Positive Behavioural Support

USER GUIDE

For

The Evaluation Matrix for Challenging Behaviour Services

The PBS Standards Measure for Wales

Practice Leader Competencies in PBS

LDAG Subgroup
Transforming Care in Wales for People with Learning Disabilities and Challenging Behaviour
March 2018

Using this Guide

This guide has been designed for assessors who use the Evaluation Matrix for Challenging Behaviour Services, the PBS Standards Wales Measure and the Practice Leader Competencies Assessment.

It contains instructions on how to use all three measures and it includes comprehensive Appendices that provide clear examples of the types of evidence assessors will need to identify in order to complete the scales.

It is important that this Guide is available to all assessors and that they become familiar with its contents.

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12 October 2016

Dear Ruth & Sophie,

Thank you for your letter of 29 September and attachments.

I am pleased to endorse the Positive Behavioural Support Measures and Guidance developed by a sub-group of the Learning Disability Advisory Group (LDAG) with the Challenging Behaviour Community of Practice. My officials will have a separate discussion with you and your colleagues about the publication and distribution of the documents.

I am grateful to the LDAG sub-group and Community of Practice for their work in developing these documents which will improve the care of people with a learning disability and challenging behaviour and help them to achieve their well-being outcomes.

Yours,

Rebecca

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INTRODUCTION

POSITIVE BEHAVIOUR SUPPORT (PBS) is the best current evidence-based practice in supporting people with learning disabilities and challenging behaviour. It is a comprehensive term that covers a wide range of approaches. Its origins are in Normalisation (or Social Role Valorisation), Applied Behaviour Analysis and Person-Centred Planning. PBS can be seen as a toolkit for behaviour change that is based on contemporary service values.

STATEMENT OF PRINCIPLE

Any specialist service for people with learning disability and challenging behaviour also should be underpinned by the following key characteristics of **Positive Behavioural Support (PBS)**:

- It is values led
- It focuses on quality of life gains
- It is inclusive
- It is based on functional analysis
- It has a systems focus
- It emphasises ecological and antecedent intervention
- It is concerned with enhancing competence and teaching new skills
- It is constructional and developmental
- Reduction in challenging behaviour is a side effect of intervention
- It is proactive and enables people to develop more appropriate behaviours
- It has a long-term focus
- It involves multi-component intervention
- It avoids the use of punitive approaches
- It distinguishes between proactive and reactive approaches
- It involves stakeholders

Any service for people with learning disability and challenging behaviour should also:

- contain clear guidelines on service user capacity, consent and decision making, in line with current legal requirements and government policy, in relation to specific assessment and intervention for challenging behaviour, i.e. conducting functional analysis, developing PBS plans and use of reactive strategies, etc.;
- adapt physical environments to the needs of the service users residing in them;
- be integrated within a wider multi-disciplinary system in which service users can access clinical and therapeutic input from specialist health professionals in the Community Support Team (CST) including: psychiatrists, learning disability nurses, clinical psychologists, speech and language therapists, occupational therapists and physiotherapists.

ABOUT THE MEASURES

All three measures were developed in response to stated service need expressed by providers, commissioners and clinicians working to improve the overall quality of service delivery in line with Positive Behavioural Support (PBS) as the most effective, evidence-based, contemporary best practice. They were developed, piloted, refined and benchmarked between 2007 and 2017. This pack of measures and supporting documents represents the final version, authored by members of the All Wales Community of Practice and the Learning Disability Advisory Group, and endorsed by the Welsh Government.

The measures are complementary to one another but all three can be used independently. Each of has an accompanying Evidence Template to facilitate gathering the necessary documentation. This separate User Guide supports the administration of all three measures. This Guide also includes a substantial set of Appendices that give detailed examples of good practice related to the measures. Assessors need to refer to these Appendices to ensure consistent interpretation of evidence,

The measures have been designed as service development tools, in that each generates an overall rating or score as well as an action plan to highlight specific areas for further improvement. Repeated administrations can help to track and demonstrate where improvements have been achieved. A brief description of each measure is given below, followed by guidance that applies to all three measures.

Evaluation Matrix

The Evaluation Matrix was designed for individual service settings to assess the extent to which they have the necessary infrastructure to be able to deliver high quality Positive Behaviour Support. It measures capacity not performance: that is, high quality infrastructure does not guarantee high quality provision. It may be used by commissioners to assess the potential suitability of services prior to purchase, and by providers for self-evaluation and service development.

The Matrix focuses exclusively on 5 sets of standards for services for people with learning disabilities and challenging behaviour, that is: standards that are over and above the requirements for non-specialist services. Therefore, to avoid duplication with other monitoring or inspection systems, aspects to do with generic service quality are not included as it is assumed that the service being assessed meets the National Minimum Standards for Domiciliary Care Agencies in Wales: these standards are referred to briefly where relevant under each of the Matrix headings. **If the service does not fully meet the minimum standards, then that section of the Matrix should not be scored.**

It is also assumed that the service being assessed upholds the following values that underpin good quality, contemporary learning disability services:

- The setting has a clear statement on its values base, making direct reference to Normalisation or Social Role Valorisation (SRV), or O'Brien's Service Accomplishments (Community presence, Competence, Choice, Participation, and Respect).
- The Values statement indicates a person-centred, proactive focus, promotion of self-advocacy, citizen advocacy, and access to mainstream services.
- The values base is a main focus of staff orientation & induction to service.

THE PBS Standards Measure

Following the successful implementation of the Evaluation Matrix, providers identified the need for a complementary tool that assesses the quality of service delivery to individuals. This led to the development of the PBS Standards Measure that is designed to be administered for individual service users. It comprises a set of 14 PBS Standards that are mapped directly to the nine Wellbeing Outcomes in the National Outcomes Framework 2014. All items are rated on the basis of clear evidence and scored on a four-point scale. The higher the score, the higher the quality of PBS provision. Benchmark scores for this measure are provided in the Appendix for reference.

Practice Leader Competencies

A key factor in providing high quality provision is Practice Leadership. This measure focuses on the Competencies required to achieve the outcomes outlined in the PBS Standards of Wales measure. There are 15 competencies, 14 of which are mapped against the PBS Standards. Again, all are rated on the basis of evidence and scored on a four-point scale.

A key purpose of this measure is to aid the development of practice leaders within an organisation. Used in this way, administration of the measure doesn't have to be rigid, but can be a more organic process integrated with management or clinical supervision. Observations can be naturalistic so the assessor can gain a realistic perspective of practice in-situ. There is no set time scale for completion of the measure as some evidence may take a while to collect and may not be an everyday occurrence. The measure is also flexible and can be used in parts only to reflect the style or requirements of the service provided.

A key requirement is for the assessor to be confident and competent in practice so they can act as Practice Leader/Coach/Mentor for the Practice leader in training. The assessor should discuss the evidence and scoring with the practice lead being assessed for each section, and give positive and constructive feedback. Peer review using this measure may also be a positive way to support development.

This measure can be complementary to other management training and assessment. Duplication with generic management skills has been avoided where possible so that the focus of this tool is on the competencies required to manage and lead the PBS approach.

HOW TO USE THE THREE TOOLS

Who should administer the Tools?

Assessors need to have a detailed knowledge of PBS, ideally in terms of clinical intervention, direct support or management. Suitable assessors are those who have a considerable amount of experience in PBS and/or hold a specialist PBS qualification, such as:

- the BTEC Professional Diploma/Certificate in Positive Behavioural Support (Level 4 or 5) or similar
- the Post Graduate Diploma in Positive Approaches to Challenging Behaviour (Cardiff University/University of Wales College of Medicine) or similar

Ideally, the assessor should be external to the setting being assessed. However, even if employed within the same organisation, the assessor should not normally be assessing their own place of work or a staff member they have direct management responsibility for. However, the Practice Leader Competencies Assessment may be used by line managers as a developmental tool for staff in training as Practice Leaders.

How many assessors should there be?

One assessor per setting is acceptable, providing they have access to the necessary information. However, when used internally, it is best for more than one person to complete the assessment, to avoid bias. Some organisations find it helpful to have one external and one internal assessor working together: this has the benefit of providing an objective perspective as well as facilitating access to the necessary evidence.

What documents are included in this suite of tools?

1. This User Guide – that describes the background and structure of the tools, outlines how to use them and provides an explanation of some of the key terms and processes in a series of Appendices, to which assessors should refer to ensure consistency in interpretation.

2. The Evaluation Matrix – for assessing one service setting.
This contains a set of standards in 5 separate domains, a Score Sheet, Summary of Findings, a section where descriptions of the setting being assessed and the assessor can be recorded, and an Action Plan.

3. The PBS Standards Measure – for assessing service delivery to one individual
This contains a series of Performance Indicators under fourteen Standards that are mapped to the Health and Social Care Wellbeing Outcomes, a Score Sheet and an Action Plan.

4. The Practice Leader Competencies Assessment – for assessing one Practice Leader.
This contains a series of Performance Criteria under fifteen Standards, fourteen of which are also mapped to the Health and Social Care Wellbeing Outcomes, a Score Sheet and an Action Plan.

5. Three Evidence Templates [one for each tool] - for assessors' use in collecting and tracking evidence, and keeping notes.

How to gather and rate the evidence

Assessors should gather information from a variety of sources, including staff at different levels. This is because different parts of any organisation are likely to represent different perspectives. For example, senior managers may be aware of certain key policies, while direct care staff, who hold responsible for implementing them, may not, thereby questioning the value of these policies. Broadening the sources of information is likely to provide a richer and more considered picture.

EACH STANDARD MUST BE RATED ON THE BASIS OF EVIDENCE. The type of evidence required is noted in each section: this can include documents or records, direct contact with staff to find out their views or understanding of particular issues, and direct observation of practice. Service settings may find it useful to use the templates to compile files of evidence for the different sections: these can then be updated on an ongoing basis to aid internal or external evaluation.

Assessors need to consider the evidence carefully and objectively and also need to keep a clear record of what evidence was used to arrive at each rating. Space is provided on the Score Sheet for assessors to give a brief account of how the evidence was gathered.

In brief, the steps are:

1. Work through the Evidence Template, collecting the relevant evidence indicated for each standard.
2. Pay attention to the type of evidence to look for.
3. Refer to the Appendix in this User Guide for sample documents and descriptions of specialist processes to help identify the correct evidence.
4. File or carefully reference the evidence in the relevant section in the Evidence template.
5. Once all the evidence is collected, the measure itself can be completed.
6. Systematically compare the evidence against each of the standards in all five sections of the Matrix or fourteen PBS standards or fifteen PL Competencies, as appropriate.
7. Make sure the evidence is valid – i.e. documents, records or direct feedback from staff assessors have talked to (not third party reports).
8. Check that the evidence matches the types of evidence suggested in the measures.
9. Use the check boxes/ratings to keep a clear record of which standards are met/and to what degree.
10. Based on the available evidence, rate each section on the Score Sheet and make a brief note of the supporting evidence used to arrive at that rating.

Note: In the Evaluation Matrix, the rating hierarchy of GOOD, VERY GOOD, and EXCELLENT is cumulative:

- To be rated **GOOD**, the service must achieve fully ALL the standards in the GOOD column for that section.
- To be rated **VERY GOOD**, the service must achieve fully ALL the standards in the GOOD column plus ALL the standards in the VERY GOOD column for that section.
- To be rated **EXCELLENT**, the service must achieve fully ALL the standards in the GOOD and VERY GOOD columns plus ALL the standards in the EXCELLENT column for that section.

NB. It is likely that many services will achieve a mixture of GOOD, VERY GOOD and, possibly, even some EXCELLENT ratings in some sections. However, it is important that the above conventions are adhered to for the overall rating.

If any service does not achieve all the GOOD standards in a section, then that section must not be rated. If a service achieves all the GOOD standards, with some VERY GOOD, that section should be rated GOOD, even if some of the EXCELLENT standards are attained, and so on.

NB. The PBS Standards measure and the Practice Leader Competencies Assessment include no overall rating for each standard, requiring only total and percentage scores, plus an overall score for the whole measure.

What the ratings mean

This Matrix is designed to assess a service's capacity to provide specialist challenging behaviour support, by considering its organisational structures and systems. The Matrix does not aim to reflect actual outcomes.

It is important to emphasise that none of the ratings reflects a poor quality service. Only those characteristics associated with good quality support for people with learning disabilities and challenging behaviour have been included. Therefore, for a setting to rate at all on this Matrix means that it possesses some of the aspects of current best practice.

Comparison with the general standard of services currently being provided for people with challenging behaviour is important for meaningful interpretation of results. The benchmarking analysis undertaken in 2013 revealed the percentage of settings currently meeting each standard. These results are given in Appendix 10, while the following descriptors are given as a general guide:

- **GOOD:** This represents a good quality of service for people with challenging behaviour. It demonstrates an understanding of the complexity of support required and shows that the service has put much effort into developing a comprehensive approach to training, assessment, staff and service user support**. A GOOD rating on all domains would indicate a sound, reliable service for people with challenging behaviour.**

- **VERY GOOD:** This rating shows that the service is above average in its achievement of standards related to challenging behaviour. It demonstrates a more sophisticated understanding of current issues to do with specialist challenging behaviour services and an awareness of best practice concerns. **Few services are likely to rate at the VERY GOOD level on all aspects.**

- **EXCELLENT:** This rating shows that the service is of an exemplary standard. For each domain, an EXCELLENT rating demonstrates the highest level awareness of evidence-based practice, with complex and advanced systems in place to sustain this level of achievement. **Few services are likely to attain an EXCELLENT rating on any of the domains.**

The scores on the PBS Standards Measure and the Practice Leader Competencies can be compared with the benchmarked scores provided in this User GUIDE. It is important to note that both these measures also represent aspirational standards and so top scores should not be expected across the board.

The Measures as Developmental Tools

One of the key functions of these measures is to act as developmental tools to promote service improvement. At the end of each tool there is space for assessors to summarise their findings and list recommendations. These can form the basis of an Action Plan for future development. The measures can then be re-administered after a suitable time period to assess whether any improvement plan has achieved the desired changes.

NB. It is important to keep in mind that the Evaluation Matrix is intended to assess the capacity of a service to provide high quality support for people with challenging behaviour. It is not designed to assess actual service user outcomes. Even if a service is rated EXCELLENT on most standards, it may not support every person with challenging behaviour successfully. Other issues, such as compatibility, may be key factors. Assessors need to keep this issue in mind at all times when assessing the service: the ratings are based on organisations structures and systems, and not on individual outcomes.

In contrast to this the PBS Standards Measure is designed for administration with individual service users, and focuses on actual outcomes achieved. In order to judge the success of a service setting, all or a representative sample of service users should be assessed.

APPENDICES

Appendices 1 – 11 are given to help assessors make informed judgements about the evidence made available to them when evaluating a service setting or outcomes for individuals. The examples and descriptions given in these Appendices are not intended to be prescriptive, but provide samples of the type of documents and systems required, to help guide assessors in deciding whether the available evidence satisfies the specified standards.

Appendices 12 and 13 contain the results of the benchmarking exercises that were conducted to provide some normative data on the both measures. Appendix 12 shows each standard in the Evaluation Matrix and the percentage of settings evaluated during the pilot phases that met each standard. The Tables also show the percentage of settings that achieved GOOD, VERY GOOD and EXCELLENT ratings on each of the 5 sections of the Matrix. Appendix 13 shows the average scores achieved on each of the fourteen PBS standards and across the PBS Standards Measure as a whole.

Appendix 1: What a good Functional Assessment should include

For relatively simple or less severe challenging behaviours, a brief behavioural assessment may be appropriate. This can be conducted by asking people who know the person well to:

- identify the challenging behaviour
- describe how often it occurs, how long it lasts and the risks it poses
- identify the time of day that it is most likely to occur
- identify common predictors and setting events
- identify common consequences

However, there are three indicators that point to the need to conduct a **comprehensive functional analysis:**

- the challenging behaviour persists despite the consistent implementation of plans based on simpler analyses
- the behaviour poses a high level of risk
- more intrusive or aversive interventions are being suggested

There are three main elements to the process of conducting a comprehensive functional analysis:

1. Data collection

There are three main ways of collecting information for a functional analysis. These are:

a) by interview, using a range of structured measures (eg the Functional Assessment Interview (FAI), the Motivational Assessment Scale (MAS), the Contextual Assessment Inventory (CAI), mental health assessments, skills assessment and so on)

b) by direct, naturalistic observation (using ABC charts or other behavioural monitoring forms, scatterplots and so on)

c) by direct observation under specific conditions (analogue assessments – these are rarely needed and would have to be done only by trained professionals under carefully controlled conditions).

A comprehensive functional assessment should always include a) and b) above

2. Formulation

This involves knitting together different information streams into a coherent single picture of why behaviours are occurring. This is a complex skill. It involves checking out whether different ways of asking the same question produce the same answer (a process sometimes called triangulation), that all key information has been included, and seeing whether the overall picture described makes sense from a theoretical and practical perspective

3. Summary statements

These are the outcome of formulation. They provide a brief overall hypothesis as to the key conditions that are influencing behaviour. As well as providing shorthand accounts of the results of the assessment, they provide the basis for planning interventions to help reduce challenging behaviour. They, therefore, provide the direction for intervention. Summary statements are organic, and may change as more assessment data become available or as feedback from interventions becomes available.

Appendix 2: What a good Behavioural Assessment Report should contain

A Behavioural Assessment Report is intended to communicate the findings of the functional assessment for a specific service user. It is designed to be read quickly and accurately and will be read by professionals, a person's carers (including both paid and family carers) and the person at the centre of the report themselves wherever possible (producing user friendly versions will often be necessary for this reason).

The report must be accurate, data-based and respectful. The latter is particularly important: people with challenging behaviour will often have extremely negative images and reputations and an assessment report can serve either to perpetuate such images or to paint an alternative picture depending on how it is written. While individual reports will necessarily vary, the best Behaviour Assessment Reports will conform to the following content criteria.

Presentation	Short sentences used wherever possible, avoiding unnecessary jargon and with technical terms explained clearly. Clear headings used throughout, any graphs or tables clearly labelled. Any assessment tools used are specified. Well presented and generally error free (e.g. spell checked etc)
Title page	Including an indication that the report is private and confidential, the service user's name, date of birth, current address, the names of those people who contributed to the report, and the date it was produced.
Personal history	A brief account of key events in the person's life, emphasising a positive image of the person
Current services	A brief description of where the person currently lives and any other services that they receive, with an indication of the levels of support provided within these services
Health and medical needs	A statement of any significant health needs that the person has (and, where relevant, a description of how these might impact upon their behaviour), plus a description of any physical treatments that the person may be receiving (including psychotropic medications) or an indication of where these are recorded
Strengths and needs	A description of the person's skills and abilities, plus any identified skill deficiencies (and, where relevant, a description of how these might impact upon their behaviour)
Motivational analysis	A statement of all the person's preferred reinforcers
Behaviours of concern	A clear description of what each behaviour of concern looks like, and an indication of the known frequency, intensity and duration of each behaviour
Early indicators	A clear description of the early signs that the person is becoming agitated and that challenging behaviour may be about to occur
Risk factors	A statement of known personal risk factors and known environmental risk factors that the person has been exposed to
Slow triggers	A clear description of identified slow triggers that is derived from detailed assessment and triangulation for each behaviour of concern
Fast triggers	A clear description of identified fast triggers that is derived from detailed assessment and triangulation for each behaviour of concern
Maintaining reinforcers	A clear description of identified reinforcers that is derived from detailed assessment and triangulation for each behaviour of concern
Summary statement(s)	A simple summary statement and/or a contingency diagram, based on a formulation of the assessment data
Mediator analysis	A summary of the strengths and needs of the mediators (that is, the plan implementers i.e. direct carers).

Appendix 3: What a good Positive Behavioural Support Plan should contain

Complex challenging behaviours require support plans that cover all areas of need. The purpose of a PBS plan is to provide the key information that staff require to provide consistent support to a service user on a daily basis. The plan should be written in a clear, concise manner, avoiding the use of jargon wherever possible. It should be based on a functional analysis and focus on bringing together the key elements of: primary prevention; secondary prevention; reactive strategies and risk management. Because a PBS plan is a summary, it can be supplemented by more detailed guidance contained in personal files.

While individual plans will necessarily vary, the best PBS plan will conform to the following content criteria.

Identifiers and plan preparation	This is key information about the plan, including the dates the plan was written, agreed with the service user, implemented and due for review. Review dates should be preferably 3-monthly, but at least annual. Plan writers' names and plan aims should also be included.
Service user pen portrait	This is a brief description of the person's strengths and abilities, likes and dislikes, family contacts and other key personal contacts. The emphasis should be on positive characteristics (challenging behaviours should be described in the next section and not here).A recent photograph may also be included, and dated. A clear, positive image of the person's face is required.
Behavioural summary statements (from functional analysis)	This is taken directly from the behaviour assessment report. The following 4 elements should be clearly and concisely described: 1. Each challenging behaviour; 2. Identified slow triggers for each behaviour 3. Identified fast triggers for each behaviour; 4. The function that each behaviour serves for the service user (e.g escape noise; gain social contact; gain access to activity, self-stimulation, and so on).
Specific health needs	Any health needs should be included, even if they are not directly related to the person's challenging behaviour
Primary prevention strategies	These are short-term and long-term strategies that help the person behave in non-challenging ways. This should be the most substantial section in the plan. It should include information on positive interaction and communication methods. It should also includes strategies for: changing environmental conditions; modifying specific triggers and skill teaching
Secondary prevention strategies	These are behaviour management procedures to prevent full-blown episodes of challenging behaviour. They should include: information on early signs that the person's behaviour may be moving off baseline; verbal and non-verbal strategies for early intervention
Reactive strategies	These are instructions on how to respond safely and efficiently to specific challenging behaviours if they cannot be prevented. These generally refer to: the use of personal space; self-protective procedures and minimal restraint. Also included should be guidelines for post-incident support for the service user and staff.
Evaluation	One section of the PBS plan should list the ways in which it will be monitored and evaluated, so that its effectiveness can be assessed.

Appendix 4: Goodness of Fit Checklist

Name of Service User:
Name Of Person Completing Checklist: Date:

Introduction: This survey is for use by staff supporting the above person and designed to help improve the effectiveness of the Positive Behavioural Support Plan (PBS Plan). Your responses will help improve the quality of the plan and make sure that the plan is as helpful as it can be. Below are 20 statements about the plan and its prospects for success. Once you have thoroughly familiarised yourself with the plan, please respond to each statement by circling the number under the rating that most closely matches your current view.

Statement	**Strongly disagree**	**Disagree**	**Can't tell**	**Agree**	**Strongly agree**
1. The PBS Plan takes into account my understanding of this person and their challenging behaviour.	1	2	3	4	5
2. The plan addresses what I feel are the highest priorities for this service user.	1	2	3	4	5
3. I understand what I am expected to do as part of this plan.	1	2	3	4	5
4. I am comfortable with what I have been asked to do.	1	2	3	4	5
5. I am comfortable with what others are expected to do (e.g. my manager, clinicians etc.).	1	2	3	4	5
6. The plan recognises the needs of the service user and staff.	1	2	3	4	5
7. The plan recognises the needs of any other service users who live with this service user.	1	2	3	4	5
8. I feel that I have the skills to implement this plan.	1	2	3	4	5
9. I feel that colleagues have the skills to implement this plan.	1	2	3	4	5
10. The plan fits in with the daily routines in this service.	1	2	3	4	5
11. The plan fits with my values and beliefs about how people with learning disabilities and challenging behaviour should be supported.	1	2	3	4	5
12. The plan includes successful strategies that I have used previously with this person.	1	2	3	4	5
13. The plan will not significantly disrupt aspects of this service so that stress and hardship will be created.	1	2	3	4	5
14. The plan recognises and builds on the strengths of this team.	1	2	3	4	5
15. The plan recognises and builds on the strengths of this service user.	1	2	3	4	5
16. The plan includes any needs I have for supervision and support.	1	2	3	4	5
17. It will not be difficult for me to work to this plan.	1	2	3	4	5
18. The plan will be effective.	1	2	3	4	5
19. The plan covers any needs for emotional support that I have.	1	2	3	4	5
20. I will be able to implement the plan in the long term (e.g. for the next year).	1	2	3	4	5

Appendix 5: Positive Behavioural Support (PBS) Plan Checklist

Service user name: .....
PBS Plan Produced by:.....
Checklist completed by:..... ....

No.	Criterion	Pass/ Fail
1	Does the plan contain a pen portrait and an up-to-date, positive photograph of the service user? Does the pen picture stress the person's positive characteristics, their key relationships etc.?	
2	Does the plan include details of: • the service user's name • their date of birth • place of residence • details of who produced the plan • the date that it was written • the date that it was shared with the service user, • the date on which it will be implemented • the date on which it is to be reviewed	
3	Does the plan provide clear summary statements that include: operational definitions of the behaviours of concern, triggers for these behaviours and maintaining functions?	
4	Have these been derived from a functional analysis?	
5	Were key carers involved in contributing to this analysis and did they have opportunities to comment on a draft behavioural assessment report?	
6	Have any contradictory findings in the data triangulation been adequately addressed and resolved?	
7	Does the plan identify all stated behaviours of concern?	
8	Is there a clear set of desired outcomes, prescribed actions and monitoring procedures in relation to any specific health needs that the person has?	
9	Does the Primary Prevention section contain an introductory statement on the service user's interactive styles?	
10	Is there a clear set of desired outcomes, prescribed actions and monitoring procedures specified in relation to primary preventative strategies?	
11	Do primary prevention strategies make up the majority of the plan?	
12	Is there a clear statement concerning early indicators of challenging behaviour in the Secondary Prevention section?	
13	Is there a clear set of desired outcomes, prescribed actions and monitoring procedures specified in relation to secondary preventative strategies?	
14	Are both the primary and secondary strategies logically consistent with the results of the functional analysis?	
15	Are any prescribed physical interventions that may be necessary clearly stated?	
16	Is there a clear set of desired outcomes, prescribed actions and monitoring procedures specified in relation to reactive strategies?	
17	Are all prescribed actions written in clear, operational terms that specify exactly what carer behaviours are required?	
18	Are all prescribed actions socially valid, practical and 'doable' in the context in which the person lives, works, spends their leisure time etc?	

Appendix 6: Positive Monitoring

Regular observation is the best way of ensuring that staff are following procedures and of identifying where they may need additional help. This helps managers to stay in touch with the day-to-day way that staff operate, and know whether the PBS plan is being implemented as intended.

Observations should cover the implementation of all elements of the PBS plan. This means that the observations format must be specifically designed around an individual service user. The way to do this is to design a Positive Monitoring Observation Form that is constructed directly from the PBS plan.

An example of a Positive Monitoring Observation Form is given below to show the general format and what it should contain:

Service User Name			
Staff member being observed			
Observer			
Date of observation		Time of observation	
Prescribed Action (Taken from the PBS Plan)	Should action have been implemented during the observation? (Yes / No)	Was action implemented as specified during the observation? (Yes / No)	Comments
List of 20 – 30 actions taken directly from across the PBS plan			
TOTAL			
Overall % score: Number of actions that were implemented divided by the number of actions that should have been implemented x 100.			
Overall comments:			
Areas of achievement (positive feedback)			
Areas of Need (constructive feedback)			
Required actions			
Next observation date			
Signed		Date	

Appendix 7. Periodic Service Review (PSR)

Periodic Service Review (PSR) is a way to assess the quality and consistency of how staff teams provide Positive Behavioural Support to one or more service users. It also functions as a system to help staff improve their own performance and the quality of Positive Behavioural Support provided to service users. PSR can be applied to most human services, such as supported living arrangements, group homes, day services, supported employment services, assessment and treatment units etc. But it must be tailored to fit each service.

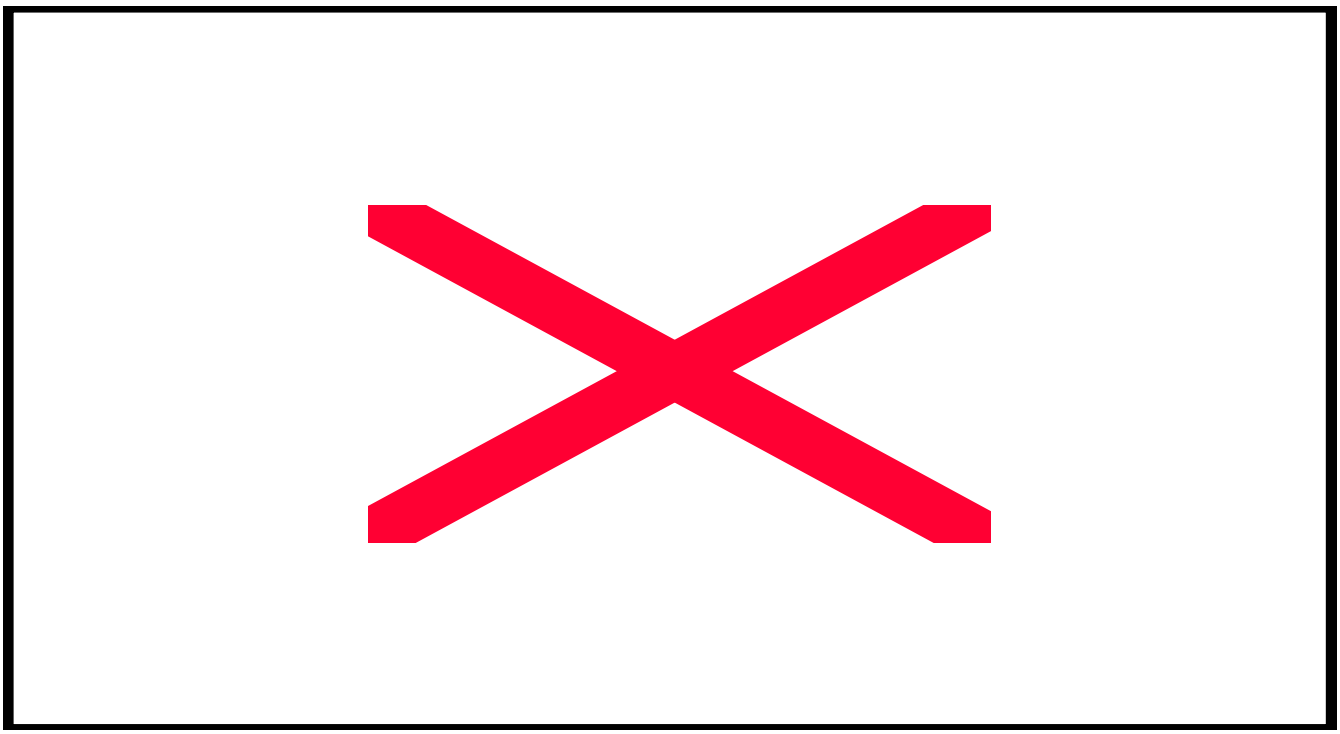
Performance standards are set in close collaboration with the staff team. 0nce standards have been set, there are three stages to conducting a Periodic Service Review.

1. Performance monitoring The team meets to review whether or not it has achieved the standards and calculates a PSR score.

2. Management feedback The PSR score is used to provide immediate feedback to the team to improve and maintain quality.

3. Remedial action Reasons for high and low scores are discussed and actions to help ensure that standards are met are identified.

The graphic below shows a very simplified version of a PSR score sheet. PSR score sheets are normally a few pages long and include key standards for all main aspects of the service.



Appendix 8. The Three-Stage Training Model

Traditional training is usually delivered in the form of short courses which can be somewhat disconnected from what actually happens in participants' places of work. Thus, its impact on how people perform their jobs is often minimal. This is because such training is often too general in nature and, at best, is successful only in raising an awareness of what people are required to do. How they actually need to do it is usually addressed quite poorly. Working with people who challenge involves developing a wide range of practical skills, and staff will not learn these skills from lectures or training workshops alone.

The Three Stage Training Model is an attempt to redress this deficiency in traditional approaches by taking the training to different levels. The stages are:

1. Verbal competence - once trained to this level, staff will be able to accurately describe what they need to do. This should be confirmed by a knowledge test using questions that sample the key points of the PBS plan.

2. Role play competence - once trained to this level, staff will be able to accurately demonstrate what they need to do, in simulated situations. The six steps in role play are: Prioritise; Describe; Demonstrate; Practice; Feedback; Mastery.

3. Practice competence - once trained to this level, staff will be able to accurately and reliably perform what they need to do under 'field conditions' in their regular workplace. The three steps in practice competence are Mentorship, Modelling, Feedback.

Evidence
The training would be supported by a number of documents such as:

Verbal competence – training plan for the sessions, written knowledge test or survey.

Role Play competence – training plan for the session, written scenarios, scripts for role players, observation and feedback forms

Practice competence – observation and feedback forms, records of which staff have been trained and when. An example observation sheet follows on the next page.

Appendix 9. Interactive Training Observation Sheet

Candidate:_____ Assessor:_____Date:_____

Elements of Positive Interaction	**Pass assessed by** (tick all applicable)	
	obs	question
Preparation: Making the environment as helpful as possible prior to presentation ▪ Staff check that everything required is available and in best position to enable the service user to use & staff member to assist- Staff set up for new, complex activity ▪ Distractions minimised- e.g. best room to use, doors closed or open, turn TV off? Other service user/ staff have planned activities so they will not disrupt. ▪ Aware of functions/ triggers re CB- prepared accordingly		
Presentation: Introducing the activity to the service user • Positive presentation to the person, clear statement that the person understands, encouraging - verbal economy, informed choice? • Appropriate level of info on what they are going to do- Too much/ little, does the person understand? • The person knows when they have started to do the activity		
Task Analysis: Breaking the activity Into steps and sequencing the steps to enable the service users to participate • Is there a written one? If so, does the member of staff follow it? • Staff member has broken down the activity into a series of steps, identifying which steps the service user will do-steps too big / small? • Staff member has planned which level of assistance to give at each step- and this matches the service users need- too high/ low? • Staff member has planned sequence to minimise the amount of time the person is kept waiting- disengaged and the need to interrupt the activity • Higher level of help on difficult steps, break down further or staff member doing discreet difficult step only Backward / forward chaining, naturally occurring prompts		
Level of Help: Providing enough help to enable the service user to participate • Ask > instruct > prompt > show > guide right level of help for each step- used flexibly moving up and down. Increase level on when difficulties are encountered. • Giving enough time for the service user to do the task, Verbal economy. Effective hand on hand promoting functional use by the person. • Staff attention- ignoring inappropriate behaviour- paying attention to the person, immediately they are constructively engaged- remaining on task with the person. • Responding quickly & appropriately to person- need more/less help		
Reinforcement: ensuring that the service user gets a reward immediately after they have participated in activity • Maximising naturally occurring rewards (backward chaining) • Praise and attention when constructively engaged- given immediately / frequently. • Activity rewards- linking a less preferred activity to a more preferred activity • Effective reinforcement/ appropriate behaviour only, combinations, variation		
Style/ positioning: general points re positive interaction • Active listening and responding to person –breaking during amber phase prior to CB • Tone of voice- facial gesture, body language – enjoyable, enthusiasm, encouragement, reassuring, general approach not nagging / bossy/ demeaning, verbal economy- • Interaction and praise is age appropriate, • Appropriate corrective feedback, eg 'do it like this', not over using 'No' 'that's bad/not right' • Staff position themselves in the best place for the service user, both stand/ sits comfortably where they can reach etc--not straining, able to breakaway easily, manual handling, health and safety		
Comments: **Assessor Signature:**		

Appendix 10: Social Validity Tests

'In Their Shoes' Test

'Sainsbury's' Test

Appendix 11: Functional Assessment Measures

AAMR Adaptive Behavior Scale - Residential and Community (ABS-RC:2) Authors: Kazuo Nihira, Henry Leland and Nadine Lambert (1993)

The Adaptive Behavior Scale (ABS) is a useful measure to assess a person's ability to cope with the natural and social demands of their environment. It was developed through research undertaken in the United States involving 4,000 people with a learning disability and has been through several revisions since its first inception in the 1960s. It is probably the most well used scale to measure adaptive functioning internationally both by clinicians and researchers.

Part 1 of the scale is designed to provide a global assessment of abilities. It is divided into 73 scored items under the ten domains of:

- independent functioning
- physical development
- economic development
- language development
- numbers and time
- domestic activity
- prevocational/vocational activity
- self direction
- responsibility
- socialisation

The scale is administered by interview and takes around 30 minutes to complete. Scoring is straightforward, and domain scores can be easily converted to standard scores and percentiles. Percentiles allow a comparison between the individuals' scores and those of the general learning disability population.

A comprehensive manual provides detailed guidance on the background, administration and interpretation of the scales. Copies of the manual and forms can be purchased directly from the publisher: Pro-Ed, Inc., 87000 Shoal Creek Boulevard, Austin, Texas 78757-6897. www.proedinc.com

Adaptive Behavior Assessment System (ABAS-II) 2nd edition Authors: Patti L. Harrison and Thomas Oakland (2003)

The ABAS-II is a multi-function tool designed for use with people with a variety of disabilities, including intellectual disability, other developmental delays, learning and emotional disorders and dementias. Like the ABS, it provides an overall assessment of a person's independent living skills, and it provides normative data so that scores can be compared to those of the general, non- disabled population. The scale can be used to aid diagnosis and classification of a variety of disabilities and disorders (not just learning disabilities) and it can also be used to assess strengths and limitations and monitor progress over time.

The scale is multi-dimensional in that it has five rating forms to allow for multiple respondents to assess the person's functioning in multiple settings – and respondents can include the person being rated him or herself. It is suitable for both children and adults and each form takes around 20 minutes to complete.

The ten skill areas covered by the scale are:

- communication
- community use
- functional academics (which includes practical literacy and numeracy skills)
- home living
- health and safety
- leisure
- self-care
- self-direction
- social skills
- work behaviour

Each of the ten sections has around 25 items that are each rated on a four point scale. Scoring is straightforward and raw scores can be converted into scale scores under the three adaptive domains of conceptual, social and practical, together with a norm-referenced total score called the General Adaptive Composite or GAC.

A detailed manual and sets of rating forms can be purchased directly from the publisher: Harcourt Assessment Inc., 19500 Bulverde Road, San Antonio, TX 78259, USA, 1-800-211-8378. www.PsychCorp.com

The Aberrant Behavior Checklist (ABC)
Authors: Michael G. Aman, Nirbhay N. Singh (1986)

The Aberrant Behavior Checklist (ABC) was designed as a research tool for assessing treatment effects. It has a broader interpretation of behaviour than many other similar measures. The ratings take into account not just the frequency and severity of behaviour, but also the difficulty posed to the person and the level of severity of challenge to the person's carers.

The checklist comprises 58 behaviour items under five broad areas:
 irritability lethargy stereotypy hyperactivity inappropriate speech

Each of the behaviour items is rated on a four point scale and codings are summed for each category. It is very easy to administer: the interviewer explains carefully the criteria on which to assess each behaviour item and also provides a list of additional definitions. Respondents then complete the scale in front of the interviewer. This takes about ten minutes.
The ABC stands up well psychometrically with good reported internal consistency. The scale has also been found to be sensitive to change, and is a good measure of overall behavioural challenge.
A clearly written manual and rating forms can be purchased directly from the publisher: Slosson Education Publications, Inc., P.O. Box 544, East Aurora, New York, 14052. www.slosson.com

The Brief Behavioural Assessment Tool (BBAT)

The BBAT was developed as a brief functional assessment of challenging behaviour. Quite often, decisions are made about how to support someone to change their challenging behaviour without really understanding why the behaviour is happening in the first place and this is why many interventions are not effective. The BBAT helps to develop a basic understanding on which to base an intervention plan.
It does, however, have some key limitations. It is a screening tool and should not be used as a substitute for a full functional assessment, especially for very complex challenging behaviour, and should NEVER be used as the only source of information. Also, like any other tool, its usefulness and validity depends on the clinical skills of the person completing it.
The BBAT helps to:

- Clearly define the behaviours of concern
- Identify key triggers
- Identify possible maintaining consequences
- Identify the person's preferences and communication skills

It is administered by interview with someone who knows the person well and takes about 90 minutes to complete.

The BBAT and Guidance notes can be obtained from The Mental Health and Learning Disability Service Delivery Unit, ABMU Health Board, Glanrhyd Hospital, Tondu Road, Bridgend, South Wales, CF31 4LN.

Functional Assessment Interview (FAI)

Authors: O'Neill, R.E., Horner, R.H., Albin, R.W., Sprague, J.R., Storey, K. and Newton J.S. (1997) Functional assessment and program development for problem behavior: A practical handbook. Pacific Grove: Brooks Cole.
The Functional Assessment Interview (FAI) is one of the most well known and used measures in functional analysis. It is designed to identify key variables – slow and fast triggers, reinforcers etc. – that affect a person's behaviour. It is usually filled in by the person conducting the functional assessment as part of structured interviews with people who have close contact with the person with challenging behaviour. Respondents can be interviewed individually or as a group and it typically takes between 45-90 minutes to complete.
The FAI is used to help:

- Describe the behaviours of concern – how they appear, their frequency, duration, intensity and efficiency
- Define slow and fast triggers
- Identify consequences
- Define functional behaviours and communication styles
- Identify the person's preferences
- Identify past behaviours and intervention attempts

As with other such tools, the FAI should be used by clinically competent professionals. It is freely available via the internet.

The Motivation Assessment Scale (MAS)

Author: Durand, V. (1986)

The Motivation Assessment Scale is a questionnaire designed to identify those situations in which a person is likely to behave in certain ways. From this information, more informed decisions can be made concerning the selection of appropriate reinforcers and treatments. The scale is completed on one behaviour at a time only, and it important that the behaviour is identified very specifically: *Aggressive*, for example, is not as good a description as *hits his sister.*

The MAS consists of 16 items, each of which is rated on a 7-point scale to reflect how often each item applies to the person. The scale is not completed by interview. The assessor needs to explain the scale very clearly to respondents who know the person very well. Once the behaviour to be rated is specified, the assessor asks the respondent to read each question carefully and circle the one number that best describes their observations of this behaviour. It is a short scale, taking about 10 minutes to complete. Best results are gained when more than one respondent rates each of the specified behaviours, and their scores are then compared. Scores are entered onto a summary sheet under four domains of 'Sensory', 'Esape', 'Attention' and 'Tangible', and the domain with the highest score indicates the main function of the behaviour being rated.

The MAS and guidance notes are available from Monaco & Associates Incorporated, 4125 Gage Center drive, Suite 204, Topeka, Kansas 66604, (800) 798-1309. www.monacoassociates.com. The MAS form (Durand, 1986) can also be found on the internet.

Contextual Assessment Inventory (CAI)

Authors: McAtee, Carr & Schulte (2004)

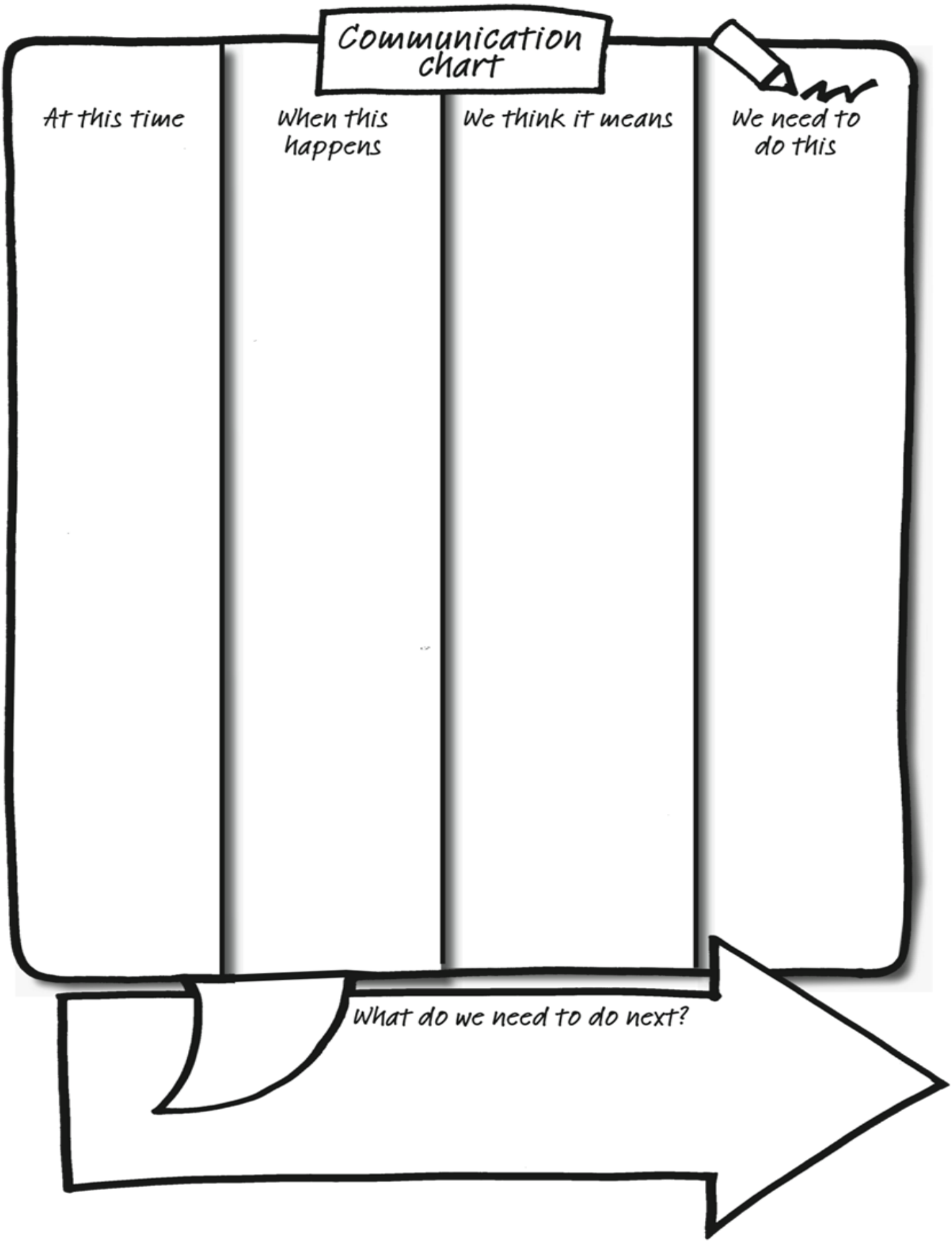
The CAI is designed to provide more detailed information on the possible contexts (slow and fast triggers) for a person to show challenging behaviour. It is a 93-item questionnaire that asks respondents to rate the likelihood of a person showing challenging behaviour in specific situations, on a five point scale from '1 = never', to '5 = always'. The 93 items are also grouped under four main headings: social/cultural, nature of task or activity, physical, and biological. The scale is not actually scored, but any item rated '4' or '5' requires further investigation, and can contribute valuable information to a functional assessment.

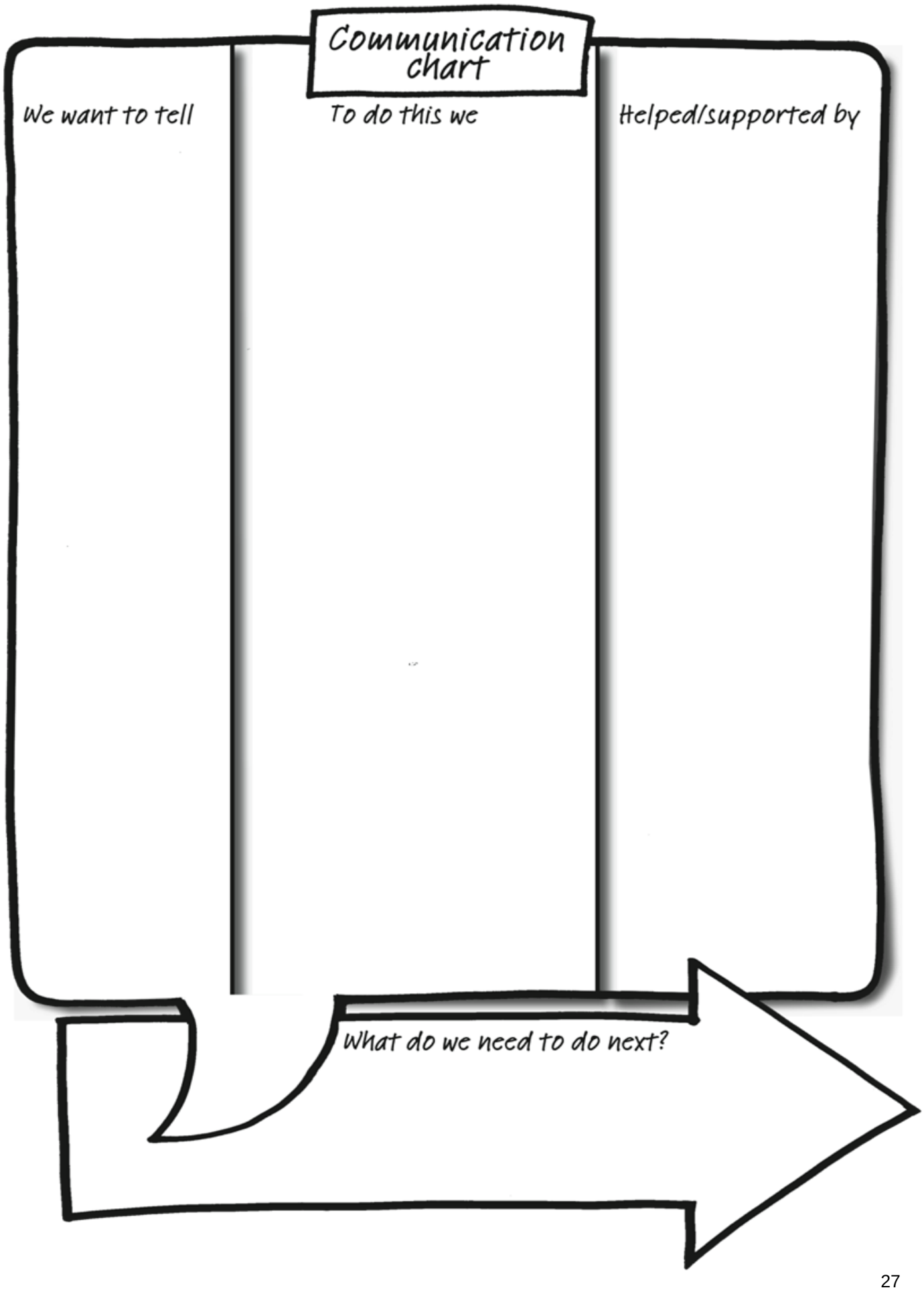
The scale can be administered by interview or it can be completed directly by respondents following an explanation from the assessor. It takes around 40 minutes to complete and should be completed independently by at least two people who know the person well.

Available in McAtee, Carr & Schulte (2004) A Contextual Assessment Inventory for Problem Behavior: Initial development. Journal of Positive Behavioral Interventions, 6 (3), 148-165.

Appendix 12: PCP Thinking Tools

Matching Staff			
Support wanted and needed	**Skills needed**	**Personality characteristics needed**	**Shared interests (nice to have)**


Communication chart
At this time
When this happens
We think it means
We need to do this
What do we need to do next?


Communication chart
We want to tell
To do this we
Helped/supported by
What do we need to do next?

Decision Making Agreement

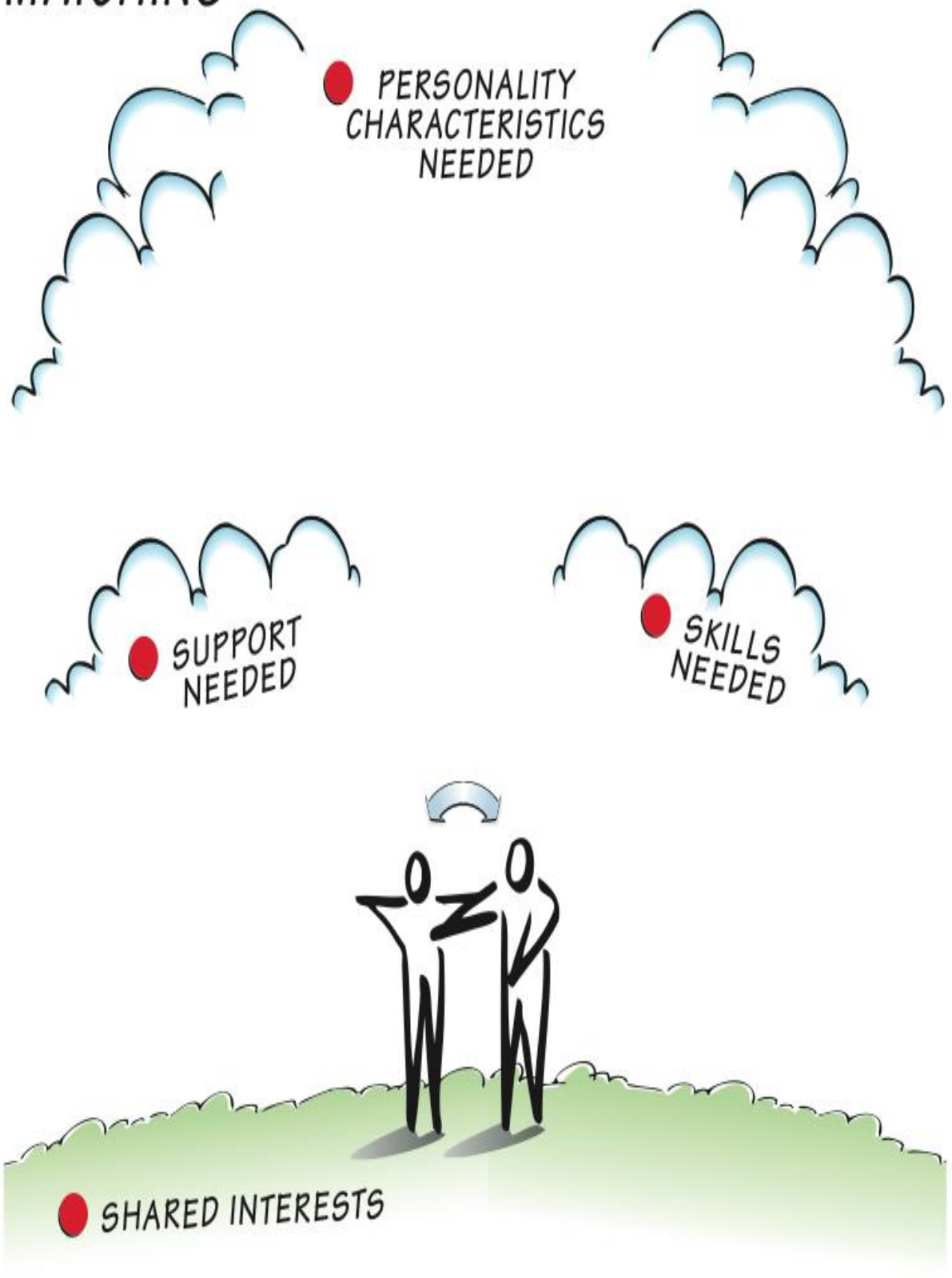
Important decisions in my life	How I must be involved	Who makes the final decision?

Decision Making Agreement

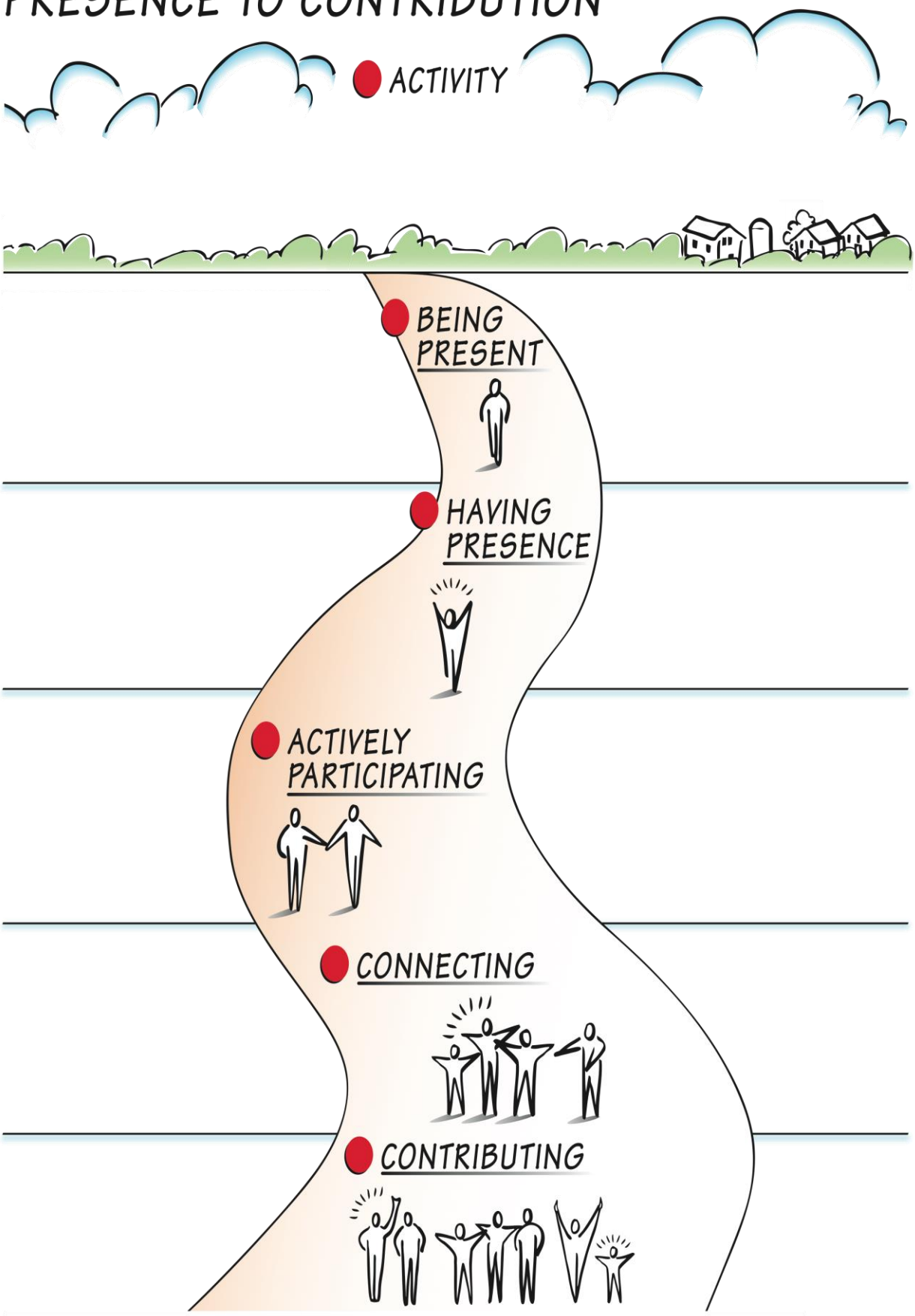
Important decisions in my life	How I must be involved	Who makes the final decision?

What would it take for me to have more control in my life?

MATCHING


PERSONALITY CHARACTERISTICS NEEDED
SUPPORT NEEDED
SKILLS NEEDED
SHARED INTERESTS

PRESENCE TO CONTRIBUTION



Appendix 13: Benchmarking results – Evaluation Matrix

Forty-five services were assessed during the final stages of piloting the Evaluation Matrix, with the aim of field-testing and of gaining normative data to establish benchmark standards for current challenging behaviour services. Just over half (52%) were third sector residential services, over a quarter (29%) were specialist challenging behaviour services, 12% were day services and a small number were outreach services or respite care settings. The following tables show the ratings on the five main sections and on each individual standard by broad setting type.

SECTION	OVERALL RATING	% ACHIEVING EACH RATING BY SERVICE TYPE			
		residential/ supported living (n = 22)	specialist challenging behaviour service (n = 12)	other – day, respite, outreach (n=11)	TOTAL (n = 45)
TRAINING	UNRATED	14	17	9	13
	GOOD	59	0	64	44
	VERY GOOD	27	83	27	42
	EXCELLENT	0	0	0	0
BEHAVIOURAL ASSESSMENT	UNRATED	14	17	27	18
	GOOD	77	42	46	60
	VERY GOOD	9	17	27	16
	EXCELLENT	0	25	0	7
PBS PLAN	UNRATED	18	17	17	16
	GOOD	59	8	8	44
	VERY GOOD	14	17	17	16
	EXCELLENT	9	58	58	24
IMPLEMENTING PBS PLAN	UNRATED	59	33	46	49
	GOOD	32	58	36	40
	VERY GOOD	9	0	0	4
	EXCELLENT	0	8	18	7
STAFF SUPPORT	UNRATED	41	41	27	31
	GOOD	46	46	36	44
	VERY GOOD	0	0	9	4
	EXCELLENT	14	14	14	20

		INDIVIDUAL STANDARDS	% residential/ supported living (n = 22)	% specialist CB residential (n = 12)	% other (day, respite, outreach (n = 11)	% total (n= 45)
SECTION 1. STAFF TRAINING & DEVELOPMENT	GOOD	The organisation provides induction and ongoing BILD accredited training specific to challenging behaviour, including: understanding behavioural principles and proactive approaches, and the use of reactive strategies (eg. PBM training).	91	67	73	80
		80% of staff supporting people with challenging behaviours undergo refresher training in the above on at least an annual basis	91	67	73	80
		The organisation demonstrates a clear commitment to' service-user driven training' to respond to identified need	82	67	73	76
	VERY GOOD	Further training in proactive approaches and methods is provided, such as Antecedent Intervention, Skill Teaching, Active Support (AS), Person-Centred- Planning (PCP) Inclusive Communication, BTEC PBS courses AND 80% of staff have completed or are undertaking the training.	46	67	27	47
		The organisation has developed its own internal network of at least 2 of the following: Positive Behavioural Management (PBM) ; Active Support (AS) trainers; Person-Centred-Planning (PCP) facilitators	82	58	36	64
	EXCELLENT	80% of staff supporting people with challenging behaviours are trained or are undertaking training in the BTEC Advanced Certificate or Advanced Diploma in PBS (or similar qualification).	23	67	9	31
		A whole organisation approach to training in PBS is integrated and operational and reflected in its annual training plan.	32	25	27	29
		Practitioner internal to the organisation is available to the setting, with appropriate specialist qualification such as the BTEC Advanced Professional Diploma in PBS or similar.	41	50	27	40
		The organisation's training and development programme includes functional analysis, behaviour plan design and practice leadership training for managers to support the implementation of PBS in practice.	23	67	27	36
		All staff with managerial responsibilities for this challenging behaviour service have completed or are undertaking the programme	23	33	36	29

		INDIVIDUAL STANDARDS	% residential/ supported living (n = 22)	% specialist CB residential (n = 12)	% other (day, respite, outreach (n = 11)	% total (n= 45)
SECTION 2. BEHAVIOURAL ASSESSMENT	GOOD	The service demonstrates co-operation with the process of behavioural assessment, via functional analysis by external professionals* i.e staff members are released for interviewing;	82	67	73	76
		basic behavioural information is collected via bespoke monitoring forms	86	67	64	76
		access is granted to observers to collect objective data in the setting	82	67	55	71
		Behaviour monitoring is a routine part of operational procedures within the service, with or without external involvement	91	67	73	80
	VERY GOOD	80% of staff know the key processes that a functional analysis involves: triangulation of data collected by multiple methods (interviews using structured tools – MAS, FAI, CAI, PASADD etc., direct observation – ABC charts, Scatterplots, MTS, CTS etc.)	5	25	18	13
		There is a clear interface between PCP and behavioural assessment - that is, behavioural assessment is undertaken in a holistic manner, taking into account the person's needs, strengths, likes, dislikes, personal and social quality of life and preferences	64	67	27	56
	EXCELLENT	Skills are developed within the service/ organisation: To undertake a basic assessment of challenging behaviour via a functional analysis (i.e. ask questions about what's happening before and after behaviour to develop hypothesis)	32	67	36	42
		Conduct direct observations to test hypothesis.	23	67	18	33
		Write a basic behavioural assessment report	32	67	27	40
		Collate and analyse records of behavioural incidents and review assessment reports in light of incoming data.	32	67	18	38

		INDIVIDUAL STANDARDS	% residential/ supported living (n = 22)	% specialist CB residential (n = 12)	% other (day, respite, outreach (n = 11)	% total (n= 45)
SECTION 3. BEHAVIOUR SUPPORT PLAN	GOOD	The service demonstrates co-operation with the process of behavioural support plan development by external professionals, i.e.: the provision of information;	77	67	73	73
		commenting on behavioural assessment report findings;	77	67	73	73
		commenting on behavioural support plan during its construction.	77	67	73	73
	VERY GOOD	Staff members have an understanding about: the purpose and components of a behavioural support plan; that a behavioural support plan should be matched onto the outcomes of a behavioural assessment.	27	67	27	38
		There is a clear interface between PCP and the behavioural support plan – that is, the plan is constructed in a holistic manner, taking into account the person's needs, strengths, likes, dislikes, personal and social quality of life and preferences	64	67	46	60
	EXCELLENT	Skills are developed within the service/ organisation to: develop a comprehensive behavioural support plan	23	58	27	33
		Monitor and review a Positive Behavioural Support plan.	23	58	18	31

SECTION 4. IMPLEMENTING PBS PLANS IN PRACTICE		INDIVIDUAL STANDARDS	% residential/ supported living (n = 22)	% specialist CB residential (n = 12)	% other (day, respite, outreach (n = 11	% total (n= 45)
	GOOD	The Positive Behavioural Support plan is implemented via staff training at the verbal level, which at least 80% of the direct staff team receive.	55	58	46	53
		Clear service performance standards are set, against which the quality of service delivery can be monitored.	59	67	64	62
		Services are monitored against set service performance standards by quarterly ad hoc visits from senior staff within the organisation and by monthly observations by the manager.	64	67	64	64
		Challenging behaviour is measured as a service user outcome via behaviour monitoring systems	82	67	73	76
	VERY GOOD	The behavioural support plan is implemented via competency-based staff training, (Verbal, Role Play & In Situ), which at least 80% of the staff team receive.	27	58	18	33
		Service performance standards are developed with the full involvement of the staff team (i.e. a bottom-up approach).	36	25	27	31
		Services are *systematically* monitored against set service performance standards by planned, quarterly visits from senior staff in the organisation and by monthly observations by the manager.	50	50	27	44
		A range of service user outcomes are routinely monitored, e.g. rates of challenging behaviour, participation levels, community presence, use of reactive strategies etc.	55	50	36	49
		Quarterly reports are produced to document the outcomes of monitoring	27	17	27	24
		Systems are in place for reporting back to staff and the organisation on a quarterly basis.	23	17	27	22
		Key stakeholders (including service users) are routinely asked for their views of service quality and improvement needs, which are documented for reference.	50	50	36	47
	EXCELLENT	Advanced systems are in place for implementing PBS plans, i.e. comprehensiveness testing; Goodness of Fit checks, competency-based staff training, Positive Monitoring and Periodic Service Review, in which at least 80% of the staff team participate	5	50	18	20
		Services are routinely monitored against the set performance standards in a robust way, to include: planned, quarterly visits from senior staff within the organisation;	32	50	27	36
		a functioning operational PSR system	14	50	27	27
		Positive Monitoring systems to assess how well PBS plans are implemented by staff in practice.	23	50	27	29
		Systems are in place for developing and implementing remedial action plans from the outcomes of monitoring. Actions set are reviewed on a quarterly basis.	14	42	18	22
		Positive and constructive feedback is provided to managers and staff on the outcomes of monitoring, and this is documented as procedure.	27	42	18	29

		INDIVIDUAL STANDARDS	% residential/ supported living (n = 22)	% specialist CB residential (n = 12)	% other (day, respite, outreach (n = 11)	% total (n= 45)
SECTION 5. STAFF SUPPORT	GOOD	Staff receive individual debriefing and support following exposure to serious incidents of challenging behaviour	73	67	55	67
		Managers provide regular direction and support to staff	82	67	64	73
		Staff report feeling supported by the organisation	59	67	55	60
	VERY GOOD	Discussion about the experience of exposure to incidents of challenging behaviour is a routine part of individual supervision sessions	73	58	36	60
		Regular peer sessions are held to debrief generally about incidents of challenging behaviour that staff have been exposed to	50	58	36	49
		Proactive stress management systems include: buddy / mentor systems introduced for new staff members;	55	67	27	51
		team building and teamwork is encouraged	59	67	36	56
		Service user focused meetings occur on at least a fortnightly basis, with clear communication strategies in place to ensure all staff have regular access to decisions made	23	25	36	27
	EXCELLENT	The service / organisation emphasises the importance of *proactive* as well as *reactive* stress management for staff.	55	58	36	51
		Proactive stress management systems encompass: individual supervision sessions used to discuss proactive steps for reducing the likelihood that stress will be experienced;	55	58	36	51
		support provided to staff to recognise the early indicators that they may be becoming stressed	50	58	36	49
		the provision of education and training in stress management strategies;	32	58	27	38
		staff forums	36	58	36	42
		staff involvement in management	50	58	27	47
		availability of occupational health	59	58	46	56
		employee assist programmes	55	58	36	51
		A range of communication systems for staff is in place that encourage active staff involvement in service management processes (eg. helpline, oncall, etc)	59	58	46	56

Appendix 14: Benchmarking results – PBS Standards Measure

Sixty individual service users were assessed during the final stages of piloting the PBS Standards Measure, with the aim of field-testing and of gaining normative data to establish benchmark standards for services. All were receiving services from the participating providers, with the vast majority living in supported living settings. The following tables show the average and percentage scores achieved on all fourteen Standards.

SUMMARY OF OVERALL RATINGS FOR EACH STANDARD		Max score	Average score n=60	Average % score
1	My PBS plan helps me have a good quality of life	21	10	48%
2	I am supported to make informed choices and have control	15	13	87%
3	I have relationships with family and friends	15	12	80%
4	I participate at home and in the community	15	7	47%
5	I live in an enriched typical environment, that suits my needs	15	10	67%
6	I am supported to communicate	21	16	76%
7	I have appropriate treatment for my physical and mental health	30	19	63%
8	My behaviours that challenge are understood	12	8	67%
9	There is a sustained reduction in my challenging behaviours	12	9	75%
10	I am not subjected to restrictive practices	27	19	70%
11	I am not subjected to punishment or punitive practice	9	8	89%
12	I am supported by staff trained in PBS	6	3	50%
13	My PBS plan is implemented consistently by the staff team	12	9	75%
14	I am safe and protected from abuse	18	13	72%
TOTAL		228	156	68%