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## Aims & Scope

The *Learning Disability Review* provides a high quality source of information and intelligence for managers, practitioners and academics working in learning disability. The *Review* focuses primarily on services in Britain, but also draws on international experience, reflecting the common concerns of people with learning disabilities and those who support them worldwide, recognising the scope for international learning and development.

The contents of the *Review* are a combination of papers commissioned by the editors and submitted by practitioners, researchers and managers and are peer-reviewed anonymously before publication. The *Review* features:

- overviews of well-developed bodies of research which aim to draw out practical implications for learning disability services

- descriptions of important innovations in services for people with learning disabilities
- summaries of useful information and commentaries on relevant and topical issues in learning disability.

Emphasis is given to bridging the experience of managers, practitioners, academics, users and carers, and to establishing a constructive dialogue between different perspectives.

Readers are invited to suggest topics or submit papers for inclusion in future issues of the *Review*.

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# Guest Editorial

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## David Allen

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In his foreword to *Facing the Challenge. An Ordinary Life for People with Learning Difficulties and Challenging Behaviour* (King's Fund Centre, 1987), David Towell noted that:

*... the way we serve people with challenging behaviour is a key test of the quality of local service provision.*

Almost 20 years on, this statement remains extremely apposite.

In the interim period, much has changed in the structure of services for people with learning disabilities. The majority of public institutions are now gone, and have been replaced in most cases by more appropriate, domestic-scale community models. However, many of these community schemes have struggled to meet the needs of people who challenge in the post-institutional era and, despite the clear recommendations of the Mansell Report (DoH, 1993), *de facto* policy in many areas now appears to involve the building of new institutions in the private sector. Concern about this trend is such that the Department of Health recently saw fit to issue a reminder to commissioners about the need to provide more local, non-institutional services for this group (DoH, 2004).

The explanations for this position are complex and multiple. Certainly, management commitment to supporting people who challenge (identified in Mansell as being a critical variable) is patchy and variable. The innovative models of service delivery

clearly demonstrated in some areas have proved hard to replicate on a larger scale, and the widespread competence in supporting people who challenge, another keystone of the Mansell Report, has also been hard to realise. The latter point is perhaps a particularly key factor in precipitating placement breakdown and stoking demands for out-of-area placements.

With hindsight, a failing of some of the leading policy documents of the last two decades is that they have focused more on service structures (such as debating the relative merits of institutional vs. community settings, specialist behavioural teams vs. special units) than service function (what actually goes on in services). This is particularly unfortunate, as there is a wealth of research in existence that points the way to offering effective support for people who challenge. This special edition of the *Learning Disability Review* therefore concerns itself exclusively with this issue, and promotes positive behavioural support as a key intervention strategy that is both ethical and effective.

In keeping with the overall aims of the *Review*, papers are presented that attempt to demonstrate the key links between research and practice. My colleagues and I provide an initial overview of positive behavioural support that reviews its historical origins, key features and effectiveness. We also explore the reasons why this approach is not more widely available to service users, and examine some ways in which this situation can be improved.

Peter Baker and John Shepard's commentary on this article elaborates on some of these themes, and highlights in particular the need to replicate in community-based models the successful results historically obtained in more 'clinical' settings. They also outline the benefits of diverting some resources

from an intensive support service to providing more general training in behavioural methods.

One apparent obstacle to the widespread implementation of behavioural support in services is the perceived clash between the structured, scientifically-derived approaches of applied behaviour analysis and the more humanistic values espoused in many caring services. Gary LaVigna & Tom Willis describe a methodology for implementing positive behavioural support which demonstrates that, far from being incompatible, these two approaches are actually complementary and mutually supportive. In this sense, the application of behavioural technology provides the means by which the aspirations of social role valorisation can be made more real for people who challenge services.

Another obstacle is that too few staff are qualified in positive behavioural support. The contribution from Caroline Dench is therefore particularly welcome, in that it describes an approach to staff training that appears capable of reaching comparatively large numbers, is effective in developing staff skills and, most important, makes a difference in the lives of the people being supported by these staff. Dench's article also provides a clear demonstration of the kind of organisational commitment to supporting people who challenge that the Mansell Report demanded.

Richard Hastings' commentary on this article makes a number of key points. In particular, he makes a plea for clearer articulation of the specific staff competencies required to drive positive behavioural approaches forward. He also draws attention to the need to validate experimentally the

contribution of some of the new concepts (such as goodness of fit between support plans and those charged with their implementation) on which advocates of this approach place a high value.

A key feature of contemporary behavioural approaches is that they include proactive strategies designed to help change a person's behaviour over time, and reactive strategies to help manage it when it gets out of control. Kathy Lowe and colleagues examine some data from a recent large-scale UK epidemiological study on challenging behaviour that looks at the relative use of these strategies for a group of people with challenging behaviour.

This theme is continued in the two book reviews that complete this issue of the *Learning Disability Review*. First, Brian McClean examines the guidelines recently published by the British Psychological Society on *Psychological Interventions for Severely Challenging Behaviours Shown by People with Learning Disabilities* (BPS, 2004). Finally, Alick Bush, one of the authors of the BPS guidelines, reviews the most recent publication from the British Institute of Learning Disabilities on reactive strategies and physical interventions for challenging behaviour.

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# Positive Behavioural Support: Definition, Current Status and Future Directions

## ABSTRACT

*This article summarises the historical development of positive behavioural support. The main features of this approach are described, and the evidence for its effectiveness outlined. Despite clear empirical support for its use, relatively few people with learning disabilities and challenging behaviour appear to have access to this form of therapeutic intervention. Reasons for this are discussed, along with recommendations for future development.*

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INTENSIVE SUPPORT SERVICE

BRO MORGANNWG NHS TRUST

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## INTRODUCTION

Positive behavioural support (PBS) has its origins in the acrimonious ‘aversives’ debate of the late 1980s and early 1990s. In behavioural terms, an ‘aversive’ is a behavioural event that is followed by escape or

avoidance responses. In other words, something happens to a person that they find unpleasant and that they thereafter seek to avoid. Receiving a fine and endorsement on your licence after going too quickly through a speed camera or burning your hand from touching a cooker hotplate are examples of aversive events that we all may encounter and learn from.

Although applied behaviour analysis (ABA) has always offered a menu of possible non-aversive and aversive intervention options for supporting people with learning disabilities and severe challenging behaviour, in practice it is the use of the latter that predominated in the research literature until the start of the 1990s. Matson & Taras (1989), for example, reviewed the behavioural intervention literature published over the preceding two decades and found that 76% of published studies used aversives alone or as part of a combined intervention package. Similar findings were reported

in Lennox *et al* (1988), while Scotti *et al* (1991) found an increasing trend to use aversives throughout the 1980s. The types of aversive used in such studies included the contingent application of forced body movement, noxious chemicals (such as an ammonia capsule placed under the nose), electric shocks and the contingent removal of preferred items and activities.

Major changes in the philosophies behind and the structure of services for people with a learning disability were occurring at this time, resulting in a move away from institutional to community-based models of provision. Against this background, the use of aversives became increasingly and appropriately criticised as being in conflict with the values now espoused. In short, it was hard to reconcile the goals of community presence, respect and community participation with, for example, the use of devices designed to give automatic electric shocks to the wearer if they self-injured (Linscheid *et al*, 1990).

Discussion on this issue consisted initially of hostile and occasionally vitriolic exchanges between the respective proponents of aversive and non-aversive approaches (Repp & Singh, 1990). Fortunately, this rather sterile and unconstructive dialogue gradually gave way to more reasoned debate. As Emerson & McGill (1989) pointed out, a weakness of ABA was that it represented a technology for intervention that was devoid of a guiding values base governing how it should be used. Despite its proven effectiveness, it could therefore easily be abused. The same authors highlighted the fact that the other major theoretical influence on services over the last three decades, normalisation or social role valorisation (SRV), suffered from similar inadequacies. In the case of SRV, however, it was not the values base that was lacking, but an accompanying technology to translate these values into practice. The obvious solution was to overcome the inherent weakness in both approaches by adding them together and creating a new values-led approach to achieving behavioural change. PBS can in many ways be considered to be the product of this fusion.

## KEY FEATURES

LaVigna and colleagues advocated the use of a non-aversive behavioural model from the mid-1980s (LaVigna & Donellan, 1986; LaVigna *et al*, 1989), but the first definitive account of PBS principles was provided in a seminal paper by Horner and colleagues (1990). The essential characteristics of PBS include the following.

- It is values-led, in that the goal of behavioural strategies is to achieve enhanced community presence, choice, personal competence, respect and community participation, rather than simply behavioural change in isolation.
- It is based on an understanding of why, when and how behaviours happen and what purposes they serve (via the use of functional analysis).
- It focuses on altering triggers for behaviour, in order to reduce the likelihood that the behaviour will occur.
- It uses skill teaching as a central intervention, as lack of critical skills is often a key contributing factor in the development of behavioural challenges.
- It uses changes in quality of life as both an intervention and an outcome measure.
- It achieves reductions in behaviour as a side-effect of the above.
- It has a long-term focus, in that challenging behaviours are often of a long-term nature and successful interventions therefore need to be maintained over prolonged periods.
- It has a multi-component focus, reflecting the facts that challenging behaviours are often multiply determined and that users typically display multiple forms.
- It reduces or eliminates the use of punishment approaches.
- It includes both proactive strategies for changing behaviour and reactive strategies for managing behaviour when it occurs, because even the most effective change strategies may not completely eliminate risk behaviours from behavioural

repertoires (LaVigna *et al*, 1989; Horner *et al*, 1990; Carr *et al*, 1990).

disabled children (Crone & Horner, 2003; Horner *et al*, 2004).

More recently, Bambara *et al* (2004) described PBS as being:

*... characterised by educational, proactive and respectful interventions that involve teaching alternative skills to problem behaviours and changing problematic environments. It blends best practices in behavioural technology, educational methods and ecological systems change with person-centered values in order to achieve outcomes that are meaningful to the individual and to his or her family.*

PBS intervention 'tools' include:

- altering known conditions that increase the probability of challenging behaviour occurring (for example environmental factors such as space and light, social factors such as the number of people in a setting, programmatic factors such as activity levels, and intra-personal factors such as mental health needs or drug regimes)
- changing specific triggers for behaviour (for example modifying instructional methods, interpersonal style, reducing demands or increasing choice)
- teaching new competencies (such as general skills and coping skills)
- use of differential and non-contingent reinforcement
- specifying changes in carer behaviour and in systems of service delivery
- reactive strategies (for example distraction, evasion, minimal restraint).

LaVigna and Willis elaborate on these intervention options elsewhere in this Issue of the Learning Disability Review.

Although the origins of PBS clearly lie in the field of learning disabilities, its utility is potentially much wider; in the United States, for example, its use has already extended into schools for non-

## EFFECTIVENESS

It is incumbent upon all practitioners to demonstrate that any intervention that they undertake has demonstrable social validity. Interventions are said to be socially valid when they address a socially significant problem, have clear evidence for their effectiveness in achieving socially significant changes and are undertaken using the least intrusive means acceptable to the main stakeholders involved (Emerson, 2001).

Challenging behaviour can lead to the person concerned being excluded, neglected, abused and exposed to inappropriate interventions. There can be no doubt, therefore, that interventions for challenging behaviour are targeting socially significant problems. Although empirical support is lacking, it also seems intuitively correct that most people would regard PBS methods as less intrusive and more socially acceptable than interventions that employ aversives. This leaves consideration of whether PBS interventions lead to socially significant changes before any conclusion about their social validity can be drawn.

Historically, the behavioural literature has been rather weak in considering this aspect of social validity. Although there are several excellent meta-analyses of behavioural outcome research (Guess *et al*, 1987; Scotti *et al*, 1996; Didden *et al*, 1997), for the most part they have tended to focus on a limited range of outcome measures and mostly on changes in target behaviours themselves.

Carr *et al*'s (1999) meta-analysis of PBS outcomes attempts to redress this balance and examines a much broader range of outcomes. They include changes in positive as well as challenging behaviour, stimulus transfer across both people and behaviours, maintenance of gains over time, impact on lifestyle change, and stakeholder views on the social acceptability and effectiveness of the intervention. Clear inclusion criteria were set for the analysis, resulting in the inclusion in the review of 109 published articles featuring 230 service user

participants and 366 measurable intervention outcomes. The authors concluded that PBS interventions:

- are increasingly addressing severe challenging behaviours (earlier criticisms were that PBS interventions tended to focus on behaviours of lesser concern)
- produce small to significant changes in adaptive, positive behaviours
- produce 90% or more reductions in challenging behaviours from baseline levels in 52% of interventions, and 80% or more in 68% of interventions
- do not vary significantly in outcome according to whether stimulus-based or reinforcement-based interventions are used alone or in combination
- do not vary significantly in outcome if non-PBS interventions are included
- show successful maintenance over periods from between one and twenty-four months in about two-thirds of interventions (although the database here is small and inversely correlated with length of follow-up)
- are likely to generalise across new settings and intervention agents in about two-thirds of cases using the 90% criterion – but evidence of generalisation across different forms of challenging behaviour is weak
- can result in effective lifestyle change and positive evaluations of social validity (but once again, these outcomes are still reported in only a minority of interventions)
- are less effective for combinations of behaviours than for single behaviours
- are twice as likely to be successful if intervention is based on functional analysis
- are also likely to be more effective if interventions include changes in the structure and quality of service systems supporting the individual with behavioural challenges
- are likely to be more effective if implemented by a person's normal carers (instead of external specialists)

- can produce positive consumer ratings for acceptability and practicality, affect levels of challenging behaviour and affect lifestyle change (but a very small number of studies reported such outcomes).

A wide range of therapies, such as cognitive behaviour therapy and psychotherapy, are now increasingly being offered to people with learning disabilities (Frankish & Terry, 2003), all of which are compatible with the use of PBS. The evidence in support of these approaches is still emerging, however. At present, PBS approaches therefore appear to offer the most ethically stringent, evidence-based intervention option for people with learning disabilities and challenging needs, and thus PBS may be said to represent a socially valid intervention approach.

## CURRENT USAGE

This being the case, an evidence-based approach to service delivery would suggest that PBS interventions would be the most common form of therapeutic support available to this group of service users. UK research shows that this is clearly not the case, indicating that only between two and twenty per cent of people in need of such interventions actually receive any kind of behavioural support (Oliver *et al*, 1987; Harris & Russell, 1989; Qureshi, 1994). It should be noted that, in all these studies, users were recorded as having access to behavioural intervention if even the most basic behavioural guidelines were in place. Had a higher standard been set (for example plans based on functional analysis, including proactive and reactive elements), these figures would have been even lower.

In contrast, 50-60% of people with learning disabilities who challenge will be in receipt of psychotropic (typically anti-psychotic) medication (Kiernan *et al*, 1995; Fleming *et al*, 1996) and 50% or more will regularly be restrained (Emerson, 2002). A recent Cochrane review (Brylewski & Duggan, 1999) concluded that there was an almost total absence of supporting data for the efficacy of

antipsychotic medication for challenging behaviour, and that:

*It is debatable whether use of antipsychotic medication for certain people with a learning disability and challenging behaviour is ethical outside of a randomised control trial.*

The risks associated with inappropriate restraint use are similarly well documented (Leadbetter, 2002; Paterson *et al*, 2003).

In summary, we are currently failing to provide people with learning disabilities and challenging behaviour with effective support. What works best is used least, and what works least is used most. The gap between the rhetoric and the reality of evidence-based practice for this group of service users is both stark and alarming.

## REASONS FOR NON-USE OF PBS

There are multiple explanations for the low use of such interventions, and the list which follows is not exhaustive. First, it is clear that we have too few expert staff trained in the competencies of PBS. There are a small number of courses around the UK that specialise in training in PBS-related skills, but the overall impact of such courses in creating a significant number of trained professionals in this area to date is low. This points to the need to develop higher-volume, lower-cost strategies for building PBS competencies. Ideally, such training should have a system-wide focus rather than being targeted on one or two 'hero innovators'.

Second, while PBS interventions are more effective, they are also much more labour-intensive than less effective alternatives. Historically, interventions have often failed to take into account the needs and abilities of those charged with implementing plans and the constraints that they work under. One of the products of the PBS movement is the development of tools to assess the 'goodness of fit' between plans and plan implementers (Albin *et al*, 1996). Although the greater resource requirements for PBS

implementation is likely to remain a difficulty, prior assessment of goodness of fit will help eliminate major imbalances between the expectations of those designing plans and the abilities of those charged with putting them into practice. Debates on the cost of intervention need to focus on cost benefit rather than cost *per se*. The fact that an intervention is cheap and not labour-intensive is irrelevant if it is ineffective, and the human costs of ineffective treatment are high.

Third, although the benefits of PBS approaches to people with learning disabilities and challenging behaviour are clearly evident from the literature, commissioners have been slow to specify that PBS support must be provided as a key element of services specialising in supporting this group of users. The recent guidance from the National Care Standards Commission in England on best practice in registered homes for people who challenge is therefore a welcome and radical departure, specifying as it does that services must have in place a behaviour plan for their users. It is stated that this must include a functional analysis report, baseline data on behavioural frequency and duration, and both proactive and reactive behavioural support plans (Wing & O'Connor, 2003).

Finally, there is a prejudice against using carefully planned and structured approaches in human services. This is often given superficial legitimacy by reference to normalisation principles or, more accurately, by reference to a distorted account of such principles (Emerson & McGill, 1989; LaVigna & Willis, 1996). By stressing a PBS model, with its clear value base, and by establishing clear links between PBS principles and practices and other key service tools, such as person-centred planning approaches (Wacker & Berg, 2002) or individual educational plans, such resistance can be overcome.

## MOVING FORWARD

Few of the intervention approaches used within PBS are new. They are tools that have been available since the advent of applied behaviour analysis, but which have somehow slipped to the bottom of the

behavioural toolkit. The marriage of behavioural technology with a clear, positive value base has served to remind us of the existence of more appropriate and valued means to achieving good outcomes for people with severe challenges.

While the core approaches within PBS reflect the established elements of the ABA model, they have become increasingly expansive and more sophisticated in recent years. Increased options for antecedent intervention (Luiselli & Cameron, 1998), the development of functional communication strategies (Durand, 1990), the construction of more focused self-control strategies such as anger management (Taylor *et al*, 2004) and more radical strategies for interrupting behavioural escalation (LaVigna & Willis, 2002) are all examples of this.

PBS is nevertheless still a developing intervention approach. Carr and colleagues (1999) identify a number of opportunities for improvement.

- Present functional analysis tools, while able to yield reliable data, are generally not user-friendly or easy to apply in community settings. Procedures that meet all three criteria are required.
- Outcome evaluation needs to be expanded to include a much broader range of measures than just behavioural change.
- Feedback from both service users and carers on the social validity of interventions should form a crucial part of intervention planning and outcome measurement.
- Greater evidence is required of the effectiveness of interventions conducted in natural settings by normal carers; the bias in the literature has historically been towards interventions conducted by specialists in segregated settings.
- More evidence is required of the outcome of long-term interventions.
- Practitioners need to be prepared to repeat functional analyses, as precipitating and maintaining factors for behaviours will vary over time.

- More evidence is required to show that interventions are being built directly upon the results of such analyses.

In addition, better understanding of the critical organisational and mediator variables (Allen, 1999) that influence successful intervention and maintenance is required. More work needs to be done on building links between person-centred planning procedures and PBS strategies, and on increasing user involvement in functional analysis (Wehmeyer *et al*, 2004). Finally, the field needs to demonstrate that it can offer effective interventions for more externally directed challenging behaviours such as physical aggression (Didden *et al*, 1997; Scotti *et al*, 1996), for behaviours that appear to serve a sensory function (Carr *et al*, 1999) and for behaviours that occur at low frequency (Whittaker, 1993).

## CONCLUSION

The development of better services for people with learning disabilities and complex behavioural needs will in part depend upon a greater use of evidence-based practices. At present, PBS interventions represent our most effective and socially valid, but least used, options for supporting this group of service users. Individual practitioners, care providers, commissioners and government all have a responsibility to ensure that access to positive behavioural support procedures becomes available to all who need them rather than to the select few who benefit from them at present.

## More information

Further information on PBS can be found on the Association for Positive Behavioural Support website ([www.apbs.org](http://www.apbs.org)).

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# The Rebranding of Behavioural Approaches for People with Learning Disabilities and Challenging Behaviour

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For many years behaviour-based approaches enjoyed the reputation of the most applicable interventions for people with a learning disability who present challenging behaviour. The popularity of these approaches subsequently waned, for many of the reasons discussed in Allen and colleagues' paper. It is an accurate reflection that fewer of the criticisms levelled were concerned with the efficacy of the approach, and more with methods of implementation. In particular, reliance on the contingent application of aversive stimulation, together with what was perceived as a cold and mechanistic approach, drew a great deal of justifiable criticism.

It is also likely, however, that there were problems with efficacy that were not accurately reflected in the literature. Most of the evidence for the efficacy of behavioural approaches was gleaned

from interventions conducted in specialised treatment settings in the USA. The reality for many individuals in the UK would have been interventions carried out in less than ideal settings that would therefore have been more prone to failure. In addition, early behavioural interventions were not particularly concerned with any understanding of why the individual might be presenting the behaviour. Usually, only topography was specified and, even then, the treatment was rarely designed specifically to account for the type of behaviour being displayed. In reality, interventions relied on a form of aversive stimulation designed to eliminate any behaviour that preceded it, virtually irrespective of the type of behaviour or the reason why the person might be presenting the behaviour. As meta-analyses indicate, this lack of understanding of why the person engages in challenging behaviour is likely to result in interventions that are less successful than the literature might suggest (Scotti *et al*, 1996; Didden *et al*, 1997).

A quiet revolution in the way in which people with learning disabilities and challenging behaviour

were treated took place in the UK throughout the 1990s. To some extent this change was inspired by recognition of the communicative nature of much challenging behaviour and the related increased sophistication of functional analysis. Central to this revolution was a reduction of emphasis on the use of punitive approaches.

On reflection, while many behaviourists in this country embraced these new approaches with great enthusiasm, perhaps not enough was done to explain their significance to those outside this group. This was perhaps due to lack of appreciation of the growing unpopularity of traditional behavioural approaches. To a certain extent, this general lack of acknowledgement of the developments that occurred in behavioural intervention persists; exponents of newer alternatives will criticise behavioural approaches as if they were currently being implemented as they were many years ago. Clearly, there is a grave danger of throwing babies away with the bath water.

The term 'positive behavioural support' (PBS) has only recently become generally accepted. This rebranding is most helpful, as it makes clear the distinction between current and more traditional approaches. Allen and colleagues' paper is very welcome, as it attempts to make clear the criteria and distinctiveness of the approach, as reflected in the use of the term in the recently published British Psychological Society *Clinical Practice Guidelines* (Ball *et al*, 2004) (see elsewhere in this Issue). As Allen and colleagues highlight, it explicitly encourages the use of the wide range of therapies increasingly on offer for people with learning disabilities. This emphasis on compatibility of approaches is a much more grown-up way of proceeding, and contrasts with argument that relies on rubbishing the past in order to move to the future.

## CHALLENGES FACING PBS

The implementation of PBS faces a number of challenges, not least, in some cases, that of cost tensions. Consider the example of a young man with challenging needs, living in a single person service

in the locality in which we work. Previously, he had experienced three placement breakdowns as a result of poor services. More recently, with the provision of PBS and the concerted efforts of a dedicated and robust team of staff, his service has achieved five years of enduring stability, a conspicuous success in the context of his placement history. However, this has not come cheaply; PBS, in his case, has included the allocation of 2:1 staffing and the evolution of single person living. In comparison with other packages of care that are often driven by financial considerations rather than by needs, some may perceive this service as unreasonably costly. There is, accordingly, considerable and continual purse-holder scrutiny, arising from the desire to make financial savings. For this reason, this high-quality, 'person-centred' service remains vulnerable to the expediencies of cost-conscious commissioners. Such attention to cost considerations fails to take account of the point usefully made by Allen and colleagues in this respect: that intervention should be driven by cost benefits, and not by cost *per se*, a policy which results in the false economy of cheap, but futile, treatment. Nevertheless, the political reality is that proponents of PBS have to compete in a climate of ever-increasing pressure on community care budgets.

Allen and colleagues discuss a number of other challenges facing implementation of PBS. In particular, they refer to the apparent reluctance of services to embrace PBS, and the still prevalent use of more traditional interventions such as medication and restraint. They outline some of the factors which contribute to this state of affairs, including the tardiness of commissioners in demanding the provision of PBS in service specifications, and an apparently inherent prejudice in services against structured approaches. Perhaps more crucially, they refer to the paucity of expertise among staff groups working in challenging needs services, and the hitherto unsuccessful efforts to address this deficiency through training. This is a problem that has been recognised in this locality, and to which we have tried to establish a systematic response.

The demands made on the Intensive Support Service in Hastings by the number of potential referrals considerably outstripped its capacity to respond. As a result, the service was targeted at those individuals who presented the most severe challenging behaviours. This left a large number of people who, while having less severe behaviour, were nevertheless in a needy state. The presentation of challenging behaviour in these people was frequently found to be related to limitations in their service environments, which, if not addressed, could result in further escalation of these behaviours.

In response to this situation, in 2001 it was decided to switch some of the resource from clinical support to training direct care staff in strategies for PBS. The training has been made available to all providers of residential care for people with learning disabilities and challenging behaviour in the Hastings locality. It is organised as a rolling, modular programme for half a day per week, in order to accommodate larger services and to acknowledge the practicalities of enabling staff attendance. So far, some 300 participants have attended the training programme, and approximately two-thirds have completed. Formal evaluation has indicated high levels of satisfaction with the course, individual participants reporting significant increases in both confidence and a sense of being supported by their employing organisations. More anecdotally, the initiative has led to discernable changes in practice and services independently implementing PBS strategies.

This training initiative has enabled us not only to address the specific training needs of individual services, but also to regulate and monitor more effectively the staff competency concerns which Allen and colleagues have highlighted.

The experience of delivering this training to direct carers has made us aware of an additional challenge which is likely to face practitioners of PBS. The emphasis on antecedent control strategies appears to be in conflict with, or be alien to, lay practices and beliefs regarding managing behaviour. Most care staff, at least initially, have little training. They are required to draw on limited previous experience of managing the difficult behaviour of

others. Usually this experience is gleaned in the arena of parenthood, and many new care staff are forced to rely on their experiences of being a parent or being parented. In a Western culture the predominant model will be contingency management, where bad behaviour will be punished and good behaviour rewarded (or, as is more usual in practice, ignored). It is often difficult to shift from this as a model of behaviour change to one where the behaviour is prevented from occurring through identification and alteration of the antecedent conditions; staff feel that they are in some way giving in. Given the reliance on direct care staff for implementation of PBS strategies, the existence of conflicting beliefs about the legitimacy of certain types of intervention strategy may present major problems, unless addressed explicitly through training.

## SUMMARY AND CONCLUSIONS

We welcome the publication of Allen and colleagues' paper as timely, and consider it an important contribution to understanding the extent to which behavioural interventions for people with learning disabilities and challenging behaviour have developed and matured over the past 15 years. The current emphasis on evidence-based practice in the NHS should mean that positive behavioural support becomes available to an increasing number of individuals with severe learning disabilities who present behavioural challenges. Furthermore, the use of a PBS framework provides a unique opportunity to focus on the compatibility of mutually beneficial approaches for such individuals.

Both this paper and that of Allen and colleagues have highlighted several major challenges that are faced in the attempt to increase the access of people with learning disabilities who present challenging behaviour to positive behavioural support. The greatest of these, as is the case with any genuinely client-centred initiative, is an increasingly cash-strapped community care system which can appear to be preoccupied with short-term financial

concerns to the detriment of people's longer-term needs.

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# A Positive Behavioural Support Model for Breaking the Barriers to Social and Community Inclusion

## ABSTRACT

*A key objective of the community care movement has been to achieve greater opportunities for people with learning disabilities to integrate and interact within their normal communities. Major barriers remain, however, for those individuals who are disabled and who also exhibit significant challenging behaviour. In addition to the unacceptability of the behaviours themselves, the support strategies used to remediate these challenges have also acted as a barrier to inclusion, because of their social unacceptability. The paper presents a model for supporting people who challenge that addresses these concerns by providing an effective, socially valid intervention approach.*

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## OUTCOMES OF BEHAVIOURAL INTERVENTION

The outcome criteria by which behavioural support strategies should be evaluated include their clinical/educational and social validity, the speed and degree of their effects on the target behaviour, the durability and generalisation of these effects and

the number and nature of any side effects generated (Favell *et al*, 1982).

Clinical/educational validity is perhaps the most important of these criteria. This most critical measure says that a support plan is valid if, as a result of bringing the behaviour itself under control and developing skills, the person's quality of life is enhanced (for example, they have more community access, opportunity, choice and control, competencies and nurturing, caring and mutually gratifying relationships) (O'Brien & O'Brien, 1991).

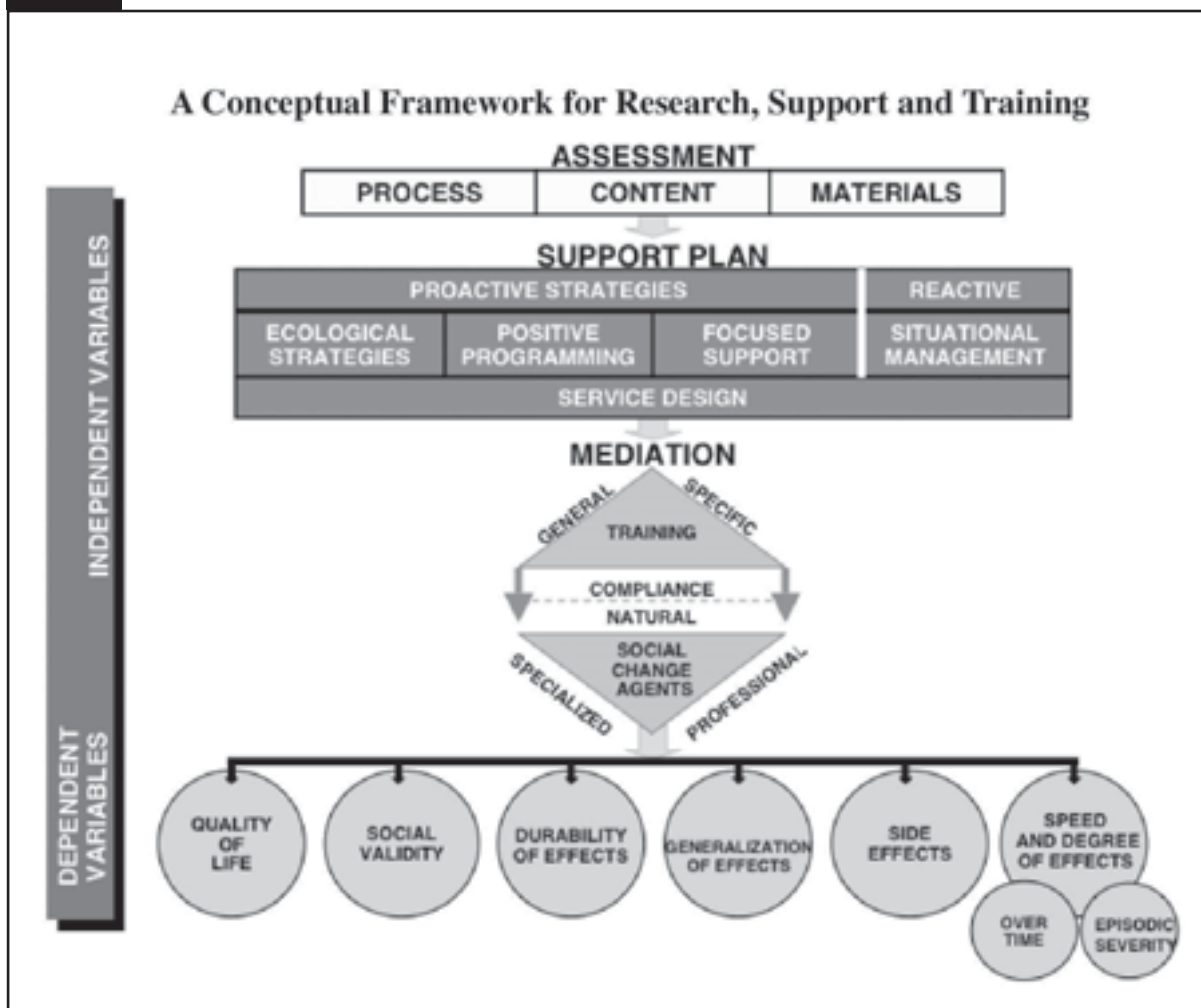
## PROACTIVE STRATEGIES

In this paper, we propose a model that addresses all these issues. The components of our multi-element support plan are illustrated in *Figure 1*, below. The first major distinction within a multi-element support plan is between proactive strategies and reactive strategies. Proactive strategies are those designed to produce changes over time. Reactive strategies, on the other hand, are those designed to manage the behaviour at the time it occurs. Included in the category of proactive strategies are ecological changes, positive programming and focused support. These three categories of proactive strategies, and their intended contributions to outcomes, are described below.

## Ecological changes

Environmental events and characteristics provide an important area of analysis, and offer significant opportunities for change as part of a support plan. For instance, some challenging behaviours could be a reaction to the crowded or noisy conditions in which a person must work, or might simply be a reflection of boredom. If this is the case, then the challenging behaviour might be influenced by simple ecological changes in which crowding and noise are reduced and the environment is made more exciting. Examples of ecological changes include changing the person's setting, changing the number and quality of interactions, changing the instructional methods used, changing instructional goals and/or removing or controlling environmental

**FIGURE 1** A MULTI-ELEMENT MODEL FOR BREAKING THE BARRIERS TO SOCIAL AND COMMUNITY INCLUSION



pollutants such as heat or cold. Generally speaking, ecological changes attempt to 'smooth the fit' between the person and his or her environment by modifying that environment.

Ecological changes may, however, take time to arrange, and may not always produce an immediate improvement in behaviour. For example, some individuals might show rapid improvement after moving from an institutional setting into the community. Others might show an increase in challenging behaviour as a result of the move. In spite of this knowledge, such an environmental change might still be pursued if it is in a normal home environment that the person can learn, through positive programming, to be successful and to enjoy living in a real home. If such a goal has validity, and if it is most realistically achievable by a change in environment, the transitional increase in challenging behaviour may have to be addressed with appropriate focused support and reactive strategies.

Ecological changes may have to be balanced with other elements of the multi-element framework. For example, giving people increased choice and control over their day-to-day lives may also require changes in their interpersonal and programmatic environments. Thus, if a person exercises choices primarily to avoid participating in most activities and/or to avoid learning new skills, they may end up having a very poor quality of life. While it is their right to choose, this right should not be taken absolutely. Rather, it is important for their care staff to acknowledge their responsibility for teaching the person how to make increasingly informed choices via positive programming.

## Positive programming

Whereas ecological changes involve altering the environmental context to smooth the fit between the environment and the individual, positive programming involves changing a person's skills to enable them to cope better with that environment. It uses systematic instruction strategies designed to give the individual greater skills and competencies which will contribute to behaviour change and social inclusion (LaVigna *et al*, 1989). This strategy

provides the constructional underpinning of multi-element positive practices, and reflects the imperative to increase the number of alternative behaviour-reinforcement sets to which the person has access (Goldiamond, 1975). There are four variations of positive programming, involving the development of general, functionally equivalent, functionally related and coping/tolerance skills.

General skill development across the domestic, vocational, recreational and general community domains facilitates the reduction of challenging behaviour by increasing the person's repertoire of socially acceptable responses (Goldiamond, 1975). The opportunity to learn and engage in a wide variety of activities thereby provides a fundamental basis for other instructional efforts.

Ecological change and positive programming have the primary goals of producing durable, generalised outcomes with good social and clinical/educational validity. Positive programming involves systematic instruction and skill acquisition. Ecological strategies, in contrast, have to do with environmental change, availability and opportunity. To illustrate the difference, ecological change could involve having access to a kitchen in one's home, having choices about what to do and having a day planner in which to schedule one's day. Positive programming might include teaching the person how to cook a meal independently, teaching the person how to make choices and teaching the person how to use a day planner to schedule a full day of interesting and desirable activities.

LaVigna *et al* (1989) describes in more detail the variations of positive programming. The most important is the ability to cope with and tolerate naturally occurring aversive events. This last category of positive programming deserves to be highlighted, because it is often overlooked in support plans and because of its critical need for anyone who is living a full life in the real world.

Life's texture includes being told such things as 'later', 'no' and 'good-bye'. It includes such things as failure, frustration, criticism, being teased, being sick and the need to perform non-preferred tasks. While we would want to help anybody find a set of life circumstances that keeps these naturally

occurring events to a minimum, anybody who has a life has these experiences.

The rub is that these events are often the antecedents to challenging behaviour. Ecologically, we may try to minimise them, and it may be important to teach the person to learn how to communicate the key messages that let us know what she or he wants or what he or she is upset about. For truly durable outcomes, however, and for the best quality of life possible, support staff may need to take on the responsibility of systematically teaching the person how to cope with and tolerate these events. They cannot just rely on the sink or swim approach or on the natural consequences to teach life's lessons. If the individuals we are concerned about were able to learn from natural consequences, elaborate intervention frameworks for addressing their behaviour challenges would not be necessary. Indeed, their serious behaviour challenges probably would not even have developed in the first instance.

## Focused support

Ecological changes, depending on their difficulty, may take time to arrange, and positive programming will also require time before new skills and competencies are mastered. It may therefore be necessary to introduce focused support strategies to achieve more rapid changes in a person's behaviour.

There are alternatives to punishment in addition to differential schedules of reinforcement that can produce this rapid effect (LaVigna & Donnellan, 1986). They include, but are not limited to, certain antecedent and instructional control strategies (Carr *et al*, 1976; Luiselli & Cameron, 1998) and stimulus satiation (Rast *et al*, 1981; Ayllon, 1963). A comprehensive support plan could also include non-behavioural strategies such as neuro-physiological techniques, medication adjustments and dietary changes.

Within the multi-element model, the purpose of a focused support strategy is to reduce the occurrence of behaviour as rapidly as possible in order to reduce risks and the need for reactive strategies. The model emphasises use of non-aversive, focused support strategies, since

punishment brings a greater risk of behavioural escalation (LaVigna & Willis, 2005) and itself may detract significantly from the person's quality of life. Further, the use of some punishment procedures may preclude the person's having access to certain environments, because of the relative lack of social validity of such strategies.

The use of non-aversive strategies is also dictated by the outcome requirement of speed and degree of effects; this is also the primary reason for using focused support strategies. Punishment, by definition, is an after-the-fact procedure. The behaviour occurs, and then the punishing consequence is provided. In contrast, stimulus satiation and antecedent control may, conceptually and procedurally, preclude the occurrence of the challenging behaviour altogether (LaVigna & Donnellan, 1986). Additionally, schedules of reinforcement may further strengthen the ability of a support plan to avoid or minimise the occurrence of challenging behaviour, as might time-based delivery of preferred events (Tucker *et al*, 1998), thereby also improving the person's overall quality of life.

Support staff who favour an emphasis on an ecological approach to challenging behaviour and who appreciate strongly the individual's rights and dignity may experience some resistance to using focused support strategies, since such strategies are often artificial and contrived. There may also be aversion to any procedure, such as a schedule of reinforcement, that is so blatantly 'behavioural'. This is of significant concern, since such strategies may be necessary for rapid control and to keep the person and others free from the risks associated with the challenging behaviour. This 'anti-technology' sentiment may be understood in the context of a history in which many believe that 'behaviour modification' has been used with a behaviour, programme or research focus rather than a focus on the person and her or his quality of life. However, the framework presented here proposes to harness behavioural technology to the end of supporting human values and dignity, as is consistent with the basic tenets of applied behaviour analysis (Baer *et al*, 1968).

People with disabilities may sometimes need to use artificial prosthetics to achieve full inclusion and an optimum quality of life. For example, a person who is physically challenged may need a physical prosthesis such as a wheelchair to gain independence and full community access. Support staff would advocate for the individual's right to the wheelchair, even though it may represent an 'artificial' means by which the person would have mobility in the community, and may in fact elicit negative attention from the community. Similarly, a person who is behaviourally challenged may need a behavioural prosthesis, such as a formal schedule of reinforcement, to gain temporary control over behaviour and to enjoy full community presence and participation, as more permanent solutions are being sought. This would suggest that support staff should be equally comfortable in advocating for the individual's right to the schedule of reinforcement, if needed, even though it may represent an 'artificial' means of behaviour control and may in fact elicit negative attention from the community. Further, rapid reduction of target behaviour occurrence is likely to increase the social validity of a behavioural support plan.

## REACTIVE STRATEGIES

The need for situational management is unavoidable when you are supporting a person whose behaviour can be challenging. For those support staff who have been resistant to using strictly non-punitive strategies, it may be partly because many advocates of a non-aversive approach have not described explicitly what to do when a challenging behaviour occurs. Generally speaking, non-aversive strategies create a reactive vacuum. Ecological strategies, positive programming and focused support strategies do not describe what to do when a behaviour occurs; they are proactive, not reactive. Punishment, in contrast, is by definition a reactive strategy and prescribes exactly how to react when the behaviour occurs. Given this critical need for ways to react to behaviour, in lieu of other suggestions, it is no wonder that some people have held on to their use of punishment.

The multi-element model calls for explicit inclusion of reactive strategies as a component of a support plan. The outcome requirement that is being addressed by a reactive strategy is a subset of speed and degree of effects. While the proactive strategies address speed and degree of effects over time, reactive strategies address the speed and degree with which individual episodes of behaviour can be brought under control with the least risk of injury to the person, to support staff and to others in the environment. The role of a reactive strategy is not to produce changes in the future, but to keep people safe in the here and now.

Traditionally, the success of a support plan has been measured only by the speed and degree of its effects. While this is also a measure of success in our multi-element approach, we take additional explicit responsibility for reducing the 'episodic severity' (the gravity or intensity) of the behaviour when and if it occurs (LaVigna & Willis, 2005). In this usage, the word 'episodic' does not mean 'intermittent', but 'with respect to an episode'. A plan that has demonstrated clinical/educational validity and has also reduced the episodic severity of the behaviour, as well as its occurrence, is likely to have greater social validity than one that does not.

The multi-element model's liberation of reactive strategies from the need to produce future effects allows more options for rapid resolution of an episode of behaviour than more traditional approaches have provided (LaVigna & Willis, 2002). This is because the reactive strategy is planned in the context of a powerful proactive plan that does focus on the future. If we have ecological changes on track, if we are actively engaged in positive programming and if we have our focused support strategies in place, it is less likely that the reactive strategy will produce a counter-therapeutic effect.

## ASSESSMENT

The components of this multi-element model, which provides for both proactive and reactive strategies, is dictated by a focus on all six outcome requirements. The design of many of these support strategies requires specific information which can be

gathered only through a comprehensive functional assessment (LaVigna *et al*, in press), including the possible influence that neurological, medical or other organic variables may have on the challenging behaviour and its meaning to the person. The purpose of an assessment process is to determine this meaning or function.

One strategy for this person-centred approach to assessment is to use personal profiling and positive futures planning (O'Brien & Lovett, 1992). Futures planning is particularly useful as a way of understanding how the person's ecology may be affecting behaviour and what ecological changes may be helpful in trying to support the person.

Personal profiling and positive futures planning is a two-step process designed to provide an understanding of a person's life and what they have experienced from their point of view, and to develop a plan that helps them reach their goals and aspirations for the future. As with the multi-element model, this approach is based on five quality of life values (O'Brien & O'Brien, 1991) derived from social role valorisation (Wolfensberger, 1983):

- presence and participation in the community
- fulfilling valued roles and gaining social respect
- maintaining satisfying personal relationships with friends and family
- expressing personal preferences and making choices
- gaining skills and competencies.

Participating in the process are the focus person and the 'stakeholders' in that person's life (a circle of support that includes family, friends, past and present support staff, and/or any others that may be able to make a contribution). If this process does not provide a sufficient understanding of the behaviour and its meaning for the person, a specific process of functional assessment should be employed.

The fundamental role of functional assessment and functional analysis in providing behavioural services represents a hallmark in the field of applied behaviour analysis (Goldiamond, 1974). Assessment methods, information and materials are considered

to have treatment utility if they have been demonstrated to contribute to beneficial outcomes (Hayes *et al*, 1987). More specifically, the utility of assessment is defined insofar as it bears relevance for developing a support plan.

The multi-element framework provides for three aspects of assessment that may have treatment utility. The first of these is the method or process of assessment. In the past, the treatment of challenging behaviour relied almost exclusively on direct, naturalistic observation. Increasingly, however, in addition to naturalistic observations, interviewing, records review and analogue situations are being used (Durand, 1990; Iwata *et al*, 1982; O'Neill *et al*, 1997). The second aspect of assessment that bears on treatment utility is the information gathered by the assessment process. Some information may seem to have obvious treatment utility (for example knowing the controlling antecedents). Other information may still be of questionable value to some practitioners (for example knowing the history of the person and of the specific challenging behaviour). Finally, the framework reminds us that assessment materials and devices are subject to exploration for their possible treatment utility, that is, their contribution to the development of effective support plans.

## MEDIATION

An inclusive framework for breaking the barriers to integration caused by challenging behaviour must also address a variety of mediator issues (Durand & Kishi, 1987; LaVigna *et al*, 1994). No support plan, regardless of its comprehensiveness and elegance, will produce the desired outcomes unless it is implemented fully and consistently. Our model delineates a number of dimensions that relate to this issue. First, three categories of social change agents are identified who may participate in the support team. They include natural mediators such as parents, siblings, mainstream teachers in education, supervisors at work and others whose relationship to the person is a natural one and has nothing to do with the person's disability or challenging behaviour. Also included are professional staff whose

relationship to the person is a function of their disability, such as special education teachers, job coaches and domestic and community living support staff. Finally, included would be specialised staff whose relationship to the person is a function of the challenging behaviour. They might include behaviour specialists, the one-to-one support staff or others who are involved specifically because of the challenging behaviour.

Second, the model delineates three aspects of training, as they may relate to the three categories of mediators. They include teaching the general skills that such support people may need to support the person, teaching the specific skills that are necessary to implement the procedures incorporated into the plan, and quality assurance systems to assure full compliance with the support plan. Such quality assurance systems, based on the principles of organisational behaviour management (OBM), include clear and operational definitions of what exactly needs to be done, competency-based training for those responsible for plan implementation, socially valid monitoring of implementation, feedback based on the results of monitoring to improve and maintain full and consistent implementation (especially visual feedback) and outcome evaluation. Web-based resources (see [www.ePSR.com](http://www.ePSR.com) for an example) are making such quality management systems based on the principles of OBM more accessible to behavioural service providers.

Third, we may also need to consider what it is reasonable to expect of a person providing support, particularly parents or parent surrogates, regardless of training. Some support strategies may be so involved or some situations so deteriorated that they require professional or even specialised staff. For this reason, we have developed an intensive support approach that allows the provision of specialised services without placing the person in a more restrictive setting or specialist units (Donnellan *et al*, 1985).

## CONCLUSION

By design and definition, good research isolates independent and dependent variables and seeks to determine the effect of the former on the latter. The variables not under study are removed or otherwise controlled. In stark contrast, while individual elements may be based on a specific study or group of studies, a person-centred support plan has an array of elements, is based on a comprehensive functional assessment and is aimed at producing a broad range of outcomes. We suggest that, because this broad context is often lacking, research findings from univariate research studies may be misinterpreted and misapplied. Additionally, we suspect that narrow interpretation of research findings has led to practices that many outside and within the field have perceived as an overuse, misuse and, in some cases, abuse of punishment technology (Donnellan & LaVigna, 1990).

The model we have proposed provides a framework for generating research questions, for discussing research findings and for incorporating the findings into multi-element, comprehensive, person-centred support plans. It also provides a model for behaviour analysts to distinguish between a person-centred support plan and the experimental investigation of isolated variables. If our strength has been in the latter, our weakness may be in the former. By adopting a model such as the one proposed here, we can only enhance the field of applied behaviour analysis through full articulation of its underlying principles (Baer *et al*, 1968).

The proposed framework provides a value base for addressing challenging behaviour. Effectiveness is ultimately measured by clinical/educational validity, that is, by the effects of the support plan on the person's quality of life, on the person's increased independence and competence, social and community presence and participation, productivity, personal empowerment and choice, and relationships and support network (O'Brien & O'Brien, 1991). It is to these valued outcomes that this model is dedicated.

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# A Model for Training Staff in Positive Behaviour Support

## ABSTRACT

*Although front-line staff are the key agents in delivering positive behavioural support in care services, effective technologies for staff training in key behavioural competencies are not very well developed. The paper describes a training model that demonstrates effective outcomes for service users, participating staff and the host organisation. The critical elements of the training are outlined and principal outcomes described.*

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## INTRODUCTION

Although there has been considerable historical interest in the implementation of behavioural strategies by front-line care staff (Kazdin, 1978), achieving delivery of complex interventions via this route has in practice often proved difficult. Emerson & Emerson (1987), for example, found that lack of knowledge of behavioural principles was closely associated with failure to implement effective behavioural interventions by front-line staff. In addition to inadequate staff training, lack of direct support from specialists (such as clinical psychologists), modelling of interventions and multi-disciplinary team involvement have all been implicated in this problem (Berryman *et al*, 1994).

However, as front-line staff have more contact with the person presenting with challenging behaviour, it is appropriate that they are seen as the

key agents in implementing behavioural strategies. It is therefore vital that effective training technologies to promote the development of appropriate competencies at this level are developed. Training staff in positive behaviour support must ensure that behavioural support plans are technically accurate and that they achieve five key outcomes:

- reductions in challenging behaviour
- generalisation of these changes across people and places
- maintenance of these changes over time
- absence of negative side effects
- improvement in the quality of life of the person concerned.

In addition, such plans must fit well with the people and environments where implementation occurs. The concept of contextual fit (Albin *et al*, 1996) refers to the degree of congruity between behavioural support plans and the variables that have a major impact on their implementation (and therefore their effectiveness).

When contextual fit is high, a support plan and its components are consistent with, or highly compatible with, the values and skills of key stakeholders and the people who implement the plan. It is readily sustainable, given the resources and constraints of the environments, conditions and systems where it is being implemented, and suitable to the unique needs of the person with challenging behaviours. In addition, the people who are the key stakeholders in the plan's implementation (such as the person with challenging behaviour, family members and friends, teachers and other direct support givers) are comfortable with the goals driving the plan and with the strategies included in it. A support plan that has good contextual fit is responsive to the values and goals of the people who will implement it, uses the experience, knowledge and skills these people bring to implementation environments and is compatible with the typical routines and daily activities that characterise the implementation environments and contribute to their uniqueness. Such characteristics cannot help but promote increased fidelity of implementation of the support plan strategies, as well as increased maintenance or sustainability of support plan implementation. People with severe problem behaviours often require long-term, comprehensive support plans that are implemented with fidelity across periods of time ranging into many years (Lucyshyn *et al*, 1995). Plans with good contextual fit can meet this requirement, increasing the likelihood of long-term success.

Just as successful behavioural interventions need to be sensitive to prevailing system variables, so staff training programmes need to take account of the organisational context in which they are to be delivered. Training in any large organisation involves investment of time, resources and commitment. At a time when staff resources are under constant pressure, turnover is high and employment opportunities are competitive, training may often be seen as a luxury. Supervisors and managers find it hard to release staff; staff's motivation to complete training courses and possibly add to an already heavy workload is diminished. This presents organisations with a dilemma. Even when the

benefits from training staff are well documented, training may therefore still be hard to justify when resources are thin on the ground. When an organisation invests in training, it is therefore important that the desired outcomes are identified and evaluated. Four such outcomes are widely acknowledged in training circles (Kirkpatrick, 1996): trainee satisfaction, trainee knowledge, changes in trainee performance and organisational impact (that is, the return for the service as a whole). This paper describes an approach to training in positive behaviour support that meets all the technical requirements for effective intervention and which has demonstrable outcomes at all four of the levels described.

## MULTI-ELEMENT BEHAVIOURAL SUPPORT: A SHORT COURSE

St. John of God Hospitaller Services provides services to approximately 1,700 people with learning disabilities in Ireland. The Callan Institute for Behavioural Support was established in 1995 as part of St. John of God Services, its role being to provide consultation and training in effective, non-aversive methods for supporting individuals who present with challenging behaviours. The Institute carried out research on the prevalence of challenging behaviour in the Services in 1995, and found that 15% of the population supported presented with severe challenging behaviour, using the criterion of Oliver *et al* (1987) that behaviour has caused tissue damage in the last month, and 28% with significant challenging behaviour (McClellan & Walsh, 1995).

In response to this need, the introduction of Multi-Element Behavioural Support: A Short Course as a model of service was proposed. This model of training was adapted from that designed by the Institute of Applied Behaviour Analysis, and based on the intensive intervention sequence (Donnellan *et al*, 1985). It addresses some of the difficulties with a specialist model and supports a logistical problem of 'coverage' while facilitating

‘contextual fit’, in that the team implementing the plan also conducts the assessment and develops the behaviour support plan while completing a competency-based training programme.

The competency-based training sought to develop skills in conducting comprehensive behavioural assessments and in designing and implementing multi-element behavioural support plans for individuals with challenging behaviour. The assessment component included a comprehensive psychosocial assessment, functional assessment, incident analysis and hypothesis testing. Intervention involved environmental accommodation, skills teaching, focused interventions and reactive strategies, while implementation was monitored using the Periodic Service Review (LaVigna *et al*, 1994) as a quality assurance tool.

In 2001, the training was accredited by the Dublin Institute of Technology (DIT), an autonomous higher education institution with a current enrolment of approximately 21,000 students pursuing 85 programmes at certificate, diploma, degree and postgraduate levels. DIT is actively involved in research and development, with €6 million in funded research annually. It is one of the largest educators of social care graduates in the country. The course attracts five credits (European Credit Transfer System) at Masters Level.

## COURSE FORMAT

The course has evolved over the last eight years in line with feedback received from participants and the organisation and in line with current practice. At present, the training lasts nine months and is divided into six teaching modules and five assignments. Each block of training is followed by an assignment. It currently involves 64 hours of contact time, a minimum of 100 hours of assignment time and additional reading. The student presents a final portfolio for review and accreditation.

The course is supported by a range of documents (including a lecture/workbook, assignment workbooks, competency-based

assignments, technical support materials, articles and a reading list) and assessed using a range of methods, including pencil and paper activities, post-tests, role play demonstrations and verbal presentations, written reports, video of fieldwork and supervisor audit to oversee the competencies applied *in vivo*. A principal clinical psychologist and a behaviour specialist teach the course. Invited speakers contribute on a variety of topics, such as person-centred planning, medical and psychiatric issues and writing reactive strategies.

Among the unique features of the training are the following.

- **Practitioner model of learning:** Each unit has an assessment matrix of competency skills and represents a continuum of competency development. Steinaker & Bell’s (1997) taxonomy of teaching and learning was adapted to provide a structure for progression along the continuum.
- **Tuition:** The student receives individualised tuition, through written review of the material on five separate occasions.
- **Workplace demonstrations:** the coursework that the student undertakes is part of the local multi-disciplinary team’s response to the person with challenging behaviour. The student presents the work to the team at intervals throughout the course. The assessment, interventions and outcomes are developed with the team.
- **Training in person-centred planning:** Throughout the curriculum, there is emphasis on ‘ordinary things for ordinary people’. Staff are supported to consider community participation, facilitating friendships and making meaningful choices, based on the framework of accomplishments identified by John O’Brien (1987).
- **Clinical impact:** A multi-element behaviour support plan is designed for one individual in the service presenting with challenging behaviour. It is based on a comprehensive assessment, is technically accurate and is embedded in a quality assurance system.

## EVALUATING THE IMPACT OF TRAINING

Monitoring effectiveness (or return on investment) is one of the most effective ways in which training and development can increase their influence in the organisation. Many organisations now link their training programmes to organisational goals. Large organisations are more likely to have long-term strategic vision, a dedicated training function, training specialists with relevant qualifications and expertise, and a culture of training (Costine, 2003).

In line with Kirkpatrick's (1996) analysis, the course has been evaluated at a number of levels. First, outcomes for service users with challenging behaviour have been reviewed. Second, the impact upon staff competencies has been measured using a quantitative and qualitative format. Third, any improvements that need to be made are considered by the course advisory board. Finally, an organisational cost-benefit analysis has been conducted.

The effectiveness of multi-element behavioural support is well documented at the first level. McClean and colleagues (2004) evaluated 138 individuals with learning disabilities who received services within the Hospitaller Order of St. John of God and were referred to the Callan Institute for positive behavioural support, using the training programme described. In this study 77% (n=106) of this group made a significant improvement (defined as a reduction to less than 30% of the baseline rate of the behaviour) at a 22-month follow-up. This study also found that the levels of behavioural reduction associated with the behavioural support plans developed and applied by front-line care staff were not significantly different from the levels of behavioural reduction of plans designed by psychologists.

In a recent training course conducted by the Callan Institute, 56% (n=25) of cases presented with significant improvement (defined by reduction to less than 30% of baseline) within three months of implementation. This study used Type III case studies (Kazdin, 1981), in which objective data was collected on a target behaviour, and continuous

assessment and data analysis were carried out during baseline and intervention phase. On completion of the training course, all behaviour support plans are implemented and monitored by front-line staff using the Periodic Service Review format. Case presentations are made each quarter to the resource teams.

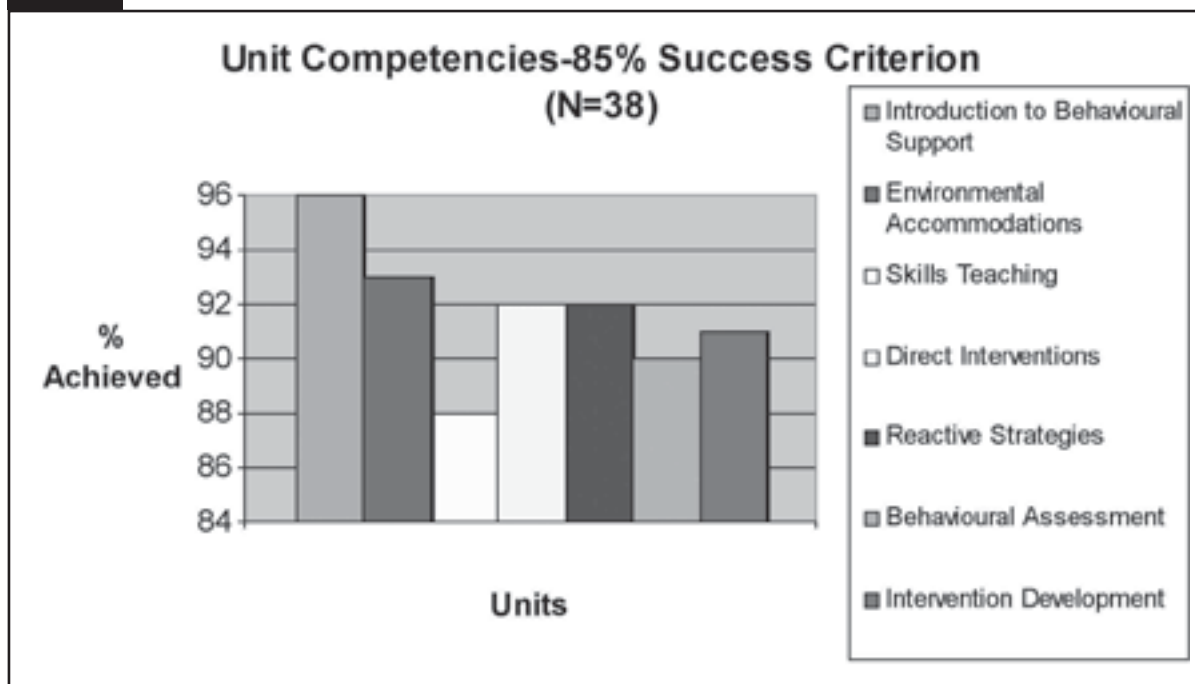
The Quality of Life Questionnaire (Schalock & Keith, 1993) was employed in an attempt to track broader outcomes for service users. Initial findings indicated that this tool appeared insufficiently sensitive to measure some of the anecdotal evidence about lifestyle change provided by staff and families. This evidence referred, for example, to the person undertaking more activities, having improved social interactions with peers and staff, appearing happier, learning new skills and earning more money.

The second level of evaluation involves the review of four areas of student progress – attitude, confidence, knowledge and support – all of which have been identified as relevant in training reviews and in integrating the principles applied in the training into practice. A recent analysis of a sample of 38 students who had completed the Callan Institute training course showed that 94% of staff rated the course as 'very relevant' and 96% as 'very interesting', and 91% reported that their knowledge had increased as a result of the course. Around 40% also indicated a need for further learning, highlighting the need for ongoing support for staff to continue this work once the course is completed.

Throughout the training course, each student completes a comprehensive behavioural assessment and intervention plan for one individual who presents with challenging behaviour which meets the standards established in the Behaviour Assessment Report and Intervention Plan Evaluation Instrument (Willis & LaVigna, 1990). This has been adapted by the Callan Institute and specifies 49 separate competencies under seven major categories. The portfolio assessment and presentation of 38 students against the 49 competencies yielded the results shown in *Figure 1*, overleaf.

The unit competencies indicate that skills teaching, specifically 'systematic instruction', needs

**FIGURE 1** UNIT COMPETENCIES (N=38)



further training and support to meet the average of 92.33% acquired in the other six units. Students are achieving an average of 91.7% across all units, with 88% in skills teaching principles. The competencies achieved by the staff members, also referred to as standards of performance or level of critical thinking (Giro, 1995), are extremely high. A pass rate of 85% has been achieved, with distinction and/or merit by 97% of students.

The third review level involves an evaluation of the quality assurance practices, the course development strategy and the former two evaluations. The course advisory board sits twice a year. There have been many recommendations made as a result of these reviews. Some are specific to the content of the course, others relate to course delivery and structure, organisational support and further staff development. One of the recommendations highlighted the need for supervisor training. A supervisors' workshop is now provided for all supervisors of staff members attending the course. It is widely acknowledged that supervisors require skills to oversee programme implementation and efficacy, since they are often required to be both an expert in behaviour and an effective manager. The supervisors are trained in the

review and audit of a behaviour support plan using a Periodic Service Review format, which includes 12 indicators of intervention fidelity which have been identified for maintaining effective behavioural support services. They also correspond to the components of the organisation's policy document on challenging behaviour.

The key skill areas on the supervisors' course are:

- understanding positive behaviour support
- using competency 'skills check' for behavioural protocols designed by the student
- developing consultation procedures and strategies for facilitating teamwork and increasing effective communication
- auditing and reviewing behaviour support plans.

These workshops are also evaluated; 52% of participants highlighted the need for workshops and information on behavioural support services and developments in this area, and 34% stressed the need for refresher workshops. Other comments identified a need for flowcharts of key supervisory skills and that the course needed to be run more frequently to allow greater access. Resources and

funding were also identified as a necessary support in order to facilitate training and to implement a person-centred service. A number of comments highlighted the need to integrate behavioural assessments into a mechanism to facilitate strategic planning for services.

The final part of the training evaluation, as identified in Kirkpatrick's work, involved an organisational cost-benefit analysis. This suggested a number of positive gains. First, there is now a culture of positive behaviour support in the organisation. Second, many of the staff trained in this model have subsequently been promoted to key managerial positions and continue to advocate and implement positive behaviour support strategies. Third, there are now trained behavioural practitioners in all the services, which facilitates access and speed of response for people presenting with challenging behaviour. Fourth, there are indications that staff make a longer-term commitment to the organisation, reducing staff turnover. Fifth, the training is viewed as cost-effective in terms of improved response times and results. Finally, the course is an accredited programme, recognised both nationally and internationally through the European Credit Transfer System.

## FURTHER DEVELOPMENTS

Since 1995, more than 350 staff have participated in the training course. To date, 75 have received accreditation. In 2002, a proposal was submitted to DIT to enable the accreditation of prior learning (APL) for students who had completed the course before 2001. This proposal was approved in Spring 2003, and students studying on the APL module have been supported for intake from September 2003. A second proposal was submitted to DIT in Summer 2002, for students who had completed the course as a team. This team learning approach allows a group of staff members to consolidate, consult and maximise contextual fit while conducting one comprehensive behavioural assessment and behavioural support plan with one individual presenting with challenging behaviour. It

is proposed that this model of learning facilitates team learning, team building and team effectiveness. This proposal was also approved by DIT in Spring 2003.

These two new modes of learning provide more flexibility for students and continue to facilitate multi-element behavioural support plans based on comprehensive assessments for people presenting with challenging behaviour. It is envisaged that students will continue this work in micro-training/support workshops to allow them to use the skills acquired and link this work to continuing professional development (CPD) credits with DIT. It is also proposed that the course be developed into two modules, one based on assessment and one on design and implementation. These modules will make up part of a proposed postgraduate programme in positive behavioural support.

## CONCLUSIONS

Costine (2003) states that an organisation demonstrating best practice in its approach to training will have all the following in place:

- formal and widely communicated training policies and plans
- clear links between these plans and the organisation's strategic vision and goals
- a focus on knowledge
- personal development opportunities linked to organisational goals
- a pervasive culture of formal and informal learning
- a proactive approach to identifying and analysing training and development need
- formal, in-depth evaluation of training and learning from both qualitative and quantitative perspectives
- built-in review and change processes
- integration of human resource development and management policies and processes.

The course described in this paper has gone a long way towards enabling the St. John of God

Hospitaller Services to develop a high-quality service for people with learning disabilities and challenging behaviour. In particular, it has built a clear link between the stated policy aims of the organisation, what staff are asked to do in helping achieve policy goals and how they are supported to apply ideas in practice. While this paper has presented some of the benefits of training staff, there are many questions still to be answered. Specifically, this model requires assessment and measurement of each of the five outcomes identified in the introduction. In keeping with the behavioural literature in general, the Institute needs to be able to demonstrate changes to quality of life more clearly, as well as providing evidence of maintenance and generalisation of behavioural change. Clearer understanding of the environmental and systemic variables that promote positive behavioural strategies is also required. Although these are important and necessary developments, it is nevertheless clear that the training has made a significant contribution to the support offered to our most vulnerable service users.

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# Staff Training in Positive Behaviour Support: Research into Practice

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## INTRODUCTION

There is evidence for the efficacy of positive behaviour support (PBS) as an intervention for people with learning disabilities who engage in challenging behaviours (Carr *et al*, 1999). In their meta-analytic review, Carr and colleagues conclude that up to two thirds of published reports of PBS show positive outcomes, as measured by reductions in targeted challenging behaviours. The criterion used here was that challenging behaviour had to reduce by least 80% over baseline conditions. Although there are fewer published studies, Carr and colleagues also concluded that these treatment effects were maintained again in about two thirds of reports.

However, it is also important to demonstrate that interventions work in everyday service settings (that is, that they are effective). This question relates to the translation of the findings of controlled research into practice. Work such as that carried out by the Callan Institute and reported in Dench's article is crucial in answering this core question. In commenting on this article and its implications, I would like to attend to four main issues: data collection in clinical services, PBS as a focus for

staff training, supporting staff training and the development of theoretical models of staff and other carer behaviour. Each of these is discussed in turn below.

## DATA COLLECTION IN CLINICAL SERVICES

Dench and colleagues past and present should be congratulated on their commitment to data collection as part of the delivery of their PBS training. Without such data collection, it is impossible to determine whether interventions can work outside the controlled environments of research studies. Ongoing evaluation of the effectiveness of all clinical work is essential if we are to contribute to an evidence base through practice-based evidence (Newman *et al*, 2003).

## PBS AND STAFF TRAINING

Dench describes a process for training staff in the use of PBS and focuses on data that include describing changes in challenging behaviour to evaluate the training. It is not entirely clear whether the purpose of PBS training is to change service users' challenging behaviours, change staff behaviour, or both. The article's Abstract suggests that the second or third of these is true. If we were to evaluate the effectiveness of training staff in PBS,

one would expect to see perhaps two key sets of outcomes.

The first would be effective behaviour change for service users, both in reduction in challenging behaviours targeted for change and in movement towards other valued outcomes (such as increased adaptive skills, improved independence in the community or improved quality of life). The second would be staff behaviour change. Here we would expect to see observational data showing the development of specific staff skills or perhaps general habilitative behaviour (for example improved frequency of staff-service user interaction). Alternatively, competency checklists could be used to assess key staff skills.

Dench discusses aspects of both these outcomes. In terms of service user behaviour, there is evidence discussed that supports the effectiveness of staff training in PBS (McClellan *et al*, 2004). Unfortunately, although quality of life was assessed with a standard scale, there do not appear to be specific targets for adaptive behaviours that one would hope are developed in the PBS programmes. Thus further effectiveness data in this domain are needed to support this particular PBS training model.

Staff outcomes are often neglected, but if this model is meant to train staff in PBS these data are essential. Dench mentions some data on staff competencies. Unfortunately, this description lacks specificity. Most important: there are no clear behavioural definitions of the seven competence areas in *Figure 1*, and there are no data showing pre- to post-training changes in these competencies.

## SUPPORTING STAFF TRAINING

It is ethically and practically important to consider the suitability of the environment in supporting applied behaviour analysis (ABA) interventions. Dench addresses this question in her discussion of contextual fit and the provision of supervisor workshops, both of which are likely to be crucial in supporting the effectiveness of staff training in PBS.

The difficulty is that we lack data to support these factors as key facilitating variables.

Two important problems are apparent here. First, the concept of contextual fit needs clarification and some description of how one assesses key variables that are to be addressed in developing 'high' or close contextual fit. We also need to see data showing that PBS plans with a close contextual fit are more effective than those with a loose fit. Second, the relative effectiveness of PBS plans developed with and without trained supervisors in place was not described. One would also expect that the most effective PBS plans (in changing challenging behaviour, for example) would be those where contextual fit is close and managers demonstrate high levels of PBS-related competencies. These are questions for future research.

A further key question, related to one of the core dimensions of ABA (Baer *et al*, 1968) is the extent to which staff PBS skills generalise. Generalisation is addressed in the PBS plans, but it is also important in evaluating the effectiveness of staff training in PBS. From Dench's description, it is not clear how generalisation of staff competencies is planned, nor whether staff competencies can, for example, extend to the design of further effective PBS plans.

## MODELS OF STAFF AND CARER BEHAVIOUR

Dench's article is a solution to the 'problem' of the development of staff competencies in delivering PBS in a variety of service settings. The training model is well structured, and there are data supporting its effectiveness along some dimensions. However, one thing that is missing from this work, and from virtually all other descriptions of staff training, is an explicit empirical analysis of required staff competencies. Where can we point to evidence that the set of competencies implied in the categories shown in *Figure 1* are those that maximise the chances that staff will design and implement effective PBS plans?

The need to understand, through suitable analytical research and through clinical assessment,

the behaviour of staff who work with those who challenge has been highlighted for at least 10 years (Hastings, 1999, 2005; Hastings & Brown, 2000; Hastings & Remington, 1994). The failure is that my colleagues and I have not developed suitable research and assessment to a stage where clinicians can carry out an informed analysis and then design staff training to address directly the functions of staff behaviours that maintain challenging behaviours. A similar problem exists in identifying the contingencies that maintain staff PBS competencies.

Do these questions matter? At theoretical level, the answer is certainly yes. At clinical level, the answer is probably an even more emphatic yes. If we want to develop maximally effective staff training that will generalise **and** maintain its effects, we cannot do so without an analysis of staff behaviour. We are happy to accept such an argument in relation to challenging behaviour itself. Why lower our standards in developing training interventions for staff behaviour?

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# The Management and Treatment of Challenging Behaviours

## ABSTRACT

*The paper considers the kinds of treatment available for people with learning disabilities and challenging behaviour. It draws on research data on the use of reactive strategies and behaviour plans for 235 children and adults rated by carers as extremely challenging, and 276 rated as very challenging, to identify any trends in the management and treatment of challenging behaviour. It finds an increase in written plans for adults but not for children, and no information on the extent to which plans are based on sound functional analyses and contain proactive as well as reactive strategies. Only half the plans were said to have been drawn up with any support from behavioural specialists, and there was no discernible change in the use of reactive strategies.*

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## INTRODUCTION

Severe challenging behaviours among people with learning disabilities are associated with a range of negative outcomes including physical injury, exclusion, abuse, neglect, restrictive practices, caregiver stress and increased service costs (Emerson, 2001). Between 10% and 15% of people with learning disabilities are estimated to present severe behavioural challenges and, although the

effectiveness of therapeutic interventions has been demonstrated (Allen *et al*, this Issue), there is still evidence of the widespread use of aversive reactive strategies. For example, Emerson (2002), in a review of several studies over the last decade, reported that restraint was used for 28-67% of children and 8-57% of adults. The equivalent figures for seclusion were 32-68% for children and 15-39% for adults, and for sedation 1-6% and 15-35% respectively.

In a more recent study of adults with severe challenging behaviour, Robertson *et al* (2005) reported on restraint being used for between 13% and 48%, seclusion for between 17% and 56%, and sedation for between 22% and 40%. Moreover, despite lack of evidence for the efficacy of antipsychotics in reducing challenging behaviours,

between 44% and 80% of people with challenging behaviour have been found to be in receipt of such medication (Kiernan *et al*, 1995; Fleming *et al*, 1996; Robertson *et al*, 2005).

In contrast, only between two per cent and twenty per cent have been reported as having access to behavioural interventions (Oliver *et al*, 1987; Harris & Russell, 1987; Qureshi, 1994). More recently, Robertson and colleagues (2005) reported that between 58% and 83% had individual programme plans that included some goals intended to reduce challenging behaviour, while between 48% and 63% were reported to have a written intervention plan. However, the authors noted that few intervention programmes consisted of more than reactive strategies.

The reactive strategies reported by carers as usually or sometimes used as the immediate response to challenging behaviour are shown in **Table 1**, below. Although distraction was the most common response for both children and adults, regardless of the degree of challenge, there was still widespread use of intrusive approaches. Physical restraint was usually or sometimes used for more than a third of children and the most challenging adults, and seclusion was used for a quarter. Sedation was reported for two-fifths of the most challenging adults and a quarter of those rated as very challenging, but rarely with children. Physical intervention by one or more carers was reported as the maximum level of intervention used for more than half the children and for between a third and a half of the adults.

**TABLE 1** REACTIVE STRATEGIES USUALLY OR SOMETIMES USED

Reactive strategy	% children (18 years old or under)		% adults (19 years or over)	
	Extremely challenging n = 72	Very challenging n = 74	Extremely challenging n = 163	Very challenging n = 202
Physical restraint	45	39	36	17
Seclusion	25	26	23	16
Sedation	6	6	42	23
Distraction	78	71	73	81
Other	64	51	64	66

## CURRENT TRENDS IN REACTIVE STRATEGIES

As part of a recent major epidemiological study, conducted in a territory with a total population of more than 1.3 million, data on the use of reactive strategies and presence of behaviour plans were collected on 235 children and adults rated by carers as extremely challenging, and 276 rated as very challenging (Lowe *et al*, 2004). The methodology employed was based on that developed by the Hester Adrian Research Centre (Emerson, 2001). Most of the children (89%) lived in family or foster homes and most of the adults (85%) lived in residential services, mainly staffed houses.

The regular use of medication for the control of challenging behaviour was more prevalent among adults; it was prescribed for more than three-quarters (77%) of adults rated as extremely challenging and for 62% rated as very challenging, compared with 27% and 15%, respectively, of children.

## CURRENT TRENDS IN BEHAVIOUR PLANS

Written behavioural plans were reported to be in place for about three-quarters of adults (74%) rated as extremely challenging and for 62% of those rated as very challenging, but for much lower proportions of children (21% and seven per cent, respectively).

Specialists such as clinical psychologists or specialist behavioural team members were reported as the main advisor for only about half the plans reported.

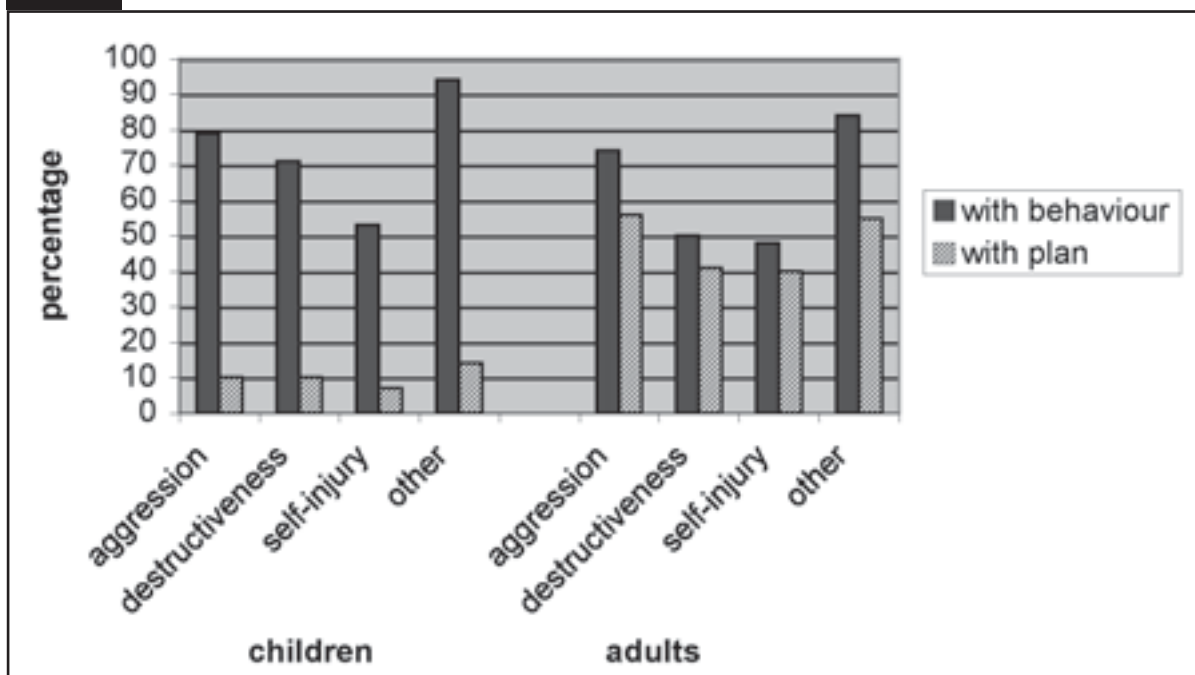
**Figure 1**, below, shows the proportions of children and adults reported as presenting severe levels of aggression, destructiveness, self-injury and other disruptive behaviours, and the proportions reported to have relevant behaviour plans.

Behaviours were so rated if they were reported to occur at least several times a week, usually or sometimes resulted in the person being prevented from taking part in activities, physical intervention by carers, injury to the person or others or damage to property, or if they would do if not controlled in the person's current environment.

## CONCLUSION

Recent studies would suggest an overall increase in the use of written behavioural plans to address challenging behaviours in community-based residential services for adults, but little change in this respect for children living in their family homes. Despite this possible trend, there remains a substantial proportion of adults who present severe levels of challenging behaviours for whom no written plans are available. Moreover, none of the cited studies has described the quality or scope of the plans in existence, that is, the extent to which the plans are based on sound functional analyses and contain proactive as well as reactive strategies.

**FIGURE 1** PROPORTIONS WITH SEVERE BEHAVIOURS AND RELEVANT BEHAVIOUR PLANS



The discrepancies between the proportions of children reported as presenting the four main types of behaviour at severe levels and the proportions reported to have relevant behaviour plans was stark. While more than 50% were rated as showing each behaviour, only about a tenth had written plans that addressed these behaviours. Although the pattern was less dramatic for adults, discrepancies were still evident across all behaviour types.

This is an area that requires further investigation, particularly as only half the plans in the current study were said to have been drawn up with any support from behavioural specialists. The latter issue is highlighted further by the apparent lack of discernible change in the rates of use of reactive strategies.

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## Psychological Interventions for Severely Challenging Behaviours Shown by People With Learning Disabilities

By T Ball, A Bush & E Emerson  
 Leicester: British Psychological Society 2004  
 Downloadable from [www.bps.org.uk/sub-syst/dcp/publications.cfm](http://www.bps.org.uk/sub-syst/dcp/publications.cfm)

**Brian McClean**

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One of the most frustrating things about working with people with challenging behaviours is the gulf that often exists between academic research and traditional professional practices on the one hand, and the needs of people with challenging behaviours on the other. The publication of the clinical practice guidelines by the British Psychological Society goes a long way towards setting a standard for professional practice. In doing so, the authors have successfully unified research and practice into a single strand that, in our current state of knowledge, is likely to improve the treatment of perhaps the most marginalised group of people with learning disabilities.

In essence, the guidelines propose that positive behavioural support (PBS) is the benchmark for intervention in the field of challenging behaviours. There are 52 guidelines in total, each of which is based on research evidence and described as either 'essential' or 'good' practice. Three essential core guidelines set out the value base of PBS. They focus on recognising the person's unique strengths and needs and unique social context, adopting a coherent process of assessment-driven intervention and considering the person and the environment as well as the behaviour. Assessment is therefore idiographic rather than diagnostic; intervention is systemic as much as intra-psychic. Seeking consent before assessment, maintaining confidentiality,

eliciting feedback, assessing risk and preventing abuse are all essential practice.

Five of the essential practice guidelines govern assessment, which should include the abilities and resources of the person, the impact of their disabilities, the impact of service and resource gaps, and their developmental, social and medical history. In keeping with the contemporary emphasis on the role of distal and molar variables in precipitating challenging behaviour, assessment should also consider environmental characteristics such as space, comfort, heat and noise, relationships, interactions, beliefs and values, quality of life and quality of care. The emphasis on setting events and antecedent intervention relies heavily on the work of applied researchers like Robert Horner, Mark O'Reilly, Glen Dunlap and Ted Carr, and is perhaps the feature that most clearly distinguishes PBS interventions from traditional applied behaviour analysis.

Baseline measurement is essential, as is functional assessment, the defining feature and linchpin of PBS. While research has found that interventions that employ functional assessment are more effective than interventions that do not, the guidelines opt for a more generic model of 'formulation'. In doing so, they appear to adopt the diplomatic verdict of the dodo at the end of the caucus race in Alice's Adventures in Wonderland: 'Everyone has won, and all must have prizes'. Interventions based on functional assessment are more effective not because they contain a written formulation, but because they specify a functional relation of behavioural contingencies. Interventions are effective if they establish contingencies (remove or moderate the effects of setting events, remove or reduce antecedents, alter the availability or effects of reinforcing consequences or establish new replacement behaviours) that compete with the contingencies for established behaviours.

The authors marshal a wide variety of proactive interventions based on the results of functional assessment, and most of them have evidence of effectiveness from well-designed cohort or case-

controlled studies. They include improving biological status, cognitive interventions (such as anger management), teaching coping skills, teaching functionally equivalent skills, environmental enrichment, non-contingent reinforcement, differential reinforcement and extinction. The danger of over-reliance on evidence-based practice lies in the assumption that research keeps abreast of practice. Much of the available research database consists of well-designed studies with high internal validity but limited application to the real needs of people with challenging behaviours and their families. For example, it would seem self-evident that changes in service environment can reduce the incidence of challenging behaviours in that setting, but to support this assertion the authors are forced to revert to a 1980 study concerning the use of prompting and attention to improve engagement. The guidelines' consistent emphasis on quality of life improvements and quality of system supports should engender a new generation of research as concerned with external validity as with questions of design and internal control.

Three of the guidelines on intervention are described as essential; they concern punishment and reactive strategies. Although the guidelines make it clear that there should be very little use of punishment, they do not expressively forbid it. Instead, they suggest that every instance of its use must be monitored in writing, the possible effects on the individual should be noted, there must be frequent reviews of its use, a date should be set for its discontinuance and the client should have a right to appeal. Informal or unauthorised use of punishment should be reported, using local child or adult abuse procedures. Punishment should be monitored by ethics committees with lay membership and, where punishment is agreed to be appropriate, every effort should be made to obtain the person's free and informed consent. It is difficult to envisage how this might occur in practice, however, given that punishment is defined in the document in the broad sense of the application of a response which is aversive. If 'aversive' is defined as any event that the person would normally act to

avoid, how could an individual consent to punishment?

They also go a long way towards setting out the framework for designing physical management techniques, but could have gone a little further by stating, strongly, that prone techniques should never be used. Taking a restrained person to the floor is implicated in about half the fatalities associated with restraint where the method of restraint is specified, but it remains an integral component of the market leader in training packages on physical intervention (Murphy *et al*, 2003; Allen, 2002). Techniques that inflict pain are proscribed, but many trainers still argue that the proscription does not cover a range of 'pain compliance' techniques, where pain is not inflicted unless the person moves or resists.

The guidelines have a particularly strong section on the ethical, professional and legal issues. This stems from recognition that people with learning disabilities are disempowered and vulnerable to abuse and neglect, and that many psychologists work in settings that cause distress and challenging behaviours. The Bournemouth ruling has accentuated concern about coercing or restricting the movements of people with learning disabilities and the importance of consent. The guidelines propose three criteria for consent – capacity, voluntariness and being appropriately informed – and state that the psychologist can carry out interventions only with the valid consent of participants. In addition, the psychologist has a duty of care, which means that they may be negligent if they do not provide an intervention when it is required to preserve the well-being of the person. Given that the majority of people with challenging behaviour are not receiving adequate treatment (Emerson *et al*, 2000), it seems that negligence could characterise the work of a majority of clinical psychologists!

There are, of course, gaps in the guidelines. The primary prevention of challenging behaviours through parent training or early intervention is not addressed. This is surprising, given the real pressure that families of young children with autism now face, following publication of research on intensive early intervention, to engage in 40 hours a week of intensive behavioural programme. Another issue not

considered is the dilemma of what to do in the event of placement breakdown due to severe challenging behaviour and, say, acute psychiatric illness. Behaviour should be assessed in everyday settings such as the person's home, school, workplace or community. The implication that specialised assessment units are inappropriate for assessments is not stated. Similarly, evidence on the deleterious effects of congregate settings for people with severe challenging behaviours is not presented. While the research evidence on the relative efficacy of special treatment units, designated beds in mainstream acute psychiatric settings or alternative models of crisis response is extremely limited, the need for guidelines in this area is pressing. It is accepted that the majority of people with challenging behaviours do not receive any effective psychological interventions, but the logistical necessity of developing psychological expertise in people (such as front-line staff and families) who are available in sufficient number to deliver and maintain psychological interventions is not discussed. Similarly, the need for professional practices that ensure that effective interventions maintain over time is not considered.

Are these guidelines comprehensive? Yes. Do they raise the bar in terms of the standards that clinical psychologists should be trying to achieve? Most certainly. Are they likely to empower people with challenging behaviours to play a more complete role as members of the community? Alas, this is less certain. The great revolution taking place in the field of learning disability is one which, I believe, will continue to relegate the role of professionals. In this new dispensation, the power of genuine partnership with the individual with learning disability and of collaboration with families will become apparent. The person is not simply someone who consents to the professional treatment on offer, but a partner in all aspects of assessment, intervention design and delivery. Individuals, family members and front-line staff usually know most about the idiosyncratic behaviour patterns of the person with challenging behaviours. The quality of a behavioural assessment or intervention is often determined by the quality of partnership we have

with the natural support system. What we will need then is not just more expertise, but psychologists who are constantly prepared to change what they do in order to empower the people they are paid to serve.

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## Ethical Approaches to Physical Interventions: Responding to Challenging Behaviour in People with Intellectual Disabilities

Edited by David Allen

British Institute of Learning Disabilities (2002)  
ISBN 1 904082 01 7

### Alick Bush

CONSULTANT PSYCHOLOGIST, COMMUNITY ASSESSMENT & INTENSIVE SUPPORT SERVICE, SHEFFIELD CARE TRUST

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Every now and again, I discover a new 'essential text' to be added to my list of recommended reading for colleagues and students who are new to this area of work. *Ethical Approaches to Physical Interventions* is my most recent addition, and joins the likes of *Cognitive Counselling and Persons with Special Needs*

(Lovett, 1985) and *Behavioural Intervention: Principles, Models and Practices* (Scotti & Meyer, 1999).

While drafting *Psychological Interventions for Severely Challenging Behaviours Shown by People with Learning Disabilities: Clinical Practice Guidelines* (Ball *et al*, 2004), I was struck by the limited literature and empirical research relating to reactive strategies. There is a large body of evidence (Didden *et al*, 1997) that interventions which are based on psychological principles are currently the most effective approaches for reducing the incidence of challenging behaviour in people with learning disabilities. Despite this background, there is a paucity of guidance for carers about how to intervene at the time when people with learning disabilities are displaying the most risky behaviours.

This book provides a comprehensive overview of this area. Each chapter considers the issues from the value-base of positive behavioural support and helps to dispel the common belief that 'the more extreme the person's challenging behaviour, the more justified one is in using restrictive and potentially aversive interventions'.

The paucity of the evidence base has meant that clinicians have often found it hard to give appropriate, clear or consistent guidance to carers in situations when people have been hurting themselves or others. As Allen notes in the preface:

*In the absence of formal advice, solutions were typically improvised by direct carers, sometimes with appropriate results, but more often than not with ad hoc responses to difficult behaviours that increased risks for both service users and carers... The net result was that in many service settings, severe challenging behaviours were managed in ways that were potentially dangerous, unethical and unlawful.*

At long last we have a book that starts to redress this, by bringing together many of the key issues into a single volume. It provides a clear framework for a wide range of potential readers. People who are likely to find this collection of papers invaluable as a means of directly influencing practice include all the practitioners in community learning disability

teams, parents, care staff and managers. It will also provide strong guidance for anyone involved in the commissioning or monitoring of services for this vulnerable group of people.

The book sets out to review some of the evidence for 'behavioural management', with particular reference to physical interventions. Since 1996 the British Institute of Learning Disabilities has been developing and promoting policies that ensure safe and ethical physical interventions. Many of the chapters address the impact of these approaches, and evaluate the efficacy of the resultant training.

The section on 'Risk' provides an important reminder that clinicians need to promote positive risk-management strategies that are based on an individual formulation. This approach contrasts with the common alternatives that may involve potentially oppressive interventions, or that may be so risk-averse that people with challenging reputations are denied the opportunity to participate in community settings.

The chapters on crisis management present powerful arguments to contradict the frequently quoted, but misguided, advice to 'ignore his behaviour; he's doing it for attention'. The authors demonstrate that effective reactive strategies can be both non-physical and constructive.

The final section of the book recognises that, despite the best efforts to develop non-physical alternatives, sometimes physical interventions will be used. When they are required, they must be safe and ethical. The authors provide a review of best practice, a salutary caution and evidence of the consequences of using potentially life-threatening practices, from the perspective of both service users and organisations.

Several of the chapters acknowledge that, in order to develop ethical and effective interventions, carers require an understanding of why the person is challenging. Such an approach will increase the likelihood that interventions can be individualised and will address the underlying reasons for the person's behaviour. The chapter 'Devising individualised risk management plans' provides a helpful step-by-step guide for carers. Many services

do not have access to appropriately experienced clinicians who can advise on the development of such plans. However, care staff who follow this guidance should be able to develop robust and ethical risk-management plans.

Finally, the book demonstrates that a systematic approach **can** reduce the use of physical interventions. The authors provide a helpful framework for developing safe and ethical practices, and point to a number of areas for future research. The challenge now is for everyone who has an interest in this area to take on board the issues raised. It is a sad fact that scandals and investigations often prompt improvements in practice; we need to implement these approaches now, and not wait for another example of abuse to trigger further inquiries.

Overall, this book provides a comprehensive overview of current best practice in this very difficult area of work. It addresses issues from a wide range of perspectives and should be essential

reading for anyone who has responsibility for providing, commissioning or monitoring the care of people with learning disabilities whose behaviour is severely challenging.

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