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The Low Arousal Approach: A Practitioner's Guide

Studio 3

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Pavilion Publishing and Media Ltd

Rayford House, School Road, Hove, Sussex BN3 5HX.

Tel : 01273 434943

E: info@pavpub.com

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The Low Arousal Approach: A Practitioners Guide

1. Introduction

[In a previous report for CareKnowledge](#), Damian Milton outlined how *'imagining otherwise'* about autism can lead to more nuanced and autistic-friendly support strategies being devised and implemented. That report showed how support strategies that have been developed without a good understanding of autistic ways of being can lead to dubious intervention goals and processes. It also suggested that when autistic people have difficulties in communicating their needs, a humble, collaborative, reflective and person-centred approach is required.

This new report explores the Low Arousal Approach to managing challenging behaviour, with particular reference as to how it can be implemented in work with autistic people.

This report aims to first detail the Low Arousal Approach's origins, theoretical underpinnings and which features constitute a Low Arousal Approach in professional practice. The report then aims to describe how the Low Arousal Approach can, and should, be applied by practitioners when supporting autistic people who display *'behaviours of concern'*. In addition, the report sets out authentic practice examples of how this approach has been applied, and the results that have been obtained.

2. History of the Low Arousal Approach

The Low Arousal Approach is a person-centred, non-confrontational method of managing behaviour. The original ideas that form the basis of this approach were developed as a response to observational data collated in the late 1980's. From these observations it was clear that staff were using consequences as a dominant way of managing 'behaviours of concern'. However, more interestingly, it was often staff and carers who triggered such behaviour through their actions.

Additionally, the use of physical interventions appeared to be unplanned and practiced in an unsafe manner. From these observations it was decided that it was necessary to develop a coherent model of diffusion and de-escalation. Furthermore, the obvious theoretical underpinning for such a model would be the link between physiological arousal and behaviour. Given the accounts autistic people give regarding sensory overwhelm and difficulties with processing and integrating sensory information, restraint is only likely to escalate the stress that the autistic person is already experiencing.

The main elements of the approach remain unchanged, so, in utilising the Low Arousal Approach in working with autistic people, the focus remains on prevention, de-escalation and, in extreme cases, planned and safe physical management (McDonnell, Waters & Jones, 2002). This approach has evolved to become a practical behaviour-management approach, not only for people with intellectual disabilities and or autism, but for the care sector in general (McDonnell, 2010). To

successfully develop a de-escalation approach in care environments, a number of key issues require careful examination by practitioners. However, first let us define what constitutes a Low Arousal Approach in practice.

3. The Low Arousal Approach

A Low Arousal Approach is predominantly a staff/carer-based intervention which focuses on reducing arousal in crisis situations. McDonnell, McEvoy and Dearden (1994) defined a Low Arousal Approach as:

“A collection of behaviour management strategies which focus on the avoidance of confrontation. This is primarily achieved by the reduction of triggers / cue behaviours which may arouse an individual who presents with challenging behaviours.”

There are four key components considered central to a Low Arousal Approach, these include both cognitive and behavioural elements:

1. Decreasing demands and requests to reduce potential points of conflict around an individual
2. Avoidance of potentially arousing triggers e.g. direct eye contact, touch and removal of spectators to the incident
3. Avoidance of non-verbal behaviours that may lead to conflict e.g. aggressive postures and stances
4. Challenging carer beliefs about the short-term management of challenging behaviours.

4. Key elements of the Low Arousal Approach

4.1 Pre-crisis intervention

There is a window of opportunity when an autistic person's arousal level is increasing and carers may intervene to avoid further escalation of stress and resultant 'behaviours of concern'. Typically, an individual will start to show 'cue' behaviours at this stage (e.g. pacing, shouting, self-injury). There are a few key strategies that practitioners can use and advise at this point:

- i. **Distract/Divert:** Try to change the subject or divert their attention to another activity. For example, if an autistic child is aggressive whilst in the waiting room of a doctor's surgery, a practitioner may focus on strategies the carer may use in this setting to distract or divert the child from the arousing stimulus/situation. For example, the parent could encourage their child to listen to their favourite music on their iPod or similar device
- ii. **Demand Reduction:** Distressed behaviours are often preceded by demands/requests. Therefore practitioners may work with the autistic person's care team or supporters, teaching them to recognise when to temporarily reduce or remove their demands or requests to help defuse incidents. **NB:**

Demand reduction is not for life, just for the moment. The solution is to focus on the time factor, for now, not the future

- iii. **Managing Aversive Stimuli:** We have all learnt to avoid the place that is too crowded, too noisy, too hot, etc. We may simply avoid entering such settings or escape them once we enter them. Escape from noise, over-crowding and excessive stimuli may all be important factors in triggering aggressive behaviour. Autistic people may be especially sensitive to excessive stimulation and may have idiosyncratic sensitivities to certain kinds of sensory stimuli. A key area of the Low Arousal Approach therefore involves practitioners exploring autistic people's sensory profiles and developing plans for the autistic person and their supporters to use, in helping the autistic person to manage these sensitivities.

4.2 Managing the critical incident

It can be extremely scary for people to manage an angry and distressed person. Most individuals who are distressed are usually extremely aroused at the time (leading to their reduced ability to process information) and so practitioners of the Low Arousal Approach advise avoiding actions or demands that will further arouse this person: *i.e. 'Don't pour fuel on the fire'*.

- i. **Verbal de-escalation:** Reduce verbal interaction, adopt a gentle tone and avoid requests/demands in these circumstances
- ii. **Awareness of non-verbal behaviours as a trigger for aggression:** Most common communication is predominately non-verbal rather than verbal. Therefore, practitioners should help to ensure carers are aware of the signals that they communicate when the autistic individual is aroused and how to present themselves in order to lower the autistic person's arousal
 - o *Appear Calm* – body language awareness; avoid tensing muscles, breathe slowly and regularly
 - o *Avoid direct eye contact* – avoid staring but try to maintain regular intermittent eye contact. Physical touch also has an arousing element and should be avoided
 - o *Personal space* – a Low Arousal Approach would suggest that when an autistic person is upset and aroused, the minimum distance to stand is approximately three feet, and for some autistic people this distance may not be enough.

4.3 Post incident recovery

Once the crisis appears to be over, the carer or practitioner must allow time for the individual to recover, which may take several hours. This is not the time to ask for an apology, make any demands, or reintroduce the initial trigger, as the individual is still likely to be highly aroused and this may lead to another crisis situation.

- i. **Debriefing:** Supporting carers after exposure to incidents of aggression is an important aspect of the approach. Immediate debriefing (talking the incident through) may help carers to cope with the emotional aftermath of an incident. In addition, their thoughts and underlying belief structures may be altered as a consequence of their experiences. Therefore an understanding of their perceptions and attributions is important.

Some guidelines for the debriefing process:

- Complete a debrief as soon as possible
 - A debrief in person, face to face, is optimum
 - Confidential and comfortable – the person being debriefed must feel comfortable with the person they talk to and trust them to keep the information confidential
 - Actively listen and be non-judgmental – this is not a time to offer solutions, just listen to the person being debriefed
- ii. **Maintaining a positive relationship with the distressed individual:** a Low Arousal Approach adopts a person-centred approach to crisis management. In care environments when a carer is confronted by aggression, this approach would suggest that the person may be expected to show a high degree of tolerance. Maintaining a positive relationship with individuals presenting with *'behaviours of concern'* may thus prove difficult for carers
 - iii. **Practice example on forgiveness:** When carers, supporters and practitioners are working with autistic people they may witness or be party to physical and or emotional *'behaviours of concern'*. Witnessing such acts or being part of an act can be difficult to process and many supporters have described feeling directly targeted or have found their relationship with the individual changing as a result. This is understandable as it can be intense 'in the moment'. However, a key part of the Low Arousal Approach is being able to forgive. A colleague once described it as a double hermeneutic approach. First forgiving himself or herself, for holding these feelings towards the individual, and then forgiving the individual. This is highly important. Not forgiving the individual may increase stress and endanger the relationship. The individual and practitioner cannot work in a low arousal manner as both will be stressed, leading to further incidents, due to the transference of stress. Further, this colleague said that, without forgiveness, they could not practice with the individual, that they could feel the tension and that only through forgiveness could they ultimately move forward in working with the individual and reduce the individual's stress

- iv. **Developing longer term therapeutic interventions:** The crisis intervention described above should only be the beginning of an intervention. The next stage might involve increasing demands after a cooling off period. The Low Arousal Approach stresses the importance of the role of psychological trauma which may lead to panic and anxiety for individuals in care environments
- v. **Developing Organisational Responses:** Managing crisis in a more acceptable manner does not in itself change the behaviour per se. In terms of intellectual disability services, creating organisations that encourage staff to adopt low arousal strategies is an area which has received less emphasis. Likewise in family settings, the Low Arousal Approach needs to be a way of life, encouraged and adopted by the whole family. It is not just for dealing with a crisis. Autistic people who have exhibited 'challenging behaviours' may often attract lots of "*rules and boundaries*", an overuse of which can actually increase the likelihood of conflict rather than reduce it. Low arousal strategies sometimes involve the reduction of general rules and boundaries. Although such approaches can be challenging for staff and carers, empowering autistic people to make choices can lead to reductions in challenging behaviour (Pitonyak, 2004)
- vi. **Designing environments from a Low Arousal perspective:** The altering of environmental factors which reduce physiological arousal is an important facet of the approach. Dunn suggested that we should pay close attention to the environment and programme in response to the sensory profile of the individual (e.g. for an individual who is sensitive to noisy environments – keeping noise to a minimum by not having the TV on in one room and the radio in another).

5. Trauma - informed behaviour management approaches

People in care environments may have either experienced or been exposed to trauma. "Trauma-informed" services are not specifically designed to treat symptoms or syndromes related to sexual, physical abuse or other trauma but they are informed about and sensitive to, trauma-related issues which are present in survivors (Harris & Falot, 2001).

Behaviour management approaches thus need to account for the traumatised nature of the populations in their care. In autism services, trauma has been acknowledged as an important factor in the presentation of 'challenging behaviours'. Person-centred approaches that acknowledge this factor (e.g. the Low Arousal Approach) tend to avoid the use of punitive consequences. This would explain the importance of giving people choices rather than boundaries (Pitonyak, 2005). Viewing an individual as 'traumatised' tends to alter our perceptions of their behaviours and modify our responses to them. For example, if we understand that a person is 're-

traumatised' every time they are restrained, it will help motivate us to seek alternatives.

5.1 Practice example

The key theme is understanding that a person is traumatised, which enables supporters' approaches towards the behaviour to change. One case, which indicated the importance of taking this approach involved a young man, whose father had passed away. There was a debate amongst his staff team as to whether he would have a normative bereavement experience. They concluded that the young man might well become extremely agitated around the time of his father's death, in subsequent years. As a result, his staff would have to be very mindful of this.

The staff then consistently adopted the Low Arousal Approach, which in practice meant accepting that the young man was traumatised and that bereavement issues can take a long time to process. On the first two anniversaries of his father's death, there was a clear pattern of the young man becoming more upset, often saying "*I miss my Dad.*" In the subsequent years this effect became less pronounced and the trauma-informed approach involved time, acceptance that he was traumatised by the process and there was no need for an intervention plan as such.

The main document developed was a bereavement plan which included a 'social story' about what had happened to his father. This was further developed as a long term conversation to have with the young man when he talked about his father's death. There was a strong focus on building up the young man's physiological arousal to stress, with physical exercise and then using this as an arousal-regulation strategy.

6. The role of carer expectations and beliefs in the maintenance of 'behaviours of concern'

Attempts have been made to explain how carers' thoughts and beliefs affect their behaviour in care environments. Care staff may have negative thoughts about the behaviour of an autistic person, e.g. '*Oh, he causes so much trouble*' which can directly affect their more deeply held beliefs such as '*I can't cope with stress*'. Altering these thoughts can help carers in their interactions with the individuals they are caring for.

Carers can bring their own personal experiences and learning history to care situations which can be quite rigid and difficult to change. For example, a care staff member may hold the belief that people who misbehave should be punished, which might lead to them asking service users to write letters of apology after incidents. In such circumstances, care staff are assuming that the individual was in control of their behaviour at the time of the incident. A more contemporary view is that some aggressive behaviour can be viewed as automatic and may at times be out of the control of the individual (Richetin & Richardson, 2008). The complex interaction of

person and situational variables (see Anderson & Bushman, 2002) makes the view that aggression can be controlled by sanction alone, a very over simplistic one.

The table below shows the complex relationship between these two variables. When a person appears more aware and in control, their behaviour may be typified by threats of harm and the individual could appear to be relatively calm: 'If you do that I will hurt you'. This type of aggression is clearly instrumental in nature. In the second instance, the person's arousal level may mean that the individual is only partially responsive to communication and an external state of hyperarousal is more obvious. In the third condition the person may be unaware that they are being perceived as aggressive but, will stop if politely prompted. In the final situation, the person is not responsive to external prompts. Many rage-like states can reach this point. To conclude, it is possible for individuals to fluctuate from one emotional state to another.

The relationship between control and awareness:

More in Control	Less in Control
The person appears aggressive with threats and seems to be in control and argumentative	The person is only partially responsive to conversation, direction and appears to not be focusing on the individual
The person shouts and becomes verbally aggressive, but will stop when prompted	The person is aggressive and distressed and does not respond to external prompts
More Aware	Less Aware

6.1 Practice Example

Perception of control was clear to see from a case involving a young woman who possessed good verbal communication and could be quite cutting with her remarks. Her care team would often internalise what she had said. As a result the care team saw her as wilful and became more frightened as they thought that she was in control of what she was doing and had pre-planned her actions. A decision square was therefore used and a thorough discussion was held with her staff team, around her behaviour. In general, the staff consensus was that her explosive episodes were a result of the young woman being stressed. The mantra became: manage the stress, not the behaviour. Cues to her stress were that she would become more

repetitive in nature and fixated on topics. In this approach the main way of helping the staff team was in getting the staff to understand that the young woman was not in control of her behaviour.

7. The role of Carer-Reflective Practices

If the behaviour of carers may inadvertently trigger aggressive behaviours, then logically, altering these behaviours may have an impact on the management of aggressive 'behaviours of concern'. It is useful for carers to engage in *reflective practice* whereby they evaluate their performance in situations and learn from both positive and negative experiences (Schon, 1987).

It is important to remember that all behaviour is meaningful and to ask yourself why the person needs to engage in that behaviour. These types of thoughts may help carers to perceive the person as less in control of their behaviour and view themselves as active contributors to the situation. In these circumstances, carers may think of solutions that focus on their own behaviour rather than changing the individual's behaviour per se. It is important to note at this point that the reasons why an autistic person may be behaving in a particular way may be very different from that assumed to be the case by carers' who are relying upon their own experiences. Due to the '*double empathy problem*' between autistic and non-autistic people (Milton, 2012) it is paramount to build rapport with the person in their care, and yet exercise humility in interpreting their actions.

7.1 Practice example

James was a twenty eight year old man with a diagnosis of autism and mild intellectual disability. He also was visually impaired. From the age of 12 he attended a residential school and at 18 transferred to an adult intellectual disability service, which was far from the family home. His 'challenging behaviours' were stated as a reason for this placement. His family visited weekly and expressed a clear wish that he returned to a placement near his family home.

When James arrived at the service he found it difficult to adjust to living with his new peers. Inadvertently, significant pressure was placed on him by both his staff team and his family. The staff adopted what they described as a 'needs-led' approach. This entailed providing James with multiple activity choices. Each day he was encouraged to interact with his peers and take walks in the local area. At the same time, his family visits increased to daily. The family began to routinely take him to a local pub and every effort was made to maximise his community opportunities.

Within three weeks James started to show behaviours which indicated a hyper-aroused state. His sleep pattern deteriorated and on four occasions he was destructive to property. The incidents tended to last between one and two hours in duration. James began to avoid the communal areas in the house, withdrawing to

his room. Staff tried to encourage him out of his room but James often began to scream when these requests were made.

In the fourth week of the scheme James had a day-long episode of destructive behaviours. This culminated in an incident of physical aggression where he punched a member of staff in the face and kicked another in the groin. The staff team felt that they could not manage this new set of behaviours. Their 'on call' manager decided to telephone the local police. Four policemen arrived and decided to arrest James after he threw a chair at one of them. The officers held him face down on the floor and applied handcuffs. This agitated him further. James was screaming, shouting and struggling with the police officers. A staff member had driven to the police station as she was concerned that he would be more agitated if he was in an unfamiliar environment. Within ten minutes of his arrival at the police station James visibly began to calm down. This settled period led to the staff member to request to take him back to his group home.

An emergency meeting was called the next day and this involved specialist advisors from the Studio 3 organisation. The staff team had clear disagreements about what they should do with James. Some were very fearful and suggested that he be placed in a hospital, whereas others felt that they should persevere. A crisis plan based on a low arousal model was adopted. There were several key elements to this;

- i. All verbal demands and requests by staff were radically reduced. It was noted that staff often requested James to 'calm down' which appeared to agitate him further. Staff were to follow a plan to avoid speaking to James on a routine basis, as this would reduce his confusion and distress
- ii. Staff were encouraged to speak in a clear and concrete manner
- iii. If James damaged property, staff were told to avoid verbally responding to these behaviours unless he damaged property in a manner where the risk of personal harm was elevated
- iv. Staff were advised that James' aggression and property destruction were an outward expression of 'panic anxiety'. This was used as a key rationale for his low arousal plan. It was explained that the reduction of his anxiety was a key aim of the plan
- v. It was discovered that staff had also been attempting to discourage James' 'stereotypical behaviours', particularly when he rocked backwards and forwards in a seated position or bounced on his bed. The Studio 3 advisors strongly suggested that staff avoid responding to his 'stereotypes' as the behaviours in essence probably served a purpose of reducing stress and anxiety
- vi. James' family were requested to reduce their visits on a temporary basis
- vii. Staff were encouraged to establish a predictable routine for every day of the week. Exercise of up to one hour per day was regularly introduced
- viii. A short term additional advice line was put in place by Studio 3 staff to be used in the event of an emergency

- ix. Studio 3 training was implemented for all staff over a four week period. The physical interventions were taught on a 'bespoke basis' (hairpulling, airway protection and the two person walkaround method was taught using role play scenarios)
- x. All staff also received specific autism-awareness training tailored to James' needs. This training focused on sensory triggers to his behaviours, especially, James' sensitivity to sounds and sudden physical contact. Positive sensory experiences (walking in the rain, swimming, car journeys) were all increased as part of a 'sensory diet' (Bogdashina, 2003)
- xi. Staff were encouraged to talk about their fear of James in team meetings and to debrief with colleagues after witnessing property destruction or aggression.

Within two weeks of implementing this plan James' behaviour began to settle. Property destruction became less frequent and there were only two incidents of physical aggression. Although some staff still expressed negative feelings about James, the majority reported that they were more confident in interacting with him. After a month of implementation, James' activity programme was altered and staff established new activities in the community.

There were many elements which led to the change in staff behaviour. James' keyworker stated categorically that 'low arousal works', but she was also worried that some staff still 'did not get him'. There were still debates between staff members, some of whom felt that they were 'giving in' far too much. This observation is often made when adopting a Low Arousal Approach (McDonnell, et al, 1998). One member of staff suggested forcibly that James needed strong boundaries as he was a bully and that his colleagues were making too many excuses to justify their hands-off approach. This individual was encouraged not to work with James in future.

8. The link between Arousal and Behaviour

Arousal has long been implicated in the 'challenging behaviour' of people with autism. It is important at this stage however, to remember that an individual's level of physiological arousal influences the way that they process environmental sensory stimuli and may also have a negative effect on human performance. Since some behaviour is mediated by a heightened state of physiological arousal; the reduction of this arousal should reduce 'challenging behaviours', at least in the short term. Low Arousal Approaches are strategies used to manage such crisis situations.

8.1 Practice example

Exercise as a means of regulation is a much more pro-active approach towards arousal regulation. Sam was a service user who often quickly became stressed and was not, in these instances, able to regulate her affect and behaviour. This was despite recognizing she was stressed, but, in the moment, she was often too highly aroused to be able to utilise stress reduction tools. It was therefore decided to put in place a regular exercise routine. From the time of implementing exercise into her

routine, it was clear that she was becoming less stressed. Incidents of her reaching high arousal reduced and she was less stressed in day-to-day life. Therefore, when she was stressed she was able to recognise the feeling and to use techniques such as mindfulness and breathing exercises, as her stress was now recognisable, from her daily arousal levels.

9. Conclusion

This report has described a model of managing aggressive behaviours in care settings called a Low Arousal Approach. The model involves the reduction of demands in crisis situations and a focus on avoiding non-verbal and verbal cues and triggers to aggression. The report further outlines how practitioners of this approach put together, and have utilised, this approach in action.

We hope that this report will highlight both the importance of taking a Low Arousal Approach when working with autistic people and will demonstrate the results that practitioners have achieved in utilising this approach with care teams and service users. Ultimately, we hope that more practitioners will use this approach and that care teams and autistic people will be encouraged to work with practitioners who take a Low Arousal Approach, to develop it further.

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About the authors

Andrew McDonnell (Clinical Psychologist and CEO of Studio 3 Clinical Services and Studio 3 Training Systems Ltd)

Damian Milton (Lecturer in Intellectual and Developmental Disabilities, Tizard Centre, University of Kent. Autism Knowledge and Expertise Consultant, National Autistic Society. Lecturer at London South Bank University. Chair of the Participatory Autism Research Collective (PARC), and Project Leader of the National Autistic Taskforce (NAT).

Andrea Page (Studio 3 Consultant and Senior Lecturer at Birmingham City University)

Simone Kendall (Assistant Clinical Psychologist, Studio 3 Clinical Services)

Tarendeep Kaur Johal (Assistant Clinical Psychologist, Studio 3 Clinical Services)

Anthony O'Connell (Assistant Clinical Psychologist, Studio 3 Clinical Services)

[Studio 3](#) are specialists in supporting individuals with a range of behaviours of concern. These include, the management of physical aggression, self-injurious behaviours (SIB), trauma and abuse (children and adults), self-harm and autism.



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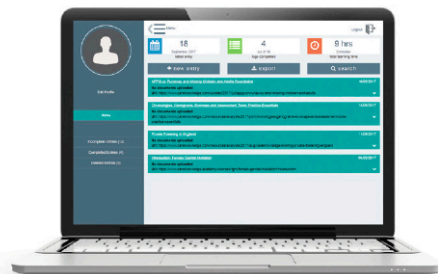


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