So you have a quality positive behaviour support plan. Job done!

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Is the job done?

Source: PNG Image
The quality of a positive behaviour support plan is integral as plan quality is directly linked to the effectiveness of positive behaviour supports, and outcomes for the individual. Measures of quality positive behaviour support plans include;

- Positive Behavior Support Assessment Guide (Kroeger & Phillips, 2007)
- Behavior Intervention Plan Quality Evaluation Scoring Guide II (Browning-Wright et al, 2013)

While the BSPQEI has acceptable psychometric properties, applying the tool in practice has proven challenging. In particular, a great deal of prior training and practice is required to use the tool reliably.
Are Positive Behaviour Support Plans Effective?

Skills of those who are formulating positive behaviour support plans

Inadequate functional behavioural assessments conducted

Plans often lack the detail needed to deliver the intervention comprehensively, therefore the PBS was not delivered as intended.

Best practice inadequately included

Majority of plans are inadequate

Plans are unreadable/incomprehensible

Clinical outcomes of staff training in positive behaviour support to reduce challenging behaviour in adults with intellectual disability – Hassiotis et al, 2018
Implementation needs to be attended to because....

Poor quality plans can be implemented well
AND
Quality plans can be implemented poorly

Thus, we need effective plans that are implemented well – quality as well as fidelity
Attitudes and Skills
Towards the behaviour based on the beliefs acquired through learning and experience.

Acceptability: the perception that an intervention is agreeable
Appropriateness: The perceived fit or relevance of the intervention in a particular setting or for a particular target audience

Subjective norms
What the person perceives to be the beliefs and values of others (inc. important others).
Acceptability: the perception that an intervention is agreeable
Appropriateness: The perceived fit or relevance of the intervention in a particular setting or for a particular target audience

Perceived/actual behavioural control
Beliefs about how difficult it will be to perform the task or the resources and opportunities available to the person.
Implementation cost: the cost of the implementation strategy for the intervention
Feasibility: The extent to which an intervention can be carried out in a particular setting or organization
Sustainability: The extent to which an intervention is maintained in a given setting

Intention
To adopt an intervention or action

Behaviour
Actual practices and outcomes
Fidelity: the degree to which an intervention was implemented as designed/intended
Coverage: The degree to which the population that is eligible to benefit from an intervention actually receives it

Barriers to Implementation

Staff report not enough time, resources, support from management to implement plans

Duration of intervention delivery and competing clinical and other responsibilities

Staff not utilising the mentoring and other supports available to them.

Lack of mentoring and supervision in positive behaviour supports

Paid carer turnover rates

Low staff levels and high caseloads

Participant/family did not want to engage or preferred other interventions/strategies

Organisational issues/barriers/workload pressures

Absence or mild/infrequent challenging behaviour
Enablers to Implementation

A focus on the environmental context of the person – systems change rather than a focus on individual change

Full, early and continued involvement of key people, such as staff teams

Those who are implementing the plan have the skills and resources to implement it, believe it will be efficient and effective, and in the best interests of the person, and have values consistent with the plan*

Training that is person-focused and “longitudinal” – for the right people and of sufficient duration

Supported implementation as part of the training process

Availability of practice leaders in PBS in the workplace

Ongoing mentoring and supervision in positive behaviour supports

*Only treatment acceptability was found to be related to decreases in behavioural frequency (McLean & Grey 2012)
The Effect of Training on Positive Behavior Support Plan Quality

Significant differences in knowledge acquisition pre-training and post-training

Significant differences in staff attribution to challenging behaviour

Significant increases in plan quality scores

Self-efficacy

Ability of frontline staff to implement functional assessments, design plans and bring about reductions in CB

McLean, B & Grey, I. (2012). A component analysis of positive behaviour support plans
Wardale, Davis, Carroll & Vassos (2014). Outcomes for staff participating in positive behavioural support training
Wardale, Davis & Dalton (2014). Outcomes for staff participating in positive behavioural support training in a secure forensic setting
The outcome of a statewide audit of the quality of positive behaviour support plans (Wardale, Davis, Vassos & Nankervis, 2018)

Background:

- Regardless of plan quality, interventions may not be implemented properly if staff do not understand the content.
- The implementers of PBSPs are rarely the clinicians/authors of such plans.
- App. 75% of direct care staff hold only secondary or vocational level qualifications.
- The reading level of PBSPs range from 12th to 16th grade level with an average of 14th grade (university undergraduate degree level).
- PBSPs can be lengthy and contain sophisticated and specific behavioural terminology.
- The BSP-QEII does not assess whether information is presented in a way that is readily accessible by the user, particularly those without advanced literacy skills.
Focus of the Research

• A review of positive behaviour support plans in relation to:
  
a) The plan’s technical completeness in relation to behaviour change technologies and clinical logic (BSP-QEII) and
  
b) The plan’s readability for those with a vested interest in the plan

• N=139 plans reviewed
• Plan length ranged from 1 to 109 pages
• Majority of plans were written by agency staff (allied health staff, front line team managers with diploma level qualifications)
• Other plans were written by independent consultants, government clinicians
• Readability was assessed using the Flesch Kincaid grade level score and the Flesch Readability statistics, available in Microsoft 10.
• An ideal Kincaid score is between 7 and 8 (accessible to 7th and 8th graders), and a higher Flesch Readability score indicates the document is easier to read. An ideal score is between 60 and 70
• The readability assessment was conducted on the “functions of behaviour” and “strategies” sections of the plans
Readability and Grade Level

Methodological Approach

Implementation science is the scientific enquiry into the act of bringing about change into effect. In the case of the present study, the intent is for legislation, policy and best practices in differentiating the methods of instruction for students with disabilities. Implementation research looks at the processes of implementation and the results of implementation, and introduces potential solutions (Peters, Adam, Alonzo, & Arvadera, 2010).
Results

Quality of Plans
• Total scores for the 139 plans ranged from 0 – 16 (mean score = 6.53)
• Total plan scores were not significantly different across author types
• Those developed for legislative authorisation requirements were found to be of higher quality with a significant difference

Readability
• On the Flesch Kincaid scores the plans required a reader to have 13 years of education in order to understand them
• Plans developed by independent consultants scored significantly higher than other plan developers
• Flesch Readability scores for the strategies sections (m=38.48) and the functions of behaviour sections (m=30.85) were well below the recommended 60-70 score range
The “Getting Run over by a Bus” Principle of Plan Development
Further Research and Development

The development of a short form quality audit tool for Positive Behaviour Support Interventions – the BSPA-tool

The BSP-QEII, appears more applicable for use by professionals with expertise in PBS and ABA, as opposed to the wider stakeholder groups that play a significant role in reviewing and implementing behaviour support plans (e.g., family members, other professionals, etc.).

The lack of a tool that can be used by non-clinician stakeholders is a gap in ensuring quality positive behaviour supports and in the safeguarding of the rights and safety of people who engage in challenging behaviours.

Such an instrument has potential applied utility in assisting families, advocates, organisations and support staff to critically evaluate proposed interventions within behaviour support plans.

The Behaviour Support Plan Audit-tool is an abbreviated positive behaviour support quality audit toll based on the BSP-QEII.
Initial Findings

The pilot reliability study assessed:

- parallel-form reliability,
- test-retest reliability, and
- inter-rater reliability.

The pilot study demonstrated parallel form reliability, test-retest validity, and inter-rater reliability of the *BSPA-tool*.

Further investigation of the *BSPA-tool* will be need to be undertaken to:
1. Ascertain the psychometric properties of the tool (reliability and validity)
2. Identify whether it can be used by non-clinicians
3. Identify the minimum training requirement for non-clinicians to use the tool
4. Ascertain user acceptance of the tool
Thank you and Questions

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References


