom.

Needs Area # 7
Mindful Emotional Self-Regulation Skills Development through Awareness Based Calming Skills and ABA/IBI etc.:

Continue:

- Bouncing, tapping;
- Respect his wish for solitude;
- Talking to people prior to events and advise of expectations;

- Have back up plans if people chose to withdraw;
- Encourage him to connect with DSPs and express his wants/needs;
- Giving choices;
- Planning; and
- Talk about expectations.

Stop:

- Overreacting;
- Making daily decision that could be choices he could make;
- Stop power struggles; and
- Planning activities that are in conflict with what you/we know are preferences.

Start:

- Introduce the "grounding" exercise;
- Helping other DSPs to realize when they are in a power struggle with him;
- Teaching him coping skills for social assistance;
- Teaching teammates coping skills; and
- Try spending one on one time with people and take them through some calming exercises.

Needs Area # 8
Contributing to Self and Others Wellbeing (e.g. volunteering, work and other meaningful experiences):

Continue:

- Self-determination of activities, offer many and frequently repeat;
- Continue to offer opportunities such as wiping the cafeteria tables if he is willing;
- Encourage to assist with vacuuming and taking out the garbage (vacuuming on weekends after lunch and taking garbage out after supper); and
- Give more choices.

Stop:

- Interfering with Gary's efforts to make change in his immediate area which impacts no one else; and
- Stop doing things for him because it's easier and faster for us, let him do things for himself.

Start:

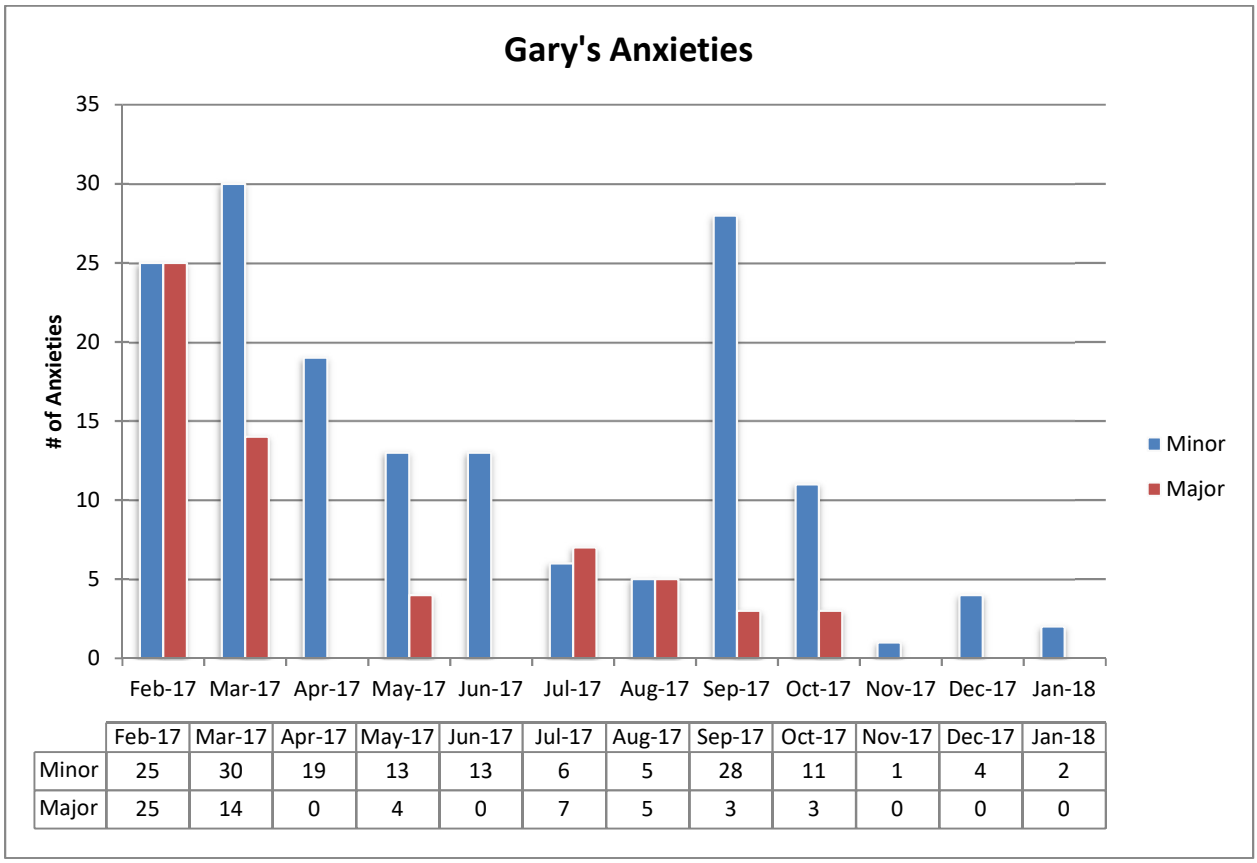
- Provide opportunities for routine chores or responsibilities (cleaning/tidying his day program area);
- Taking him to the car wash to assist with washing the van;
- Have him assist with vacuuming out the van; and
- Assisting with more household chores.

Gary Today:

Gary seems much more relaxed and has a "relieved" facial appearance. He has lost weight, looks younger and more frequent smiles are seen. He will engage in preferred, offered activities and when he declines, it is in a calmer, quiet manner. He is engaging in some activities like puzzles and drawing which he previously did, but has not cared to do for years. Gary has returned back to playing cards which also haven't been seen in a long time. He has actually created a sorting game with specific rules to follow to order the deck which is something that he loves to play. Gary will now allow or invite staff to sit right beside him, or move their chair closer to him and uses a lower tone of voice when speaking with others.

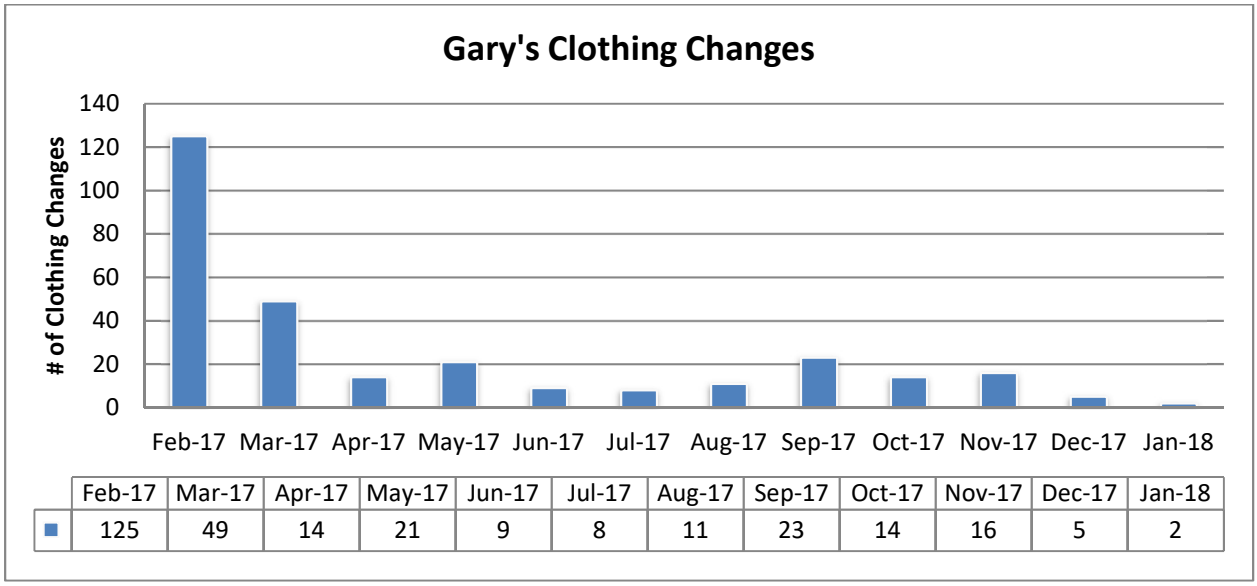
He can now maneuver in his place of day support and at home with the lights on and with his eyes open. Gary has been able to experience his community differently as he has less anxiety and agitation. He has gone for walks in neighbouring parks, shopping and attended various events. He has also been able to experience his home life differently as well as he has engaged with chores like doing the laundry to help not only himself but also others within his home.

Gary's incidents of major and minor anxieties along with the frequency of changing his clothes have been charted for the past 12 months. Both of the following charts illustrate a decreasing trend line in the number of incidents of anxiety.



	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Minor	25	30	19	13	13	6	5	28	11	1	4	2
Major	25	14	0	4	0	7	5	3	3	0	0	0

*Minor Anxiety- defines incidents that are shorter in duration and lower in intensity. Once the cause of anxiety has been addressed, the anxiety will cease and Gary can be verbally redirected.
*Major Anxiety- defines incidents of longer duration with an increased intensity. Physical redirection may be needed.



	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
■	125	49	14	21	9	8	11	23	14	16	5	2

Contributions of Successful Implementation

1. Improved self-regulation of supporters to identify bringing their greatest level of emotional maturity to ensure that they were bringing their most optimal level of support.
2. All supporters, including paid direct supporters, clinicians and family members were in agreement to include exploratory models of support alongside traditional support to ensure a comprehensive model of support for Gary.
3. The organization that supports Gary was very much committed to ensuring that Gary was receiving the financial support he needed to help cover the cost of added supplements that are not covered through his drug benefits.
4. Thorough review of medications ensuring optimal medication regime.
5. Identifying unmet biomedical needs through along with implementing correct supplements, vitamins and minerals.
6. Modifications to diet to include more whole foods, low carb, low sugar, low grain, low dairy and low casein.

Limitations

1. Direct consent was not given by Gary, however implied consent was acknowledged as he was open to continually trying new things at his pace.

Alex

A Bit About Alex:

Alex is an extraordinarily bright, young, 23 year old man who can discuss in great detail how the universe has come to be, the theory and science behind universal black holes and will question the validity of many possibly theories of many different things with a very rationale method of reasoning. Along with a passion for philosophy and physics, Alex also enjoys watching Star Trek and other Sci-Fi shows along with watching YouTube and Netflix videos. Alex also has a passion for food, namely fast cooked freezer food like frozen pizzas and chicken nuggets.

Alex has a diagnosis of Childhood Disintegrative Disorder which is on the Autism Spectrum. He also has a cyst on his brain (on the right hippocampus) that has been deemed inoperable and there is no confirmed evidence of it causing any concern with Alex's wellbeing.

Communication is very important to Alex and he likes to check in to see if you understand what he is saying and if you are on the same page. He enjoys when people take interest in things that he is interested in and enjoys being a teacher on the subjects which people are not familiar with.

He is very capable of navigating the world around him yet struggles time and time again with a chronic underlying anxiety paired with questioning and doubt for just about everything. He often lives his day in an intense state seeming consistently anxious and unsure. When he is anxious, Alex speaks loudly using a very forward tone and asks many questions as to what would be happening as the day/week/month progresses. He will then engage in power struggles with supporters that have resulted in aggression and acts of violence towards the supporter. Alex also cycles through rounds of sleeplessness that could be a few days at a time.

Additions Through CCS Towards A More Comprehensive Wellness Plan:

In addition to his current supports, the following additions were made to ensure the most optimal support was being offered to Alex:

1. Full medication review from an independent Pharmacist to ensure medications were fully meeting his medical needs.
    a. Modified diet including more home cooked meals, low sugar, low grain, low dairy and casein modifications were also made.
2. Involvement of a Naturopath.
    a. Treatment based on results from Organic Acid Test and sensitivity to tomatoes;
    b. Elimination of candida overgrowth; and
    c. Introduction of Mitomatrix, Vitamin B Complex and probiotic.
3. Daily cardio exercise.
4. Minimizing the exposure of EMF through the installation of dirty electricity filters and use of grounding mat.
5. Enhanced the development of supporters to become more mindful, emotionally self-regulated as they provide support.
    a. Gaining an understanding of behavioural contagion and entrainment as they engage in their role as a supporter and the ultimate effects that has on the level of anxiety of others; and
    b. Identifying when they were getting into power struggles and being able to redefine negotiables vs. non-negotiables;

c. Identifying key intra-personal insights to bring a perspective of understanding and authentic compassion.

Alex's Comprehensive Wellness Plan:

Needs Area # 1
Environment Management, Skilled Advocacy and Competent and Compassionate Support from Mindful Emotional Self-Regulated Support Professionals:

Continue:

- N/A as supporter specific.

Stop:

- N/A as supporter specific.

Start:

- N/A as supporter specific.

Needs Area # 2
GI, Bowel and Digestive System Management and Holistic Treatment,Nutrition and Pain Management:

Continue:

- Encouraging the eating of veggies and fruit and making them easily and readily available. Continuing to talk about trying to choose healthier options.

Stop:

- Access to unhealthy food, allowing food to be accessible to allow for binge eating during the night.

Start:

- Modeling healthy eating by bringing more fruits and veggies as staff meals while supporting;
- Not bringing in snacks like chips for us;
- Making homemade food;
- Trying almond milk or other alternatives;
- Consistency with food provided by staff; and
- Adding yogurt to dips or making homemade dips for veggies.

Needs Area # 3
Brain Coherence Balancing, Inflammation Regulation and Mirror Neurodevelopment:

Continue:

- Encouraging exercise;
- Getting out for more walks like was happening before the move; and
- Trying to get Alex interested in walking with dogs again.

Stop:

- Try to stop the excessive sedentary life of watching a screen.

Start:

- Encouraging movement;
- Try suggesting bouncing activities;
- Pick up the pace when walking (must get cardio up);
- Encouraging foods high in Glutathione (a list has been printed out);
- Tracking sleeping patterns better;
- Try swimming and walking a track; and
- Try tapping.

Needs Area # 4
Human Energy System – Building, Balancing and Protection from Radiation and Electromagnetic Fields (EMF):

Continue:

- Trying to get out to walk on Mother Earth at least once a day;
- Allowing bare feet when possible; and
- Trying to get into bed versus couch for night sleeping.

Stop:

- Exposure to excess EMF by using EMF filters and keeping cell phones away.

Start:

- Trying to walk bare foot in the grass or sand in nice weather;
- Perhaps trying a textured mat to walk on in the apartment;
- Perhaps a grounding mat for the bed;
- Using EMF filters in the apartment;
- Assessing clothing to make sure it isn't an irritant; and
- Better quality shoes.

Needs Area # 5
Sensory Integration and Processing:

Continue:

- Trying to do shift change in hallway or spare room to prevent voices talking in the background;
- Encouraging bottle squeezing; and
- Watching for signs of sensory anxiety.

Stop:

- Having cell phones on vibrate;
- Rapid speech; and
- Moving quickly and noisily through the apartment.

Start:

- Speaking loudly and clearly;
- Trying to get access to a warm pool or hot tub;
- Drawing and writing on the computer; and
- Finding out more about food textures that are pleasant or unpleasant for Alex.

Needs Area # 6
Trauma Desensitization and Mood Disorders Prevention and Treatment (e.g. PTSD, OCD):

Continue:

- Carefully monitoring and observing things that seem to cause anxiety and adjusting the environment before it moves to anger or aggression; and
- Reminding Alex of his capabilities and that we are a team here to help.

Stop:

- Stressing the need to be alone until there is a feeling of safety and much lower anxiety in his new living situation;
- Stop engaging in power struggles and speaking as one would to a child.

Start:

- Working as a team to get on the same page with philosophies and approaches to decrease anxiety and confusion for all involved;
- Start slowly working toward new achievements and making sure recognition is given when accomplishments are made; and
- Look for and eliminate as many triggers as possible.

Needs Area # 7
Mindful Emotional Self-Regulation Skills Development through Awareness Based Calming Skills and ABA/IBI etc.:

Continue:

- Try to identify and catch situations and feelings both in staff and individuals supported that could lead to an emotional hi-jack and potential escalation; and
- Allow appropriate touch (i.e. palms offered up) to gain connection and promote calm.

Stop:

- Feeling anxious or the need to redirect quickly if touch is initiated by the person supported (it is appropriate to have human-human contact in a gentle and compassionate way); and
- Avoid redirecting if sadness or negative emotions are expressed, rather allow these emotions to be expressed and support as best as possible.

Start:

- Sharing catching moments with all staff so that staff can be on the same page and learn from experiences;
- Encouraging more eye contact; and
- Trying tapping technique for calming.

Needs Area # 8
Contributing to Self and Others Wellbeing (e.g. volunteering, work and other meaningful experiences):

Continue:

- Working on stories and exploring meaningful activities that can be done outside of the apartment and followed up consistently; and
- Focusing on Alex's abilities to build self-confidence and acknowledging to Alex when the staff have learned something.

Stop:

- Focusing on the things that Alex may not do or won't want to do and rather focus on the possibilities of things that could be done;
- Doing things that Alex can do on his own (however not if Alex is in a negative space and will lead to a power struggle); and
- Stay away from having child-type items in the apartment and speaking in a way that could be insulting as if we are talking down to someone of lesser intelligence.

Start:

- Reaching out to the community in search of new activities that can be done;
- Exploring volunteer opportunities for Alex to give back;
- Trying to type out stories and getting them completed; and
- Looking for activities that can inspire Alex's stories and creativity.

Alex Today:

Overall, Alex has had a significant improvement in his overall general physical appearance. The skin on his face has because less irritated and red, his skin on his scalp is not scaling as it was and overall, he has lost weight.

Alex enjoys trying new foods far beyond the initially preferred frozen foods. He enjoys trying recipes with healthy alternatives including fresh fruits and vegetables, smoothies, avocado and lentils. Before Alex had a tendency to seek food as where now his food seeking tendencies have dropped.

Alex has most recently been able to express how he is feeling in verbal ways in which he hasn't before. He overall seems to engage with others in a more calm way without the need to escalate or aggress. He enjoys getting out and walking and the team has reported that he has more energy. Most recently he directed his own medical appointment which can illustrate his increase in confidence and sense of ownership of his life when engaging with others.

Although he does seem to continue through periods of sleeplessness, overall, Alex seems like a much more calm less irritated young man.

Contributions of Successful Implementation

1. Improved self-regulation of supporters to identify bringing their greatest level of emotional maturity to ensure that they were bringing their most optimal level of support.
2. Improved communication skills of the supporters when Alex experiences anxiety and agitation.
3. Improved skills of advocacy amongst the supporters when working with clinicians.
4. Identifying unmet biomedical needs along with implementing correct supplements, vitamins and minerals.
5. Modifications to diet to lower the amount of gluten, sugar and casein.

Limitations

1. Alex was admitted to hospital for two weeks to treat an infection in his foot. During his stay his Psychiatrist made the call to eliminate a medication that he deemed was no longer needs. This caused Alex to go through a period of a few weeks of increased anxiety and aggression, outbursts of tics and he also experienced some dramatic weight loss.
2. The traditional medical team surrounding Alex was very hesitant in pursuing any exploratory, biomedical avenues of health. When approached to consider measuring the unmonitored cyst on Alex's brain to see if it has grown in the last 15 years, both the medical and psychiatric team became extremely resistant to any investigation and deemed that follow up was not necessary as they felt it did not pose any concern.

Michael

A Bit About Michael:

Upon initially meeting Michael, it is quickly noted that he is a bright 26 year old man. He has a great sense of humour and has played jokes on his supporters by hiding items under the panels of the drop ceiling and has watched his puzzled supporters as they try to figure out what happened to that "too big to flush down the toilet" item. Michael enjoys all types of food with the exception of meats and cheese and quite enjoys baking and food preparation. He enjoys organizing things, sorting activities, looking through newspapers, magazines and at photo albums. Michael also enjoys people watching, swimming, grocery shopping and listening to pop music.

Michael has the diagnoses of autism, obsessive compulsive disorder, epilepsy and lead poisoning. He has had a long history of challenging expressions of behaviour, which could be violent and aggressive. When he becomes anxious, these expressions include hitting, punching, pushing, charging at people and objects, banging walls and windows and various self-injurious behaviours, including hitting his head, violent dropping to the floor, slamming into walls and biting his hands, wrists and upper arms. In year past, he was often escorted by police to hospital and had an admission lasting 6 months with 3:1 staffing.

Michael also has a history of headaches and a family prevalence of migraines which has long been though to contribute to his levels of agitation and aggression.

Additions Through CCS Towards A More Comprehensive Wellness Plan:

In addition to his current supports, the following additions were made to ensure the most optimal support was being offered to Michael:

1. Full medication review from an independent Pharmacist to ensure medications were fully meeting his medical needs.
    a. Trialed an SSRI for OCD;
    b. Consolidated amount of prescribed antipsychotics;
    c. Addressed migraine pain through prescribed migraine medication;
    d. Reconsidered medications to be given to calm before bed; and
    e. Modified diet including more whole foods, low gluten and low dairy and casein modifications.
2. Involvement of a Naturopath.
    a. Treatment based on results from Organic Acids Test;
    b. Elimination of candida and clostridia overgrowth; and
    c. Introduction of Mitomatrix and probiotic.
3. Daily rebounding and cardio exercise.
4. Minimizing the exposure of EMF through the installation of a harmonic panel filter.
5. Enhanced the development of supporters to become more mindful, emotionally self-regulated as they provide support.
    a. Gaining an understanding of behavioural contagion and entrainment as they engage in their role as a supporter and the ultimate effects that has on the level of anxiety of others;
    b. Identifying when they were getting into power struggles and being able to redefine negotiables vs. non-negotiables; and
    c. Identifying key intra-personal insights to bring a perspective of understanding and authentic compassion.

Michael's Comprehensive Wellness Plan:

Needs Area # 1
Environment Management, Skilled Advocacy and Competent and Compassionate Support from Mindful Emotional Self-Regulated Support Professionals:

Continue:

- N/A as supporter specific.

Stop:

- N/A as supporter specific.

Start:

- N/A as supporter specific.

Needs Area # 2
GI, Bowel and Digestive System Management and Holistic Treatment,Nutrition and Pain Management:

Continue:

- Provide a balanced menu of food for Michael and monitor his portion sizes;
- Encourage fruit and vegetables with each meal;
- Ensure Michael drinks a minimum of 8 cups of liquid a day;
- Continue to explore a prophylactic migraine medication;
- Track BM's.

Stop:

- Providing casein and gluten foods;
- Providing meals and snacks high in refined carbs and processed foods;
- Phase out acetaminophen.

Start:

- Regular consultation with Naturopath;
- Gluten and casein free diet;
- Test and treat for vitamin and mineral deficiencies as well as infections and food sensitivities;
- Start probiotic; and
- Start a PRN migraine medication.

Needs Area # 3
Brain Coherence Balancing, Inflammation Regulation and Mirror Neurodevelopment:

Continue:

- Following sleep hygiene routine;
- Ensuring no caffeine in the evening;
- Encouraging walks and swimming;
- Teaching communication skills; and
- Increasing multi-level task prompting.

Stop:

- Using white sugar, casein and gluten foods.

Start:

- Using rebounder;
- Research handles for donated rebounder;
- Using a balancing cushion;
- Purchase balancing ball chairs;
- Integrate specific exercise goals for 30 minutes;
- Encourage butterfly hug and hand tapping; and
- Encourage high sulfur vegetables.

Needs Area # 4
Human Energy System – Building, Balancing and Protection from Radiation and Electromagnetic Fields (EMF):

Continue:

- Following a sleep hygiene routine;
- Keeping lights off;
- Encouraging daily baths;
- Promoting walking;
- Turning off the television when Michael is not watching it.

Stop:

- Bringing cellphones into Michael's unit;
- Turn off the Wi-Fi;
- Michael's tablet when he is not using it.

Start:

- Research cork based footwear and grounding blankets;
- Add a filter to the house electricity panel;
- Offer a relaxing bath in the evening;
- On outings be aware of high electrical places;
- Research Tesla necklace.

Needs Area # 5
Sensory Integration and Processing:

Continue:

- Providing preferred clothing, sunglasses, and baseball hats;
- Providing a safe environment for Michael;
- Take Michael to the Chill Zone;
- Low lighting;
- Providing various food choices (textures and spicy food); and
- Label upcoming sensory input (dogs barking).

Stop:

- Reduce task expectations depending on Michael's mood and wellness; and
- Limit sensory input during task expectations.

Start:

- Treat Michael's Blepharitis to decrease light sensitivity;
- Purchase ear filters to decrease sound;
- Replace Michael's outdoor swing;
- Use the rebounder at [place of day support];
- Have a sensory assessment completed by an OT and follow daily sensory diet; and
- Research toilet play.

Needs Area # 6
Trauma Desensitization and Mood Disorders Prevention and Treatment (e.g. PTSD, OCD):

Continue:

- Encourage outings, exercise, and social interaction;
- ISP goal of meaningful day;
- Interact calmly;
- Provide hand massages; and
- Follow the BSP and support Michael with his identified triggers by providing a safe and calming environment.

Stop:

- Requesting that Michael participate in activities at the table;
- Prevent masks put on his face. Leaving him alone in his suite for long periods of time; and
- Considering an 'off' mood as a need for cancellation of all activities.

Start:

- Have a med review completed;
- Trial SSRI for OCD;
- Consolidate anti-psychotics;
- Staff 'catch' themselves and take a break while requesting support from team; and
- Add a hand massage to his evening routine.

Needs Area # 7
Mindful Emotional Self-Regulation Skills Development through Awareness Based Calming Skills and ABA/IBI etc.:

Continue:

- Labelling Michael's emotions;
- Providing quiet time when Michael identifies that he requires it;
- Follow the BSP while lowering expectations when Michael is identifying that he is struggling with self-regulation; and
- Providing calming music when requested, reassure Michael.

Stop:

- Over supporting the person; and
- Overstimulating the person.

Start:

- Provide bilateral stimulation calming;
- Teach parasympathetic breathing exercises;
- Teaching emotion signs;
- Meditative breathing exercises; and
- Start yoga.

Needs Area # 8
Contributing to Self and Others Wellbeing (e.g. volunteering, work and other meaningful experiences):

Continue:

- Volunteering to pick up food at Gentle Rain and take it to House of Blessing;
- Exploring interests and trying new things to expand on Michael's meaningful day goal;
- To develop life skills (example cooking, cleaning, self-care); and
- Attending Special Olympics.

Stop:

- Over supporting;
- Hiding your own feelings from him; and
- Limiting his experiences based off of your own expectations of him.

Start:

- Explore possible job opportunities such as a paper route;
- Taking Michael to [place of day support] to the music program; and
- Discuss setting up a monthly family visit.

Michael Today:

Michael has had higher energy levels and generally a more cheerful disposition. He has lost 15 lbs., no longer has stomach bloating after he eats and his facial acne has disappeared. Overall, Michael seems calmer and is able to express his needs more clearly. He not only uses gesturing, sign and a picture exchange, but he has also initiated verbal communication with his staff as in the past he has been described as being non-verbal.

When Michael does experience times of anxiety, the intensity of agitation and aggression have dropped considerably and the duration of the incident is much less. Michael seems to recover more quickly from those times of agitation and can be redirected more easily than before.

He is also initiating engagement with activities, such as rebounding, and also initiating social engagements with his supporters. Michael is getting out and exploring different options and activities within the community because his anxiety has lowered. He is involved in a program with the local community pool which would have been almost unheard of just a few months ago. He has also been able to spend time with his family celebrating holidays which in years past, would have also been a great challenge.

Since implementing a comprehensive plan of wellness for Michael, the following chart highlights a 10 month snapshot of some significant changes contributing to his improved quality of life. The data below is also supported through supporter testimony and additional documentation.

Data Collected	Month of April 2017	Month of January 2018
Number of activities in which Michael participated.	24.23	36.55
Average length of time for engagement (minutes).	258.83	346.06
Average length of face time with staff (minutes).	261.23	349.19
Average time on outings (minutes).	63.9	89.19
Headache symptoms (average observances).	1.77	0.23
Making picture choices (average incidences).	2.83	3.58
Independent signing (average incidences).	8.53	12.0

Contributions of Successful Implementation

1. Improved self-regulation of supporters to identify bringing their greatest level of emotional maturity to ensure that they were bringing their most optimal level of support.
2. All supporters, including paid direct supporters, clinicians and family members were in agreement to include exploratory models of support alongside traditional support to ensure a comprehensive model of support for Michael.
3. The organization that supports Michael was very much committed to ensuring that Michael was receiving the financial support he needed to help cover the cost of added supplements that are not covered through his drug benefits.
4. Thorough review of medications ensuring optimal medication regime.
5. Identifying unmet biomedical needs through along with implementing correct supplements, vitamins and minerals.
6. Modifications to diet.

Limitations

1. Direct consent was not given by Michael however implied consent was acknowledged as he was open to continually trying new things at his pace.

Deanna

A Bit About Deanna:

Deanna is quite a self-sufficient young woman who is 28 years old. She has a passion for Yu-Gi-Oh cards, playing her Nintendo DS, watching t.v. and movies, drawing, eating out and shopping. She's been described as an intelligent, kind, funny, creative and persistent young woman who has a fabulous memory. She values her solitude and quiet time and can find it hard to engage socially with others.

Deanna's family is very much involved within her life and often take her for visits to the family home, and for outings for a meal and to the movies. With the help of her supporters, Deanna helps with chores around her house and takes cares of other personal responsibilities for her own self.

Deanna has a diagnosis of Autism Spectrum Disorder and a Pervasive Developmental Delay. When situations present themselves as unpredictable or a change is to happen with her environment or schedule, Deanna can easily become agitation and aggressive. When Deanna becomes agitated it is manifested in outward acts towards herself and others including yelling, scratching, hitting, punching, biting, kicking, pulling hair, throwing objects and punching/striking objects.

Deanna is a very likeable woman who knows what she likes and isn't afraid to ask to get it.

Additions Through CCS Towards A More Comprehensive Wellness Plan:

In addition to his current supports, the following additions were made to ensure the most optimal support was being offered to Deanna:

1. Modified Diet.
    a. More whole foods, low gluten, low dairy and casein modifications were made.
2. Daily Cardio Exercise.
3. Enhancing her own skills of mindful, emotional, self-regulation:
    a. Through morning meditations and biofeedback; and
    b. Continuing with her breathing exercises.
4. Enhanced the development of supporters to become more mindful, emotionally self-regulated as they provide support:
    a. Identifying when they were getting into power struggles and being able to redefine negotiables vs. non-negotiables; and
    b. Identifying key intra-personal insights to bring a perspective of understanding and authentic compassion.

Deanna's Comprehensive Wellness Plan:

Needs Area # 1
Environment Management, Skilled Advocacy and Competent and Compassionate Support from Mindful Emotional Self-Regulated Support Professionals:

Continue:

- N/A as supporter specific.

Stop:

- N/A as supporter specific.

Start:

- N/A as supporter specific.

Needs Area # 2
GI, Bowel and Digestive System Management and Holistic Treatment,Nutrition and Pain Management:

Continue:

- Healthy morning snacks.

Stop:

- Processed snacks;
- All chocolate milk (use ¼ cup of dark almond milk and mix ¾ cup of almond milk);
- Remove peanut butter/honey- replace with healthier options;
- Monitor grocery list.

Start:

- Smoothies;
- Weekly baking of healthy snacks;
- Clients help bake healthy snacks;
- Use natural peanut butter and honey;
- Self-report own bowel movements (create chart to hang in bathroom);
- Increase intake of protein ex. meatballs; and
- Protein added to smoothies eventually.

Needs Area # 3
Brain Coherence Balancing, Inflammation Regulation and Mirror Neurodevelopment:

Continue:

- Meditation;
- Daily walks (exercise);
- Stretching; and
- Mental Games.

Stop:

- Eating unhealthy snacks to reduce gut and brain inflammation from the processed food.

Start:

- Seeing a Naturopath;
- Trampoline; and
- Replace dining room chairs with bouncy ball chairs.

Needs Area # 4
Human Energy System – Building, Balancing and Protection from Radiation and Electromagnetic Fields (EMF):

Continue:

- Effective bed time routine;
- Melatonin at night; and
- Trying to encourage her to use weighted blanket.

Stop:

- Using our cellphones in her proximity.

Start:

- Purchase the filters for her room;
- Proper footwear- buy crocs;
- Walking barefoot in back yard;
- Get better blinds; and
- Sleep mask trial possibly.

Needs Area # 5
Sensory Integration and Processing:

Continue:

- Rocking and stimming- self-regulating; and
- Listening to music- she rocks to music and enjoys this.

Stop:

- Sleeping on her couch, instead use her bed.

Start:

- Look into getting new equipment- swing, hammock and trampoline;
- Memory foam for bed- sleeping on her bed instead of her couch- look into why she sleeps on her couch; and
- Get updated sensory OT assessment.

Needs Area # 6
Trauma Desensitization and Mood Disorders Prevention and Treatment (e.g. PTSD, OCD):

Continue:

- Meditation; and
- Daily walks and stretching.

Stop:

- Having her engage in activities she does not enjoy.

Start:

- Encourage meditation in anxiety stage and before her DS;
- Mindful movement after lunch;
- Hand massages;
- Trampoline;
- Morning stretches (a set sequence); and
- Validating feelings- both good and bad.

Needs Area # 8
Contributing to Self and Others Wellbeing (e.g. volunteering, work and other meaningful experiences):

Continue:

- Encourage communications of needs; and
- 20 minute calming.

Stop:

- Enforcing activities that aren't enjoyed and not necessary; and
- Restricting things she enjoys.

Start:

- Communicating better with parents; and
- Help create better plans for parent outings.

Deanna Today:

Deanna has made some changes in her diet to lower the amount of processed foods, lower the amount of gluten and casein and lower the amount of sugar that she was consuming. She will often now bring her own snacks when visiting with others and participates within the process of preparation and baking.

Visits with her family have also shifted slightly to not always involve food as part of the visit. This is something that her supporters have reported as successful and that Deanna and her family have adjusted to not always needed to eat when they are together.

Deanna does continue to experience incidents of anxiety and can verbally and physically aggress however there have been times in which Deanna has coped with her anxiety that in the past, would have provoked an outburst (i.e. a dental appointment that has been a successful visit as where in the past, PRN medications would have been required for calming). Overall, Deanna's supporters have commented

on how well she has adjusted to the changes that have been made and that she continues with her daily practice of meditation and breathing exercises.

Contributions of Successful Implementation

1. All of Deanna primary support team were in agreement to include exploratory models of support alongside traditional support to ensure a comprehensive model of support for Deanna.
2. Improved self-regulation of supporters to identify bringing their greatest level of emotional maturity to ensure that they were bringing their most optimal level of support.
3. Modifications to diet to lower the amount of gluten, sugar and casein.

Limitations

1. Direct consent was not given by Deanna however implied consent was acknowledged as she continued to try new things.
2. A bit of a delay during connections between interdisciplinary clinicians.

Chris

A Bit About Chris:

Chris is a young man of 36 years who has a smile that can light up a room. He enjoys playing ball, going for drives, flipping through magazines, relaxing outsides, playing with his sensory toys and grabbing a drink at Tim Hortons. Chris also has a great sense of humour that can get anyone to giggle with him.

Chris' family is very involved. He will often go out with his dad on Tuesday afternoons and seems to welcome his dad with excitement every time. Upon returning home from being out with his dad, Chris is often up for the entire night afterwards. He'll often visit with his mom and sister on Thursdays and go for dinner to a fast food restaurant of his choice.

Chris has a diagnosis of Autism Spectrum Disorder, Behaviour Disorder, Epilepsy and Tuberous Sclerosis. At times Chris seems to become confused and become quite agitated and aggressive. When Chris is anxious or aggressive, it is often manifested through hitting, slapping, pushing and through self-injurious head banging.

Chris is often on the go as he volunteers as a delivery man every Tuesday delivering meals to local shelters.

Additions Through CCS Towards A More Comprehensive Wellness Plan:

In addition to his current supports, the following additions were made to ensure the most optimal support was being offered to Chris:

1. Modified Diet.
    a. More whole foods, low gluten, low dairy and casein modifications were made.
2. Rebounding exercises and daily cardio.
3. BB-ABC Exercises (Bilateral, Bio meridian Awareness Based Calming).
4. Enhanced the development of supporters to become more mindful, emotionally self-regulated as they provide support.
    a. Gaining an understanding of behavioural contagion and entrainment as they engage in their role as a supporter and the ultimate effects that has on the level of anxiety of others;
    b. Identifying when they were getting into power struggles and being able to redefine negotiables vs. non-negotiables; and
    c. Identifying key intra-personal insights to bring a perspective of understanding and authentic compassion.
5. Connected with a Registered Holistic Nutritionist.
    a. Treatment based on ruling out sensitivities around gluten and other intolerances.
6. Still to connect with an Occupational Therapist trained in sensory integration/processing.
    a. Treatment based on results from sensory assessment tools.

Chris' Comprehensive Wellness Plan:

Needs Area # 1
Environment Management, Skilled Advocacy and Competent and Compassionate Support from Mindful Emotional Self-Regulated Support Professionals:

Continue:

- N/A as support specific.

Stop:

- N/A as support specific.

Start:

- N/A as support specific.

Needs Area # 2
GI, Bowel and Digestive System Management and Holistic Treatment,Nutrition and Pain Management:

Continue:

- Regular appointments – dental, MRIs, neurology;
- Regular medications – daily medications, flax seed, pain medications; and
- PRN Lorazepam medication (for seizure control).

Stop:

- Adding sugar to coffee/tea.

Start:

- Reducing processed foods;
- Measuring quantity of coffee;
- Keeping a food diary;
- Tracking bowel movements;
- Start supplementing sodium in a healthier form;
- Presenting herbal tea as an option instead of coffee;
- Monitor B12 levels; and
- Trying alternatives like almond milk.

Needs Area # 3
Brain Coherence Balancing, Inflammation Regulation and Mirror Neurodevelopment:

Continue:

- Current exercise routine with [place of day supports];
- Sensory items (new book in AM); and
- Introduce strategies that get Chris moving in the morning.

Stop:

- Assuming that just because he is quiet, he is calm and does not need interaction; and
- Assume we know what will work or won't work and be prepared to trial new approaches/strategies.

Start:

- Incorporating "Noticing";
- Introducing new concepts such as the mini bouncer;
- Increasing exercise opportunities (new book at bottom of stairs in the morning, carrying heavy items from one side of the yard to the other);
- Encouraging more communication paired with the signs (for example, asking Chris to shake his head "no" if he doesn't want something);
- Ensuring items like bubbles are available again; and
- Swimming.

Needs Area # 4
Human Energy System – Building, Balancing and Protection from Radiation and Electromagnetic Fields (EMF):

Continue:

- Preparing the environment for sleep (start turning lights down at 2000 hours);
- Encouraging a bath in the evenings.

Stop:

- Extra cell phone use.

Start:

- Lowering EMFs in the house;
- Start educating staff about cell phone usage;
- Blow bubbles for him in the bathroom;
- Grounding mat if possible.

Needs Area # 5
Sensory Integration and Processing:

Continue:

- To make available a variety of sensory input.

Stop:

- Nothing at the present time-waiting for sensory assessment to be completed.

Start:

- Sensory assessment required to determine what to continue, stop and start;
- Based on the screening tool it was suggested we try the following;
- See if Chris might be able to communicate which item is heavier/lighter;
- Test whether Chris responds to verbal cues or when his name is called;
- Test whether he would be averse to licking stamps, envelopes, stickers because of taste;
- Test if he has difficulty controlling eye movement to track and follow moving objects.

Needs Area # 6
Trauma Desensitization and Mood Disorders Prevention and Treatment (e.g. PTSD, OCD):

Continue:

- Sensory Integration;
- Continue acknowledging what he is trying to communicate;
- To be aware of the need to provide a calm environment; and
- To provide praise and encouragement.

Stop:

- Ignoring the situation when head banging in a different room-a script will need to be added to PBSP for staff to use as a reference when providing responses to Chris in situation in which he is head banging in a different room and staff needs to approach him to remind him to use his ASL so they can help him with what he needs/wants.

Start:

- Increasing sensory integration in more of a diet;
- BB ABC-Begin to Model;
- Start modelling one of the calming techniques (eg. butterfly, hand pressure);
- Modeling precise communication style that works (simple language);
- Incorporating more choices-diverse items that he might not pick on his own;
- Praise him for doing a good job, remind him of his good achievements (eg. helping with delivering food on Tuesday mornings); and
- Keeping him informed as to what is going on, where he might be going, what is expected of him etc.

Needs Area # 7
Mindful Emotional Self-Regulation Skills Development through Awareness Based Calming Skills and ABA/IBI etc.:

Continue:

- To expect Chris to use his communication signs/pictures to talk (ASL).

Stop:

- Using long phrases and open-ended questions;
- Stop making choices for Chris without providing him an opportunity to make his own choice;
- Being frustrated when Chris is using wrong ASL to communicate; and
- Giving him one question after another without giving him the time to process information.

Start:

- Paraphrasing back to Chris so he is aware of what you have understood from him;
- Start fully giving Chris full attention face to face and follow his lead;
- Giving Chris time to process information;
- Start recognizing things he is doing at other programs e.g. volunteer work, etc.; and
- Start using digital camera to document activity to discuss & review when he returns home from an activity.

Needs Area # 8
Contributing to Self and Others Wellbeing (e.g. volunteering, work and other meaningful experiences):

Continue:

- To provide support to Chris in his community activities (volunteer work, swimming, exercise walks); and
- To provide a welcoming atmosphere for Chris' family when visiting him at home.

Stop:

- Assuming that Chris won't enjoy an activity without giving him the opportunity to try it.

Start:

- Looking for more opportunities that can be safe and fun for CHRIS to participate in the community;
- Start acknowledging Chris' efforts to communicate;
- Start acknowledging Chris is not a "morning person" and limit demands; and
- Start breaking down difficult tasks into smaller/manageable bits and pieces.

Chris Today:

Chris continues to experience less redness on his face and seems to be very much enjoying trying the new foods and recipes that have been introduced with the diet modifications that were made. His overall levels of anxiety seem to have lowered and the incidents of head banging (with exception of the recent introduction of a helmet for safety) have overall dropped as well.

Supporters have reported that Chris also seems to be engaging in more meaningful communication through his signing and gestures. He has been seeking out different activities than before (i.e. balancing on his balancing disks) and seems to have an increase in tolerance adjusting form activity to activity.

Chris now lives in his own apartment which his supporters say have lowered some of his triggers for anxiety and continues with his volunteer position as a delivery person. He still experiences regular rounds of sleeplessness but overall, Chris seems to be engaged and connected with his world.

Contributions of Successful Implementation

1. Chris now lives in his own apartment. There has been a trend line correlation of lowered levels of incidents (heading banging) since he's been in in his own space.
2. Improved self-regulation of supporters to identify bringing their greatest level of emotional maturity to ensure that they were bringing their most optimal level of support.

3. The organization that supports Chris was very much committed to ensuring that Chris was receiving the financial support he needed to help cover the cost of added supplements that are not covered through his drug benefits.
4. Modifications to diet to lower the amount of gluten, sugar and casein.

Limitations

1. A bit of a delay to connect with Occupational Therapist specialized in Sensory Integration/ Processing.
2. Chris had a new protective helmet introduced in the beginning of 2018. Since its introduction, there has been a spike in incidents of aggression and head banging.

Kimberley

A Bit About Kimberley:

Kimberley is a smart, capable and complex 33 year old woman who has a witty sense of humour. Currently, she lives in her own in an apartment, within a group living setting. Kimberley likes to play tennis, soccer, and also enjoys swimming, walking, bowling, working on math, numbers and her IPAD. She enjoys using her IPAD for bowling games and facetiming with her family. She volunteers at a local school and has a laundry job which she completes once a week. Kimberley's family is very much involved and she enjoys visiting family and family friends but experiences a great deal of anxiety prior to the visits if she is aware of them before they happen.

Kimberley has a diagnosis of 10 P Syndrome, scoliosis, sleep apnea and hearing loss. At times Kimberley can get quite anxious and perseverate mainly on ideas and people. Things that cause Kimberley to experience anxiety are inconsistencies in the approach of support, guessing, managing meals and food, changes in her schedule, bared arms with arm-pits exposed, life jackets, changes in routine, snack and meal time, staffing schedules, not having Kraft Dinner or Diet Pepsi in the home, blue jeans, sweaters with hoodies and parties.

Kimberley is a very welcoming and engaging person. At times though, her anxieties can cause her an amazing amount of frustration leading her to hurt herself or others both physically verbally.

Additions Through CCS Towards A More Comprehensive Wellness Plan:

In addition to his current supports, the following additions were made to ensure the most optimal support was being offered to Kimberley:

1. Modified Diet.
    a. Low gluten, low sugar, low dairy and casein modifications were made.
2. Rebounding exercises and daily cardio.
3. BB-ABC Exercises (Bilateral, Bio meridian Awareness Based Calming).
4. Enhanced the development of supporters to become more mindful, emotionally self-regulated as they provide support:
    a. Gaining an understanding of behavioural contagion and entrainment as they engage in their role as a supporter and the ultimate effects that has on the level of anxiety of others; and
    b. Identifying key intra-personal insights to bring a perspective of understanding and authentic compassion.
5. Still to connect with a Registered Holistic Nutritionist.
    a. Treatment based on results from Organic Acids Test.
6. Still to connect with an Occupational Therapist trained in sensory integration/processing.
    a. Treatment based on results from sensory assessment tools.

Kimberley's Comprehensive Wellness Plan:

Needs Area # 1
Family and Support Professionals Intrapersonal Maturity: self and others mindful emotional-regulation, facilitation and advocacy skills:

Continue:

- N/A as supporter specific.

Stop:

- N/A as supporter specific.

Start:

- N/A as supporter specific.

Needs Area # 2
Gastrointestinal (GI): bowel, digestive and immune systems treatment, nutrition, pain management, dental and myofunctional disorders, illness prevention and treatment:

Continue:

- To support Kimberley to swim;
- To support Kimberley to go outside and play soccer;
- To support Kimberley to play tennis;
- To support Kimberley to bowl;
- To support Kimberley with proper daily oral hygiene after meals and when waking and going to bed;
- To support Kimberley to regularly attend dental appointments;
- To support Kimberley to regularly attend medical appointments; and
- To support Kimberley to regularly attend health & wellness appointments (eye, hearing, c-pap assessments, dietary).

Stop:

- Purchasing and preparing processed food (particularly high carb /sugar based foods);
- Over explaining about foods that are healthy;
- Supporting Kimberley to take frequent naps;
- Supporting Kimberley to sit for long periods using IPAD and/or doing numbers; and
- Parking close to entrances when out in the community.

Start:

- To track and document breakfasts, lunches, dinners (type and quantity);
- To track all fluids and intake (type and quantity);
- To include Kimberley in tracking;
- To introduce portion control (measuring amounts);
- To introduce a healthier diet;
- To purchase healthier foods – vegetables, fruits;
- To prepare and cook nutritious meals from scratch (see recipes in duo-tang);
- To introduce two servings of fruit per day (avoid bananas and pineapples);
- To introduce zucchini pasta on Sunday nights (1 month);
- To introduce homemade zucchini pasta on Sunday nights (after one month);
- To introduce chickpea flour (in place of wheat);
- To track all bowel movements and urine output;
- To consult to a Holistic Nutritionist; and
- To consult with a Naturopath.

Needs Area # 3
Emotional Wellness: mental and neurological health and disorders treatment, trauma desensitization and triggers elimination, psychological wellbeing:

Continue:

- To support Kimberley to feel safe by supporting her to know and repeat her safety plans (power outages, thunder storms);

Stop:

- Over supporting – over explaining and or talking with Kimberley about fears; and
- Staff will not discuss information about medical appointments of others in the home when Kimberley is able to hear.

Start:

- To introduce supports of Wellness Plan;
- To talk up to Kimberley;

- To talk to Kimberley and keep information brief; and
- To ask Kimberley to tell you the information when she knows it in order to assist her to develop her use of memory.

Needs Area # 4
Brain Development, Coherence Balancing and Inflammation Regulation:

Continue:

- To expand physical daily activity - swimming, tennis soccer walking, rebounder, and a light medicine ball.

Stop:

- Using word "calm"; and
- Supporting periods of over-napping – avoidance.

Start:

- Using the rebounder 10 minutes each morning;
- Using rebounder to increase use throughout the day – building up to 10 minutes each time;
- Supporting breathing exercises - lifting arm;
- Supporting her to recognize calm;
- Mindfulness walking;
- Staff will introduce butterfly tapping; and
- Staff will eat with Kimberley and will model mindfulness.

Needs Area # 5
Human Energy System – A Need for Sleep, Balancing and Protection from Wireless Radiation and Electromagnetic Fields (EMF):

Continue:

- To support Kimberley to wear CPAP mask (during fire and hot water checks, the overnight staff will check if she is wearing mask and the machine is on and document on charting).

Stop:

- Supporting Kimberley to nap throughout the day**;** and
- Using iPad prior to bed.

Start:

- To research other CPAP masks for Kimberley to wear;
- To chart nightly use of CPAP machines;
- Introduce filters in Kimberley's apartment;
- To introduce rebounder activity for 10 minutes each day; and
- To chart use of rebounder and other fitness activity each day.

Needs Area # 6
Sensory Integration and Processing:

Continue:

- To assist her to remove tags or labels from clothing when proving to be bothersome;
- Be aware of labels in clothing prior to purchasing and ensure they are not bothersome and can be removed;
- Assist Kimberley to wash new clothes after purchase and assist her to choose soft loose clothing;
- To be aware of volume in venues etc.;
- To be aware of volume of radio when in vehicles;
- To be aware and support Kimberley's balance when navigating uneven grounds;
- To be aware of Kimberley's hesitation of rides that are fast moving like a roller coaster;
- To be aware of presence and aware of Kimberley's state of mind and support accordingly, (for example prickly bushes, trees etc. – at times can be fearful and at other times she's not; and
- Assist Kimberley with building her cardio physical routine to minimize anxiety (parking further away and walking to places and at pace of being late, 10 minutes of rebounder in the morning, and in PM, swimming and other physical activities etc.).

Stop:

- Over supporting fears when it could escalate situations.

Start: • Kimberley to meet with a Registered Holistic Nutritionist; and • Kimberley to be referred for a hair analysis.
Needs Area # 7 ***Accommodations, Behaviour (ABA Learning), Communications and Contributing to Others Wellbeing:***
Continue: • To speak clearly concisely and calmly; • Support her to wear hearing aids; • To support positive social interactions that build her social skills; • To be mindful and emotionally present when supporting and socializing with Kimberley; and • Speak up to Kimberley and not assume she does not understand, ask her to repeat it back to demonstrate her understanding.
Stop: • Redirecting when stories are being embellished about staff.
Start: • To educate and support co-workers to understand, learn and explore CCS strategies and tools; • To introduce 10 minutes physical in morning at the start of her day (rebounder); • Support physical and cardio activities at least 10-15 minutes 3x a day – soccer and rebounder; • Staff will park further her away and walk like you are late for an appt. to build up Kimberley's cardio and physical; • Take time to look and give feedback to Kimberley about her work; • Assist Kimberley to explore an APP for audio books; • To assist Kimberley to participate in scrap booking class (build hobbies and interests to develop friendships); and • To be aware when Kimberley embellishes stories that it may be her way to create conversation and assist her to have appropriate conversations.

Kimberley Today:

With only a few months of implementation underway, it seems as if Kimberley has experienced some improvement as she has become more open to discussing things beyond her perseverations. She has adjusted to some modifications to her diet and has been loving bouncing on her rebounder.

Overall, Kimberley seems to have lowered some of her anxiety however with more time to implement the comprehensive wellness plan, it is expected that she will lower her anxiety even further.

Contributions of Successful Implementation

1. Improved self-regulation of supporters to identify bringing their greatest level of emotional maturity to ensure that they were bringing their most optimal level of support.
2. BB-ABC exercises, rebounding and cardio.
3. Modifications to diet to lower the amount of gluten, sugar and casein.

Limitations

1. There have only been a few months to allow for implementation which can limit the outcomes to date.

Appendix V - Insight From a Family- A Letter of Testimony

Jess & Brad Smith
410 County Road 25
Picton, ON K0K 2T0
613-476-1428

March 7, 2018

Re: Our Experience with the Conscious Care Protocol

I am writing this letter to shed light on the questions you may have regarding the Conscious Care and Support Protocol. For most people this seems like a strange and foreign concept but for our family, it is an everyday journey. It has proven time and time again to yield positive results in our son's physical and mental health and his ability to live a happy fulfilling life. Please allow me to explain why I support this program with such passion.

We adopted our sweet boy as a baby and quickly came to realize that he was not a "typical" child. He has severe sensory issues, developmental delays and many other struggles, FASD, Autism and a Developmental Delay for starters. For years we struggled to support him unassisted until that task became impossible. We were desperate and tired of sitting on waiting lists, not being given proper instruction or direction as to how to help him. At this point we sought out a Naturopathic Doctor which was recommended by a friend. When we saw the occurrence of restrained rages drop from three one hour sessions each week to one a month, after removing milk from his diet, we were convinced. This started our journey to natural healing and my obsession to find real answers, not band-aid solutions.

Along the way we have hit some pit falls such as, once we saw a professional doctor in the field, we were given many medications to help calm him and stop his behaviours. These medications were not successful in doing so and in my opinion, eventually triggered his autoimmune disorder which caused critically low blood platelets because they damaged his already struggling digestive system. We saw mild improvements while on these drugs but we believe that was because he was taking them at night and they have sedative effects. We have since realized that he has an issue with sleep and we use edible medical marijuana to aid him in resting. That is the only medication he currently takes outside of his supplements.

We were told the medical community had no answers for us and that we could give him blood transfusions, take his spleen out or put him on prednisone which would allow his body to recover temporarily but they could give us no long-term solution that would allow us to manage his care successfully. I started to search for answers that would give me direction as to how to help his body become healthy again and figure out why he was so sick. I found direction from the internet and started supplements to coat his digestive tract, we immediately saw improvement. He gained 5 pounds in 6 weeks, the bruises that covered most of his body for almost 2 years were nearly gone, his platelets rose from 25,000 to 50,000 and his mood regulation improved. Once again we were shocked and it reaffirmed, we were on the right track.

During this time he was attending St. Gregory's Catholic School in Picton two hours a day, he has since returned to full days and is having great success. The team at the school was the most supportive and helpful group I could have asked for. I have worked with Suzanne McKerral at the school and board level, Stephanie Bryne-Shaw eventually replaced her within the school and both have been amazing at assisting us through this very difficult time. The Principal, Kevin Dorey has allowed his team to extend themselves beyond what is typical, to be creative and think outside the box. This has allowed my son to stay within his community and continue the consistent and caring relationships they have all built with him. We are forever grateful for their commitment and dedication to our family and our son's well-being, we could not have done this without them.

Seeing his success, we sought out another Naturopath to further aid in our quest for healing. We added a few more supplements and dietary restrictions and we saw his platelets move from 50,000 to 106,000 and the Oncologist following our case released us from her care. Around the same time I was generously offered a course through Community Living Prince Edward and was asked to join a project that would follow my son's progress. I gladly accepted and have not been sorry.

Peter and Addy from the Conscious Care and Support Program reaffirmed what I've already been doing and have given me many suggestions on how to make life even better for our son. We have been connected with a Holistic Nutritionist and had tests done to allow them to see how his body functions and what deficiencies he has, through her recommendations we have once again seen great gains in his ability to regulate. He has not been restrained since July 2017 and his ability to function in public has improved drastically. He can process his feelings, explain them to us and apologize for behaviours he knows are unacceptable. He is growing, gaining weight and has never been this happy in his whole life. We will gladly continue to follow the Conscious Care and Support protocol. Currently we are talking to The Listening Center to aid in his sensory processing needs and are planning to have a detailed Occupational Therapy assessment done by their recommended therapist. We will also continue following his progress and ever changing needs with the professionals we have been put in touch with.

Personally, I have learned many things through the course. The Conscious Care protocol not only aids the person struggling but those supporting them, and I for one needed that. Being the main caregiver to a child with such complex and intense needs is something that I cannot explain to you. It is the most demanding and exhausting task I have ever taken on but to see the successes our child is having and to see him happy, is all I need. This program will help so many people if it is implemented properly. Open your minds. Open your eyes and allow this amazing journey to teach you. I've never learned so much and I am so grateful and encouraged that we, and anyone like us, finally have real HOPE.

Sincerely,

Brad and Jess Smith