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
Caswell Service Profile

- PBS implemented in the context of other service developments and good practice:
  - See Think Act relational security
  - Restrictive Physical intervention training focussing on a preventative approach and de-escalation
  - Reflective practice delivered on all the wards
  - Co-production/ service user involvement agenda
  - Core values

So PBS fits well with the culture and values of the service
PBS: Policy Context

Since Winterbourne View in 2011, there have been further exposures of misuse of restraint (e.g. Rainsbrook and Medway Secure Training Centres). A number of reports have been published focussing on minimisation of restrictive practices and promoting a more proactive approach:

PBS: Policy Context

• Department of Health (2014) *Positive and Proactive Care: Reducing the Need for Restrictive Interventions.*
• NICE Guidance on *Violence and Aggression* (NG10) and *Challenging Behaviour* (NG11), both 2015.
The main themes from these policy documents are:

- Minimise the use of restrictive physical interventions ensuring they are only used as a last resort.

- Have an understanding of the context and meaning of service users’ behaviours e.g. through functional analysis.

- Work in a person centred, recovery focussed manner that recognises service users strengths, needs and aspirations and promote their quality of life.

- Staff need to be trained in the safe management of challenging behaviours, to include PBS approaches, de-escalation and risks associated with restraint.
PBS: Policy Context

- Involve service users in all aspects of their care needs and promote positive relationships between services, the people they support and their families.

- Support people to balance safety and freedom of choice.

- Develop support plans that aim to prevent behaviours occurring in the first place (primary prevention), de-escalate difficult situations (secondary prevention) and safely manage behaviours when they occur using the least restrictive option (Crisis Management).

- All those involved in the development of PBS plans should receive supervision from a suitably qualified and experienced person.
What is PBS?

- An understanding of a person’s behaviour is developed based on functional analysis, considering environmental triggers (slow and fast) 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 (RED behaviours) 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.
What is PBS?

• Reduction of challenging behaviour as a side effect of the intervention.

• Pro-Social (GREEN) behaviours are encouraged through recognition and reinforcement.

• 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 person's needs and wishes.

• Collaboration, empowerment and choice are central.
What do we mean by **RED** and **GREEN** behaviours?

Examples of **RED** behaviour:

- Bullying / intimidating other patients
- Dishonesty
- Disruptive behaviour on ward
- Violence
- Sexually inappropriate behaviour
Examples of GREEN behaviour

- Assertiveness
- Calm and pleasant in behaviour
- Compliance with ward rules
- Polite when interacting with staff / patients
- Managing their emotions themselves

GREEN BEHAVIOUR
- PBS: The Model

- Crisis Management
- Secondary Prevention
- Primary Prevention
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.
  - The 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.
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.
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.
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.
- A PBS Action Plan has been developed and is reviewed in the meetings.
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 and half a day to unqualified staff.
  • To date 100% of R.N’s and 94% 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.
  • 15 staff have commenced Advanced Professional Diploma training in PBS and will become Behaviour Specialists upon completion of course. With attrition we have 8 left, they are all starting to qualify now.
  • We have four publications related to PBS, one under submission and four underway.
  • Safe Wards currently being rolled out across the clinic.
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”
  - Service User Assessment Tool.
  - We have developed the Forensic Functional Assessment Measure

- Individual PBS plans developed (I-PBS)-
  - Currently there are thirteen live plans (2 in the women’s service).
  - Sixteen people have left the service who had active plans

- 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.
Complete Baseline assessments
Challenging Behaviour Checklist (CBC)

Functional Analysis

Forensic Functional Assessment Measure (FFAM)
Contextual Assessment Inventory (CAI)
Client Assessment Tool
ABC Charts

Interpretation of Assessments
Identify slow and fast triggers and maintaining functions

Meeting - Psychologist, Nursing team, OT
Agree interventions

Develop PBS Plan
Agree Monitoring and review process
Agree with service user
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). Confidence was maintained at 6 months follow up for qualified, unqualified, male and female staff.

- **Attributions:**
  - This data was more mixed. Although changes did occur after training, for both qualified and unqualified staff, men and women, indicating a broader understanding of the causes of challenging behaviour and consideration of environmental factors, these tended not to be maintained at follow up.
Results of PBS Plan Evaluation

- 22 plans evaluated pre-implementation and 3 monthly post implementation. For inclusion needed to be in the service at least 6 months after their PBS plan was implemented.

- Waiting list control- 16 people had double baseline measurements to identify if the changes were normal (e.g. getting better) or related to the intervention.

- Evaluated using the frequency measure of Challenging Behaviour Checklist (Harris et al. 1994), adapted for use within this population.
Results of PBS Plan Evaluation

- Of the 22, 19 were still remaining in the service at 9 months post intervention and 16 at 12 months.

- There was no significant difference in frequency of challenging behaviour between the double baselines of the waiting list control group ($z = -0.285$, $p = 0.776$).

- There was however a significant difference between baseline and last measurement ($z = -3.921$, $p = <0.01$).

- There was a significant reduction in the frequency of challenging behaviour between baseline and 3 months post intervention ($z = -3.930$, $p = <0.01$), but no significant difference between 3 and 6 months, 6 and 9 months and 9 and 12 months indicating behaviour did not return to baseline levels.
Frequency Pre and Post PBS Intervention
## Results of PBS Qualitative Plan Evaluation: Service Users Experiences (n=10)

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Evaluation: Service Users Experiences

• My Plan:
  • Understanding my story:
    “It’s a fair representation of me, it’s got me to a tee....Well I had to give my explanation of how things are, say if I lose my rag so that everyone is aware of how to deal with that problem” (p7)

Or not....

“Well it’s not about my behaviour, it’s not the truth, it’s not what I have said is happening to me, it’s what they think is happening to me...” (p5)

• Good days, bad days, triggers

“Yes, it can tell you how you are feeling on a bad day or a good day. Because sometimes people think that if you don’t feel very well, least people know how to treat you. Treat you with respect then” (p2)
Evaluation: Service Users Experiences

• My Involvement

“I have put my views across... I like being involved... I remember now going through it with [my primary nurse] and she went through it with me” (p6)

“They ask you your side of things [which] makes you feel better because you got your side of things over” (p10)

• How I understand PBS
  • What it is

“To support me through emotional times, all different kinds of behaviour...supporting me in my different behaviours” (p7)
Evaluation: Service Users Experiences

- Why me?
  “It would have been better if somebody had explained it all to me... sometimes I struggle to understand things, like PBS, I didn’t understand what that was until you said that right now, they should have explained that to me before all of this [my plan] went ahead” (p8)

- Accessibility
  “I have problems taking it in... it’s best to have things written in the right manner because you have a better understanding then” (p10)

- An Efficient Summary
  “It’s more efficient in it, better that it’s all in one place...... basically it’s like all of that (care plans) but in one thing... explaining things to everyone..... gets on your nerves after a while” (p4)
Evaluation: Service Users Experiences

- How PBS has helped: The benefits of PBS
  - Reflecting on my behaviour
    “You get angry sometimes. It’s just that rage, you don’t care, you don’t think about the pro’s and cons of losing your temper. But now I do. I don’t lose my temper no more..when I was on (PICU) I was.....always head banging, I was fighting, swearing and shouting, chucking things. I stopped doing that now, I don’t do it no more... I have learnt to deal with my anger different now.” (p2)
  - Noticing and wanting to change
    “It’s going to keep me on the straight and narrow...Its keeping me positive. Keeping me focused... because information written down is keeping me on the right track” (p10).

Or not...

“Basically the truth is, I don’t think that it done much for me, what helped me was the tablets that I have been given, and the time that I have had to rest like” (p1)
Evaluation: Service Users Experiences

• Making the Plan Work
  • Staff fidelity to the plan/model

  “People just scan through it and say, yeah I am aware of that, I am aware of that and three, four days later, boom back to normal, like nothing happened....The other day I lost my rag about something and I was immediately followed to my room and it says in [the plan] leave me alone” (p7)

  “(The plan says) If I am unhappy I just go to my room and they just leave me...they are doing that, they don’t mind about that” (p8)

• Keeping the plan alive

  “Obviously I think that it will change with progressing throughout the ward(s)...Well I think [the plan] will be altered...As much as I progress, they can always go back to this plan and pick out parts to avoid coming back.” (p9)
Evaluation: Service Users Experiences

• Implementation
  • Barriers: Staff Resources
    “I think if you’re on a ward and there is three, five, seven or whatever, you know it is not going to take that long to read and I think people should be made to read them to be honest” (p9)
  • Suggested Improvements
    “I think just work more with staff with it, so you can actually see the things being done like and see them taking it on board.... (also) perhaps make it more available to people. Put more things on the walls like on (ward).....-people will know about it then, and if they read it and are interested in it, they will ask more about it then won’t they” (p4).
## Evaluation: Staff’s Experiences - Graeme Karger – N= 11 staff

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Evaluation: Staff’s Experiences

- THEME ONE: THE FUNCTIONS

- Providing Accessible Information

“It’s really helpful to give that broad overview of the person, what’s important to them and how to best support them really…” (Kate)

- Preventing Escalation and Managing Risk

“The people that benefit a lot from it (PBS) are people who are potentially high risk but can be disorganised and can make staff feel quite uneasy. And if staff have a clear way of understanding that person, knowing how to move forward at those times, as de-escalation measures that can be much better than just punitive, say stopping leaves or stopping internal activities and things like that. That can be much better.” (Dale)
Evaluation: Staff’s Experiences

• Seeing the Individual

“I mean it’s written in the first person isn’t it? So I think that’s very important, I think that differentiates it from other documents. Urm, and ………. I think the patient feels less like an object then, ….. less part of ‘the system’ as it were. I think they feel…… It’s more about them and more about their needs. (Robert)

• THEME 2: APPRAISING A NEW APPROACH

• A Positive and Beneficial Approach

“I think it’s been overall very, very positive, it’s been very rewarding, empowering, exciting.” (Michael)
Evaluation: Staff’s Experiences

- A Developing Approach

“It’s (PBS) a newish approach for, certainly for mental health and certainly for forensic nursing…” (Michael)

- Appraised in Relation to Other Approaches

“We used to do care plans where we’d sit round and sort of pontificate about what the patients problems were, where as this much more involves the patient.” (Lindsay)

“It’s difficult for me to say from the work I do how much of any changing in behaviour is directly related to a PBS plan, because there’s other things we’re doing as well” (Helen)
Evaluation: Staff’s Experiences

• THEME 3: COLLABORATIVE CHALLENGES

• Engagement

“If there was something that wasn’t quite right (in the PBS plan) then we were happy to communicate that between each other, we’ve got that kind of relationship where we can, you know, talk quite openly, and take on each others ideas” (Sophie)

• Mental Health

“I’ve tried to interact with him and sort of done the client (assessment) but ……… he had some delusional beliefs, that it was psychoanalysis and that I was doing something detrimental to his mental health. So sadly he didn’t get involved” (Kate)
Evaluation: Staff’s Experiences

• **Insight**

“The guy I’m working with now, … there is no collaboration because he … (believes) he’s a doctor who is in charge of the clinic so it’s very difficult for that sort of conversation, … people would need insight to collaborate…” (Matt)

• **THEME 4: STAFF VARIABLES**

• **Attitudes & Values**

“It (PBS) just cuts against their core beliefs about power, control, ‘I’m the nurse, you’re the patient’ … ‘you’re the criminal, you’re here to be punished’ which isn’t our organisational philosophy at all, … this is a hospital, this isn’t a prison.” (Michael)
Evaluation: Staff’s Experiences

- **Fidelity**

  “…when the wards can be really unsettled, when they’ve got a million things to do, (...) when there’s a crisis situation, which there might be on an ICU ward, ...... you can slip from the sort of plan really, or not have time to go and look at it, so that is a problem.” (Robert)

- **Resistance to Change**

  “I think some people don’t like change and some people just (...) they’ve got their attitudes and set ideas already about it and it’s a bit of a battle to kind of win them over.” (Jeff)
Evaluation: Staff’s Experiences

- **THEME 5: ORGANISATIONAL ISSUES**

- MDT Processes and Involvement

  “It’s a collaborative effort between the staff on the ward and patient obviously, but with a few of us on the clinical team as well, some of the psychologists will actually meet to draft the plan, so I think that really helps so everyone can have input…” (Robert)

- Resources

  “…the less staff we have the less quality of life stuff we can do and I think there is a link between the quality of life and the PBS stuff isn’t there?” (Matt)
Evaluation: Staff’s Experiences

- **Cultural Incongruence**

  “…their liberty is deprived, we can’t do a lot of things they want to do. So obviously there are limits to what you can actually do, even with a PBS plan, because, you know, if they like to go and run on a beach somewhere, their favourite thing to do, well they can’t.”

  *(Robert)*

- **Conclusion**

  Overall, PBS appears to translate into a forensic mental health setting and is generally appraised positively by staff. There are, however, a number of factors that are perceived to impact the delivery of PBS, some of which arise from the unique nature of providing an approach underpinned by social role valorisation in a forensic context.
PBS as an ‘Ethos’

PBS is not just an approach to use with individuals, it is an ethos held within the organisation that results in less violence and therefore a reduced need to use reactive strategies.

- Care and support are focussed on preventing escalation, recognising and de-escalating distress, using the least restrictive options
- Activity and engagement are core to PBS and promote recovery and well-being of service users
PBS is not a Panacea..

- We work in environments where individuals present with risk behaviours and are detained under a section of the MHA for these reasons. We will not prevent violence and challenging behaviour all together.

- When someone is off baseline they may well not want to engage in primary preventative strategies- do you want sit and do crosswords when you are extremely distressed and aroused? Some people will and some won’t.

- If someone is distressed or unwell you are likely to be working more in the secondary prevention and crisis management areas of the PBS plan than the primary prevention.

- If someone is presented with known triggers they may well present challenging behaviours- having a PBS plan does not “inoculate” them from presenting with behaviours in these circumstances but it makes staff aware of how to manage situations when behaviours or early warning signs occur.
Embedding PBS in the Service

- Re-formatted the notes
- Case presentations re: PBS plans
- Interim plans/ grab sheets
- Guidelines re: ABC charts to help motivate staff to complete them
- CTM report (work in progress)
- Meeting to set up active support
- Behavioural specialist on each ward - working to embed the model and link between ward team PBS team
- Using DASA – link to part of plan
Interim Positive Behavioural Support Plan: these are the behaviours that other people may find challenging or risky.

- I may make threats to harm others e.g. “I know people who will break your legs”, “I will fuck off R.C.”. I can also present as threatening non-verbally e.g. staring baring or picking up object.
- I have made allegations about staff.
- Staff have found items e.g. scissors amongst my belongings.
- Staff are concerned that sometimes I facilitate and support other services users with grievances leading to them complaining about issues.
- I have used illicit substances and alcohol in both the community and secure environments including Canwell Clinic. I have done this with other service users too.
- I am keen to develop a relationship in part because I am in hospital. Staff are sometimes concerned about the vulnerability of other service users I may approach and discuss my sexuality with. I may spend a lot of time with them and may pat or touch them (e.g. play footsy).
- I have a history of harm, violence and weapon use but this has not occurred within the clinic.

What are the possible TRIGGERS of these risk behaviours?

Slow triggers:
- Emotional arousal/stress - this can lead to stress and paranoia.
- When I am stressed/ I can become more focused on myself, often refusing food, being hungry and less tolerant at these times.
- I can feel jealous of other service users and the care they are receiving, I often compare myself to them.
- I have had a difficult and chaotic life having both experienced and witnessed abuse. I have been diagnosed as having a personality disorder as a result of the trauma I have experienced. This impacts on my relationships with others and my ability to manage emotions.
- I tend to ruminate on my problems, which makes me more stressed.
- The use of illicit substances and alcohol.
- I have a history and sometimes experience pain from this.
- New or unfamiliar staff on shift. People consider to lack influence or power.
- Unsettled ward environment.
- Leaves increase or getting closer to discharge, plans around discharge, worries about transition.
- Too stimulated or bored.
- Frustration with restrictions and boundaries in the clinic, e.g. searches, 2:1 staffing etc.
- Worry/difficulties in family dynamics.

Fast triggers:
- To be asked to do something I am not happy about, for example body or room searches etc.
- Cancellations and changes to planned activities.
- People being direct or firm, I can feel punished.
- Disagreements with family, staff or peers.
- Not being able to get my needs met or a desired object/outcome or activity. This is especially so if I feel others are getting a better deal.

What is believed to be the possible function of the behaviour?

- I relieve stress and tension.
- I experience pleasure relating to some of my behaviours e.g. reinforcement from young peers, sensory change in substance misuse.
- I avoid transition and discharge.
- I feel valued and respected by my peers.
- I relieve boredom.
- I get my needs met or get desired outcomes.

Primary Prevention: What can reduce the risk of challenging behaviour?

- I am a very sociable person and enjoy banter and jokes with staff and other service users.
- There are a number of staff that I engage well with, and I find it easier when they are the ones who give me feedback and offer me reassurance when I need it. I sometimes struggle when they are not around.
- Boredom makes me dwell on my distressing thoughts, and although it can be difficult at times it’s helpful to try to think of distractions that I could engage in. I might listen to music or find this relaxing. I enjoy my leaves when they are available, I often like to go with other service users for the company. I also enjoy the cafe and talking to my family. I am at the moment finding the 2:1 staffing intrusive however.
- If there is something that I can’t have, if there is a cancellation or change to my care activities please offer me a rationale for the decision, and if possible suggest an alternative time or activity.
- When staff speak to me please use a calm tone and manner, don’t match my mood if I’m not happy. Please show that you are listening to me.
- Please keep me informed of decisions regarding my future and involve me as much as possible in my care. Another consideration no matter how busy is to include me in treatment meetings and discuss my future and involvement as much as possible within the available limits.
- Please help me express my feelings and offer reassurance about any worries or concerns that I have. Reduce the amount of verbal communication be clear and simple. Try and negotiate with me, empowering me with some choice, even if it’s very limited. For example what I could say to the clinic team, possible alternatives. Try to distract me to an alternative activity, and think about whether I might just prefer some space. Make sure I do get lots of praise and reinforcement when I am able to calm down.

Secondary Prevention: What can be done to REDUCE the impact of TRIGGERS?

People can tell when I am stressed because of my facial expression, I look unhappy, my eyes are smaller. I can be louder and swear more. I become more threatening in my stance, I may bang my fist on the table and I may complain to other service users. I may also disengage from staff, refuse to meet or participate in meetings with my team or care related processes. When I am presenting in this way it is important that you remain calm and do not match my mood. Find out what is troubling me, and if possible help me to problem solve. It’s better if a member of staff who knows me well and has a good relationship with me does this, preferably a qualified member of staff too. Currently any such interactions with me are on a 2:1 basis. Listen to me, validate my feelings and offer me reassurance about any worries or concerns that I have. Reduce the amount of verbal communication; be clear and simple. Try and negotiate with me, empowering me with some choice, even if it’s very limited. For example, what I could say to the clinic team, possible alternatives. Try to distract me to an alternative activity, and think about whether I might just prefer some space. Make sure I do get lots of praise and reinforcement if I am able to calm down.

Crisis Management: How to Support me in a Crisis?

If I am feeling particularly agitated, consider the use of PRN medication. I suggest I attempt distractions such as listening to music. Tailing with staff will help, if I engage with this, help me to problem solve. It’s better if a member of staff who knows me well and has a good relationship with me does this, preferably a qualified member of staff too. Currently any such interactions with me are on a 2:1 basis. Listen to me, validate my feelings and offer me reassurance about any worries or concerns that I have.
Clinical notes formatted in line with PBS plans

- **Who I am**: All info about the person e.g. contacts, tidal model and who I am page of PBS plan

- **Clinical Notes**: Running records/ professional notes

- **My Health Needs**: Any physical or mental health related care plans/ info. Medication care plans/details. Health related monitoring

- **Understanding my Behaviours**: Slow triggers/ fast triggers/ relapse indicators. HCR20

- **Primary Prevention**: Activity based care plans, Leaves, Coping or other skill development, Primary prevention section of PBS plan if they have one, Recovery star.

- **Secondary Prevention and Reactive Strategies**: Violence/ self harm/ physical intervention based care plans. Secondary Prevention And Reactive Strategies sections of PBS plan if they have one.

- **Evaluation/ Review**: Details of plan evaluation details. Review dates. Group reports

- **Care and Treatment Plan**: CTPs, No decision about me without me

- **Miscellaneous**: Letters/ reports/ 3rd party info
The aim of this was to develop a ward ethos for the team and to offer guidance to new and relief staff working on the ward. Also to articulate the values and good practice already happening on the ward and not captured elsewhere.

Used interim plan format- asked for slow and fast triggers, primary, secondary and crisis management.

Six service users contributed, in addition, two focus groups of staff (n=14) to co-produce the ward ethos.

Their responses were themed and a poster developed

This will be used in the induction of new staff and service users to the ward.
Examples:

- **Slow Triggers**
  - “*Remember, I am paranoid, these things make it worse:* Staff whispering to each other, staff laughing/joking with each other.”

- **Fast Triggers**
  - “*Disappointments can be difficult to handle:* Delayed/cancelled activities, being declined PRN medication, having to wait for a lighter if it goes off the ward, staff unable to meet service user request due to being allocated to observations, receiving bad news, frustrations due to lack of supplies (medications/food choices etc.).”
Primary Prevention

“Be mindful of our experience of detention; e.g. don't talk about going out on the weekend, wanting to 'get out of here' at the end of the shift or complain about shift patterns etc. Don't talk with us about drugs/alcohol/violence, drinking on the weekend, going out to parties etc. If brought up by us, provide pro-social/health focussed responses and redirect conversation if appropriate. Avoid talking about family life. It reminds us of our lack of contact with our own family.”
Secondary Prevention

“Good quality communication with us means: Consider the best ways of saying things, using appropriate gestures, don’t argue back or shout if we are distressed. We become frustrated if we feel like we are being told what to do or being treated like a child (e.g. being asked to go to bedroom). Consider things that may help with us, offer suggestions and ask us what we think would help.”
Crisis Management

“If an incident occurs: Consider the needs of all of us, i.e. maintain safety by activating alarms, liaise with unit nurse ensure enough staff are available to assist. Consider PRN medication, time off ward or make an alternative area available (e.g. low stimulus, side rooms, courtyard).”
The DASA-IV

• A barrier to the implementation of PBS on the intensive care ward was some uncertainty about when to move from primary prevention to secondary prevention and the use of reactive strategies.

• This led to the continued use of primary prevention strategies with individuals who were acutely distressed or emotionally aroused, where the strategies highlighted under secondary prevention would have been more applicable.

• People became frustrated with the model and developed views that PBS did not work.
The Dynamic Appraisal of Situational Aggression (DASA-IV) (Ogloff & Daffren, 2006) was implemented to help predict the likelihood of violence/aggression over a 24 hours period.

The DASA –IV consists of 7 of factors which are most strongly correlated with violence/aggression in the short term:

- Irritability
- Impulsiveness
- Unwillingness to follow instructions
- Sensitivity to perceived provocation
- Easily angered when requests are denied
- Negative attitudes
- Verbal threats.

Score 0 or 1 for each
DASA-IV

- A score of 0-1 indicates low risk, 2-3 moderate risk and a score of 4 or more is predictive of high risk for violence/ aggression.

- A set of guidelines was written to match DASA-IV score with PBS interventions
  - 0-1 supports the use of primary prevention strategies
  - 2-3 secondary prevention strategies
  - 4 or more indicates the need for reactive strategies

- This intervention enables clearer links between service users’ behaviour and the PBS model and offers guidance to staff, advising them on the level of support, and section of the plan, they should be implementing based on a service users behaviour.

- Yet to be evaluated
What next????

- We are in the process of testing a “Forensic Functional Assessment Measure” (FFAM)- This is a functional assessment interview tool developed specifically for the forensic population. Hoping to go to publication with this in the next 2 months.

- We have collected data from focus groups of staff about their experiences of PBS to see how we can improve its implementation. This is currently being analysed.

- We have developed a service user questionnaire and have been collecting comments- we hope to look at this in the new year.

- Our first behavioural specialist has completed her course, four others will finish over the next 2 months.
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.
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:

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

- 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:

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>30</td>
<td>2</td>
</tr>
<tr>
<td>Management Dif</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Severity</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

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


Thank You

• Any questions?

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