

Introducing Positive Behavioural Support (PBS) Within a Medium Secure Forensic Mental Health Service

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Caswell Clinic



- 5 Wards:- 61 service users
- **Penarth Ward**:- Intensive Care Unit (Male). 8 beds
- **Tenby Ward**:- Admission/Assessment (Male). 14 beds
- **Ogmore Ward**:- Continuing Care-Recovery. (male). 14 beds
- **Cardigan Ward**:- Continuing Care-Recovery (Male only). 14 beds
- **Newton Ward**:- Admission & Assessment (Female). 11 beds



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What is PBS?

- An understanding of a person's behaviour is developed based on functional analysis, considering environmental triggers and reinforcing consequences. This is the basis for formulation and intervention.
- It is values led and promotes service user involvement.
- It focuses on prevention of challenging behaviour through feedback, skills training, altering or reducing triggers or reinforcements, and improving service user quality of life.
- It eliminates the use of punitive approaches.
- It has a long term focus- is developmental and can be service user directed.



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What is PBS?

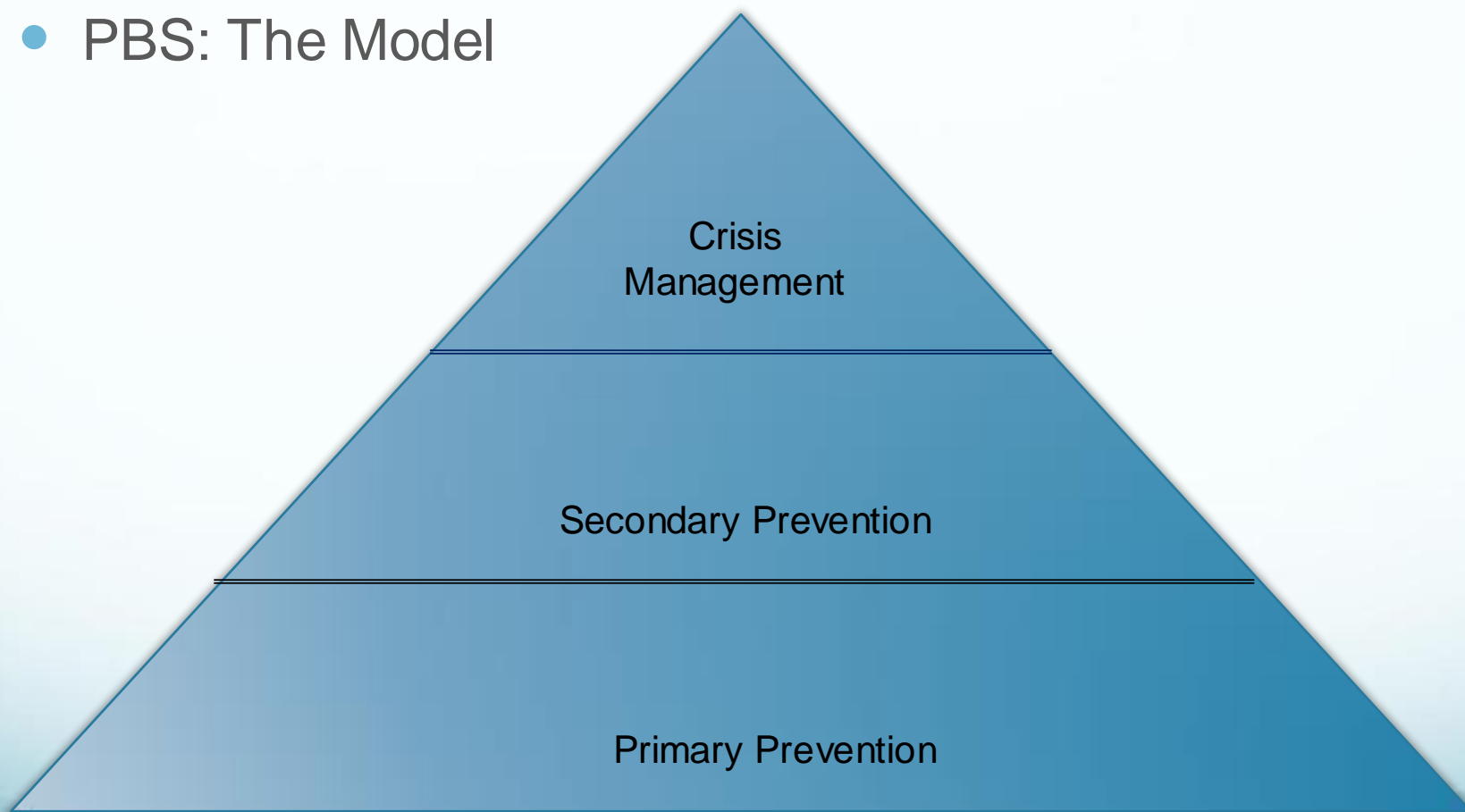
- Reduction of challenging behaviour as a side effect of the intervention.
- The PBS model identifies early warning signs that challenging behaviour may occur and suggests de-escalation and distraction techniques prior to crisis management.
- Post incident support is outlined within the plan.
- The PBS plan is a live document and should change with a persons needs and wishes.
- Collaboration, empowerment and choice are central



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- PBS: The Model



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Primary Prevention: Largest Part of the Plan

- Changing the environment
- Improving communication styles and opportunities
- Offering programmes of activities
- Addressing mental and physical health
- Improving carer confidence and competence
- Eliminating or modifying triggers
- Reinforcing pro-social behaviour
- Empowerment and choice
- Increasing rates of access to preferred reinforcers
- Increasing rates of engagement
- Modifying demands
- Providing additional help
- Embedding disliked tasks between more preferred tasks
- Teaching skills e.g. Coping skills, social skills, general skills, functionally equivalent skills
- Positive role-modelling by carers



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Secondary Prevention

- Active listening
- Stimulus change/ removal
- Prompting to use coping skills
- De-escalation
- Not ignoring as this may increase distress/ behaviour
- Strategic capitulation
- Diversion to reinforcing or compelling activities



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Crisis Intervention

- Proxemics
- Breakaway
- Minimal physical intervention
- As required medication
- Post incident support
- Can be employed as advanced directives as promoted within policy



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Why PBS at Caswell?

- High levels of challenging behaviour being experienced.
- Skills and knowledge existed within the service (clinical nurse specialist and psychologist).
- Value base attractive to clinical teams and service management.
- Recognition that more restrictive approaches were not working, or were having a detrimental impact on therapeutic relationships.
- Approaches reactive to crisis resulting in longer term crisis management- not proactive or preventative.
- Little or no understanding of the causes and functions of challenging behaviour by clinical staff.



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Caswell Perspective

Previous Approaches and Barriers

- RAID (Reinforce Appropriate, Implode Disruptive) training undertaken – circa 2005 for 1 ward – PICU. This is an approach based on differential reinforcement- reinforcing pro-social behaviours and ignoring challenging behaviours.
 - Only one ward trained and the skill base was dispersed across the clinic as new wards opened.
 - Inconsistent approach to functional analysis – often ABC charts were not analysed or findings considered within care plans.

Caswell Perspective

Previous Approaches and Barriers

- Review of Aggressive Incidents on PICU between January 2008 and June 2010 undertaken. Triggers often not identified and Inconsistent and unstructured approaches to managing incidents identified. Little thought or plan on how to prevent incidents occurring.
- PBS launched on PICU in 2011- PBS link nurses identified.
 - Focus on 'positive' aspects of engagement and prevention of challenging behaviours was appealing to clinicians.
 - No cost issues due to in house expertise and knowledge.
 - Links with Swansea University to Develop Practice Innovation Unit status.
 - Published paper in "Mental Health Practice" (Griffiths and Wilcox, 2013).

Barriers Encountered

- Staff Attitude!!!! – Some staff believed we were rewarding challenging behaviours, or they felt they were being ‘manipulated’ by the service users.
- Comments of “there must be a consequence to this”, “they shouldn’t be allowed to get away with this..”, “they have got to learn”
- Limitations of initial training:
 - Focus only on one ward – service users and staff moved – dilution of skills and knowledge. Lack of consistency in following care plans.
 - Small service user group to focus on (8 max – not all on PBS plans). Led to some inconsistent decisions and clinical team approaches.
 - Feeling of “What next....” PBS seen as effective but somehow limited.
 - Limited capacity of the psychologists to provide on-going training and support to ward staff.



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Next Steps.....

Survey PICU 2013.

- PICU staff surveyed on their views/ hopes/ and needs in relation to PBS. This highlighted:
 - Staff were still trying to implement PBS within the area, however:
 - Staff often felt excluded from writing the PBS plans and wanted more input in their development so they had a better understanding of them.
 - There was a desire for more training- some staff had not received any whilst others had only received parts of the training and not all of it. Those that had received training wanted to be updated to refresh their skills.
 - Primary nurses wanted more support from other disciplines in promoting a PBS approach.
 - There was a need for assessment tools that could be used to analyse challenging behaviours.
 - There was a need to audit and evaluate the success of PBS plans.
 - The approach adopted varied across the team, there was a need for more consistency and commitment to the PBS approach on the ward.



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Where we are now!!

- Functional analysis tools have been introduced to compliment ABC charts and are included in the training for qualified staff. These are:
 - “Contextual Assessment Inventory”
 - “Brief Behavioural Assessment Tool”- Smith and Nethell (2013)
 - Service User Assessment Tool.
- Individual PBS plans developed (I-PBS)-
 - Currently there are eleven live plans.
 - Two more underway in the men’s service.
 - Three women identified for plans, we are beginning the process.
- I-PBS plan- developed within ABMUHB LD Services. Service users perspective and narrative (written in first person). Service user involvement central, all plans agreed with the service user before implementation.

Where we are now!!

- The PBS training and resources have been re-developed and provided to nurses, OTs and psychologists.
 - A full days training is being provided to qualified staff.
 - Half a day to unqualified staff.
 - To date 97% of R.N's and 68% of HCSW's, 100% OT's and 83% psychologists across the clinic have had training.
 - Staff from fellow disciplines (e.g. Medicine and social work) have also received training.
 - Qualified staff being supervised/ supported through their first functional analysis and I-PBS plan.
 - 10 staff have commenced Advanced Professional Diploma training in PBS and will become Behaviour Specialist upon completion of course.



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Where we are now!!

- Current Challenges:

- ***Specialist Support Across the Clinic***

Rotation of staff across the wards leaving clinical areas without a trainee behavioural specialist insitu.

- ***Change Management:***

Scepticism by some staff although largely outweighed by positive responses. It does highlight the challenges of implementing change and engaging staff in a fundamentally different approach to challenging behaviour.

- ***Managing Expectations:***

Supporting staff to recognise when crisis management is the only option for managing imminent risk of violence and realising this is not a failure of either PBS or team members.

- ***Resources:***

Only one person still maintaining responsibility for developing plans and supervising trainees, this will change when the specialists have completed their training.

- ***Communication:***

It can be difficult to organise effective communication to ensure PBS plans are known to all, particularly when service users move wards.

Governance: PBS Implementation Group

- Core PBS implementation group set up 2013- involving ward managers PICU + Acute admissions ward, psychologists and head OT. Functions of the group:
 - Review and agree assessment tools to be used within the clinic. Agree process of implementation of PBS within the clinic.
 - Consider PBS training needs, review training and plan training dates to meet needs.
 - Identify potential service users appropriate for PBS and monitor their progress.
 - Develop service user information.



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PBS Implementation

Group cont...

- Evaluate the effectiveness of PBS and training within the clinic-agree process.
- Feed back process to service managers/ clinical governance systems.
- Dissemination of results i.e. via publications and conferences.
- Network with learning disability specialist services within the health board and external forensic services implementing PBS.
- PBS Action Plan has been developed and reviewed continually.



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Results of Training Evaluation

- *Confidence:*
 - Confidence in working with challenging behaviour significantly increased after training for both qualified ($t(29) = -6.56, p=0.000$) and unqualified staff ($t(27)=-5.67, p=0.000$).
 - Qualified staff showed significant reductions in attributing the cause of challenging behaviour to the service user ($p<0.001$), attributing challenging behaviour to the personal control of the service user ($p=0.027$) and considering challenging behaviour as more stable and changeable ($p=0.013$). This was not replicated for unqualified staff.
 - CHABA measures attributions for causality of challenging behaviour: Causes measured: Biomedical, learned, emotional, physical environment, stimulation. All causal attributions increased significantly for qualified and unqualified members of staff, with the exception of emotional attributions which increased only for qualified staff.



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Results of PBS Plan Evaluation

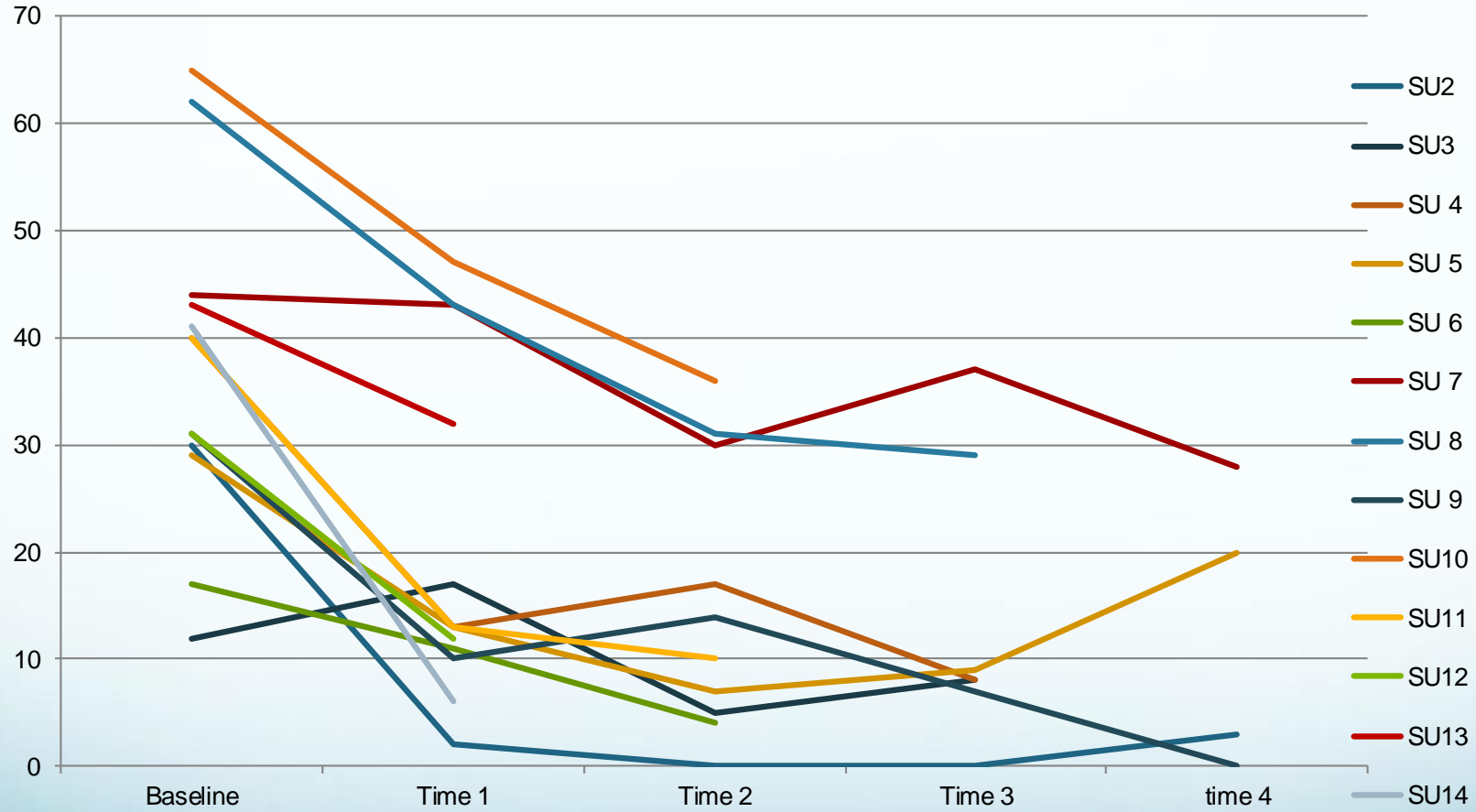
- 12 plans evaluated pre- implementation and 3 monthly post implementation
- Evaluated using the Challenging Behaviour Checklist (Harris *et al.* 1994) adapted for use within this service.
- Currently significant difference between baseline and last measurement ($z=-3.297$, $p=0.001$)



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Frequency Pre and Post PBS Intervention



Results of PBS Qualitative Plan Evaluation: Service Users Experiences (n=10)

Master Theme	Sub Theme	Number of SU
1. My Plan	A- Understanding me / sharing my story	9
	B- Good days, bad days, triggers	3
	C- My Involvement	10
2. How I understand PBS	A- What it is	8
	B- Why Me	8
	C- Accessibility	4
	D- An efficient summary	4
3. How PBS has helped me; the benefits	A- Reflecting on my behaviour	5
	B- Noticing and wanting change	6
4. Making the Plan work	A- Staff fidelity to the model and plan	4
	B- Keeping the plan alive	6
	C- Implementation (barriers & suggestions)	2



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Next Steps

Recommendations

- Options appraisal in relation to interim report underway.
- One behavioural specialist on each ward and clinical teams.
- Training days attended by all staff across the clinic.
- Development of a structured review process.
- Improve communication systems.
- Interim plan development for new admissions to PICU.
- Set up audit trail based on good practice framework.
- Disseminate and share outcomes via publications and conferences.



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Take home messages:

- From our experience within the clinic the effectiveness of PBS is based on a number of factors:
- Service user collaboration from the start.
- Multi-disciplinary involvement and commitment to PBS.
- A service wide commitment to embedding the value base of PBS within it's practice, reducing the need for reactive strategies.
- Training of staff across the clinic in the principles of PBS
- On-going evaluation of effectiveness being fed back to clinical teams and service user feedback being used to improve processes



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Case Study

- Gwyn- age 26.
- Gwyn had history of poly substance misuse and petty offending to fund addiction. IQ in borderline range, limited social skills, aggressive assertion to get his needs met.
- Index offence- Unlawful wounding, assault occasioning actual bodily harm- 3 assaults included in these charges. History of violent offending 2005- 2013.
- Presented with paranoia and psychosis exacerbated by substance misuse. Section 37/41 MHA.



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Case Study

- Assessment – BBAT, CAI, client assessment. Important for his motivation to be engaged in the process and set his own recovery goals.
- Behaviours:
 - Throwing things at people- kicked a ball at someone's head
 - Self harm- cutting arms (mainly in prison)
 - Slamming doors
 - Shouting and swearing at people
 - Threatening to hurt others or damage the environment
 - Refusing to do things/ non-compliance/ breaking clinic rules
 - Anti-social- pro-criminal/ pro-violent attitude shared with peers
 - “Egging on” others behaviours

Case Study

- Triggers:

Slow	Fast
Psychosis- particularly paranoia and anxiety Female/ inexperienced staff Boredom Large groups of peers Lack of confidence and low self esteem Medication changes and side effects Borderline IQ	When asked to do something new or difficult Requests refused without explanation Authoritarian or stern approach from staff Being given corrective feedback insensitively Feeling criticised- especially in front of peers Having requests declined

- Maintaining functions: Escape/avoid difficult situations, acceptance and admiration from peers, feeling less vulnerable.

Case Study

- Primary Prevention:
 - Communication Strategies: Simplify language, no complicated or abstract terms, check understanding, rephrasing, provide rationale if say no/ make changes, use calm friendly tone, give feedback sensitively and on a 1:1- not in front of peers etc.
 - Social role modelling- giving feedback sensitively and showing appropriate ways to manage social situations.
 - Providing 1:1 sessions to discuss goals and progress
 - Activity Timetable- more structure and distraction- preventing boredom.
 - General skills- parenting skills, independent living skills- role modelling and breaking skills down into smaller steps.
 - Support to maintain drug abstinence- drug education and relapse prevention group.
 - Differential reinforcement- offer praise and positive feedback when he walked away from difficult situations and did not get involved, or asking staff for support
- Secondary Prevention and Crisis Management:

Early indicators, distraction, validation of feelings, opportunity to talk to staff, give time and space to calm, prn, safe holds etc.

Case Study

- Evaluation- moved from PICU, acute then rehab within 3 month period
- Checklist for Challenging Behaviour:

	Pre	Post
Frequency	30	2
Management Dif	13	1
Severity	2	0

- Qualitative feedback from Service User:
 - “Helped me move to where I am today”
 - “Clear to understand”



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Thank You

- Any questions?
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