Positive Behavioural Support: Definition, Evidence, and Implementation

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- Positive Behavioural Support – rooted in the understanding of, and supporting, the behaviours that challenge of people with intellectual disabilities
- The components of the PBS framework
- A narrative about effectiveness of 'PBS' for people with intellectual disabilities
- Suggestions from the existing evidence base about the delivery of PBS in practice
- Limitations of the existing evidence base/directions for future research

Positive Behavioural Support in the UK: A State of the Nation Report

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Challenging behaviour

“culturally abnormal behaviours of such an intensity, frequency, or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities” (*Emerson*, 1995)

1. The behaviour (what a person is doing)
2. The behaviour is severe, frequent or long-lasting, and
3. What the behaviour leads to (harm to self or others, results in abuse by others, restricts participation in everyday life, leads to exclusion)

A behaviour is only “challenging” if it is severe, long lasting or frequent enough to (and does) lead to negative outcomes

How many? Prevalence

- *Conservative* estimate from population-based data in the UK (Emerson et al., 2014) = 1 in 6, to 1 in 9 children display CB
- In population-based studies, approximately 1 in every 5-6 adults with ID known to services engages in significant CB. Bowring, Totsika, Hastings et al. (2017):

Challenging Behaviour	Prevalence [95% CI]
Overall CB	18.1% [13.9%, 23.2%]
Self-injury	7.5% [4.9%, 11.4%]
Aggressive-destructive	8.3% [5.5%, 12.3%]

Vulnerability factors

Biological:
- Additional syndromes
- Autism
- Physical health issues (eg pain)
- Epilepsy/seizures
- Sensory impairments

Psychosocial:
- Lack of communication skills
- Negative life events
- Family stress
- Mental health issues
- Lack of meaningful activity
- Impoverished social networks
- Institutionalised accommodation
- Socio-economically disadvantaged

Cumulative risk

Maintaining processes

- Pain reduction
- Positive automatic re-inforcement

Challenging Behaviour

- Other people's behaviours

Impact

Biological:
- Effects of psychotropic medication
- Harm to self

Psychosocial:
- Exclusion
- Harm to others
- Mental health issues

[from Bowring, Painter & Hastings, 2019]

Normalisation/ Social Role Valorisation

Disability/ human rights

Deinstitutionalisation/ Community care

Positive Behavioural Support

Behaviour change theory and research

Challenging behaviour research

	Goal to reduce behaviours that challenge	No focal goal to reduce behaviours that challenge
Goal to increase skills, opportunities and/or environments that support life quality	**Positive Behavioural Support** Reduced risk of behaviours that challenge in the context of increased life quality	Other **Person Centred Supports** (e.g., Person Centred Planning) Other **Constructive Behavioural Approaches** (e.g., Precision Teaching) Other **Biopsychosocial Approaches** (e.g., Approaches to supporting communication) Other **Rights and Values Movements** (e.g., Self-Advocacy, Deinstitutionalisation)
No focal goal to increase skills, opportunities and/or environments that support life quality	**Aversive Behavioural Practices** (e.g., timeout, over-correction, other aversive punishments alone) Other **Biopsychosocial Approaches** (e.g., psychotropic medication alone) **Restrictive Practices** (e.g., seclusion, restraint)	Services and supports that seek to contain behaviours that challenge in circumstances associated with deprivation, restrictiveness and poor quality of life (e.g., non-habilitative secure provision, many everyday provisions that, often hampered by lack of skill and resource, tolerate and accept both continued behaviours that challenge and poor QoL)

[from Gore et al., IJPBS 2022]

Rights and values

A focus on rights and good lives

PBS

Theory and evidence-base

Ways to understand behaviour, needs and experience

Process and strategy

A systematic approach to high quality support

[from Gore et al., IJPBS 2022]

Rights and Values: A focus on rights and good lives	1. Person-centred foundation
	2. Constructional approaches and self-determination
	3. Partnership working and support for key people
	4. Elimination of aversive, restrictive, and abusive practices
Theory and Evidence Base: Ways to understand behaviour, needs, and experience	5. A biopsychosocial model of behaviours that challenge
	6. Behavioural approaches to promote learning, experience, and interaction
	7. Multi-profession and cross-discipline approaches
Process and Strategy: A systematic approach to high quality support	8. Evidence informed decisions
	9. High quality care and support environments
	10. Bespoke assessment
	11. Multi-component, personalised support plans
	12. Implementation, monitoring, and evaluation

[from Gore et al., IJPBS 2022]

Pieces of PBS - evidence

- The behavioural intervention technologies integral to PBS have been examined in a high quality meta-analysis of 285 single case experimental and small N design studies (Heyvaert et al., 2012). Results showed that reductions in challenging behaviours were associated with large effect sizes across these studies
- Versions of the *Prevent-Teach-Reinforce* model primarily for children: manualised, several RCTs

PBS Trials in adult services systems

- 63 adults with ID and CB individually randomised to support as usual or SAU + referral to a specialist PBS community team. No data recorded on nature of PBS supports or SAU. PBS group greater reduction in CB at follow-up and trend for lower overall costs (Hassiotis et al., 2009) CB outcomes maintained at 2-year follow-up, no cost differences (Hassiotis et al., 2011)
- 23 community teams (246 adults with ID and CB) randomised to staff training in PBS with SAU vs SAU alone. PBS training – 6 days by recognised PBS trainers, ongoing mentoring support. No data collected on SAU. Fidelity checks completed on available PBS plans all rated as inadequate. No group differences for CB or any secondary outcomes (Hassiotis et al., 2018)

RCTs – added/integrated components

- Family based PBS for 54 families of young children (mean age 4 years) vs PBS with parental optimism training. 8-week manualised PBS programme. Approx. two thirds completed intervention in each group. Video recordings for fidelity checks. PBS+ group greater reduction in CB at follow-up (Durand et al., 2013) *[Similar rationale to MBPBS – Singh]*
- 24 social care settings for adults with ID (81 participants) randomised to standard PBS support vs enhanced system wide care with PBS. Fidelity checks completed on system wide care improvement elements but not standard PBS support. System wide care group greater reduction in CB at follow-up, but no difference for quality-of-life measures (McGill et al., 2018)

PBS community team evaluation

All age *PBS service* run as an MDT (Bowring et al., 2020)

- 39 children, 46 adults; mix of ID and autism
- PBS intervention model: functional assessment, multi-component interventions (following NICE Guidelines, 2015/18)
- PBS model described but no supporting fidelity data reported
- Follow-up (at close of intervention range 15-160 weeks): large effect size positive changes in quality of life (25% achieving Reliable Change); large effect size reductions in CB (73% Reliable Change, clinically significant reduction for 72%)
- Positive carer satisfaction data and “social validity” ratings

Evidence considerations

- PBS is a complex framework with 12 components. Rarely are all components addressed with clarity when describing PBS interventions being evaluated in research. PBS components also likely feature in SAU
- Fidelity to PBS is most often measured wrt Behaviour Support Plans (e.g., BSP-QEII, new *Behaviour Support Plan Content Appraisal Tool* [*BSP-CAT*])
- PBS interventions vary according to context and purpose (e.g., family support, social care services, community health services). Each requires an explicit Logic Model, co-production, and testing for effectiveness
- There is a lack of robust process evaluation of PBS interventions
- No single existing study can be used to answer the question of whether 'PBS' is effective, but can help address which ways of 'doing' PBS work best

Implementation

- ***Do*** - Delivering PBS through/led by a specialist team/service of skilled people may cost no more than usual supports but produces better outcomes. Evidence that typical delivery of PBS model by a specialist team leads to improvements in challenging behaviour *and* quality of life
- ***Do not do*** - Short PBS training courses for staff in typical community services may not be effective and can lead to poor PBS implementation
- ***Do*** – Use versions of PBS with theoretically-supported additions to potentially improve effectiveness (especially combined with staff/family well-being elements)

Implementation 2

https://pbs-academy.com/behaviour-support-plan-content-appraisal-tool-bsp-cat/

https://pbs-academy.com/

PBS Competence Framework

Workbooks for ***people with ID*** to understand PBS and contribute to their PBS Plan

Commissioners and care managers: contract specification, PBS monitoring tools

Service Providers: self-assessment checklist

Family carers: 5 guides on PBS, what to look for in a good PBS service

Support workers: competencies portfolio

+ Tool for checking the quality of PBS services

PBS Standards

Services/Teams, Training Providers, Individual Practitioners

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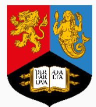

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