## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Background Information</td>
<td>4</td>
</tr>
<tr>
<td>Person-Centred Care</td>
<td>5</td>
</tr>
<tr>
<td>Positive Behaviour Support (PBS)</td>
<td>7</td>
</tr>
<tr>
<td>What is it?</td>
<td>7</td>
</tr>
<tr>
<td>How does PBS help?</td>
<td>8</td>
</tr>
<tr>
<td>Behaviours of concern and restrictive practices</td>
<td>8</td>
</tr>
<tr>
<td>The Pyramid Model</td>
<td>8</td>
</tr>
<tr>
<td>Universal response (Positive prevention strategies)</td>
<td>10</td>
</tr>
<tr>
<td>Primary response (Response to potential harm: People who exhibit mild behaviours of concern or who are at risk of developing behaviours of concern)</td>
<td>10</td>
</tr>
<tr>
<td>Secondary response (Response to actual harm: People who exhibit moderate behaviours of concern)</td>
<td>10</td>
</tr>
<tr>
<td>Tertiary response (Response to escalated harm: People who exhibit severe behaviours of concern)</td>
<td>10</td>
</tr>
<tr>
<td>The evidence base for using PBS</td>
<td>10</td>
</tr>
<tr>
<td>Key components of PBS</td>
<td>11</td>
</tr>
<tr>
<td>Values</td>
<td>13</td>
</tr>
<tr>
<td>Theory and evidence base</td>
<td>14</td>
</tr>
<tr>
<td>Process</td>
<td>15</td>
</tr>
<tr>
<td>References</td>
<td>17</td>
</tr>
</tbody>
</table>
INTRODUCTION

Care for people with a disability has previously been a medical model that has emphasised personal impairment and focussed on curative or rehabilitation strategies to adapt individuals to the world around them rather than attempting to adapt the context to the individual.

A more modern and progressive social model is person-centred care, which better understands the needs of an individual, and the barriers to daily life and wellbeing caused by social attitudes, policies, or the physical environment. This development in disability care has been described as a move from a deficit model to a support-based model.¹

BACKGROUND INFORMATION

The United Nations Declaration of Rights of Disabled Persons (1975) is the foundation document that has guided legislation to support people with disabilities around the world. It evolved out of a movement of disabled people and their advocates who campaigned for community living rather than institutional care, and for people to have control over personal assistance as a fundamental right to independent living.

Momentum in this movement increased after the International Year for Disabled Persons in 1981. The 2006 United Nations Convention on the Rights of Persons with Disabilities now requires governments to provide services that enable people with disabilities to exercise their rights.

A more recent trend has seen the language of human rights replaced by a new discourse of consumerism defined by what people can purchase in a market economy. As the current model provides funding to people with disabilities to purchase services, person-centred approaches to providing care for people with disabilities is clearly consistent with consumerism. An increased demand for services from people with a disability and a decline in the availability of unpaid carers has led to a market solution to providing person-centred care.²

A national Productivity Commission Issues Paper in 2010 Disability Care and Support reported a growing impetus to providing more control for people with disabilities and their carers including individual funding and consumer directed care so that people with disabilities could choose their own services.³

¹ Kirkman 2010, p. 8.
² Kirkman 2010, p. 10.
The Productivity Commission stated:

Currently, the overarching goal of Australian governments’ disability policies is to enhance the quality of life and increase the economic and social participation of people with disabilities and their families, including enhancing and protecting their rights.4

The Australian Government had asked the Commission to consider how a national disability scheme could be designed, administered, financed and implemented. This included consideration of a variety of options, including a no-fault social insurance model and approaches used in other countries.5

The National Disability Insurance Scheme (NDIS) is now in place and is being rolled out around Australia, with eligible people being able to progressively access the scheme, depending on their age and where they live. The NDIS has been designed to provide eligible people with a flexible, whole-of-life approach to the support they need to pursue their goals. It also fosters social inclusion and economic participation.

The first stage of the NDIS in South Australia began on 1 July 2013 for children aged 13 years and under. From 1 February 2016 the NDIS will progressively be available across South Australia. By July 2018, it is estimated that around 26,000 people in South Australia will access the NDIS, including around 17,000 people from the existing South Australian specialist disability system.6

The term ‘person-centred care’ is used to refer to many different principles and activities, and there is no single agreed definition of the concept because:

> Person-centred care is still an emerging and evolving area,
> If care is to be person-centred, then what it looks like will depend on the needs, circumstances and preferences of the individual receiving care,
> What is important to one person in their care may be unnecessary, or even undesirable, to another; and
> It may also change over time, as the individual’s needs change.7

Person-centred approaches are “ways of commissioning (funding), providing and organising services rooted in listening to what people want, to help them live in their communities as they choose. People are not simply placed in pre-existing services and expected to adjust, rather the service strives to adjust to the person. Person-centred approaches look to mainstream services and community resources for assistance and do not limit themselves to what is available within specialist services.”8

Person-centred approaches include a broad range of actions at individual, organisational, systemic and community levels to support and facilitate the person with a disability being listened to and placed at the centre including:

> Planning processes using a range of tools and resources,
> Person-centred thinking,
> Service delivery,
> Service design,
> Communication; and
> Community work.9

---

5 Productivity Commission 2010, p. 3.
6 National Insurance Disability Scheme.
7 Health Foundation 2014.
8 Life without Barriers p. 4.
9 Life without Barriers p. 4.
The key features of person-centred planning are:

> The person is at the centre of decision-making,
> Family members and friends are full partners in that process,
> The plan reflects the person’s capacities, what is important to the person and specifies the support they require to make a valued contribution to their community,
> The plan builds a shared commitment to action that will uphold the person’s rights; and
> The plan leads to continual listening, learning and action and helps the person to get what they want out of life.\(^{10}\)

Person-centred outcomes:

1. Individuality – everyone’s differences are recognised and respected.
2. Choice – the right of individuals to make informed choices, and take responsibility for those choices and related risks is supported.
3. Privacy – information and activities are kept confidential.
4. Independence – individuals are empowered to do activities for themselves and their dignity is treated in a respectful way.
5. Inclusion – people are supported to participate in all aspects of community that they choose and are viewed as valued and equal citizens.\(^{11}\)

Resources:


\(^{10}\) Life without Barriers p. 5.
\(^{11}\) Life without Barriers p. 5.
There is now several decades of research on the effectiveness of PBS that spans adults, children and young people with development or intellectual disabilities; typically developing children and young people with other emotional and behavioural difficulties; and people with other neurological conditions, such as an acquired brain injury, who display behavioural difficulties.12 This resource focuses on some of the more recent research providing the evidence base for PBS and presents a “how to” guide for using PBS.

What is it?

PBS can be described as a process used to develop assessment-based behaviour support plans for the intervention on an individual basis of persistent challenging behaviour. When developed these individual behaviour plans guide caregivers and professionals within natural contexts that results in a reduction in the challenging behaviour, and leads to the acquisition of new skills and lifestyle changes for the individual with challenging behaviour.13

PBS has been used internationally in so many context that multiple definitions exist. The following comprehensive definition was developed as an overall definition and scope of PBS as it has developed in the UK.

Positive Behaviour Support is a multi-component framework for:

a. developing an understanding of the challenging behaviour displayed by an individual, based on an assessment of the social and physical environment and broader context within which it occurs;

b. with the inclusion of stakeholder perspectives and involvement;

c. using this understanding to develop, implement and evaluate the effectiveness of a personalised and enduring system of support; and

d. that enhances quality of life outcomes for the focal person and other stakeholders.14

Challenging behaviour is often attributed to the individual with the behaviour, but it is the people around that individual who are challenged by the behaviour. Individuals who engage in challenging behaviour are telling the people around them that something is wrong or missing and that they need help to make it better. The challenge is for people to build support for this individual and her or his family.15

Positive Behaviour Support:

> is both a philosophy of practice and a term to denote a range of individual and multisystemic interventions that aim to effect change in an individual's behaviour and ultimately their quality of life,

> is applicable to all people and has been used to support children and adults, people with and without disability, and people in a range of settings,

> recognises that all people, regardless of their behaviour, are endowed with basic human rights and that any assessment, intervention or support should be respectful of those human rights; and

> recognises that all human behaviour serves a purpose, including those behaviours that are deemed to be behaviours of concern.16

---

12 Gore et al 2013, p. 15.
13 Blair et al 2010, p. 68.
14 Gore et al 2013, p. 15.
16 Disability Services 2013, p. 15.
How does PBS help?

PBS is about working with families and carers to understand why an individual has a need to engage in challenging behaviours. Some of the ways it can assist include:

> helping an individual understand their daily life using clearer ways of communicating with them such as introducing a picture schedule,
> changing the environment to make it better for the individual, such as reducing high noise levels,
> improving the person’s lifestyle so they have more interesting and enjoyable activities to keep them involved and connected with their community, such as recreational or other activities of interest; and
> changing the environment so that the person is involved in meaningful and positive relationships with others.17

Behaviours of concern and restrictive practices

Disability Services in South Australia have chosen to use the term behaviours of concern as ‘challenging behaviours’ has often been used as a label with negative connotations. Some of the negative connotations involve restrictive practices that have been used to manage challenging behaviours, which are definitely not used with PBS.

Behaviours of concern are behaviours of such intensity, frequency or duration as to threaten the quality of life and/or safety of the individual or others, may seriously limit or deny lifestyle opportunities and/or the use of ordinary community facilities, impede positive interactions with others in the environment and are likely to lead to responses that are restrictive, aversive or result in exclusion.18

Disability Services SA has drawn on the Office of the Public Advocate’s Interim Restrictive Practices Policy for the definition of restrictive practices.

Restrictive practices are acts of removing another person’s freedom. It involves any practice, device or action that interferes with a person’s ability to make a decision or that restricts the person’s movement. Examples of restrictive practices include practices used for safety or behaviour management purposes and may involve the use of a device, deactivation of a device such as a wheelchair, physical force, medication, a locked door to prevent a person from freely moving about or seclusion/detention. It does not include the use of devices for therapeutic purposes or to enable the safe transportation of the person.19

For Positive Behavioural Support to bring about adaptive change, it is first important to understand the purpose of the individual’s:

> existing behaviours,
> their aspirations; and
> the range of skills they already have.

In order to develop effective change strategies it is important to understand the context in which any behaviours of concern occur and the environments in which the person lives and needs to learn to use more adaptive behaviours.20

The Pyramid Model

Disability Services in South Australia uses a Pyramid model, which is also in use internationally21, to illustrate that positive behaviour support must be used at all levels of service provision. The Pyramid Model is comprised of four tiers with an emphasis on prevention, and the provision of services that support the emergence and maintenance of positive behaviours, as well as the reduction of behaviours of concern:22

18 Disability Services 2013, p. 5.
19 Disability Services 2013, p. 5.
20 Disability services, 2013, p. 15.
21 Blair et al 2010, p. 70.
22 Disability Services 2013, p. 18.
Response to Actual Harm
(Moderate* behaviours of concern), Specialist clinical services, Clinical and Case Management services, Targeted training resources, Crisis intervention

Response to Potential Harm
(Mild*/at risk of developing behaviours of concern), Person-centred planning, Vulnerable persons are identified, Training resources, Clinical and case management services

Response to Escalated Harm
(Severe* behaviours of concern), Intensive specialist clinical services, Intensive accommodation options: ie respite, therapeutic accommodation services, Crisis Intervention

Positive Prevention strategies
Human Rights-Based Framework, Positive Behaviour Support Framework, Person-Centred Service Framework, Systems and processes for all individuals, Data Collection

*Definitions of levels of behaviours of concern (severe, moderate, mild) can be related to the Risk Assessment Matrix.
Universal response (Positive prevention strategies)

These universal strategies are positive prevention strategies that aim to create environments and services that support children and adults to exhibit positive behaviours, e.g. effective person-centred planning and service delivery, staff recruitment and induction processes, and referral and intake processes.23

Primary response (Response to potential harm: People who exhibit mild behaviours of concern or who are at risk of developing behaviours of concern)

People with these issues ideally need to be supported without the need for specialist positive behaviour support by:

> effective person-centred planning,
> accessing clinical services where required; and
> the provision of effective case management services.

Secondary response (Response to actual harm: People who exhibit moderate behaviours of concern)

People at this level need some access to trained PBS practitioners working from within their local community or from within identified specialist teams. Services at this level could be either episodic or ongoing with PBS practitioners providing direct and specialised services to support people through:

> person-centred planning,
> case management services,
> crisis intervention (where indicated); and
> the provision of specific targeted interventions to support people exhibiting moderate behaviours of concern.24

Tertiary response (Response to escalated harm: People who exhibit severe behaviours of concern)

People at this level need access to trained PBS specialists who provide direct services through time-limited intensive services or less intensive services provided on an episodic or ongoing basis with an aim of providing support at reduced levels in the future. Services at this level would include:

> functional and specialist assessment,
> crisis intervention where indicated; and
> implementation and review of specialist behaviour support interventions.25

The evidence base for using PBS

There is now international evidence strongly in favour of using PBS as a model of intervention for children, young people, and adults with behaviours of concern. Systemic reviews of single case and small group studies have found that they demonstrate significant reductions in challenging behaviours following PBS interventions.26

A study conducted in South Florida in 2010 in a classroom for 3-year-olds in a community child care program in a high poverty area within a large urban area serving children with and without disabilities reported very positive results

23 Disability Services 2013, p. 19.
24 Disability Services 2013, p. 19.
for individualised PBS.\textsuperscript{27} The child care program was selected to participate in a program using the Pyramid Model for PBS. There were three children who had behaviours of concern during circle time. The study reported several key findings that are relevant to the use of individualised PBS by classroom personnel in community early childhood programs:

1. The intervention derived from the individualised PBS process was effective in reducing the three participating children’s behaviours of concern and increasing their engagement during circle time activities, regardless of who implemented the intervention,

2. The classroom staff successfully implemented the individualised behaviour support plans and generalised the implementation of the intervention strategies to non-trained routines,

3. Teacher implementation during non-trained routines resulted in improving the participating children’s target behaviours; and

4. Changes in the target behaviours of two children were maintained in their new classrooms.

The staff viewed the individualised PBS intervention as effective, feasible and generalisable and reported increases in overall instructional quality and reduced teaching stress. The target children were able to enjoy classroom routines, interact positively with teachers and peers, and participate more actively in the classroom.\textsuperscript{28}

Educators often have to deal with behaviours of concern and children with diverse backgrounds. Research has indicated that positive teacher-child interactions and effective behaviour management lead to positive child outcomes. A study conducted in the USA in 2013 investigated how the method of delivery of professional development for teachers in using positive behavioural management strategies in their classrooms influenced their future practice.

It found that experiential training was an important element.\textsuperscript{29}

In this study, educators who had the opportunity to practice positive behaviour management strategies and observe other educators practicing the same skills demonstrated these competencies more than educators who attended a lecture and then discussed the use of these strategies; an outcome consistent with previous research findings that supported the use of experiential learning.\textsuperscript{30}

It was found that early childhood educators who were taught positive behavioural supports, and then had the opportunity to practice these strategies, exhibited greater rates of positive attending throughout the school year. They also rated as having classrooms that were better organised, engaging, and well-managed.\textsuperscript{31}

**Key components of PBS**

This section explaining “how to” deliver PBS is based on a framework developed in the UK that is practical and strategic to a number of stakeholders. It draws on previous definitions of PBS, relevant research, and the professional experience of the authors to create a multi-component framework that captures what is known and understood about best-practice for supporting individuals with behaviours of concern and to usefully inform the development of competencies in PBS practice, service delivery, training and research.\textsuperscript{32}

PBS has several core dimensions that differentiate it from other approaches. It can be seen as 10 overlapping elements that can be categorised as values, theory and evidence base, and processes, as set out in Table 1. **PBS is a multi-component framework that requires the use of all these elements, which results in a form of positive behaviour management that is considered to be greater than the sum of its parts.**\textsuperscript{33}

\textsuperscript{27} Blair et al 2010.
\textsuperscript{28} Blair et al 2010, p. 76. 

\textsuperscript{29} Fabiano et al 2013.
\textsuperscript{30} Fabiano et al 2013, p. 457 & 458.
\textsuperscript{31} Fabiano et al 2013, p. 459.
\textsuperscript{32} Gore et al 2013.
\textsuperscript{33} Gore et al 2013, p. 15.
Table 1: Key components of PBS*

<table>
<thead>
<tr>
<th>Values</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prevention and reduction of behaviours of concern occur within the</td>
<td>Prevention and reduction of behaviours of concern occur within the</td>
</tr>
<tr>
<td>context of increased quality of life, inclusion, participation, and</td>
<td>context of increased quality of life, inclusion, participation, and</td>
</tr>
<tr>
<td>the defence and support of valued social roles</td>
<td>the defence and support of valued social roles</td>
</tr>
<tr>
<td>2. Constructional approaches to intervention design builds stakeholder</td>
<td>Constructional approaches to intervention design builds stakeholder</td>
</tr>
<tr>
<td>skills and opportunities and eschews aversive and restrictive practices</td>
<td>skills and opportunities and eschews aversive and restrictive practices</td>
</tr>
<tr>
<td>3. Stakeholder participation informs, implements and validates</td>
<td>Stakeholder participation informs, implements and validates</td>
</tr>
<tr>
<td>assessment and intervention practices</td>
<td>assessment and intervention practices</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theory and evidence base</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4. An understanding that behaviours of concern develop to serve</td>
<td>An understanding that behaviours of concern develop to serve important functions for people</td>
</tr>
<tr>
<td>important functions for people</td>
<td></td>
</tr>
<tr>
<td>5. The primary use of applied behaviour analysis to assess and support</td>
<td>The primary use of applied behaviour analysis to assess and support behaviour change</td>
</tr>
<tr>
<td>behaviour change</td>
<td></td>
</tr>
<tr>
<td>6. The secondary use of other complementary, evidence-based approaches</td>
<td>The secondary use of other complementary, evidence-based approaches to support behaviour change at multiple levels of a system</td>
</tr>
<tr>
<td>to support behaviour change at multiple levels of a system</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7. A data-driven approach to decision-making at every stage</td>
<td>A data-driven approach to decision-making at every stage</td>
</tr>
<tr>
<td>8. Functional assessment to inform function-based intervention</td>
<td>Functional assessment to inform function-based intervention</td>
</tr>
<tr>
<td>9. Multi-component interventions to change behaviour (proactively) and</td>
<td>Multi-component interventions to change behaviour (proactively) and manage behaviour (reactively)</td>
</tr>
<tr>
<td>manage behaviour (reactively)</td>
<td></td>
</tr>
<tr>
<td>10. Implementation support, monitoring and evaluation of interventions</td>
<td>Implementation support, monitoring and evaluation of interventions over the long term</td>
</tr>
<tr>
<td>over the long term</td>
<td></td>
</tr>
</tbody>
</table>

Values

Positive Behaviour Support (PBS) originally developed out of a number of human rights and values-based movements that embraced social role valorisation, person-centred planning, and self-determination. These values are central to PBS.\(^{34}\)

PBS aims to enhance quality of life as both an intervention and an outcome for people who display behaviour that challenges and those who support them. A central objective is to increase the focal person’s repertoire of adaptive behaviours and their range of positive life opportunities.\(^{35}\) The use of PBS should involve practices that are consistent with these values and reflect the following key principles.

Prevention and reduction of challenging behaviour occurs within the context of increased quality of life, inclusion, participation, and the defence and support of valued social roles

PBS uses behavioural technologies and other evidence-based approaches with the explicit aim of generating long-term lifestyle changes. An outcome of PBS should be enhanced wellbeing and an increase in meaningful and valued participation in community life for the focal person and other stakeholders. Positive changes in behaviour need to be sustained and supported to evolve over a significant period of time, encapsulating years rather than weeks or months. When interventions aimed at improving quality of life and community engagement are aligned with a functional understanding of the individual’s challenging behaviour, a reduction in the challenging behaviour is likely to occur. However, this is seen as a secondary gain within PBS.

The ultimate focus for intervention, selection and implementation should concern quality of life changes that are centred on an individual’s needs, preferences, and active community participation.\(^{36}\)

Constructional approaches to intervention design builds stakeholder skills and opportunities and eschews aversive and restrictive practices

Constructional intervention and support means explicitly aiming to increase the focal person’s repertoire of adaptive behaviours and range of positive life opportunities. Such interventions are likely to reflect person-centred goals and may include:

> Helping individuals to experience more choice and control,
> Increasing access to favoured and purposeful activities,
> Developing meaningful and positive relationships with others; and
> Enhancing physical and mental wellbeing.\(^{37}\)

Stakeholder participation informs, implements and validates assessment and intervention practices

To be consistent with person-centred values, PBS practitioners need to include stakeholder values in two ways:

1. As agents of behaviour change; and
2. As persons for whom the improvements in the focal person’s quality of life may form part of the process of assessment and intervention.

Families and professional carers and, if possible, the focal person need to come together to act as valued change agents through the consultation and support processes embedded in PBS. Stakeholder input is essential to:

> ensure the form of selected interventions and assessments are achievable within the focal person’s life context; and
> validate the social significance of the outcomes pursued.

How the focal person’s behaviour is developed and maintained is intricately connected to the behaviour and wellbeing of other stakeholders.

---

34 Gore et al 2013, p. 16.
36 Gore et al 2013, p. 16.
37 Gore et al 2013, p. 16.
Involvement of stakeholders as intervention implementers together with wider effects to deliver training and direct support to staff and family carers is therefore also required to deliver the kind of durable changes characteristic of PBS.38

Theory and evidence base

The conceptual model that underpins PBS views behaviours of concern as functional. They are not viewed as a deviancy, diagnosis, mental health condition or as a deliberate attempt by the individual to cause problems for themselves or others. Behaviours of concern within PBS are seen as the focal person’s best attempt to exert influence and control over their lives. In PBS behaviours of concern are primarily understood as learnt behaviour that is developed and maintained within:

1. the context of an individual’s abilities, needs – including their physical and mental health – and circumstances.
2. the properties of the social and physical environments within which the behaviour occurs.

Behaviour affects the environment, and the environment selects behaviour. Thus, behavioural function may be conceptualised as the product of interaction between the two.39

These social and physical environments often contain or lack important features that are proactive of behavioural challenges, and the term challenging environments has been used to stress that many of the causal factors behind such behaviours lie outside the person.40

An understanding that behaviours of concern develop to serve important functions for people

Considerable evidence suggests that the behaviours of concern amongst people with learning difficulties is often maintained by the social consequences that follow the behaviour and relates to ongoing interactions with caregivers. However, there is also a broader context. The likelihood of such behaviours is also influenced by:

> genetics, e.g. behaviours of concern is more likely in people who have particular genetic syndromes,
> an alteration in the person’s physical or mental wellbeing; and
> the focal person having a limited capacity to otherwise influence their world, e.g. having limited communication skills.

More than one of these kinds of factors can contribute to the occurrence of behaviours of concern necessitating functional assessment and function-based interventions that are person-centred and multi-component.41

The primary use of applied behaviour analysis (ABA) to assess and support behaviour change

Applied Behaviour Analysis (ABA) is fundamental to how PBS should be defined and practiced:

> the functional model of behaviours of concern and the vast majority of assessment and intervention procedures central to PBS are directly grounded in the use of ABA; and
> PBS uses assessment and data collection methods that are largely based on the behaviour analytic technologies and the routine use of interventions that stem from and are reliant on the competent use of ABA.

However, the PBS approach demands high levels of flexibility and emphasises the use of natural assessment environments. PBS focuses on both micro and macro analysis and intervention and seeks to implement principles and strategies for behaviour change at multiple levels of a system.

Whilst each of these elements may at times be reflected in the wider practice of ABA, they are considered as essential and defining features for how behavioural technologies are routinely utilised within a PBS framework.42

38 Gore et al 2013, p.17.  
39 Gore et al 2013, p.17.  
41 Gore et al 2013, p.17.  
42 Gore et al 2013, p.18.
The secondary use of other complementary, evidence-based approaches to support behaviour change at multiple levels of a system

Although grounded in ABA, PBS uses additional approaches to assist in achieving all of its aims. However, these additional approaches must be evidence-based and consistent with the functional account of challenging behaviour. This use of additional approaches is not a substitution of ABA and may include psycho-educational work, self-management or therapeutic interventions with carers and individuals who display behaviours of concern with systems analysis to assist in formulating the wider context in which behaviours of concern operate and are maintained.  

Process

A data-driven approach to decision making at every stage

The PBS process is values-led and data-driven. Each stage of assessment, intervention planning and implementation incorporates decision-making that is grounded in research literature relating to behaviours of concern and the data that has been gathered about the focal person and her or his environment(s).

Functional assessment to inform function-based intervention

PBS requires that both assessment and support arrangements are personalised as no two people are the same and every referral situation is unique, although the principles governing behaviour remain constant. The PBS process involves the development of a multi-layered intervention plan that:

- begins with a systematic assessment of when, where and how the individual displays behaviours of concern; and
- aims to develop an understanding of behavioural function, i.e. how it helps the individual to cope better or exert some control over their immediate environment.

This process is often referred to as a ‘functional assessment’ and is based on methods derived from ABA such as direct behavioural observation. However, it will often incorporate other forms of data obtained from less direct methods, such as rating scales and interviews. At a minimum, a good functional assessment provides:

- a clear account of antecedents and the consequences that accompany episodes of behaviours of concern; and
- an appraisal of the broader context to ensure that other factors influencing the individual’s behaviour are properly defined.

Functional assessment addresses a two-part question:

1. What function does this behaviour serve?
2. Why do behaviours of concern and not some other behaviour serve this function?

This part of the process requires an understanding of the social and material environment and is crucial for:

- developing intervention strategies that are consistent with the findings of assessment; and
- ensuring that all intervention components are consistent with one another.

Multi-component interventions to change behaviour (proactively) and manage behaviour (reactively)

PBS intervention plans have multiple components and are:

- devised with everyone who has a stakeholder interest; and
- internally consistent and correspond to a prior analysis and formulation of assessment findings.

43 Gore et al 2013, p.18.
44 Gore et al 2013, p.18.
45 Gore et al 2013, pp.18 & 19.
At a minimum, PBS plans will include an operational definition of target behaviours and proactive strategies to:

1. increase stakeholder quality of life,
2. eliminate antecedent contexts likely to evoke behaviours of concern,
3. provide functionally equivalent alternatives to behaviours of concern; and
4. supply coping strategies and learning opportunities to reduce the likelihood of behaviours of concern occurring over the long term.

A secondary but important part of the plan should describe a range of reactive strategies to guide responses to behaviours of concern if and when they occur. These strategies should be:

> the least restrictive and most effective available,
> focus on ways to reduce potential harm; and
> minimise the risk of escalation in the behaviour.

Person-centred intervention plans commonly include:

> individualised approaches to increasing skills and behaviours that may serve a similar function to the behaviour displayed by the individual,
> modifying the focal person’s physical and social environment to reduce antecedents associated with behaviours of concern and increase those associated with more adaptive alternatives; and
> broader strategies to increase the individual’s physical and emotional wellbeing together with opportunities to develop other positive behaviours in general.

The PBS plan will often also include contextual factors that may influence the focal person’s behaviour by including strategies to support positive change in the wider system and improve stakeholder’s quality of life.46

Implementation support, monitoring and evaluation of interventions over the long term

Clear guidance on how strategies will be implemented, by whom, and by when should be included in the PBS plan. Progress with implementation needs to be reviewed periodically and the effectiveness of strategies evaluated.

Monitoring systems typically include:

> the continued use of data collected on the occurrence and non-occurrence of behaviours of concern,
> quality-of-life indicators; and
> mastery of particular PBS strategies specified in the plan.

Monitoring and re-implementation is often required over the long term as persons are expected to encounter deficiencies in the material and social environment more than once in their lifetime. Monitoring that translates into continuous evaluation enables prevention through early identification and intervention – effectively preventing or attenuating potential crises related to behaviours of concern.

REFERENCES


