WAAMH
Western Australian Association for Mental Health

Bite-sized NDIS

Workbook 3:

Everything Positive Behaviour Support

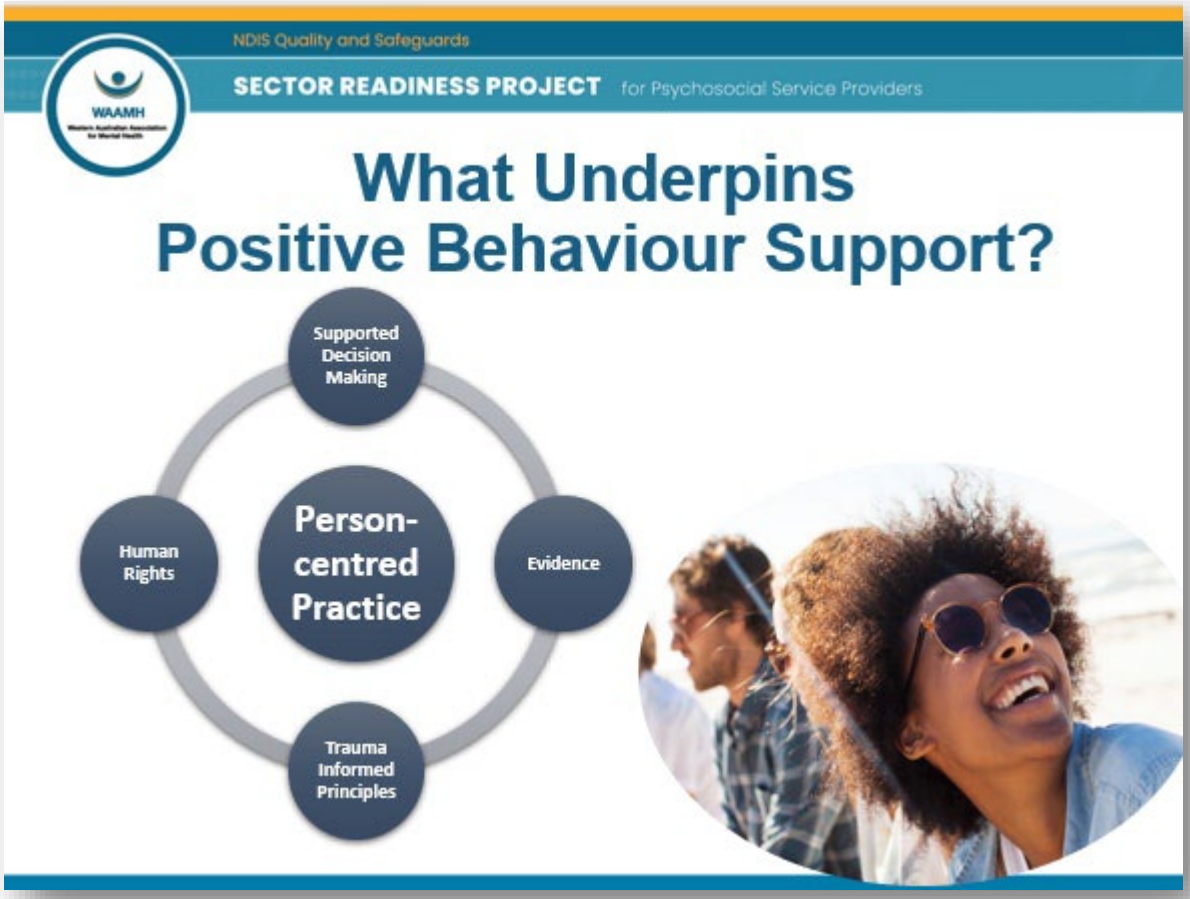
Content Warning:

This workbook focuses on restrictive practices, which may be distressing to some people.

We encourage you to use your judgement, liberal self care, and remember the number for Lifeline is 13 11 14 if you need to debrief.

Introducing PBS

As we talked about last week, restrictive practice should be the last resort, and PBS (positive behaviour support) should be the first response to challenging behaviour. An understanding of what underpins PBS is crucial, as it informs the way in which practitioners respond to challenging behaviour.



PBS is essentially a person centred practice, this means the person and their well-being is the focus of all the work. Some people will tell you PBS exists to reduce challenging behaviour, but the NDIS Q&S Commission states that the primary focus should be on improving the person's life, and reduction in challenging behaviour is a secondary consequence of that.

PBS is evidence based, meaning there is scientific data to “prove” its efficacy. It is worth noting though, that some of this evidence is contested and there is speculation that because PBS is delivered by such a spectrum of providers, not all who understand the basis and intricacies of it, there are varied results.

PBS should also be practiced according to trauma-informed principles. These principles recognise the uniqueness of each individual and the role that trauma has played/is playing on their life. WAAMH does a great training on trauma informed practice if you’d like to know more about this – it’s a very rich area of knowledge and very pertinent to working in this industry.

PBS is underpinned by the validation of human rights and dignity of risk. This means that we recognise the United Nation’s Charter on the Rights of People with Disability, and centre those rights (to make mistakes, or choices that may not be in the person’s best interest). Essentially, it means, at every step of the way, people are given authentic choices.

Finally, PBS invokes supported decision making. This ties in with the ethos of human rights, by recognising that we all make choices in consultation with others and supporting people to make decisions.

Food for Thought

How can you better support participants to make decisions, rather than making decisions for them?

1. Person centred planning – identifying the goals, strengths and needs of the person.

2. Including others – who live and work with the person to contribute to the assessment, planning and implementation process. This can include family members, carers, support workers, and other professionals.

3. Assessment and intervention – a functional behaviour assessment to understand the reason for the behaviour.

4. Developing a Positive Behaviour Support Plan (PBSP) – this plan lays out strategies for improving the person's life and addressing any needs. The plan is for both the person and anyone involved in their life so that everyone can work together. This includes prevention, responding to early warning signs, and reactive strategies.

5. Reducing restrictive practices – Restrictive practices are limitations placed on a person to prevent them from harming themselves or others. These practices limit a person's rights or freedom in some way. Positive behaviour support aims to reduce or end the use of restrictive practices. This focuses on quality of life and respect for the person's human rights.

6. Skill building – e.g. to help them communicate, take part in fun activities, and avoid using challenging behaviour.

7. Staff development – educating and training staff to understand how to put support strategies in place.

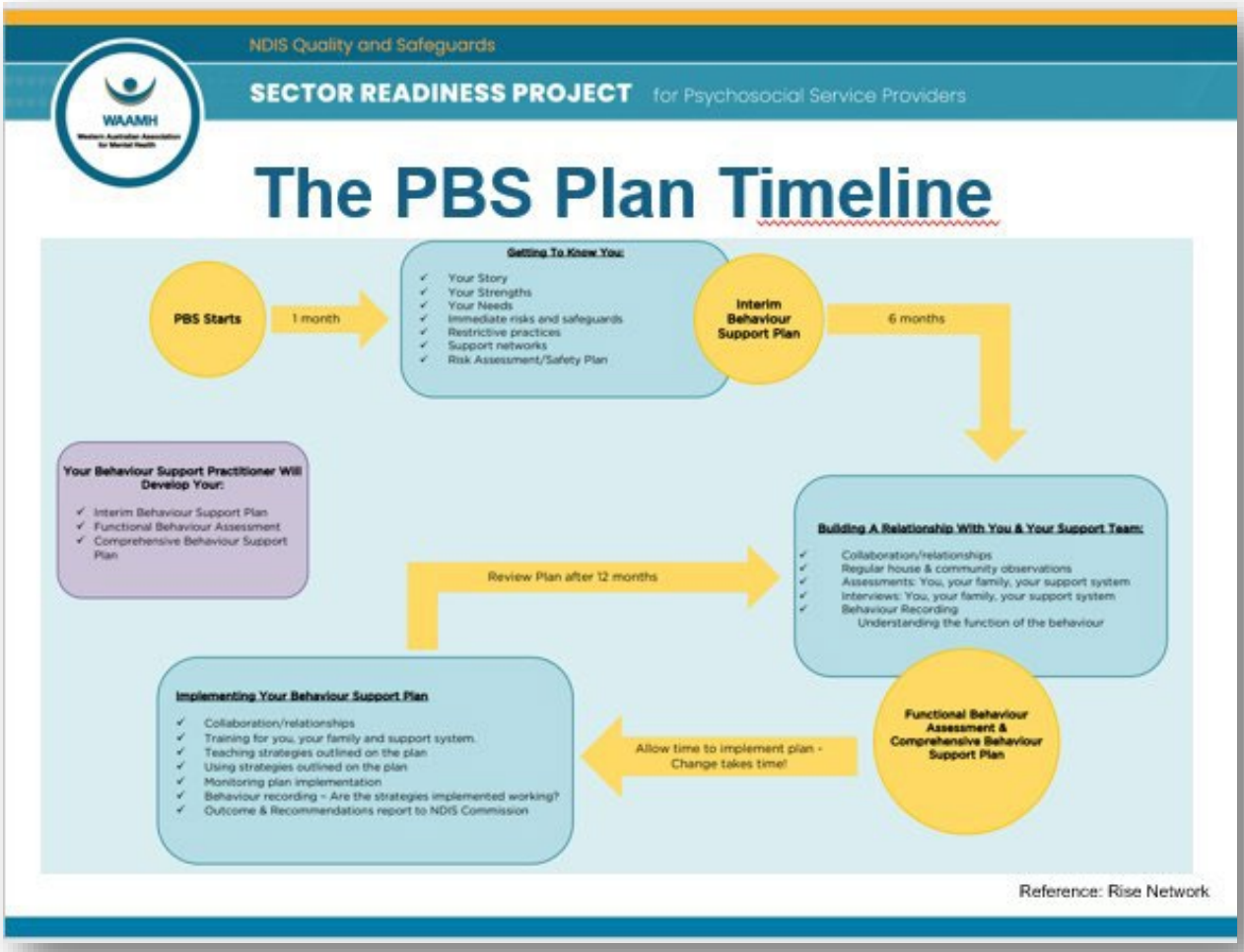
8. Environment changes – changing some parts of the surroundings can help, e.g. removing unwanted noise.

The Process

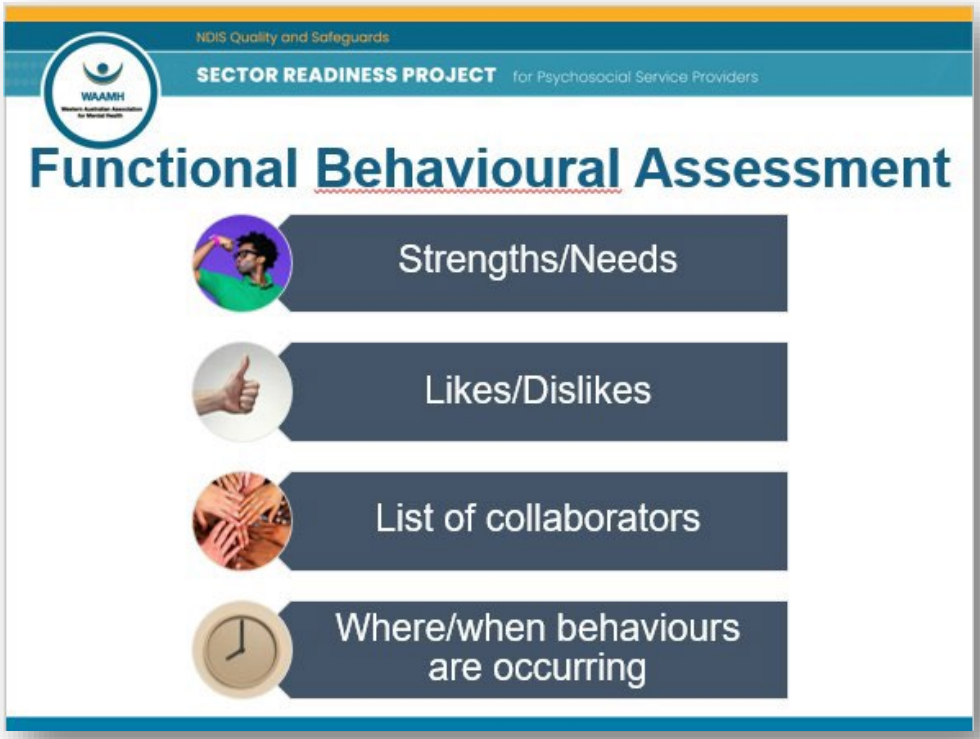
Within a month of PBS being established, the practitioner will develop an Interim Behaviour Support Plan. They do this by getting to know the person's story, strengths, and needs. They'll assess the immediate risks and safeguard that counter those risks. In other words, if someone is at a risk of self-harm, but has strong family support, they'll document that. They'll write up any restrictive practices they deem necessary, after completing a thorough risk assessment.

Remembering that restrictive practices can only be implemented when the person is at risk of hurting themselves or someone else. They'll also make a safety plan with the person. Within 6 months of the completion of the interim behaviour support plan, a more thorough assessment takes place, called a Functional Behaviour Assessment, or FBA. Through the course of regular house and community observation sessions, and collaboration with the person, their support workers, and any significant others, they'll record behaviours and attempt to hypothesise why

these behaviours take place – what need is not being met? This hypothesis (the function of the behaviour) will inform the comprehensive behaviour support plan, which is longer and more detailed than the interim BSP (behaviour support plan). After 12 months, there must be a review of the comprehensive BSP.



FBAs (Functional Behavioural Assessments) come in many variations. It's an organisational/practitioner choice. Most should include a list of the person's strengths (what they're good at) and needs (what they require assistance with), their likes and dislikes, a list of who is involved in their care and how, and when and where the behaviours of concern (challenging behaviour) are occurring.



The FBA should also include the frequency of behaviours (daily, weekly, monthly, etc), and the person's baseline (how they present when their 'cup is full'), concluding with a hypothesis or theory about the function of the behaviour – what need is not being met when these behaviours occur.

This is an example of an FBA from Rise Network. Every PBS practitioner/organization will have a different layout and different titles, but the core information should be similar. As you can see, it is fairly precise and direct.

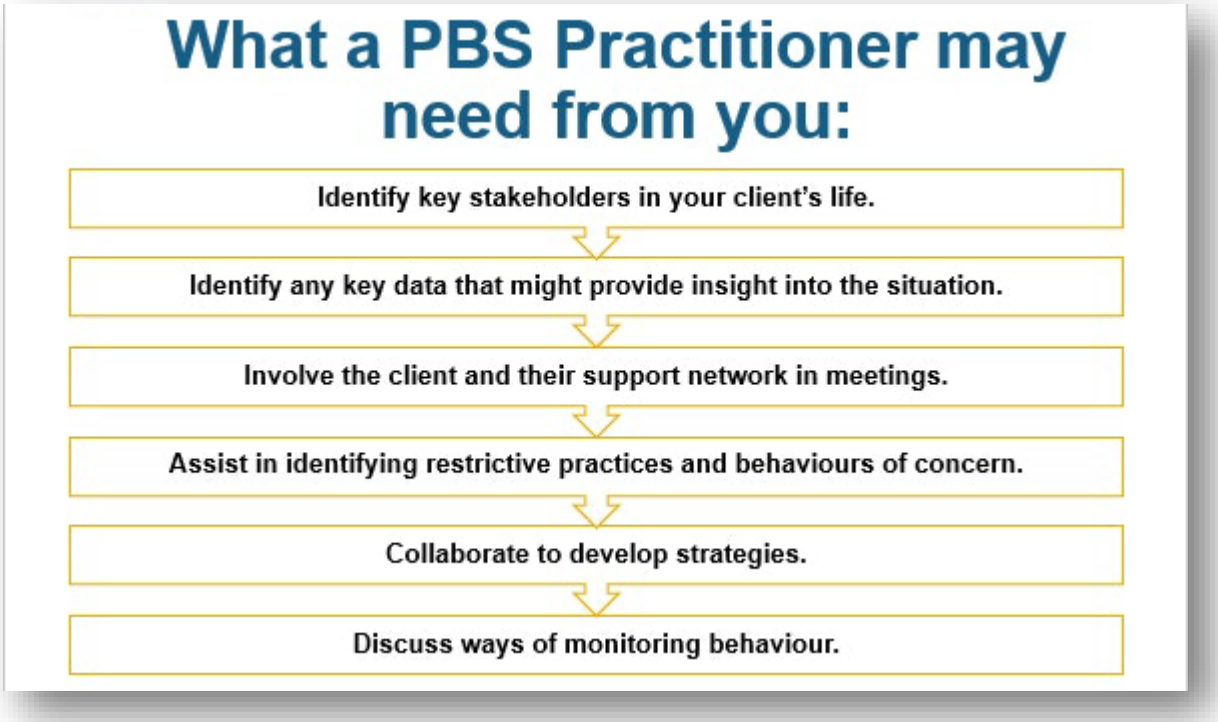
Type	Harm to self - other
Description	Hygiene – lack ot personal care (showering)
Frequency / Duration	Weekly/daily
Intensity	**Medium/likely**
Triggers	1. Not prompted to shower 2. Not prompted by his favourite staff 3. Not going on an outing to meet his girlfriend/friends
Low risk scenarios	1. Favourite staff on who can prompt successfully 2. If [redacted] chooses to shower of his own accord 3. [redacted] is going to an event with his girlfriend/friends
High risk scenarios	1. [redacted] is not prompted to shower by staff 2. Favourite staff are not on shift 3. [redacted] is not going out or choosing not to go out of his home
Function of the behaviour hypothesis	This behaviour has always been part of [redacted] life but has significantly increased of late. It is hypothesized that this has occurred due to a change in [redacted] medication as his mood is lower and the recent moving of his girlfriend to a different location and is now unable to see. This is a sensory behaviour as this feels good to [redacted] not to do so or he does not care.

Data Collection

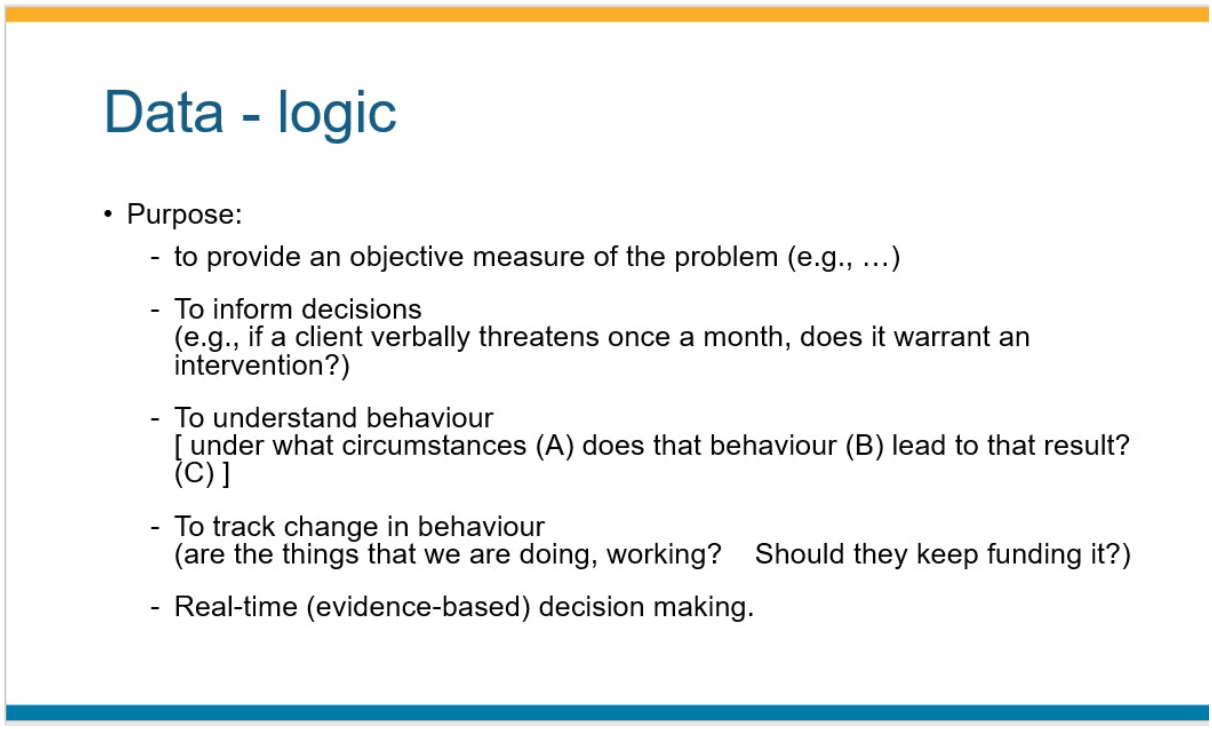
Collaboration between NDIS behaviour support practitioners and implementing providers: It is important that the NDIS behaviour support practitioner and the registered NDIS provider implementing the behaviour support plan work with the person with disability, and with one another, to develop and understand the behaviour support strategies for the person with disability.

Collaboration with health and allied health professionals: A medical practitioner should exclude any medical or physical conditions for the onset of the behaviour. A collaborative approach with different professions including health, occupational therapist, speech pathology, and physiotherapist can help to assess the person's context, systems and environment in which the restrictive practice will be used.

Consideration of the individual: Culture, religion, beliefs, sexual expression, linguistic circumstances, the gender of the person, and their family should be taken into account. This reflects good practice and is consistent with the NDIS Act 2013, the NDIS Practice Standards and Quality Indicators, and the values and principles outlined in the Positive Behaviour Support Capability Framework.



Although much information will come from interviews, assessments, and observations by the practitioner of the person in their environment and interactions with the people around them, the PBS practitioner may also ask to see case notes, incident reports and any behaviour monitoring charts already in place, in order to form a theory as to why the behaviour occurs. They may also ask for medical and independent reports (for example, by a psychiatrist or psychologist) to establish what else is going on for the person. This is also because people may not have the words to describe their experiences, and if they're unwell or in pain, this may well be contributing to their behaviour.



The importance of record keeping and information management for NDIS providers https://www.disabilitysupportguide.com.au/talking-disability/the-importance-of-record-keeping-and-information-management-for-ndis-provider

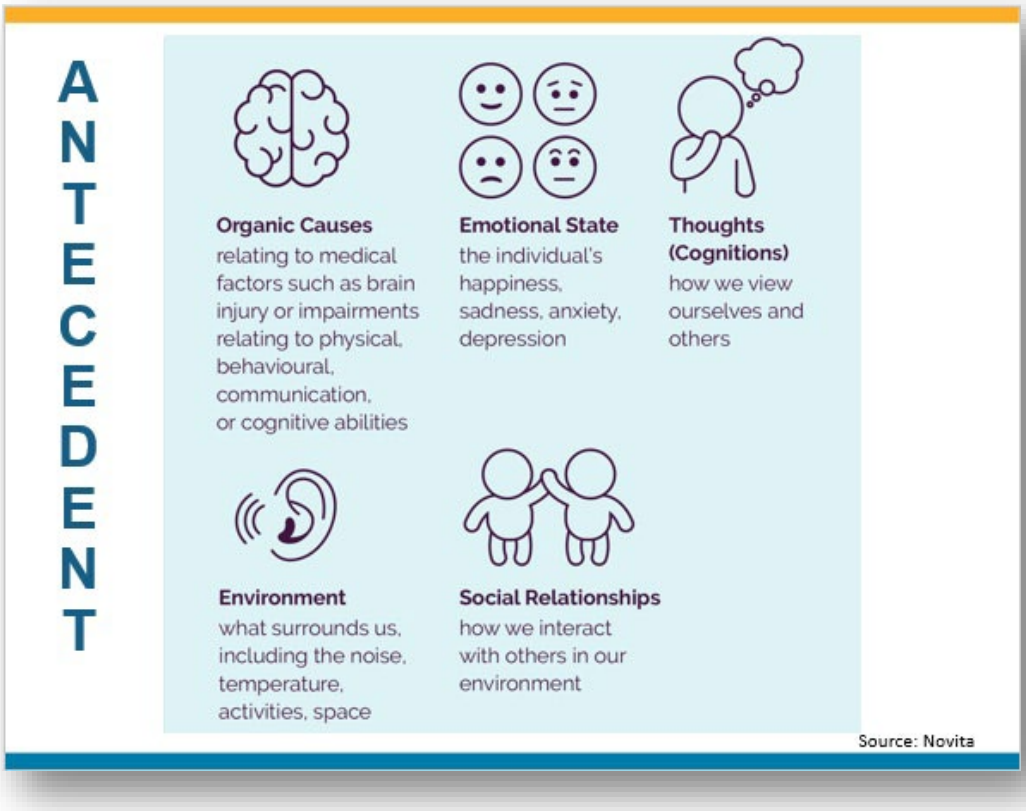
3 Theories

Now we're going to look at 3 theories that can be applied to PBS. Not all practitioners subscribe to all these theories, but it is helpful to know as most practitioners will subscribe to some of them…

1. The ABCs of PBS
2. FERB (Functionally Equivalent Replacement Behaviour)
3. Poly-Vagal Theory

The ABCs of PBS

ABC is an acronym (we love acronyms, don't we?) that stands for antecedent, behaviour, consequence. This theory really informs data collection and the hypothesis of behaviour – why it is occurring.



What happens immediately before the behaviour? Could this be the cause of the behaviour?

They can also be considered as triggers for the behaviour, such as:

•things that other people did or said

•an emotional state, g. depressed, tired, anxious

•the environment, g. hot, noisy, cramped, smelly, bright lights.

What is the observable behaviour? Before you respond to an actual behaviour, the key is to understand the purpose of the behaviour and what it may be expressing about unmet needs. Although emotions can be running high, there are still strategies that can prove useful during the behaviour itself:

•appear calm and speak in an even tone

•give simple directions and prompts about coping mechanisms

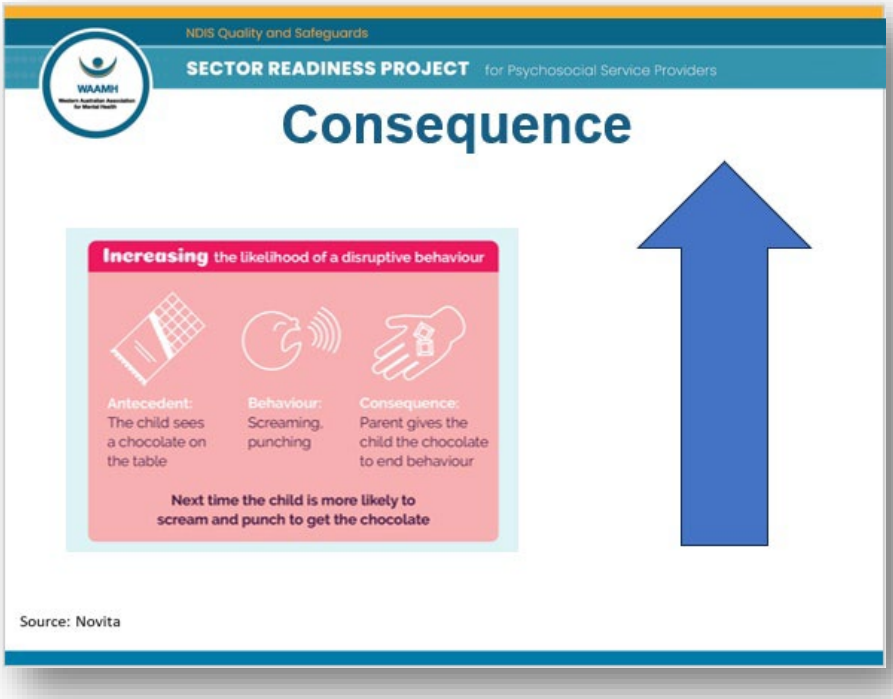
•use non-threatening hand gestures

•manage your personal safety and remember the strategies agreed on for dangerous incidents

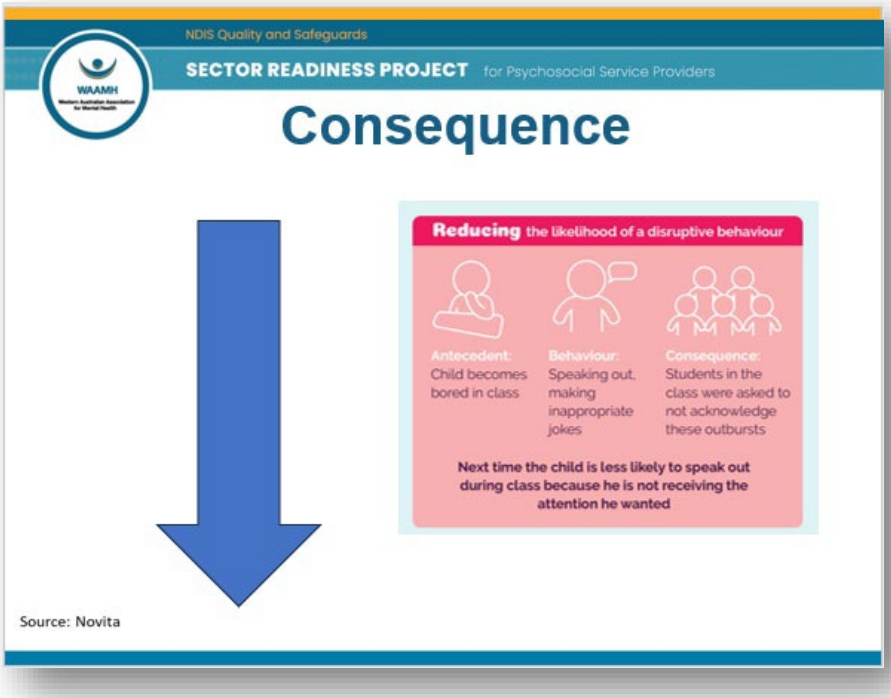
•recognise when it is time for disengagement/exit strategies for crisis situations

•ignore the behaviour

What are the immediate and delayed reactions from everyone involved? The consequences, or our responses to behaviours of concern, are very important. For example, a pleasant consequence can simply reward the behaviour, while a negative consequence may discourage it.

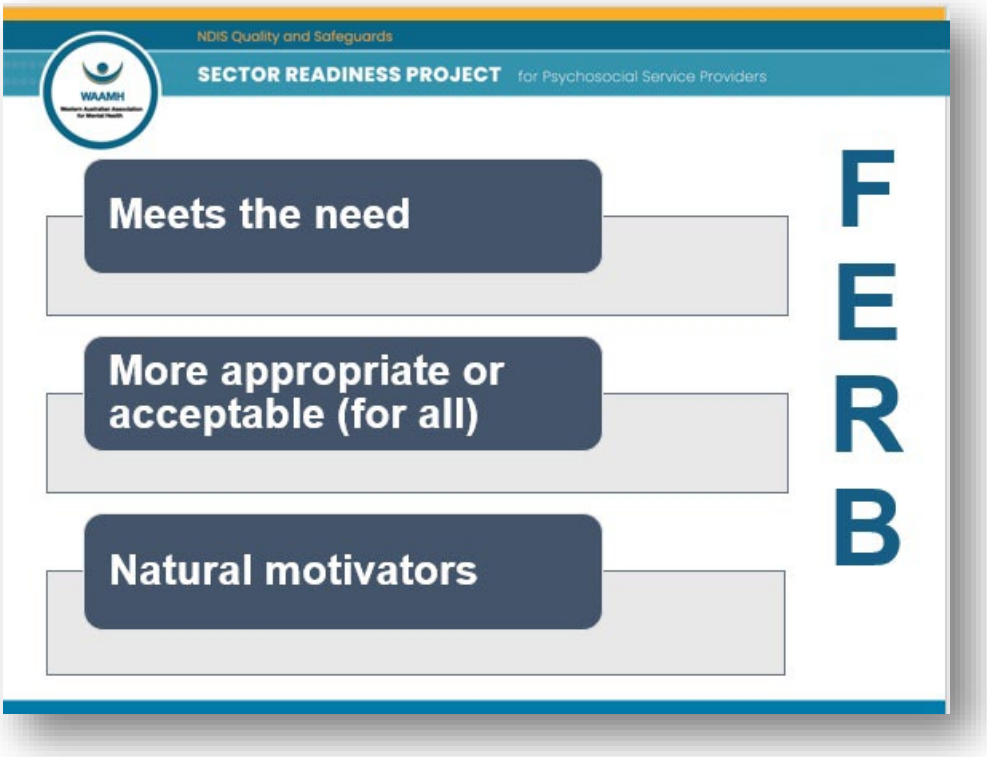


What happens after the behaviour? Could this be reinforcing the behaviour?



FERB

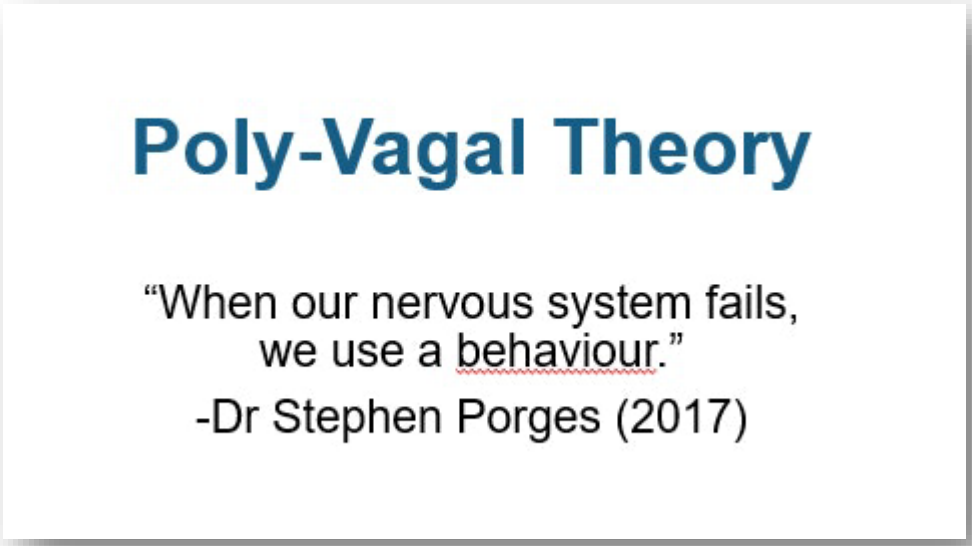
FERB is another acronym; it stands for Functionally Equivalent Replacement Behaviour. This is the name of a behaviour that is taught to the person who exhibits challenging behaviour, as something they could do when they feel the urge to undertake said challenging behaviour. This is a skill building exercise, and will be taught to the person when they are feeling well and at “baseline”.



The purpose of a FERB is that it meets the need that the original behaviour met. So if someone is seeking attention and connection, the replacement behaviour must also end in attention and connection. If someone is seeking an escape, the replacement behaviour should also allow them to exit the situation. It is a more socially acceptable or appropriate behaviour, not just for the people around the person exhibiting challenging behaviours, but also an acceptable means of achieving the ends for them. Tied into that, there must be natural motivators – if the end result of the FERB is very indirectly linked to the function (or purpose) the behaviour, the person is unlikely to undertake it.

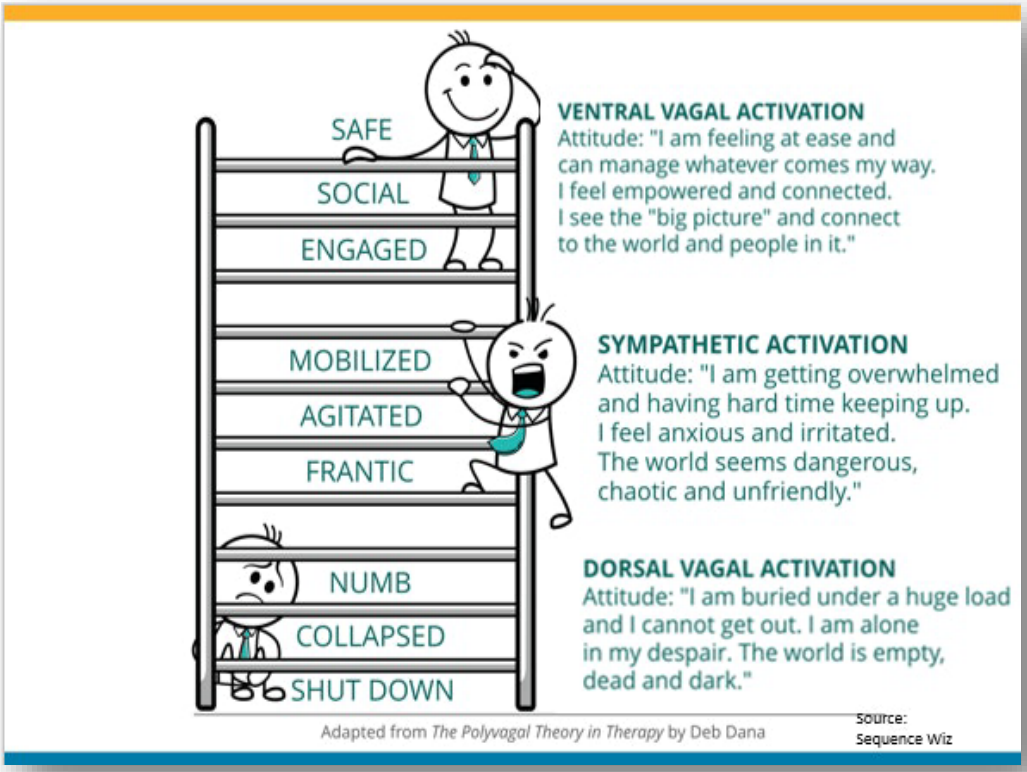
When choosing a replacement behaviour for the target behaviour, it's best to choose behaviours that are already seen in a person's behaviour repertoire or require very little teaching so the person can access the reinforcement with the least amount of effort. Replacement behaviours must be observable and measurable; as is the definition of the target behaviour.

An example that comes to mind occurs often in the school classroom. A child becomes overwhelmed with the work, and misbehaves significantly, knowing that this will get them expelled from the classroom and sent to the principal's office, where they will be free of the overwhelming work. The FERB may be as simple as them being taught to notice when they are getting overwhelmed and signalling to the teacher that they would like to take a five minute walk. This means the need (getting away from the work) is being met, but in a more acceptable, less disruptive manner.



The final theory we will be investigating is that of Poly-vagal theory. We could talk all day about the vagal nerve and the intricacies of this theory, but given the time limits we'll just be looking at how it intersects with PBS.

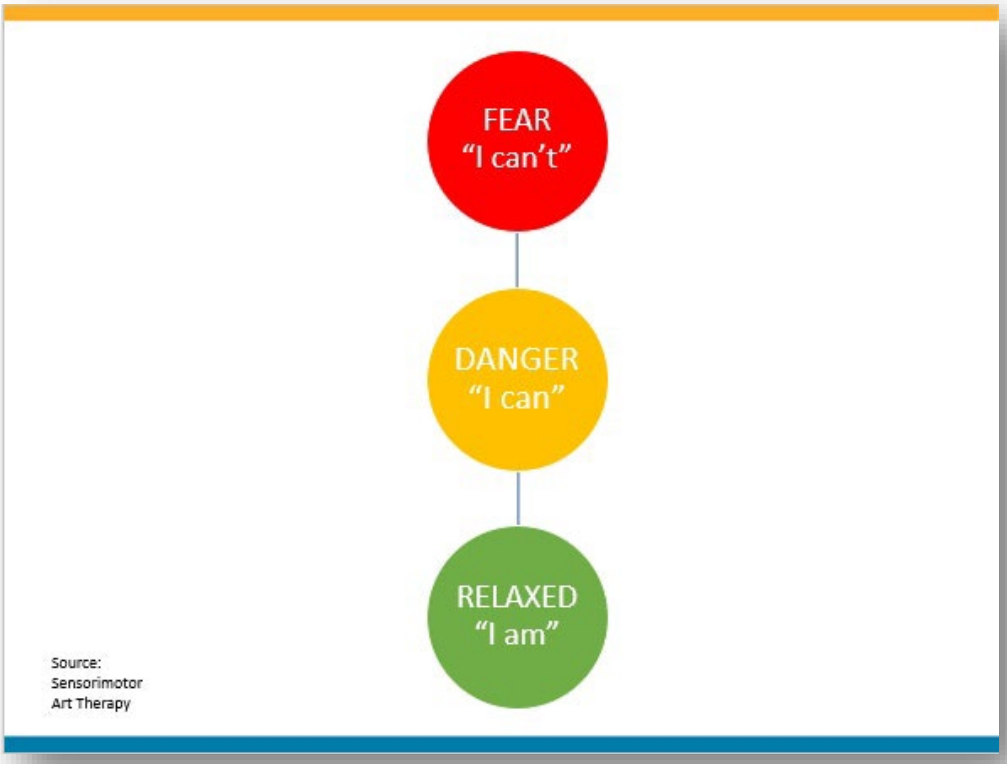
The core theme of poly-vagal theory is that, as humans, we move up and down this ladder, based on feedback we receive from the outside world (proprioception) and also our inner world (our thoughts, feelings, etc).



At the top of this ladder is what is termed the ventral vagal activation – this is where we're feeling good; we're safe, social and engaged. We can learn and grow, and process setbacks.

Slightly down the ladder is sympathetic activation; this is when we're feeling overwhelmed, we are mobilized, agitated and frantic. The world seems chaotic and unfriendly, and we may become aggressive in response to that feeling. This is where the fight and flight responses come in.

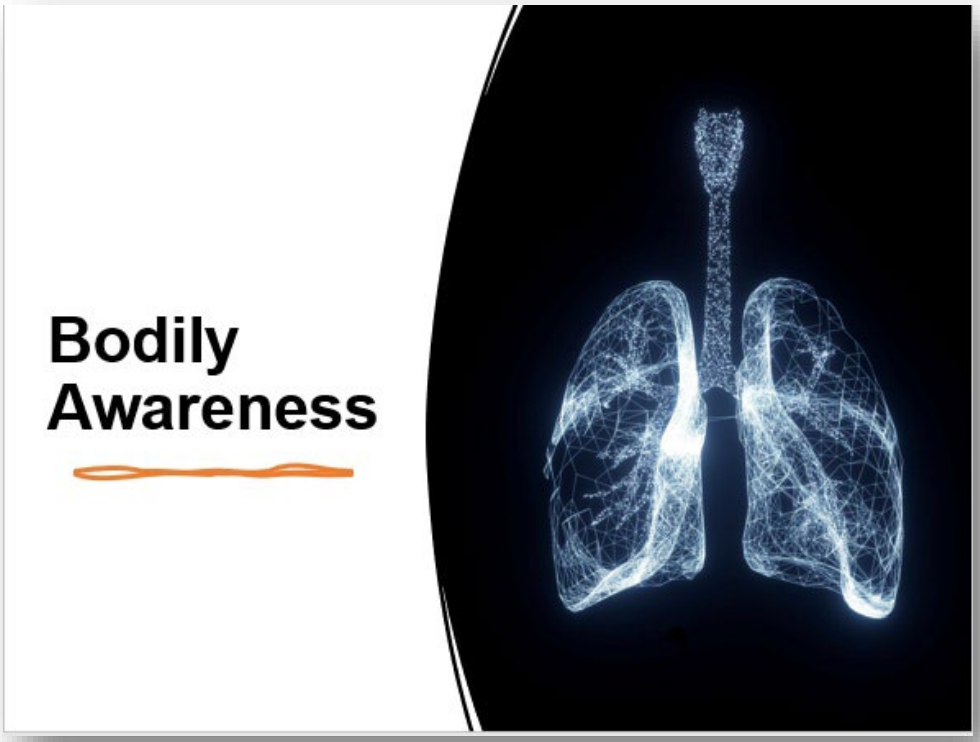
At the bottom of the ladder is the dorsal vagal activation, where we feel numb, collapsed, and shut down. We may be despairing and lack all energy. Dissociation may well occur. This is where the freeze/play dead response comes in, some people even faint when they're at this place in the ladder.



Another way of looking at the same concept is as a traffic light system. So, whereas before we looked at dorsal vagal activation as the bottom of the ladder, here it is represented by the red stop light. We are so paralysed by fear and dread that we essentially shut down. We are so overwhelmed by the feeling of "I can't" that we essentially stop functioning.

The middle of the ladder, the sympathetic activation, is represented here by the warning yellow light. This is where we have perceived danger, and, as mentioned earlier, are entering the fight or flight response. We may cry, or rage, yelling and screaming, making exaggerated movements. We are so overwhelmed by the sense of danger that we feel "I can" and must act.

Finally, what was the top of the ladder, the ventral vagal activation, is represented here with the green go signal. We feel safe, we are calm and open to learning. We can connect with others and ourselves. We are able to comprehend new information and process it. We feel "I am…" because we are feeling connected and mentally sound.



You may be wondering what this theory has to do with PBS… Well, when we use this theory of being, we can make sense of behaviour in a different and arguably more helpful way as it avoids blame and simply assigns behaviours as a human response. This is a video of Dr Dan Siegel explaining the brain: https://youtu.be/gm9CIJ74Oxw

So when we understand that someone has entered that yellow or red zone, they have "flipped their lid", and aren't in their thinking brain, we don't try to reason with them, but engage strategies to bring them back down to the green, thinking, processing zone.

Further, when someone is in that nice green zone, we work with them on understanding their bodies.

Sometimes, support workers will state that behaviours of concern come "out of nowhere" – and this may be the experience of the person exhibiting those behaviours too. This is because the person may well have low bodily awareness, and doesn't notice that their discomfort is increasing, until they've entered the yellow zone and a behaviour kicks in.

Educating people about bodily awareness can help them implement FERBs – for example, telling someone that they're starting to feel overwhelmed, before they actually get there.

Another reason Vagal Theory is important to PBS is because it focuses on co-regulation, the idea that the zone of the staff member is as important as the participant.

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SECTOR READINESS PROJECT for Psychosocial Service Providers

Rights and values

NOT PBS	SOME PBS	GOOD PBS
• Use of crude, uninformed behaviourist approaches such as reward and punishment • Restrictive practices used to manage behaviour are compromising human rights	• Some well-intentioned discussions of values, though not translated into practice • Restrictions and blanket rules are present	• Clear values that are translated into practice • Diversity is celebrated • The supported person is empowered to lead the life they choose and to be included in society • Restrictions are regularly reviewed, and a plan is in place to reduce them

Communication

NOT PBS	SOME PBS	GOOD PBS
• Belief that people "understand everything we say" and so we don't need to adapt our communication styles • Reliance on verbal communication – people are considered 'non-compliant' when they don't understand • Total or inclusive communication is not used (eg signs, gestures, photos, pictures)	• Some visual communication is seen on the walls but is not routinely used in practice (eg a symbol timetable, a photo staff rota) • Some adapted communication is used, but is not at an appropriate level for the person (eg using symbols and full sentences with a person who only understands objects and single words) • Some communication tools are used to support choice making but only limited to some activities/times (eg for meal planning)	• Staff and other carers can describe the difficulties in understanding and communicating that supported people have and what they do to support this • Total or inclusive communication is seen being used regularly and frequently (eg signing, pictures, photos, gestures, facial expression) • Specific tools are used to support people's communication and choice making (eg photos, pictures, drawing, high tech aids and iPads) routinely in most situations

Understanding behaviour

NOT PBS	SOME PBS	GOOD PBS
• Behaviour is seen as deliberately challenging and 'dysfunctional' (labels such as 'violence' or 'malicious damage' are used) • The supported person is blamed for behaving in ways that other people find difficult • Behaviour is not understood as a way of communicating distress and other emotions • No recognition of the impact of trauma, sensory issues and environment	• There is some understanding that all behaviour has meaning • No structured functional assessment; only uninformed ideas that behaviour is 'intentional' or 'attention-seeking' • Limited understanding of the impact of trauma, sensory issues and environment	• Understanding that all behaviour has function and meaning • Recognition that distressed behaviour results from a supported person's needs not being met • A structured approach to functional assessment informs the support plan content • Support includes understanding the impact of trauma on the person being supported and meeting their communication and sensory needs

Capable environments

NOT PBS	SOME PBS	GOOD PBS
• The supported person has to 'fit' the service provided • Institutionalised 'one size fits all' approach • No concern with changing the environment, or the support provided	• Some limited improvements to physical environments • Some key elements of capable environments not present • Managers mainly administrate and don't spend much time in the setting	• Person-centred adaptations to the environment and support that fits the supported person's needs • All twelve elements of capable environments are present • Team-based practice leaders coach colleagues to get the support right for each person

Restrictions

NOT PBS	SOME PBS	GOOD PBS
• A risk-averse 'control' culture • Reliance on restrictive practices, including medication, to control behaviours of concern • High levels of blanket restrictions that reduce opportunities for the supported person • Institutional, locked-door culture • PBS plans largely focus on reactive approaches • Restrictions and restraint are not accurately recorded or monitored	• Restrictions and blanket rules are present, though increasingly questioned • Some attempts to balance restrictions and risk with rights and opportunities	• Person-centred • Positive risk-taking • A 'can do' attitude • Low levels of restriction • Staff challenge restrictive practices • Data is used to inform decision-making • PBS plans focus on preventative approaches, rather than reactive

Relationships

NOT PBS	SOME PBS	GOOD PBS
• Relationships are not considered to be important • No focus on developing rapport • Staff 'do' things to the supported person • High use of different, temporary staff • Staff don't know the supported person well • The supported person is seen as the problem	• Some staff may have a good relationship with the supported person • Rapport is not considered as something that should be further developed • There are some attempts to maintain relationships with the supported person's family and friends	• Relationships are considered to be very important • Staff know the supported person well and build positive relationships with them • Relationships with the supported person's family and friends are actively supported

Meaningful engagement

NOT PBS	SOME PBS	GOOD PBS
• Institutional 'hotel model' culture • Activities are limited and not person-centred • The supported person is not given opportunities and support to participate	• Staff only offer the most able people opportunities and support to participate in activities • Supported people with behaviours of concern are left to their own devices • Active Support is an occasional event, not a way of life	• An attitude of enabling, and positive risk-taking • Staff understand the supported person and are ambitious in supporting them to achieve their aspirations and potential • Staff are skilled in Active Support and use it regularly every day

Choices

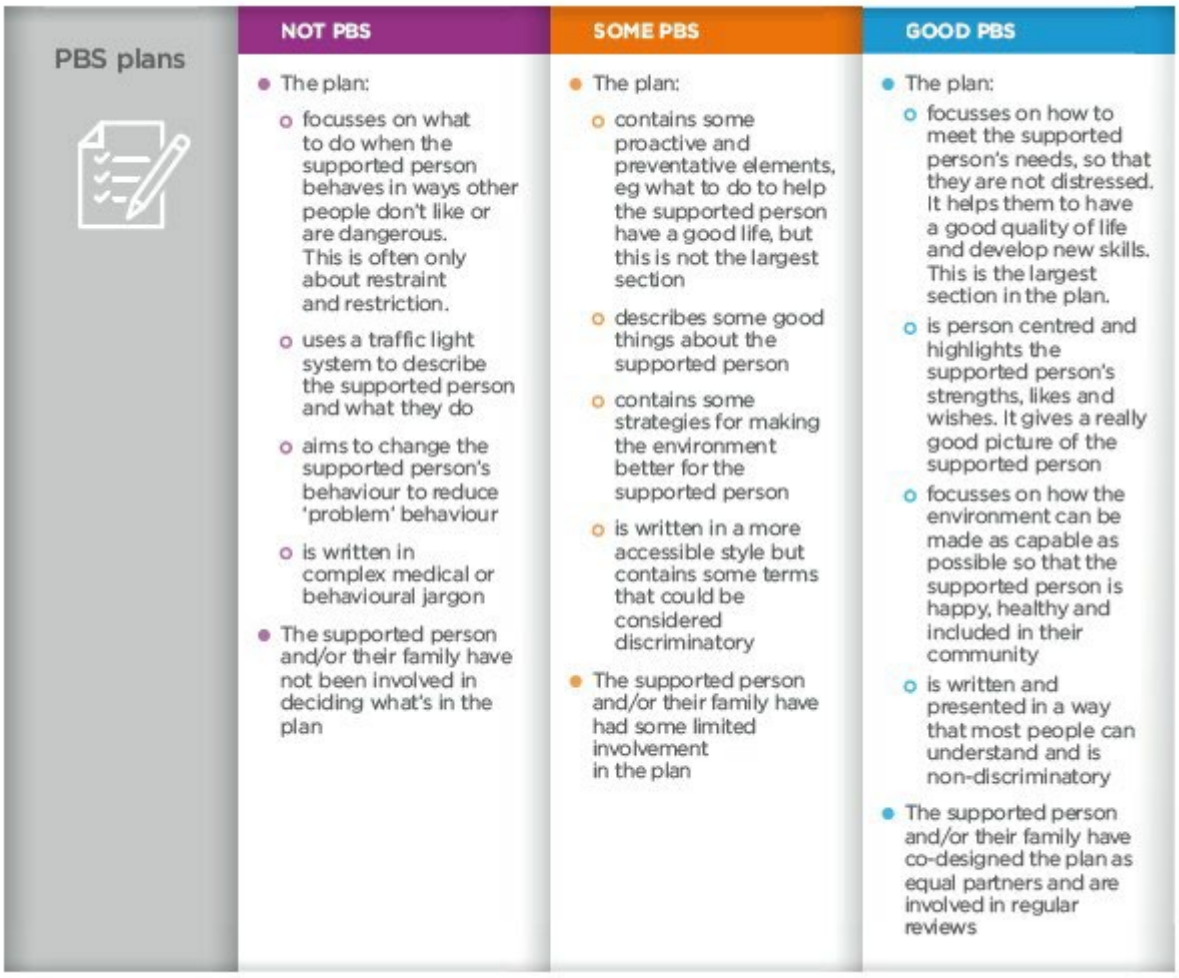
NOT PBS	SOME PBS	GOOD PBS
• Staff make the decisions • No support for choice and decision-making by the supported person	• Staff provide token choice in some situations • The supported person has some, limited, control	• Choice and support for decision-making happens daily with staff • The supported person can exert control over their own lives

Skill development

NOT PBS	SOME PBS	GOOD PBS
• The supported person is viewed as incapable of learning • No attempts at skill development with the supported person • Staff do everything for the supported person	• There is some focus on maintaining skills • No attempts at developing new skills • Staff do almost everything for the supported person	• Staff enable the supported person to do things themselves, and become more independent • The structured teaching of skills is ongoing

Systems change

NOT PBS	SOME PBS	GOOD PBS
• Systems are rigid and maintain the status quo • Systems serve the needs of the staff and organisation, not the supported person • Systems are complex and bureaucratic	• Everyone is not clear about what the systems are and how they work • Systems are difficult to follow, and mainly serve organisational needs • Any system change is seen as too difficult	• Systems are in place to enable the supported person to have a good quality of life, and receive person-centred suport • Systems are flexible • Systems are reviewed and changed to meet the needs of supported people they serve



PBS plans	NOT PBS	SOME PBS	GOOD PBS
	• The plan: ○ focusses on what to do when the supported person behaves in ways other people don't like or are dangerous. This is often only about restraint and restriction. ○ uses a traffic light system to describe the supported person and what they do ○ aims to change the supported person's behaviour to reduce 'problem' behaviour ○ is written in complex medical or behavioural jargon • The supported person and/or their family have not been involved in deciding what's in the plan	• The plan: ○ contains some proactive and preventative elements, eg what to do to help the supported person have a good life, but this is not the largest section ○ describes some good things about the supported person ○ contains some strategies for making the environment better for the supported person ○ is written in a more accessible style but contains some terms that could be considered discriminatory • The supported person and/or their family have had some limited involvement in the plan	• The plan: ○ focusses on how to meet the supported person's needs, so that they are not distressed. It helps them to have a good quality of life and develop new skills. This is the largest section in the plan. ○ is person centred and highlights the supported person's strengths, likes and wishes. It gives a really good picture of the supported person ○ focusses on how the environment can be made as capable as possible so that the supported person is happy, healthy and included in their community ○ is written and presented in a way that most people can understand and is non-discriminatory • The supported person and/or their family have co-designed the plan as equal partners and are involved in regular reviews

Conclusion

In this workbook, you have learned:

- The purpose of PBS
- The timeline and processes of PBS in the NDIS context
- 3 theories that underpin PBS practice

Remember, restrictive practice should only be used as a last resort, after person-centred, positive behavioural strategies have been attempted.

Other Resources

- The CAREhub has a vast selection of the WAAMH Sector Readiness Project's tools and templates available: https://carehub.waamh.org.au/

- The NDIS Commission has resources on PBS: Self-assessment Resource Guide for the Positive Behaviour Support Capability Framework | NDIS Quality and Safeguards Commission (ndiscommission.gov.au)

- NDS has a great library of resources too: NDIS Quality and Safeguards Resources

- BILD explores PBS well: Positive Behaviour Support (PBS) | bild1