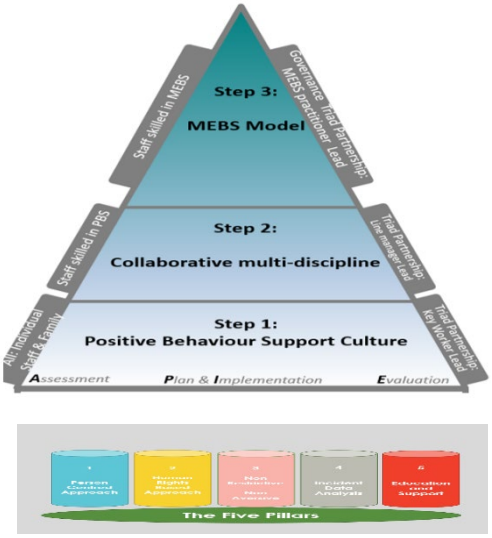
Saint John of God Community Services clg.

Positive Behaviour Support Policy

(Children and Adults Intellectual Disability)



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SJOGCS08 Positive Behaviour Support Policy (Children and Adults Intellectual Disability)

Document Reference No.	**SJOGCS08**
Revision Number	4
Approval Date	April 2023
Due for Revision	April 2026
Document drafted by	Policy Working Group (as listed in Appendix 13)
Document reviewed by	Quality and Safety Sub-Committee of the Board of Saint John of God Community Services clg
Document Approved by	Board of Saint John of God Community Services clg.
Responsibility for implementation	Director(s) and Designees
Responsibility for evaluation and audit	Director(s) and Designees
Number of Pages	Policy including Appendices – 70 pages Policy – 34 pages Appendices – 36 pages

Document Review History		
Review Date	Reviewed by	Signature
February 2022 – March 2023	PBS Policy Working Group	

Document Change History	
Change to Document	**Reason for change**
Main points: • New term introduced 'Behavioural support need' in line with HSE document; • Symbol for PBS is now agreed. • Five Pillars is clearly outlined as a pre-requisite with a graphic now in place. • Using Your Environment (and other quality of life tools) can also be used at STEP 1. • 12 key components of PBS are outlined. • ADM is outlined in Section 6. • Multi-disciplinary input in relation to a behaviour support plan can be evidenced by signatories on a behaviour support plan. • Terms of Reference for the PBSC were updated. • Based on assessment a clinician may decide that PBS is or is not required for the behavioural support need and will offer a more suitable alternative, and the PBS policy will not apply. • Easy read document received input from adults supported in DSE and Liffey Region. The Appendices contains additional information, all of which will be available on the intranet. This policy will be updated in 2025 or sooner in accordance with national policy.	Policy due for review and was reviewed using the 'A rights based approach to behavioural support HSE Guiding Principles'

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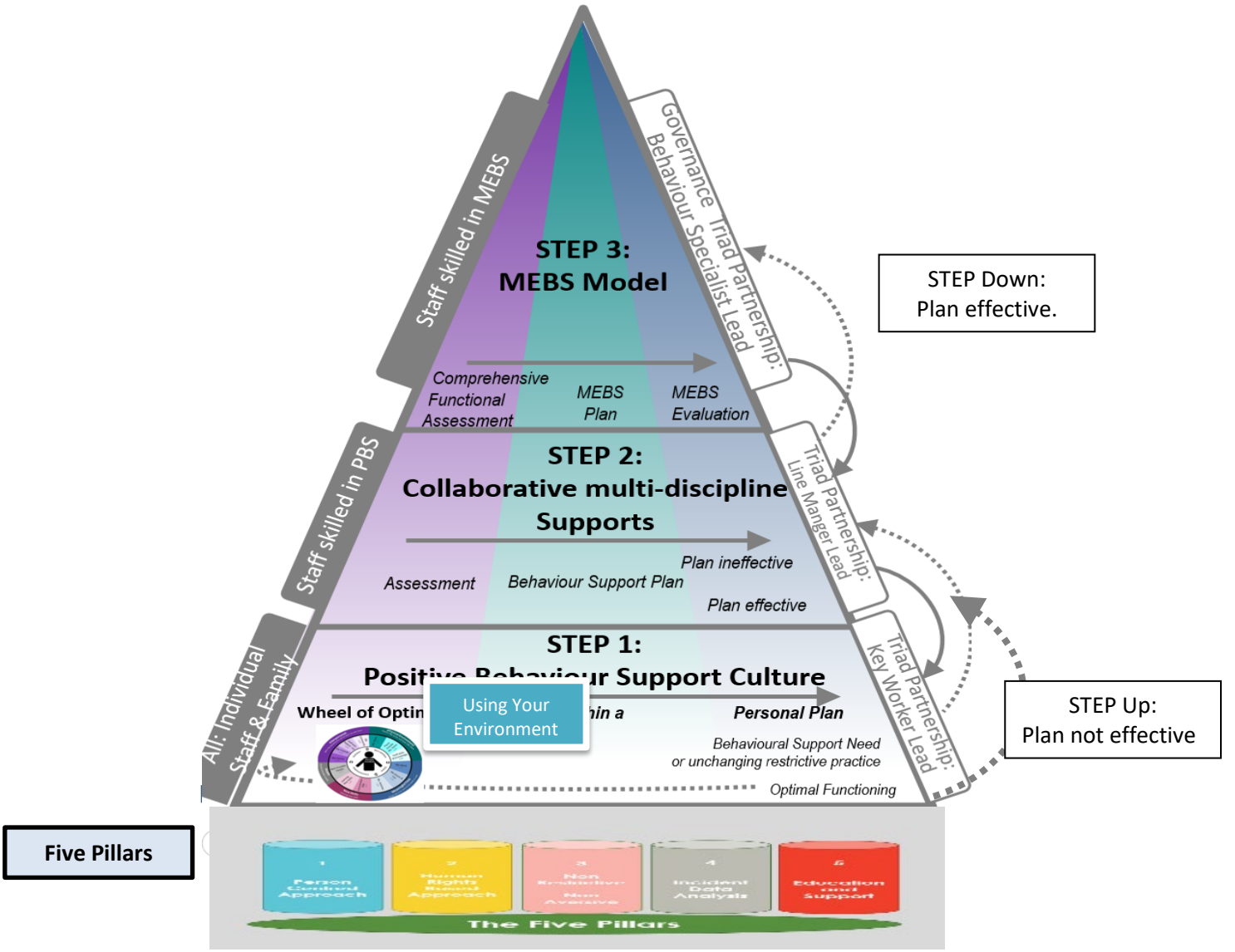


3-Step Model of Positive Behaviour Support

Quick Guide: This 3 Step model of PBS sits on 5 pillars; before implementing STEP 1; each pillar should be reviewed to see if the behavioural support need can be supported by reviewing the

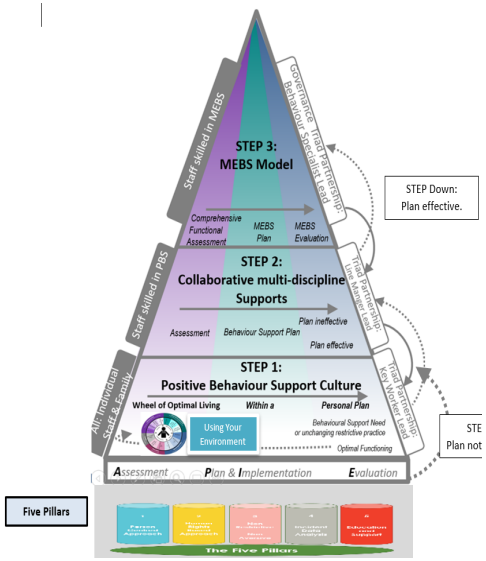
1. Personal Plan (which includes the person-centred plan, and the personalised care and support plan (which includes the person's communication documentation e.g., Triple C Profile/Communication passport/Communication Profile. Communication strategies should also be reviewed as part of this process).
2. Human Rights Based Approach (review any rights issue that may be causing distress for the individual,)
3. Ensure the use of non-restrictive and non- aversive supports.
4. Review and analyse incident reports to assist in understanding the function /message.
5. Consider if staff support and education in the area of Positive Behaviour Support might help.

If after this review, the behavioural support need is still not understood, use the Wheel of Optimal Living or Using Your Environment or alternative person-centred quality of life tool. A referral can be made to the MDT (STEP 2) with the individuals consent if the behavioural support need is not reducing and/or a restrictive intervention has been used and/or there is an imminent risk of serious harm.

Positive Behaviour Support Flow Chart (local procedures can be attached, if required)

START

Behavioural Support need identified.



Behaviour Report Form Completed by staff and/or

Adverse Incident Form (NIRF/NIMS)

and/ or Safeguarding Form

and /or Risk Assessment (If PBS plan available review it)

(If required)

Safeguarding Referral

Restrictive Practice Notification

Serious Incident Management Policy

1. Behaviour Report Form (and NIMS/NIRF) received by the Line Manager, for assessment, review, forwarding and filing.

2. Recommendations noted and communicated to the team by the Line Manager.

Notifications and Reporting Procedures completed to:
Legal and Statutory Authorities e.g. Family, HIQA, Garda, Designated Officer

Local Service Committees, e.g., PBSC, Equality and Human Rights Review Committee, Restrictive Practices Committee; Quality and Safety Committee etc.

If the behavioural support need is on-going and /or If Restrictive Practices are used,
Review the five pillars and then proceed to STEP 1: PBS: Wheel of Optimal living and/or USING YOUR ENVIRONMENT. Note: A STEP 2 referral can also be made at this time.

Positive Behaviour Support Committee Supports this process

Quality and Safety Committee

1. Introduction

Saint John of God Community Services clg. (SJOGCS) provides a range of services to both children and adults with Intellectual disabilities in residential, day and respite services. SJOGCS's values of Hospitality, Compassion, and Respect, underpin all activities related to service provision and individual support. This policy aims to promote the provision of Positive Behaviour Support and the realisation of individual rights and support each Individual in the context of their family life, their natural support network, and their community.

2. Policy Statement

SJOGCS is committed to providing Positive Behaviour Support with individuals (children and adults) with intellectual disability and behavioural support needs which is in keeping with the HSE Guiding Principles of 'A Rights Based Approach for Behavioural Support'. This SJOGCS policy advocates Positive Behaviour Support (PBS) and the application of the PBS 12 principles. The Multi-Element Behaviour Support (MEBS) Approach, MEBS Model and MEBS Plan evidences a comprehensive and structured application of Positive Behaviour Support. For many years now, SJOGCS has been committed to MEBS for the provision of Positive Behaviour Support. SJOGCS is committed to supporting individuals with their optimal lifestyles and to provide all support together with the individual using non-aversive and non-restrictive strategies.

3. Purpose

The purpose of this policy is to ensure a collaborative, preventative, integrative and consistent approach in supporting individuals both children and adults who may be at risk of or present with behavioural support needs within SJOGCS.

This policy is based on the following statements of good practice:

3.1 A behavioural support need can arise when an individual has additional support requirements. It is expected that a Person-Centred Planning (PCP) process (e.g., using the five principles of a Person-Centred Approach) as part of the personal plan will be used to achieve the desired lifestyle or optimal functioning level for the individual. If this is inadequate or unresponsive, a behavioural support needs may arise.

3.2 This policy advocates that the 12 principles of Positive Behaviour Support are used for behavioural support needs.

3.3 This policy also seeks to ensure a human rights-based approach in supporting each individual, others sharing their environment, including those responsible for supporting them. It does this while ensuring best practice within the current legislative and regulatory requirements.

4. Scope

This policy will support children and adults with intellectual disability who receive residential, respite or day supports /services including children's outreach services from SJOGCS.
This policy is for all staff / volunteers working in residential, respite and day services for adults and children with intellectual disability in SJOGCS and will also be a reference guide for interagency working as required. (For example, Young Adult Teams, MHID, HSE Disability Services.)

This Positive Behaviour Support policy is not intended for children attending Saint John of God schools. However, it is best practice and should be used as a reference where appropriate.

SJOGCS Children's services will work collaboratively with schools (together with the family) and multi-disciplinary teams (for example the Children's Disability Network Team, School age team, early intervention) and/or other agencies to ensure a sharing of information for assessment, planning, implementation, and evaluation of Positive Behaviour Supports for children with behavioural support needs in their services. NOTE: in line with GDPR a data sharing agreement will be required as part of ongoing and frequent interagency working.

5. Definitions

5.1 **Behavioural support is defined** as using a 'Human Rights informed, evidenced based behavioural support model in a compassionate, empathic and collaborative way to understand the needs and concerns of the person and provide supports that are liked and agreed to by the person in order to achieve valued outcomes for everyone involved.'

Behavioural support may be required if a behavioural support need arises i.e., a person's behaviour is interfering with their ability to maintain their relationships; interfering with their ability to engage in a meaningful life and interfering with their ability to express themselves in ways that do not cause themselves or others harm. Behavioural support may also be required if there is an area of concern of imminent risk of serious harm and /or a restrictive practice is either being considered or has been used.

(Reference: A Rights Based Approach to Behavioural Support Guiding Principles Guiding Principles Subgroup Policy: Provision of Behavioural Support - Schedule V no. 5 Health Care Act 2007, Regulations 2013. Version 1. Approved by the Independent Governance Review Group HSE July 23, 2020)

5.2 **Functional Approach:** A functional approach is best understood as completing an assessment to find the function, reasons, or 'message' of the behavioural support need. Traditionally we talked about what the behaviour looked like, for example, hitting self in the face, refusing to get off the bus, cowering, crying, pushing another person, using the toilet 4 times an hour. In the past individuals were described in terms of their behaviour; for example, 'he is non-compliant', 'she is anxious all the time', 'he engages in self-injurious behaviour' with a focus on getting the behaviour to stop without necessarily understanding the reasons or function, i.e., what the individual was trying to communicate through their behaviour. Positive Behaviour Support considers the reasons why 'a behavioural support need is occurring', this is called 'using a functional approach'.

5.3 **Positive Behaviour Support Approach** Positive Behaviour Support (PBS) is defined as an application of the 12 key components outlined below which are informed by person-centred values and behavioural technology and to understand the function or reason for a behavioural support need. Once the function or reason is identified, a Positive Behaviour Support Plan is developed and implemented. The uniqueness of PBS lies in the fact that it integrates these 12 key components into a cohesive whole. (Gore et al 2022)

12 Key components of PBS (Gore et al, 2022)	
Rights and Values **A focus on rights and good lives for people with intellectual disabilities and those who care for them.**	1. Person Centred Foundation.
	2. Constructional approaches and empowerment.
	3. Partnership working with Stakeholder Involvement
	4. Elimination of Aversive, Restrictive and Abusive Practices.
Theory and Evidence Base: Understanding behaviour, needs and experience	5. A biopsychosocial model of behaviour.
	6. Behavioural Approaches to promote learning, doing and interacting.
	7. Multi-Professional and cross discipline approaches.
Process and Strategy. A systematic approach to ensuring high quality support	8. Evidence informed decisions. Data driven approach.
	9. High Quality Care and Support Environments
	10. Functional assessment
	11. Multi-component PBS Plans
	12. Implementation, monitoring and evaluation.

5.4 STEP 1 of the 3-step model of PBS: Step 1 May be required if an individual has behavioural support needs that are infrequent yet when they do occur, they interfere with their ability to maintain their relationships; interfere with their ability to engage in a meaningful life and interfere with their ability to express themselves in ways that do not cause themselves or others harm. The keyworker takes the lead here and together they review the five pillars, namely the 'Personal Plan (including Communication Documentation) Human Rights Based Approach, Non-aversive non-use of punishment, incident reports and education and support' to review if additional supports are required and then the Wheel of Optimal Living is completed or a review of the USING YOUR ENVIRONMENT or other person-centred quality of life tool occurs.

Note: A member of the MDT may consult at Step 1 in order to support the Wheel of Optimal and/or USING YOUR ENVIRONMENT or other person-centred quality of life tool.

- **Wheel of Optimal Living** (WOL) includes the five key dimensions of optimal living, dimensions that each of us can identify with as being important to live a good life: namely, interpersonal, physical environment, health, skills, and meaningful time. It has at its centre the principles of choice, communication, inclusion and non-aversive and comes with a set of prompts and resources. It evidences the 12 principles of Positive Behaviour Support, based on the individual's needs including a consistent response when the behavioural occurs (based on the review of behaviour report forms for example) that meets the individual's request/need and/or wishes. WOL can be used at STEP 1 when a behavioural support need arises or to prevent behavioural support needs from arising. It is implemented as part of an individual's personal plan. It can be used with or without the USING YOUR ENVIRONMENT tool or an alternative. (Person centred quality of life tool)
- **Using your Environment as part of My Personal Plan:** Using Your Environment Assessment is a person-centred planning assessment to support the person to discover, plan and achieve the life they want to live. The aim of the Using Your Environment assessment is to support the individual to develop a person-centred plan. This is completed through gathering information on what is important to the individual; their dreams, hopes and wishes as well as the skills, activities, and roles that they currently do and those they would like to be able to do going forward – it can enable the individual to create their Life Vision, identify their outcomes and set meaningful goals. USING YOUR ENVIRONMENT can also be used /reviewed at STEP 1 of the PBS policy to discover if any aspect of the USING YOUR ENVIRONMENT may assist in supporting a behavioural support need. It can be used with or without the wheel of optimal living.

5.5 STEP 2 (of the 3-step model) and Multi-discipline and Collaborative Working and Positive Behaviour Support: If a behavioural support need is unchanging or a restrictive practice has been used or there is an imminent risk of serious harm in relation to behavioural support a referral to STEP 2 Positive Behaviour Support can be made as per your local procedure.

Positive Behaviour Support uses a multi-theoretical approach where various disciplines (PBS Practitioner, Psychology, Social Work, Occupational therapy, Psychiatry, Social care, Healthcare assistants, Physiotherapy, Speech and Language Therapy, Nursing) work together as required to apply the 12 principles of Positive Behaviour Support, through assessment, design of the Behaviour Support Plan (PBS Plan or MEBS plan can be used at STEP 2)-, implementation, and evaluation. It is recognised that some disciplines will have significant expertise in PBS. These practitioners are likely to have a role in coordinating the PBS supports. All contributors (including clinicians, keyworker, individual supported) should sign the plan as appropriate.

- **Behaviour Support Plan:** This policy uses the term Behaviour Support Plan to mean either a Positive Behaviour Support Plan or a MEBS plan. The **clinician writing the plan** will identify what type of intervention of Positive Behaviour Support is required i.e., Positive Behaviour Support Plan or a MEBS plan based on presenting issues and/or efficacy of interventions used to date. *A PBS plan or a MEBS plan can be provided at STEP 2, only a MEBS plan is recommended at STEP 3.*

- **Positive Behaviour Support Plan** has proactive and reactive strategies, all of which are functionally informed/ functionally based, non-functionally based, non-aversive and non-restrictive (see Appendix 10 for definitions). A Positive Behaviour Support Plan is multi-component, and it can consider environmental supports, skills teaching, antecedent interventions and reactive strategies, and other interventions including system change strategies and support for staff and family, all informed by the biopsychosocial assessment.

5.6 STEP 3 (of the 3-step model) Multi-Element Behaviour Support Model: The Multi-Element Behaviour Support (MEBS) Model is a comprehensive and structured model applying the 12 key components of Positive Behaviour Support. The uniqueness of this model lies in the comprehensiveness of the assessment (process, content, and materials), the development of a MEBS plan (which meets clear criteria, including the use of functionally based and/or non-functionally based, non-aversive and non-restrictive reactive strategies.), implementation and monitoring using the Periodic Service Review and evaluation across 6 outcome measures. STEP 3 of SJOGCS Policy is aligned with the MEBS Model.

5.7 MEBS Approach: A MEBS approach is best described as

- Using an assessment across a number of areas (for example, communication documentation, sensory profile, cognitive profile, heath profile, environmental profile, life story profile including a functional assessment) to formulate a bio-psycho-social and environmental understanding of the behavioural support need.
- A MEBS Plan (meeting the key criteria identified below)
- The use of a Periodic Service Review.
- Evaluation across a range of outcomes.

If these four criteria are not in place, a MEBS approach has not been used.

MEBS Plan: A MEBS plan has as a minimum the following 4 criteria:

- Long-term and short-term goals with data collection methodology.
- Minimum of 7 interventions as outlined below.

Proactive Strategies				**Reactive Strategies**
Environmental (x 1)	Skills (x 4)	Focused Support (x 1)		Reactive Strategies (x 1)
At least one intervention in one of the following areas: • Physical • interpersonal, • programmatic environment(s)	One skill in each of the following areas: • General Skill • Functionally Equivalent Skill. • Functionally Related Skill • Coping and Tolerance Skill	At least one intervention for example, antecedent control, reward contract, stimulus change/control; satiation.		At least one reactive strategy designed to reduce episodic severity, which is functionally based/functionally informed and non-aversive /non-restrictive. Non-functionally based reactive strategies (which are non-aversive and non-restrictive) can also be used when they reduce episodic severity.

- Mediator analysis and supports outlined.
- Periodic Service Review (with performance definitions) to monitor implementation and evaluation.

If these 4 criteria are not met, a MEBS plan is not in place. A PBS plan may be in place.

5.9 Restrictive Practice: Restrictive practices are defined as 'the intentional restriction of a person's voluntary movement or behaviour'. S.I. 367 of 2013 The Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013

Restrictive practices include:
Physical and Mechanical Restraint: Physical restraint is any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot easily remove that restricts freedom of movement or normal access to one's body. (HIQA 2019)

Environmental restraint is the intentional restriction of a resident's normal access to their environment, with the intention of stopping them from leaving, or denying a resident their normal means of independent mobility, means of communicating, or the intentional taking away of ability to exercise civil and religious liberties. (HIQA 2019)

Medication used as a restraint, which is the intentional use of medication to control or modify a person's behaviour or to ensure a patient is compliant or not capable of resistance, where the treatment is not necessary for a condition.

If a restrictive reactive strategy or any restrictive intervention is included as part of the behavioural support recommended- this can be noted by the lead clinician e.g., they might state:

- This plan is a Positive Behaviour Support Plan (or a MEBS Plan) designed to achieve the following desired outcomes for the individual (and their family, circle of support) (list)
- this plan and/or consultation note also includes on a temporary basis the following restrictive practice(s) (name them here) with a clear protocol attached as an appendix.
- The plan/consultation note includes interventions, supports (e.g., skills, adapting the environment, direct interventions and reactive strategies) and actions designed to also reduce/remove the use of the restrictive practice and as such is reviewed by the clinician with the individual and monitored by the clinical governance process (including due process review Equality and Human Rights Committee) for an 'area of concern of imminent risk of serious harm' relating to a behavioural support need.
- *A restrictive intervention is reviewed at a minimum once every three months.* If this time frame is not appropriate the review should occur within a time frame agreed with the individual and the team (including MDT as appropriate) and outlined in the plan. If the restrictive practice is not required within a 3-month time frame the restrictive practice is removed from the individual's behaviour support plan.

6. Assisted Decision Making (ADM) in the context of Behavioural Support

SJOGCS respects an individual's right to make decisions and are implementing all policies to reflect this position in line with the Assisted Decision Making (Capacity) Act 2015.

Capacity and information have been identified as elements important to informed consent. Informed consent is central to all assessments and supports provided as part of behavioural support under the SJOGCS Positive Behaviour Support Policy.

Capacity refers to the ability of the individual to engage in the decision-making process. (Aka decision making capacity) 'Information' concerns the individual's access to the facts necessary to make a decision and the person's ability to understand the facts and circumstances relevant to a given situation/decision. All information related to any specific decision must be presented to the person in a medium the person understands, in line with the guiding principles listed below.

Assisting Decision Making must be in line with the Nine Guiding Principles of the Act which are:

1. Presume every person has the capacity to make decisions about their life.
2. Support people as much as possible to make their own decisions.
3. Don't assume a person lacks capacity just because they are making, have made or are likely to make what might be considered an unwise decision.
4. Only take action where it is really necessary.
5. Any action should be the least restriction on a person's rights and freedoms.
6. Give effect to the person's will and preferences.
7. Consider the views of other people, where necessary.
8. Consider how urgent the action is.
9. Use information appropriately.

For informed consent the individual must demonstrate that they can:

- Understand the information relevant to the decision in question.
- Retain that information long enough to make the decision.
- Use or weigh that information as part of the process of making the decision.
- Communicate his or her decision.

If Decision Making support is deemed to be required- refer to HSE National Consent Policy /SJOGCS and/or HSE (including Decision Support Service) resource when available.
www.decisionsupportservice.ie

Behavioural support also considers other individuals, for example peers, staff, family members who live with/spend time with an individual with behavioural support needs. Where an individual declines behavioural support (either through assessment/plan) this will be acknowledged and the needs of others for example, the individual's sharing the environment, staff will be considered and supported in line with all relevant policies, Supports Policy, Risk and Safeguarding, Violence Harassment and Aggression in the work place, Complaints Policy and evidence the decision-making process.

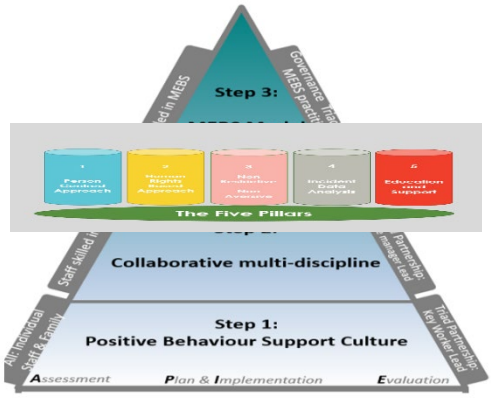
The ADM 2015 does not apply to children however, all children have the right to express their views freely with their views being given due weight according to their age and maturity. In order to realise their rights, children with disabilities must be provided with disability and age-appropriate assistance (HSE National Consent Policy, 2022)

Where children are unable to give valid consent for themselves, they should be as involved as possible in the decision-making process. Even very young children may have opinions about their healthcare and have the right to have those views taken into consideration. This is in line with the Irish Constitution and UNCRC. (In SJOGCS Policy on Children's Rights and specifically Lundy's model of Participation in Decision Making)

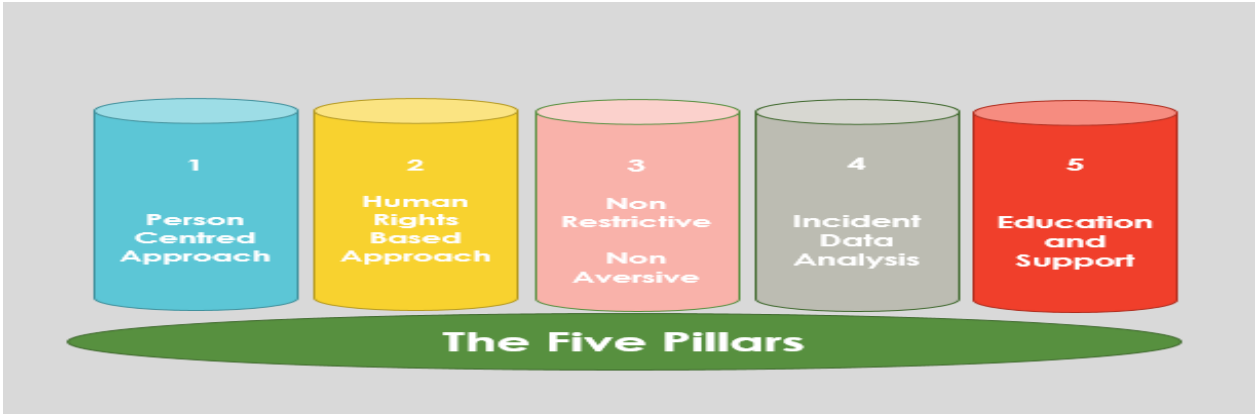
7. Structure and Foundations of this Policy

This policy sets out the use of a 3-step approach for the provision of Positive Behaviour Support. This 3 Step Model recognises a step up and/or a step-down approach in the level of support an individual may require. Each step uses APIE – Assessing, Planning, Implementing and Evaluating to ensure evidence-based practice. These three steps sit on five pillars, which underpin the SJOGCS PBS policy and are attended to in the context of understanding a behavioural support need:

1. Being person centred and using a person-centred approach (as evidenced in the Personal Plan and Life Vision).
2. Using a Human Rights Based Approach.
3. Non-restrictive and non-aversive practices in support of behavioural support needs.
4. Incident Data Analysis, risk assessment and safeguarding practice.
5. Education and support for staff (and family as appropriate).



The Five Pillars



7.1 Using a Person-Centred Approach

SJOGCS advocate and use a person-centred approach in all areas of our support with children and adults with behavioural support needs. This is evidenced in an individual's personal plan and in their communication documentation. We listen to and include the individual as we identify strengths, and skills and find possibilities and solutions to improve skills and life outcomes to support each individual as they strive to contribute to their own lives, their family, and their community. Both policy and the evidence base are clear that effective services start by listening to the individual, their needs, wishes and aspirations, and then planning, advocating, and designing services around these.
Effective Person-Centred Planning (as per *SJOGCS Person Centred Approach Policy 2021)* is considered to be the best way of achieving success – and thus is at the heart of staff practice and service provision.

Evidenced by: Each individual has a personal plan based on their Life Vision, informed by the five principles of a person-centred approach. The personal plan is reviewed to see if any additional supports can be provided to assist with the behavioural support need.

7.2 Human Rights Based Approach

SJOGCS advocates and uses a Human Rights Based Approach (HRBA). A HRBA is an established framework and set of guiding principles for ensuring that human rights are upheld *(SJOGCS Policy on Equality and Human Rights (Promotion and Protection)* for individuals with behavioural support needs and those supporting them and that the link between personal plans (using Person Centred Planning) and a HRBA is firmly established. In order to do this, it is proposed that personal plans and services are provided in accordance with a person-centred approach and the five HRBA principles. These principles, defined in the context of their relevance to a person-centred approach, are listed below.

1. **An Expressed link to Human rights**– Human rights must be at the heart of policymaking and service delivery. Approaches should be in line with the legal rights set out in Irish and international laws. This includes identifying and naming the rights that the person may not be supported to exercise or that may be restricted and evidencing a commitment to enabling an individual to hold said rights. Individuals supported are 'rights holders.
2. **Participation** – Everyone is entitled to active participation in decision-making processes which shape their lives and affect the enjoyment of their rights. Each individual must know what their rights are, be supported to understand them if necessary and can influence decisions affecting them.
3. **Accountability** – Those responsible (duty bearers) for respecting, protecting, and fulfilling human rights must be accountable for their actions or their failures to act. There should be effective strategies in place to identify rights infringements and remedies in place when human rights breaches occur. This includes advocating with the person.

4. **Non-discrimination and equality** – All individuals are entitled to their rights without discrimination of any kind. A HRBA requires that laws and practices guarantee full and equal enjoyment of human rights to vulnerable groups on the same basis as anyone else. In order to achieve this, these groups may require a special focus. All types of discrimination should be prohibited, prevented, and eliminated.
5. **Empowerment** – Everyone is entitled to claim and exercise their rights. People must be educated about their rights, equipped with the necessary skills to claim them, and participate in the development of policies which affect their lives. This represents a shift from models which see people as being in need or as passive recipients of charity, but instead views them as people empowered to claim their rights.

Evidenced by: Each individual has a personal plan which includes a Rights Review (guided by a Human Rights Based Approach) as outlined in the Convention on the Rights of Persons with Disabilities (United Nations, 2006) & Convention on the Rights of the Child (1990). The rights review is reviewed to see if any additional supports can be provided to assist with the behavioural support need.

7.3 Non-Restrictive and Non-Aversive Practices in meeting Behavioural Support Needs

It is the policy of SJOGCS that behavioural support evidence a commitment to the non-use of aversive, punishment based and restrictive strategies, where possible. A non-restrictive strategy, also referred to as a non-right's restrictive strategy, is a strategy which does not restrict a human right as interpreted through the *Universal Declaration of Human Rights* (UN, 1948). Some examples of restrictive strategies are physical restraint, mechanical restraint, medication used as a restraint, environmental restrictions (e.g., locked doors), limited access to money or punishment-based strategies (such as a personal item being taken away). This list is not exhaustive, and each strategy must be evaluated to see if it could be considered restrictive. This is of particular relevance to staff as they respond to a behavioural support need. A non-aversive strategy is usually understood as a strategy that is preferred and not aversive to the person.

Non-restrictive strategies place priority on understanding the function of the behavioural support need and building all supports around this.

As such, evidence shows that the severity of a behavioural support need can be reduced, and the individual's behavioural support need calmed by using non-aversive and non-restrictive strategies. This can include the use of functionally based reactive strategies, which means listening to the individual and honouring the request for example, offering a preferred item. In the short-term this is the correct support, and should the person need additional supports, a referral could be made for more specific supports signalling a transition from Step 1, to Step 2, or Step 2 to Step 3 of the PBS step model used in SJOGCS.

Should the use of a restrictive strategy be indicated, SJOGCS Restraint Reduction Policy (2019 or update) is adhered to.

7.3.1. Restrictive and Aversive Strategies: These strategies include positive punishment (an intervention the person finds unpleasant is used) and negative punishment (something the person finds rewarding is taken away). SJOGCS is committed to the reduction in, and the non-use of these strategies. These strategies are aversive strategies and can only be recommended and overseen by a suitably qualified clinician, with the consent of the individual, and in adherence with SJOGCS Policies on Restraint Reduction and Equality and Human Rights.

7.3.2. Restrictive Strategies/restraint, as per Restraint Reduction Policy No 32; A recommendation for use of restrictive strategies for an area of concern of imminent risk of serious harm relating to behavioural support need, requires a clinically valid assessment, evidence of previous interventions, a rationale, risk assessment, informed consent/decision-making framework, formal notification to the Equality and Human Rights Committee (and if used, to HIQA) and a plan for reinstatement of the restricted right is required.

Evidenced by: Each individual who presents with a behavioural support need is supported using non-aversive and non-restrictive practices, where possible as evidenced in their personal plan. Should the use of restrictive strategy be indicated, it is implemented in accordance with this policy and SJOGCS Restraint Reduction Policy (32). All responses to a behavioural support need are reviewed to see if any additional supports can be provided to guide how best to support the behavioural support need.

7.4 Incident Data Analysis, Risk Assessment and Safeguarding Practice

A behavioural support need can cause harm, both to the individual presenting with the behavioural support need and to those around them. Incident data analysis and review is governed by HSE Integrated Risk Management Policies and the HSE Safeguarding Vulnerable Persons Policy as approved by the Board of SJOGCS.

Evidenced by: Each individual's file contains information including for example, behaviour report forms, NIRF (NIMS) adverse incident(s), incident reports, risk assessment(s) and safeguarding concerns as required. Personal plans evidence the analysis and review of data arising from records of the behavioural support need. (See APIE section 6.4). This learning is used to guide and inform additional supports that may be required to support the behavioural support need.

7.5 Education and Support for Staff and other support Stakeholders as appropriate:

Staff training, education, support, and mentoring is provided on a range of topics as identified by and with the individuals who have behavioural support needs. Training is also provided to enable practice which supports a preventative, reflective approach to behavioural support needs. Training is provided to staff, carers, volunteers, and family members, as appropriate, e.g.: Person Centred Planning and the development of a Personal Plan, Total Communication, Triple C, Using Your Environment, Wheel of Optimal Living, Positive Behaviour Support, identifying a behavioural support need, risk assessment, de-escalation and emergency management, recognition of abuse, reflective practice, and any other needs identified as necessary to support the individual.

Evidenced by: There is evidence of a training and support plan being followed. This is reviewed to see if any additional supports /training can be provided to assist the staff team (other stakeholders) with the behavioural support need.

8. Assessing, Planning, Implementing and Evaluating (APIE)

Every Step of SJOGCS Positive Behaviour Support 3 step approach, in line with MEBS, is underpinned by the *APIE* framework – (Yura & Walsh, 1967) to understand the function of the behavioural support need. – STEP 1 -WOL and/ or Using Your Environment or other person-centred quality of life tool,) if required; STEP 2: PBS; STEP 3 MEBS Model

8.1 **Assess:** Complete an assessment and formulation on the biological, psychological, social, individual, environmental, communicative and behavioural factors that may impact and/or contribute to a behavioural support need. These, together with any additional assessments (e.g., a functional assessment) lead to a clear formulation and identification of the function or message of the behavioural support need. The assessment and formulation should be clearly documented with the contributors named.

8.2 **Plan:** The formulation arising from an assessment guides the specific interventions and supports in the written plan. Plans are developed with the individual in line with best practice on consent and assisted decision making as outlined in HSE National Consent Policy 2022 and may include a multi-theoretical approach. All plans are documented with the contributors named, including the clinician who has governance of the plan at STEP 2 and STEP 3.

8.3 **Implement:** The plan has a guide for implementation attached. This can be in the form of a checklist or actions of what to do, by whom and when it is to be completed, or as part of a MEBS plan a Periodic Service Review. The plan is integrated into the person's personal plan file by the keyworker and is implemented as required.

8.4 **Evaluate:** The effectiveness of a plan for a behavioural support need can be measured by reviewing the desired increase in the person's life outcomes and quality of life; the removal/reduction of any aversive/restrictive strategies; a reduction in the frequency and episodic severity of the behavioural support need; the maintenance of the behavioural change over time and the generalisation of the behavioural change to different places, community facilities and people. Social validity is also measured, in that the supports and strategies are liked, preferred, and believed to be useful and effective by the individual and their circle of support and can be used in ordinary community settings. The evaluation also identifies if the current support(s) should be maintained, discontinued, or reviewed and by whom and, as appropriate, if the individual has been discharged by a clinician.

Evidenced by: Each individual who presents with a behavioural support need has an APIE approach used at each step (which will also establish function) and the support plan integrated into their personal plan.

9 Procedure

9.1 The 3-Step Model of Positive Behaviour Support for preventing and supporting a Behavioural Support Need in SJOGCS.

This 3-Step model includes:

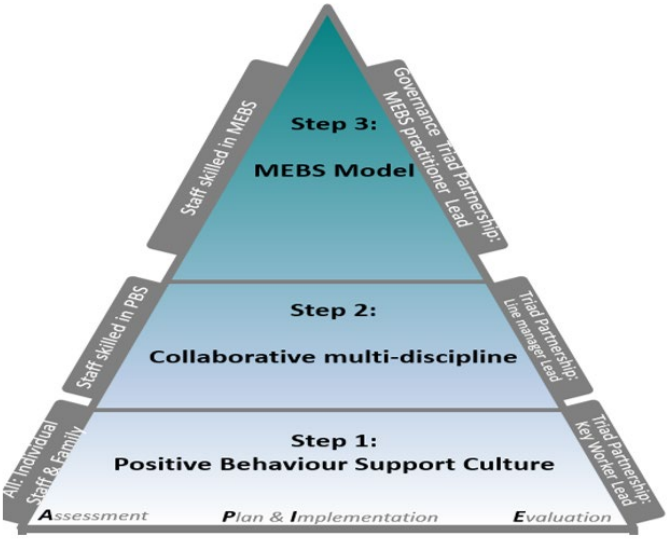
Step 1: Service Level: Positive Behaviour Support Culture using the Wheel of Optimal Living and/or Using Your Environment or other to review the Personal Plan.

Step 2: Area Level: Collaborative multi-disciplinary Supports for a Behaviour Support plan. (Positive Behaviour Support plan or a MEBS Plan)

Step 3: Specialist Level: Positive Behaviour Support which is specialist led using the Multi-Element Behaviour Support Model.

Foundations: These steps are underpinned by the five pillars outlined above (see Section 7.1) and APIE.

Governance: At each step, a triad partnership (individual, staff and family as appropriate) with alternating roles responsible for governance.



At Step 1, governance is led by the key worker with the individual, circle of support and overseen by the Line Manager, which includes a review of the Personal Plan.
Note: A member of the MDT may consult at Step 1 in order to support the Wheel of Optimal Living and/or Using Your Environment /or other.

At Step 2 the line manager takes the lead in making a referral/accessing additional supports with input from the individual, the key worker, and includes multi-disciplinary supports for example, the behaviour practitioner along with other disciplines as required. The clinician(s) uses the most appropriate APIE at STEP 2 for the provision of PBS.

If the clinician's assessment/formulation identifies that PBS is not appropriate, the clinician then oversees their treatment plan and evaluation, as outlined in their consultation note and this policy does not apply.

At Step 3 a MEBS specialist, e.g., a behaviour practitioner or other clinical professional, takes the lead with input from the individual, the key worker, line manager, circle of support and collaborative interdisciplinary input as appropriate to implement the Multi-Element Behaviour Support Model.

Personnel: Support is provided at service level by all staff at Step 1; by area level at Step 2; and by a specialist at Step 3. Support at each level is always in consultation with the individual, and with their circle of support, for example, family, friends, job coach, and any other professional providing support to the individual as it relates to the behavioural support need.

Cumulative Model: This model requires staff/clinicians to review and take-on-board the previous plan of supports developed at the forgoing steps, if applicable, including the 5 pillars, before acting. As such, documentation forms an important part in establishing a record of supports which can inform subsequent assessments and plans for Positive Behaviour Support. Documentation of the APIE- assessments, plans, implementation, and evaluation at each step is required.

Note:

A. At STEP 2 and STEP 3: If the PBS or MEBS plan requires significant interdisciplinary collaboration for the identified behavioural support need, each clinician, contributor signs the plan.

B. A referral for a behavioural support need may be made directly to a member of the MDT in the absence of supports/interventions at a previous level. If the clinician's assessment/formulation of the reason for referral identifies that Positive Behaviour Support is not appropriate this policy does not apply, and an alternative evidence-based intervention will be discussed /offered by a member of the MDT.

10. Roles and Responsibilities

The roles and responsibilities for the following staff groups and committees under this policy are outlined below:

10.1 All Staff (front line supervisors / line managers)
10.2 Specific tasks for staff at STEP 1, STEP 2 and STEP 3.
10.3 Practitioners with PBS (MEBS) expertise.
10.4 Regional Director of Services;
to include establishing a structure and process on Restrictive Practices.
10.5 A Local Equality and Human Rights Committee.
10.6 Positive Behaviour Support Committee.

10.1 All Staff

All staff are responsible for the following:

10.1.1 To read and sign off on this policy.
10.1.2 To share this policy in an accessible format, with individuals /family as appropriate.
10.1.3 Implement each individual's Personal Plan (as guided by a Person-Centred Approach) enabling the individual's life vision.
10.1.4 Implement a Human Rights Based Approach which includes evidence a commitment to using non-aversive and non-restrictive strategies when at all possible.
10.1.5 Record incidents of a behavioural support need as required. (Local behaviour report forms, NIRF, Safeguarding for example)
10.1.6 Ensure that the well-being of all parties who experience, observe, or are involved in an incident and/or are at risk, are promptly responded to and incidents recorded.
10.1.7 Use incident reports as a 'learning and reflection' tool, to assist in understanding the behavioural support need.
10.1.8 All staff members are responsible to observe for good PBS practice. If any practice is observed that is concerning for an adult or child this is communicated to the line manager in keeping with this policy, the policy on Restraint Reduction and to the Designated Officer, if applicable as per the HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures Policy (Current) and /or Children's First National Guidelines for the Protection and Welfare of Children (2017) (and other policy as appropriate.)
10.1.9 Participate in the appropriate assessment and plan using the five pillars and then at each STEP; at STEP 1-with WOL/UYE; STEP 2: PBS and STEP 3 MEBS.
10.1.10 Implement the strategies /interventions as written in the plan (WOL/UYE, PBS /MEBS plan)

10.1.11 Evaluate the plan for effectiveness, for example increase in quality-of-life indicators as identified by the individual, reduction in the behavioural support need, (including harm to self or others), removal of restrictive intervention (if applicable).

10.1.12 If a referral to MDT is required, discuss this with the individual and evidence the decision-making process.

10.1.13 Staff together with their line manager are responsible for identifying, accessing, and completing their education and support needs as appropriate for the behavioural support needs of the individual's they support (including family/carer support and education) as required. Evidence of staff education and support is filed in their personnel file. For example:

- Induction to SJOGCS PBS Policy
- 1 hour workshop on PBS and the MEBS Model
- eLearning Course on MEBS (Part 1 and/or Part 1 and Part 2)
- 1-day workshop PBS/MEBS
- Webinar Series and/or Workshops on Wheel of Optimal Living

Education and support can be accessed through the local MDT or Callan Institute or external training bodies as appropriate.

10.1.14 Staff will support Families with PBS information, education, advice, and support as required.

10.1.15 Restrictive Practice: If, under very limited circumstances, an aversive/restrictive strategy is recommended (*see SJOGCS* Restraint Reduction Policy), all staff members adhere to the practice guidelines for its use as per the Restraint Reduction Policy No 32 and the Equality and Human Rights Policies Adults 2020, Children 2021).

10.1.16 If an emergency a restrictive practice (*see* Appendix 10: Glossary of Terms and Definitions and Abbreviations) is used, this prompts a review of the Personal Plan (including the Life Vision as identified in the Person-Centred Plan), a review of Step 1 of the 3-Step Model of PBS and a referral to Step 2. Please note: All use of Restrictive strategies (to include restraint) needs to be recorded on your local reporting system such as behaviour report form, (BRF), NIRF (NIMS), restraint log, and the data sent to the line manager and/or Person in Charge.

10.2 Specific Tasks for Staff at each STEP of the PBS Policy

STEP 1: The person taking the lead is the '**Keyworker'**

1. Before using STEP 1, together with the individual, and their family as appropriate, and the team review each of the 5 pillars to review the learning from each of these areas to assist in understanding the behavioural support need.

2. Use the Wheel of Optimal Living and/or Review Using Your Environment (or other) to identify if any needs as identified by these tools may be contributing to a behavioural support need.

3. Develop a plan based on the review of the 5 pillars and the WOL/UYE. Make this accessible, as appropriate and integrate it into the Personal Plan.

4. Implement the plan (ask for assistance if required from MDT)

5. Evaluate the plan for outcomes, if effective, integrate the plan into the individual's Personal Plan.

6. Continue to record behavioural support needs.

7. If the local staff team (together with the individual and their family as appropriate) note that STEP 1 is ineffective, for example, an increase in behavioural support need, the use of a restrictive practice, or a safeguarding concern due to a behavioural support need A referral to STEP 2 may be required. Discuss with line manager.

8. Keyworker then collaborates with individual supported, line manager and any other professional at STEP 2 /STEP 3 as required.

STEP 2: The person taking the lead is the **Line Manager** with collaborative multi-disciplinary input.
(As per Regulations (SI No. 367 of 2013, Health Act 2007 – see Appendix 12).

1. STEP 2 referral can be made to the MDT regarding a behavioural support need. (In line with best practice and the spirit of the Assisted Decision-Making Act (2015), *see* HSE National Consent Policy and the ADM 2015)

2. Support and ensure collaboratively working and input with the individual, team, the line manager, the MDT member, and the family, as appropriate, to complete the assessment; to develop the plan, to oversee and monitor plan implementation and evaluate the effectiveness of the plan (at least once a year or more frequently if required or as advised by the clinician.)

3. Ensure that the plan (consultation note) is on file and in date (within the last 12 months)

4. At team meetings review the plan, implementation, and evaluation with notes of this review on file, with particular attention on outcomes in quality of life as defined by the individual and the reduction/removal of any restrictive practices, along with a reduction in the behavioural support need.

5. If the plan needs to be updated/amended, contact the clinician/or make a referral to MDT/Clinician as appropriate.

6. On review if the plan is found to be effective and still required, document and continue to implement with the review note available. If the plan is no longer required, step down to STEP 1 (or STEP 2) or revert to the Personal Plan with appropriate input from MDT as required.

7. Provide and/or access staff (family) support for example with implementation of interventions, education/workshops, reflective practice, debriefing, if required.

8. Line manager reviews their own support/training needs in relation to for example, PBS, WOL, UYE MEBS eLearning module, with their line manager.

9. Continue to review and summarise all records of behavioural support needs or assign this review and action any further supports required.

10. If the collaborative multi-disciplinary input (together with the individual) is ineffective, for example, an increase in behavioural support need, the use of a restrictive practice, or a safeguarding concern due to a behavioural support need, the line manager together with the individual can make a referral to STEP 3.

STEP 3: The person taking the Lead is **Behaviour Practitioner in MEBS Model. (For example, Psychologist/CNS/Behaviour and Risk/)**

1. Respond to a STEP 3 MEBS referral.

2. Work collaboratively with the individual, team, MDT members, the line manager and the family, circle of support and any other professional as appropriate to complete the APIE.

3. Review support provided at previous STEPS, if available.

4. On review if the plan is found to be effective and still required, document and continue to implement with the review note available. If the plan is no longer required, step down to STEP 1 (or STEP 2) or revert to the Personal Plan with appropriate input from MDT as required.

5. On review, if this input (together with the individual) is ineffective, for example, an increase in behavioural support need, the use of a restrictive practice, or a safeguarding concern due to a behavioural support need, access additional supports as required.

10.3 Practitioners with PBS expertise including expertise in the MEBS model

Practitioners with PBS and MEBS expertise (who also have access to appropriate support and supervision) such as Behaviour Specialists/Clinical Nurse Specialists in behavioural/Behaviour and Risk Coordinators/Psychologists and any other discipline as appropriate are responsible for the following:

10.3.1 Active Caseload

Maintain an active caseload in the provision of PBS assessment, PBS /MEBS plan/intervention design, implementation/ monitoring, and evaluation, at STEP 2 and STEP 3. This includes providing consultation as required at any step. (And document as appropriate)

10.3.2 A Positive Behaviour Support Culture

- The practitioner uses information (for example from the five pillars, incident reports, from a front-line manager conversation, observation, from summary data collated by quality and safety, audit reports, MDT) to feedback positive practice and support the staff team in their work.
- At least one practitioner with PBS and MEBS expertise is a member of the regions Positive Behaviour Support Committee.

10.3.3 Support and Education

- Provide training to staff as required and/or as appropriate as informed by the training plan and in collaboration with the HR department.
- The local clinician reviews the data to identify an appropriate individual (with a behavioural support need) and then in conjunction with the line manager, PBSC and HR identifies a staff member supporting the individual to complete the Practice Certificate in MEBS (With Callan Institute) if appropriate.
- The local clinician provides supervision to staff undertaking the Practice Certificate in MEBS, if resources permit.

10.4 Regional Director of Services

10.4.1 Positive Behaviour Support Committee

- Establish a Positive Behaviour Support Committee (PBSC)
- Receive an annual report on the work of the PBSC.

10.4.2 Restrictive Practice Governance

- Establish a Restrictive Practice Review structure and process (for areas of concern of imminent risk of serious harm, where physical restraint, mechanical restraint, environmental restraint, and medication used as a restraint may be required in relation to behavioural support needs) in each local service. This structure and process is designed to support an inter-disciplinary, evidence-based practice forum governing all restrictive practices in relation to behavioural support in keeping with SJOGCS Restraint Reduction Policy. This is outlined in the local services local operating procedure if required.
- Receive an annual report on the work of the Restrictive Practice Governance Review Structure and Process.

10.4.3 Access Additional Supports

- Independent advocate (service) is available to individuals, should they require it in relation to their behavioural support needs.
- Legal representation is available to any individual, should they require it, in relation to their behavioural support needs.
- Access supports from Callan Institute for behavioural support needs where necessary. Callan Institute provides training, consultation, workshops and Practice Support in PBS, Wheel of Optimal Living Support, the Multi Element Behaviour Support Model, Functional Assessment and implementing and evaluating MEBS plans on request. Bespoke support is also available.

10.4.4 Review and Sharing

- Receive an annual report from each of the above committees (PBSC and Restrictive Practice Governance) on Positive Behaviour Support Services and Restrictive Practices in the service which is shared with the local Clinical Governance/Quality and Safety Committee.
- Receive a summary audit of this policy annually as captured in internal /external audit reports and share this audit with the Chair of the PBSC, Person in Charge, Programme Managers, Line Managers/Supervisors and the Clinical Governance/Quality and Safety Committee where appropriate.

10.5 A Local Equality and Human Rights Review Committee

Each service has in place an Equality and Human Rights Committee. This committee is available to review due process in relation to any rights issues including restrictive practices as they relate to behavioural support needs on behalf of individuals (children and adults) with an intellectual disability. The committee is also responsible for reviewing data on aversive or restrictive strategies for areas of concern of imminent risk of serious harm including behavioural support needs with a view to ensuring due process and rights reinstatement/progressive realisation is actioned.

10.6 Positive Behaviour Support Committee

The Positive Behaviour Support Committee (PBSC), as established by the Director, has responsibility for promoting, implementing, and ensuring compliance with this policy. The committee is responsible for the following outcomes and develops its terms of reference using the guidance in Appendix 6.

Desired Outcomes:

1. To promote PBS culture within the local service.
2. To use data to inform strategic planning and resource management.
3. To evidence a commitment to restraint/restriction reduction and oversight as it relates to physical, mechanical, environmental and medication used as a restraint in relation to behavioural support needs.
4. To present a summary report of its activities on an annual basis to the Director or Designee. (Quality and Safety Committee)

17. Use of Practices and Approaches which are not in keeping with Positive Behaviour Support (including a MEBS Approach/MEBS Model)

Our Service collaborates with family members and other professionals within a range of state and community agencies. It is expected that all agencies /practitioners will apply the HSE 8 Guiding Principles on a Rights Based Approach to Behavioural Support. This policy is in keeping with these principles.

Should an approach be advocated, recommended, or implemented by another party (agency /clinician) for an individual supported by SJOGCS which does not adhere to the HSE Guiding Principles on a Rights Based Approach to Behavioural Support and as a result this policy, a staff member noting this should contact their front line supervisor / line manager and/or safeguarding designated officer in their Service.

The will and preference of the adult and in the case of children the best interest of the child (with the voice of the child present) along with the 9 guiding principles of the ADM are central to the discussion at all times. This process is documented.

18. Consultation

This policy was developed by a Policy Review Group (See Appendix 13)

19. Revision and Audit of the Policy

This policy is audited for implementation/ internally by the Programme Quality and Safety Department, self-audit teams and externally by HIQA. Data from these audits informs the revision of this policy.

a. All summary/feedback from audits is made available to the local Chair of the Positive Behaviour Support (PBS) Committee on an annual basis. This summary/feedback forms the basis of the subsequent reports shared with the Local Quality and Safety Committee and/or the Director.
b. The Regional Director of Service presents the audit report to the Director of Programme, Quality and Safety Department.
c. This Policy will be reviewed in January 2026

20. Implementation of the Policy

The Regional Director will prepare a plan to ensure the implementation, audit, and review of this Policy.

21. References

- Assisted Decision-Making (Capacity) Act 2015 (irishstatutebook.ie)

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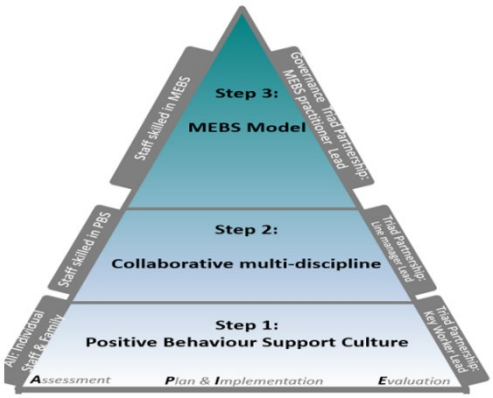
13. List of Appendices

Additional information is included on the intranet that will support and provide a rationale for the policy, procedures, protocols, and guidelines. This includes:

Appendix 1:	What is the 3-Step Model of PBS? (Page 35)
Appendix 2	Wheel of Optimal Living (Page 39)
Appendix 3	Using Your Environment (UYE) Assessment as part of my Personal Plan (Page 53)
Appendix 4:	Individual Checklist for Positive Behaviour Support (Page 55)
Appendix 5:	Service Checklist for Positive Behaviour Support (Page 56)
Appendix 6:	Positive Behaviour Support Committee Terms of Reference Guidance (Page 57)
Appendix 7:	Sample List of Interventions as part of a MEBS Plan (proactive and reactive) (Page 59)
Appendix 8:	Guidelines for Reactive Strategies (de-escalation and resolution) as part of a MEBS Approach, a MEBS Plan and the MEBS Model for all steps of the policy (Page 60)
Appendix 9:	Sample List of Interventions that make up a Reactive Strategy (for de-escalation and resolution) in a MEBS Approach, MEBS Plan and the MEBS Model (Page 61)
Appendix 10:	Glossary of Terms and Definitions (Page 64)
Appendix 11	Legislation / other related Policies (Page 66)
Appendix 12	Extract from Statutory Instruments. S.I. No. 367 of 2013. Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (Page 67)
Appendix 13:	Members of the Policy Working Group (with active consultation with SLT) (Page 68)
Appendix 14:	Local Operating Procedure (If required, can be attached here) (Page 69)

Appendix 1: What is the 3 Step Model of Positive Behaviour Support

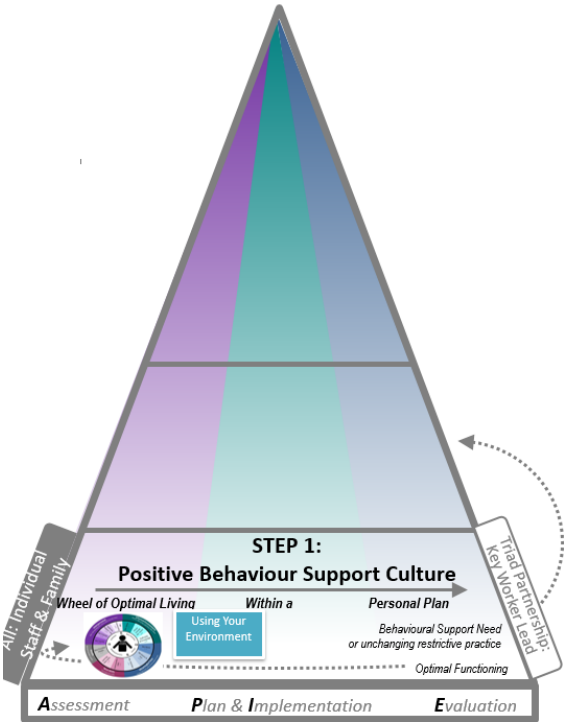
This policy sets out the use of a 3-step approach for the provision of Positive Behaviour Support. This 3 Step Model recognises a step up and/or a step-down approach in the level of support an individual may require. Each step uses APIE – Assessing, Planning, Implementing and Evaluating to ensure evidence-based practice. These three steps sit on five pillars, which underpin the SJOGCS PBS policy and are attended to in the context of understanding a behavioural support need:



1. Being person centred and using a person-centred approach (as evidenced in the Personal Plan and Life Vision).
2. Using a Human Rights Based Approach.
3. Non-restrictive and non-aversive practices in support of behavioural support needs.
4. Incident Data Analysis, risk assessment and safeguarding practice.
5. Education and support for staff (and family as appropriate)

STEP 1: Service Level: Positive Behaviour Support

Step 1 is built around a Positive Behaviour Support (PBS) culture which embodies universal promotion of PBS (and the 12 principles) and as depicted in the *Wheel of Optimal Living* (*see* Section 1.2) or Using Your Environment (UYE). The Wheel or UYE can be used when a behavioural support need arises, or to prevent behavioural support needs from arising.



Personnel: All staff and members of circle of support (together with the individual) are equipped to provide the supports to ensure optimal living through a Positive Behaviour Support culture.

Governance: At Step 1 governance is led by the key worker overseen by the Line Manager.

Assessment and Formulation: A Wheel of Optimal Living or UYE is used with the individual together with the circle of support, to consider the areas where supports can be provided.

Plan and Implementation: The plan (using the Wheel of optimal living or UYE) which is drawn up and implemented in this step is linked to the individual's personal plan.

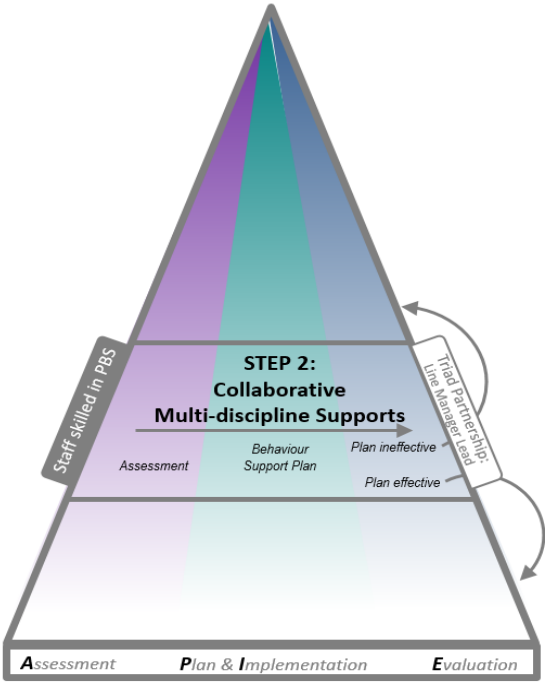
Evaluation: Progress is evaluated, and the plan reviewed for optimal living; the reduction/elimination of restrictive practices and the reduction in behavioural support needs (e.g., frequency and/or episodic severity of the behavioural support need the risk assessment ratings).

Transition 1a: A reduction in the behavioural support need and increase in optimal functioning signal effective intervention and indicate that the level of support can be maintained and integrated into the Personal Plan.

Transition 1b: Identification of an on-going behavioural support need, use of an unchanging or Emergency restrictive practice, a risk assessment or safeguarding concern despite evidence of continuous implementation of a PBS approach using APIE may indicate the need to review or move to Step 2. In such cases a referral is completed by the keyworker with the individual's consent, in line with best practice and assisted decision making and sent to the appropriate professional/ team (CDNT/) e.g., Speech and Language Therapist, GP, Occupational Therapist, Psychologist, Behaviour Specialist, CNS, Social Worker, Psychiatry. The key worker also completes any additional forms required e.g., Rights Restrictions, Safe-guarding, Adverse incident, Risk assessments. Copies of all referrals and forms are kept in the individual's Personal Plan(file)

Step 2: Step 2: Area Level: Collaborative Multi-Discipline Support

Step 2 supports are implemented for specific behavioural support needs requiring collaborative, multi-discipline professional (practice) supports and/or when behavioural support needs were not met or reduced by Step 1. A review of the APIE for Step 1 and the WOL/UYE as part of the personal plan is recommended. This is followed by an assessment (e.g., Functional assessment or other clinically valid assessment) to develop a formulation /understanding of the behavioural support need which informs a behaviour support plan (PBS plan or MEBS plan), implementation, and evaluation.



Governance: At step 2 the Line Manager comes to the fore, coordinating the APIE of supports from a range of specialties, for example, including staff skilled in PBS if available. With input from the individual, the circle of support and the key worker.

Personnel: Support at this step is provided by staff available to the individual (residence/day, family, school, work etc.). This may also include, psychology, OT, SLT, CNS, Behaviour practitioner, social work, GP, psychiatry supports. It may also include staff skilled in PBS (and /or the MEBS Model).

Assessment and Formulation: An assessment (e.g., A Functional assessment or other clinically valid assessment) is undertaken to gain a better understanding or formulation of the factors that are related to the behavioural support needs. This is undertaken and documented by the collaborating professionals to inform the plan.

Plan and Implementation:

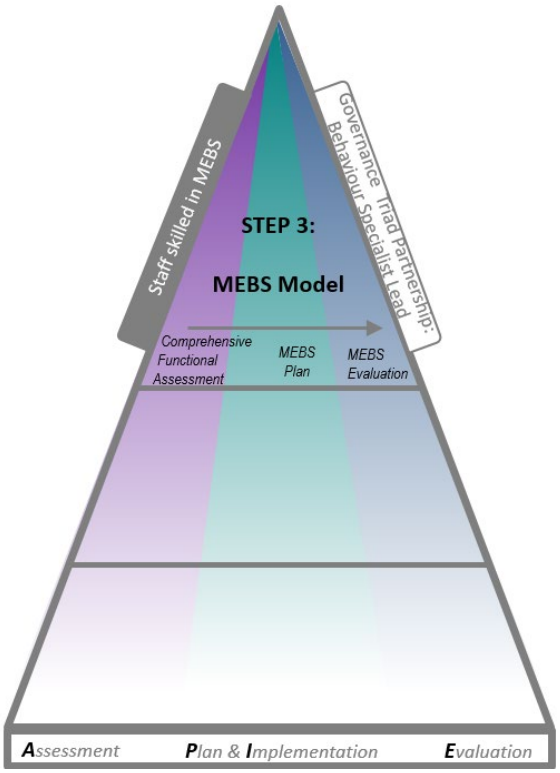
A clinically valid PBS or MEBS plan drawing on collaborative supports is developed, documented, and implemented. A behaviour support plan (PBS plan or MEBS plan) within this context includes proactive and reactive strategies which can include all of the following: environmental strategies, communication skills and supports and alternative skills, direct interventions e.g., trigger control strategies and reactive strategies that are functionally and evidence based.

Evaluation: The plan is reviewed and documented by collaborating professionals to establish if it has been effective or ineffective. This will determine which of the two following support transitions are undertaken.

Transition 2a. Maintain Step 2: If the evaluation shows that the intervention has been effective, the level of support can be maintained or stepped down to STEP 1.

Transition 2b. Upward Transition: If the evaluation shows that the intervention has not been effective e.g., the behavioural support need has not been met or a restrictive practice is used, or a risk assessment or safeguarding concern is identified) this can signal the need to review the current supports or step up to Step 3 supports.

Step 3: Specialist Level: Positive Behaviour Support using the MEBS Model



Step 3 supports are initiated if the behavioural support need persists without reduction after progressing through the two lower steps of the support model. Step 3 begins with review of the APIE for Step 1 and Step 2. This is followed by specialist interventions using the Multi-Element Behaviour Support (MEBS) Model it its entirety or other evidence-based specialist interventions led by for example, a Behaviour Practitioner, Psychologist, Psychiatry, Speech and Language Therapist, Occupational Therapist, and informed by the principles and practices of Multi-Element Behaviour Support Model.

Personnel and Governance: Supports at this level are provided by specialist staff, for example staff skilled in Positive Behaviour Supports using the Multi-Element Behaviour Support Model with the appropriate support and supervision and they hold governance responsibility. Involvement of the individual (and their circle of support), key worker, team and Line Manager and other professionals is invited as required in order to work constructively, collaboratively, creatively, and responsively together.

Assessment and Formulation: A comprehensive behavioural assessment is undertaken with formulation informing intervention, namely a Multi-Element Behaviour Support plan.

Plan and Implementation: Multi-Element Behaviour Support Plan has proactive strategies addressing environmental factors, skills teaching, direct intervention, and reactive strategies. (a minimum of 7, one in each category) and meets the four criteria outlined.

Evaluation: The intervention is evaluated against six outcomes as identified in the MEBS Model in order to establish if it is effective or ineffective. This will determine which of the two following supports may be required.

Transition 3a. Maintain Step 3.

If the evaluation shows that the intervention has been effective, the level of support can be maintained or stepped down.

Transition 3b. Additional Supports: If the review shows that the intervention is not effective a collaborative inter-disciplinary approach is implemented led by one of the following: Behaviour Practitioner, Psychologist, Psychiatry, Speech and Language Therapist, Occupational Therapist, with experience the principles and practices of Positive Behaviour Support (namely the MEBS Model).

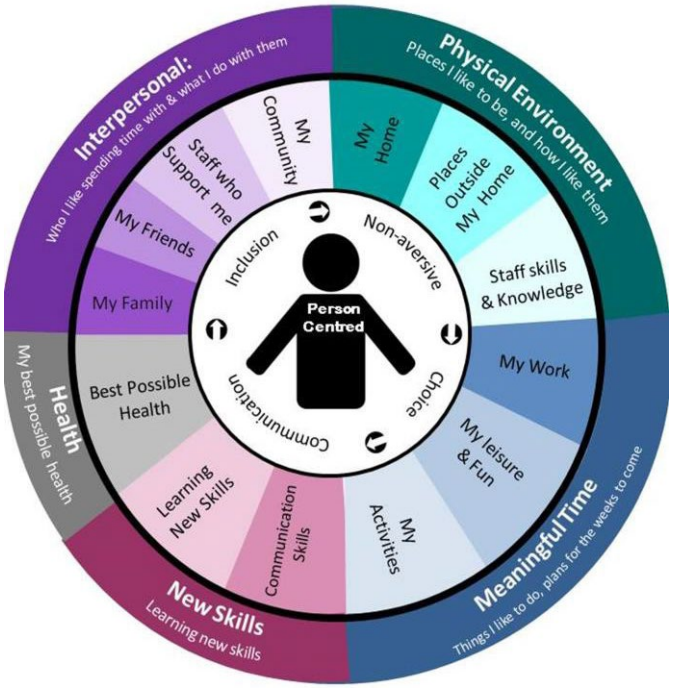
Appendix 2: Wheel of Optimal Living

Positive Behaviour Support Culture: Wheel of Optimal Living

SJOGCS promotes a Positive Behaviour Support (PBS) culture. As we know good person-centred planning identifies the Life Vision and enables each individual we support to live well. The Wheel of Optimal Living has as its centre a person-centred approach. However, should a behavioural support need arise within the context of good person centred planning The *Wheel of Optimal Living (WOL)* can be used. The WOL includes the five key dimensions of optimal living, dimensions that each of us can identify with as being important to live a good life. The WOL can be used when a behavioural support need arises or to prevent behavioural support needs from arising. It is implemented as part of an individual's personal plan. All behavioural support needs are responded to using a functional approach and understanding, this is particularly relevant when supporting an individual who is upset/distressed.

The five dimensions are:

1. **Health:** My best possible health.
2. **Interpersonal:** Who I like to spend time with on a daily and weekly basis, and what I do with them. This may include my family, friends, staff who support me (home, school, work, leisure) and my community.
3. **Physical Environment:** Places I like to be in and how I like them to be. This may include my home and outside my home, and staff (family members and others) with skills and knowledge to facilitate these environments.
4. **Meaningful time:** Things I like to do during the day and plans I make for the weeks and months to come.
5. **Learning New Skills:** Communication skills and supports and other skills which I can use, and new skills I want to learn.



Reflecting the key principles of Positive Behaviour Support, and a person centred approach the wheel outlines four guiding principles of, communication, choice, non-aversive/non-restrictive and inclusion. These principles apply to all aspects of life e.g., non-aversive interpersonal life; a choice in my health support, a non-aversive physical environment, choice in my day, choice in the skills I learn etc.

1.1 Wheel of Optimal Living (WOL)

1.1.1 Using the Wheel to Assess Optimal Living in a PBS Culture

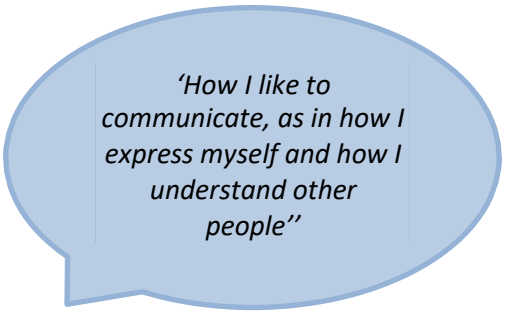
The core principles (below) and dimensions of the Wheel of Optimal Living can be used with the individual, staff, and family members to consider the areas where support can be provided. Once completed, support can be provided in the key areas identified from the wheel. Along with this, a response (based on the function /message of the behavioural support need) for supporting any distress or behavioural support need can also be included.

Core Principles Underpinning the Wheel

The principles of communication, choice, inclusion and non-aversive/non-restrictive are relevant to each of the five dimensions of optimal living.

- **Communication Skills and Supports**

The most effective starting point for understanding a behavioural support need is to acknowledge that it (the behavioural support need) is purposeful and functional – as in, it is an individual's way of communicating something about themselves and their current situation. SJOGCS is committed to a Total Communication Approach which



"Encompasses use of all means of communication, acknowledgement of all attempts at communication and identification of opportunities for communication" (SJOGCS Policy on using a Total Communication Approach, 2019) Moreover, individuals are encouraged to appropriately express their feelings and are helped to deal with issues that impact on their emotional well-being.

Evidenced by: *Each individual has communication documentation that details their communication abilities. The person will be supported by staff to use the most appropriate Total Communication approach best suited to that person.*

- **Choice**

Self-determination is a core concept of the Convention of the Rights of Persons with Disabilities (UN, 2006) and in keeping with a person centred approach, each individual is supported to make choices, based on their preferences (likes and dislikes), and receive information and support to assist in decision making so that each individual can direct and have autonomy in their daily routine(s) e.g., choices in clothing, meals, snacks and diet, occupation, leisure pursuits, health, friend and family contact, their daily and weekly diary /schedule, in their own home and personal possessions etc.

'Having enough information to help me understand what is happening, for myself, what I want, what I like, with help if necessary and having information to assist with decisions I might need to make.'

Evidenced by: *Each individual has included in their personal plan, choices they make regarding their preferences, choices, and autonomy in their daily routines. This can be based on a preference checklist or list of 'things I like and things I do not like' derived from interview/observation for each part of the Wheel of Optimal Living.*

- **Inclusion**

Inclusion and participation are core concepts of the Convention of the Rights of Persons with Disabilities (UN, 2006) and are reflective of PBS values and a person-cantered approach. In keeping with this principle each individual is supported to play an active role and feel that they belong and are socially valued in all aspects of their life: at home, at school/work, at leisure, in the community and at an interpersonal level with their friends, family members, in the community and with staff members.

'Being an equal partner in all aspects of my life.'

Evidenced by: *Each individual has evidence in their personal plan of how their 'belonging to and feeling socially valued' has been included in the assessment in the Wheel of Optimal Living and documented in their personal plan.*

- **Non-Aversive**

It is the policy of SJOGCS that a behavioural support need should be responded to using non-aversive and non-restrictive strategies with the priority placed on reducing the episodic severity of a behavioural support need in order to maintain safety for all.

'Staff respond to me in ways which I like and are not aversive or restrict my rights. (And are functionally informed)'

Evidenced by: *Each individual has included in their personal plan a commitment to, and evidence of, reactive strategies for a behavioural support need which are non-aversive and non- restrictive (and functionally informed).*

1.2 The Five Dimensions of the Wheel of Optimal Living

1.2.1 The five dimensions of the Wheel of Optimal Living include the following:

1. Health
2. Interpersonal
3. Meaningful Time
4. Physical Environment
5. Learning New Skills (including communication)

1. Best Possible Health as a Dimension of Optimal Living

Health is a state of complete physical, mental, spiritual, and emotional and social well-being and not merely the absence of disease or infirmity (WHO, 2006). Accordingly, best possible health is supported for each individual and documented in their Personal Plan

'When I physically and emotionally feel as good as I can, life feels better.'

Evidenced by: Each individual has a health screening completed as part of their personal plan and there is evidence that this is reviewed in the context of a behavioural support need to assess if a 'health' need is contributing to the behavioural support need.

2. The Interpersonal Dimension of Optimal Living

This dimension of optimal living considers

a) Family: Each individual is supported to maintain their contact and role within their family. Families are also supported as they support their family member.

'Who I like to spend time with and what I do with them. This may include my family, friends, staff who support me and my community.

b. Friends: Each individual is supported to make, keep and enjoy their friends and develop relationships.
A friend is a person whom one knows and with whom one has a bond of mutual affection, typically exclusive of a professional relationship, and may include intimate/sexual relationship

c) **Relationship with staff:** Each Individual is supported by staff members who they like e.g., who are kind, listen, speak nicely and respectfully, are reflective and mindful, provide assistance and support as required, have a person-centred approach and are an advocate for the individual and act professionally and responsibly at all times.

d) **Living and participating in the community:** Evidence shows that individuals with a behavioural support need are best supported in ordinary community settings, in a place to call home, having socially valued roles (in school, work, and the community), using individualised supports and a person-centred approach.

Evidenced by: Each individual has an Interpersonal profile (*see* Appendix 1) completed and there is evidence that this is reviewed in the context of a behavioural support need to assess if an 'Interpersonal' need is contributing to the behavioural support need. A community participation plan is also included as part of their personal plan.

3. Meaningful Time as a Dimension of Optimal Living

Each individual is supported to have meaningful activities, hobbies, tasks, fun, school/college, and work to participate in each day and meaningful activities to look forward to each week or month. Routine, choice, engagement, and fun promote a sense of wellbeing.

'Things I like to do during the day and plans I make for the weeks and months to come.'

Evidence by: Each individual has a completed Meaningful Time profile e.g. a 'meaningful day (weekly) schedule' as agreed with them which includes a review of any environmental factors that need to be adapted for the individual. There is evidence that this is reviewed in the context of a behavioural support need to assess if a 'meaningful time' need is contributing to a behavioural support need.

4. The Physical Environmental as a Dimension of Optimal Living

a) My home: Each individual is supported to express, with the appropriate total communication supports where, and with whom they like to live. They are supported to make choices to facilitate their comfort, support, pleasure, and privacy within their home.

Places I like to be in and how I like them to be, including my home, outside my home, and reflective staff with skills and knowledge to facilitate these environments'

b) Outside my home: Each individual is supported to have full access to a range of environments of their choice outside their home, to afford them a variety of opportunities and activities. Any specialised training, support, adaptations, or personal assistance required to facilitate enjoyment of these environments is identified and provided by those supporting the individual.

c) Reflective Staff with the Skills and Knowledge to facilitate these environments: Each individual is supported by staff (family or others) who are reflective practitioners and have the knowledge and skill to support an individual as they participate in their physical environments; for example, mobility, communication skills and supports (expressive and receptive), skill development (coping and tolerance); self-care; access etc.

Evidenced by: Each individual has a physical environment profile completed and there is evidence that this is reviewed in the context of a behavioural support need to assess if a 'physical environment' need is contributing to a behavioural support need e.g.

a. An opportunity to express their preferred living arrangements which is recorded in their personal plan.
b. An activities support plan which outlines environments and activities the person would like to access, and the supports required to do so.
c. Reflective Staff with the Skills and knowledge to support themand this is identified in their personal plan.

5. Learning New Skills Dimension of Optimal Living

Learning new skills plays an important role in feeling good about one-self. Skill development can occur in communication, both in expressing oneself and in understanding others; and in other areas for example self-care e.g., grooming, dressing, washing etc.; activities of daily living e.g., cooking, cleaning, gardening, shopping; leisure e.g., painting, cycling, music; and in work or education etc. Each individual has the opportunity to identify skills they would like to learn, and they are supported to learn these using evidence-based strategies in active support and skills teaching.

'Appropriate communication skills and supports and other skills I can use, and new skills I want to learn to make life better'.

Evidenced by: Each individual's communication documentation and a skills profile is reviewed in the context of their behavioural support need to assess if a 'skills' need is contributing to a behavioural support need. e.g., new skills and supports in communication and other skills need to be explored.

1.3 Sample Prompt Tool for the Wheel of Optimal Living (including worked example)

The following prompt tools provide suggestions reflection and assessment and are intended to augment the tools currently in use when considering a behavioural support need.

1) Health Prompts

Health is a state of complete physical, mental, spiritual, and emotional and social well-being and not merely the absence of disease or infirmity (WHO, 2006). Accordingly, best possible health is supported for each individual as required in keeping with our policy on 'Best Possible Health'. A best possible health profile may need to be completed.

Physical Health	***Mental Health***	***Social Well being***
These are my physical health needs, which include my sensory processing needs, my dental health and my sexual health: *This is how they are supported:* *This is what I now need to support my physical health needs:* ***Consider:*** *assessing for pain; headache, earache, toothache; gastrointestinal upset; infection; hydration; nutrition; constipation; foot problems; age-appropriate screenings (menopause, cancer, dementia); along with acute and chronic conditions the individual is diagnosed with.*	*These are my mental health needs:* *This is how they are supported:* *This is what I now need to support my mental health needs:* ***Consider:*** *assessing for worry and stress as it may relate to the individual's life at the moment; along with acute and chronic conditions the individual is diagnosed with (e.g., consider; relaxation, mindfulness, therapy).*	*These are my emotional and social well-being needs:* *This is how they are supported:* *This is what I now need to support my emotional and social well-being needs.* ***Consider:*** *assessing for meaningful friendships, caring staff, family support, meaningful roles and meaningful activities, fun, resilience, emotional needs; valued in their daily occupations and relationships; spiritual needs, financial needs, along with acute and chronic conditions the individual is diagnosed with.*
This is how I like to get information about my health needs: *This is how I like to be included in my health needs, assessment, plan, and treatment:* *This is how I communicate and talk about my health needs:* *These are the supports and adaptations I need as I make choices and communicate about health needs and as I plan for my health needs:* *These are my health needs, which if addressed could reduce my behavioural support needs:* *(Note: Rights Restrictions check is complete)*		
The following was identified as contributing to a behavioural support need. and the following supports, interventions and resources will now be provided:		

2) Interpersonal Prompts

My Family	*My Friend*	*Staff who support me*	*My community*
Each individual is supported to maintain their contact and role within their family. Families are also supported as they support their family member.	*Each individual is supported to make, keep and enjoy their friends, including intimate relationships.*	*Each Individual is supported by reflective staff members who they like, have a person centred approach and are an advocate for the person.*	*The evidence shows that individuals with a* behavioural support need *is best supported in ordinary community settings, in a place to call home, having socially valued roles.*
This is my family (family tree): *This is how I am or what I do as a son/daughter, sister/brother, aunt/uncle, partner/spouse etc.:* *This is who I like to spend time with in my family:* *This is what I like to do with my family (member(s):* *This is how often I like to see my family (member):* *This is how I would like to have more contact with my family (member(s):* *This is what I do not like about (or where I have problems coping) my contact time/opportunities with my family and where I might need some help:*	*These are my friends:* *This is how I am or what I do as friend:* *This is who I like to spend time with:* *This is what I like to do with my friend(s):* *This is how often I like to see my friend(s):* *This is how I would like to have more time with my friends:* *This is how I would like to meet new friends:* *This is what I do not like (or have problems coping with) about my contact with my friends and where I might need some help:*	*These are my staff who support me:* *This is how they support me:* *This is how I like to spend time with my staff:* *This is what I like to do with my staff:* *This is how often I like to spend time with my staff:* *This is the information I need from my staff:* *This is how my staff could improve their support:*	*These are the places in my community:* *These are the people in my community:* *This is what I do in the community:* *This is who I like to spend time with in the community:* *This is how often I like to go to the places in my community:* *This is what I do not like about (or have problems coping with) my time and places in my community, and where I might need some help:* *In my community, these are some of the opportunities I would like to explore, try and have more of:*
This is how I like to get information about my family/friends/staff/community: *This is how I include the important people in my life in my home(house) on a daily/weekly basis:* *This is how I like to be included in my family/friends/staff/community issues discussions on a daily basis:* *This is how I communicate and talk about my family/friends/staff/community on a daily basis.* *There are the supports and skills my family/friends/staff/community need to support me every day:* *This is how my time with my family, friends, staff, and people in the community could be improved upon to reduce/meet my* behavioural support needs *on a daily basis* *(Note: Rights Restrictions checklist is complete)*			
The following was identified as contributing to a behavioural support need and the following supports, interventions and resources will now be provided:			

3) Environmental Prompts

My Home	*Places outside my home*	*Reflective Staff with Skills & Knowledge*
Each individual is supported to express where, and with whom they like to live. They are supported to make choices to facilitate their comfort, support, pleasure, and privacy within their home.	*Each individual is supported to have full access to a range of environments of their choice outside their home, to afford them a variety of opportunities, relationships, roles and activities.*	*Each individual is supported by reflective staff (family or others) who have the knowledge and skills to support them as they participate in their physical environments e.g., mobility, communication skills and supports (expressive and receptive), skill development (coping and tolerance), self-care, access etc.*
This is how I like my home to be: *This is how I like my bedroom to be:* *This is how I like my kitchen to be:* *This is how I like my sitting room to be: (etc.)* ***Consider:*** *all senses e.g., noise, lighting, space for resting, hobbies, friends etc.; smell, movement, crowds, textures, privacy, personal belongings, access to food/drinks, seating/furniture, adaptive equipment, assistive technology.* *This is who I like to live with:* *This is what I do not like about my home (or where I have problems coping) and where I might need some help;*	*These are the places outside me home that are important to me:* *That relate to school/work; leisure, friendships, volunteering; family, spirituality, health:* *This is what I do there (consider all places):* *This is who I like to spend time with when I am there (consider all places):* *These are the supports, adaptive equipment, assistive technology, people (skills and knowledge) I now need when outside my home:* *This is what I do not like or find hard when outside my home and where I might need some help:*	*These are my staff who support me:* *This is how they support me when I am out and about:* ***Consider:*** *mobility, communication skills and supports (expressive and receptive), skill development (community skills, coping and tolerance), self-care, access, reactive strategies, adaptive equipment, health supports.* *These are other things that could be tried and /or that I need:*
This is how I like to get information about my home and my life outside my home: *This is how I like to be included in issues & discussions about my home and my life outside my home:* *This is how I communicate and talk about my home, life outside my home and what I need:* *There are the supports and adaptations I need in my home and as I use places outside my home:* *These are the / There are no restrictive practices used with me in my home:* *This is how my environments could be improved upon to reduce/meet my* behavioural support need. *(Note: Rights Restrictions check is complete)*		
The following was identified as contributing to a behavioural support need and the following supports, interventions and resources will now be provided:		

4) Meaningful Time Prompts

Each individual is supported to have meaningful activities, hobbies, tasks, fun and work to participate in each day and meaningful activities to look forward to each week and month e.g., in environments (physical, interpersonal and programmes) that have a goodness of fit for their individual needs and allow for some consistency and predictability as required by the individual.

My Work	My Leisure time and fun	My Activities
This is my job: *These are my jobs in my home:* *These are my jobs outside my home:* *These are my jobs in the community:* *These are jobs I would like to try:* ***Consider:*** *what I do, what I like about each job, what I do not like about each job, how often I do each job, and the payment I receive: the people I meet: adaptive equipment, assistive technology, etc.* *This is what I do not like about my job(s) (or where I have problems coping) and what supports might help:*	*These are my hobbies and interests:* *This is how I enjoy them at home alone:* *This is how I enjoy them with my family, my friends and in the community:* *This is what I do for fun and enjoyment:* *These are some other hobbies and interests I would like to try:* ***Consider:*** *what I do, what I like about each hobby/leisure activity, what I do not like: how often I do each hobby/leisure: the people I do the hobby with: adaptive equipment, assistive technology, etc.* *This is what I do not like about my leisure time and fun (or where I have problems coping) and what supports might help:*	*These are other activities I do e.g., cooking, shopping, cleaning, etc.* *This is how I do them at home alone:* *This is how I do them with my family, my friends and in the community:* *These are some other activities I would like to try:* ***Consider:*** *what I do, what I like about each activity, what I do not like: how often I do each activity: the people I do the activity with: adaptive equipment, assistive technology, etc.* *This is what I do not like about my activities (or where I have problems coping)*
This is my daily /weekly schedule: *This is how I like to get information about my daily and weekly schedule:* *This is what I like and don't like about it and how I like to be included in my weekly schedule:* *This is how I communicate and talk about my weekly schedule:* *These are the supports and adaptations I need to help me understand my daily and weekly schedule:* *These are the supports and adaptations I need as I make choices and communicate about my weekly schedule and as I plan for upcoming activities and things to look forward to:* *This is how my daily /weekly schedule could be improved upon to reduce/meet my* behavioural support needs. *(Note: Rights Restrictions check is complete)*		
The following was identified as contributing to a behavioural support need and the following supports, interventions and resources will now be provided:		

5) Skills Building Prompts

Learning new skills plays an important role in feeling good about one-self. Skill development can occur in *communication*, both in expressing oneself and in understanding others: and in other areas like *self-care*, e.g., grooming, dressing, washing etc.; *activities of daily living*, e.g., cooking, cleaning, gardening, shopping; *leisure:* e.g., painting, cycling, music; *work*: education etc. Each individual has the opportunity to identify skills they would like to learn, and they are supported to learn these using evidence-based strategies for skills teaching.

<table>
<tr><th colspan="2">Communication Skills and Supports</th><th>Other Skills</th></tr>
<tr><td>Expressing my-self:

Refer to and / or update current communication documentation in relation to expression

This is how I express myself:

This is how I communicate the following critical messages - without using a behavioural support need
• 'No:
• I want….:
• break
• finished
• I feel …pain, sad, angry, happy, disappointed

This is how I recall a memory to you.

I am having difficulty communicating (telling you) the following and this is what might help. (In the context of a behavioural support need)</td><td>Understanding others:

Refer to and/or update current communication documentation in relation to understanding

This is how I need information to be provided to me so I can understand it

This is how I need information to be provided to me about new events or situations if different from above

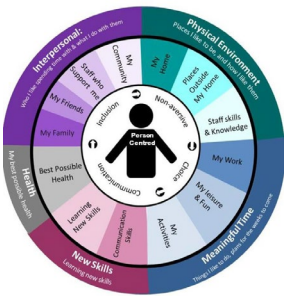
This is how I need information to be provided to me so I can remember:</td><td>These are the skills I am learning:

These are the skills I would like to learn:

(Complete a skills profile via interview, review the Personal Plan observation, skills assessment and consider, skills needed for work, fun, leisure, self-care, relaxation and body awareness, identity, friendships, relationships, sexuality, independent living, friendships, community etc.)

If I could do [a named skill] my day would be a little easier:</td></tr>
<tr><td colspan="3">This is how I like to get information about learning new skills:
This is how I like to be included in Identifying and learning new skills:
This is how I communicate.
These are the supports and adaptations I need as I make choices and communicate about my skills learning.
This is how others could improve their communication with me:
These are skills/ communication skills and supports I could learn to meet my
behavioural support needs (Note: Rights Restrictions check is complete)</td></tr>
<tr><td colspan="3">The following was identified as contributing to a behavioural support need and the following supports, interventions and resources will now be provided:</td></tr>
</table>

Vignette: Emily was presenting with a behavioural support need in her home. She was observed to hit herself on the side of her head or hit another person as they walked by. Her Personal Plan, specifically her person-centred plan including communication documentation was reviewed along with a number of behavioural report forms and a risk assessment, and it was agreed with Emily that the Wheel of Optimal Living would be completed. In the **Interpersonal dimension**, it was identified that Emily did not have any friends to spend time with. She was also unsure of what staff member was working with her each evening. The Physical **environment dimension** identified that she did not have a chair to sit on in her bedroom and the **Meaningful Time dimension** discovered that the evening time was a little boring for Emily and she had little to do. The New **Skills dimension** indicated that Emily could not ask for a specific activity and no communication supports were in place. Emily was also not learning any skills in the area of hobbies or things to do at home in the evening time. The **health dimension**, as part of social well-being indicated that Emily was possibly lonely in her home. The keyworker and the team, together with Emily and her circle of support agreed that Emily's behavioural support need was communicating that she was feeling bored in the evening and that she was trying to communicate 'I would like something to do please'. They put the following plan in place:



Interpersonal	Physical Environment	Meaningful Time	Skills	Health
-A staff picture schedule -Time with a friend- and things to do with a friend(s). -Using social media to stay in touch with my family.	-A Chair in my bedroom	-My evening schedule.	-Hobby sampling -Jewellery making -Communication Skills and Supports to communicate 'I would like to do X' - Communication Skills and Supports to communicate: 'I need some help please' -Relaxation skills & body awareness (including breathing exercises). Skill: 'Making a choice on what to do now/next' -Accessible story on 'Let's do something, can you help'	-Feeling lonely (learning about emotions)

Supporting Emily's behavioural support need in the moment (using the message/function): a two-part response may be required.

- If Emily has hit a peer, this peer will need support and a safeguarding report (and NIRF) is required. If Emily has hit a staff member, the staff member may need support and a NIMS report is required/ If Emily has hit herself, she will require support for this (and a NIRF report is completed) as she may have hurt herself.
- As the function was agreed as 'she was feeling bored in the evening and that she was trying to communicate 'I would like something to do please''; staff will support Emily by acknowledging her and affirming it is 'boring' offering her a choice on what she might like to do now. Note: Now is not the time to teach, support Emily by 'listening to and responding to the message' she is trying to communicate and when everyone is calm (on another day perhaps), we can explore the skills teaching aspects of the Wheel of Optimal Living Support.

Appendix 3: Using your Environment (UYE) Assessment as part of My Personal Plan

The My Personal Plan/Using Your Environment Assessment is a *person-centred planning assessment to support the person to discover, plan and achieve the life they want to live.* It was developed by the Occupational Therapy department at St John of God Dublin South East as a goal setting tool.
The aim of the Using Your Environment assessment is to support the individual to develop a person-centred plan. This is completed through gathering information on what is important to the individual; their dreams, hopes and wishes as well as the skills, activities, and roles that they currently do and those they would like to be able to do going forward - enable the individual to create their **Life Vision**, identify their **outcomes** and **set meaningful goals**.

The Using Your Environment Assessment identifies **Ability** to do a task and the **Importance** of the task to the person across 190 tasks which are broken down into 12 sections to achieve a balanced meaningful daily routine.
My Relationships:

- Being a Family member and friend

My Voice

- Being an advocate

How I spend My Day:

- My Daily Routine
- Using My Community
- Being an adult worker or volunteer
- Keeping Myself Safe
- Leisure at Home
- Leisure in the Community

Where I live/ daily tasks

- Looking after my home: Cleaning, Cooking and Making Snacks

My Health

- Keeping my Body Healthy
- Keeping my Mind Healthy

Looking after myself: Personal Care Using a Person-Centred Approach, the keyworkers for both day and residential services (as appropriate) will complete this assessment with the individual and their circle of support. Where an individual avails of both day and residential services, the residential key worker will take the lead in this process. Where an individual lives with their family, day services key worker will take the lead in the process.
The Using Your Environment Assessment is in line with the St John of God Community Services Person Centred Approach Policy 2022 and incorporates the 5 key principles underpinning a person-centred approach are self-determination, inclusion, valued social roles, contribution, participation, and human rights-based approach.

References:

Kielhofner, G., & Burke, J. P. (1980). A model of human occupation, part 1. Conceptual framework and content. *American Journal of Occupational Therapy*, 34, 572-581.

Law M., Baptiste S., McColl M.A., Opzoomer A., Polatajko, H. & Pollock N. (1998) *Canadian Occupational Performance Measure.*3rd edition. CAOT Publications ACE. Ottawa, Ontario.

Law M., Cooper B., Strong S., Stewart D., Rigby P. & Letts L. (1996) The person-environment-occupation model: Atransactive approach to occupational performance. *Canadian Journal of Occupational Therapy,* 63: 9 - 23.

Mayers, CA (1998) An evaluation of the use of the Mayers' Lifestyle Questionnaire. *British Journal of Occupational Therapy,* 61(9), 393–98.

Personal Outcome Measures (1991) – The Council on Quality and leadership:http://www.thecouncil.org/Personal_Outcome_Measures.aspx

Occupational Therapy Department

09.05.2022

This tool can be accessed from Occupational Therapy.

Appendix 4: Individual Checklist for Positive Behaviour Support

Name: **Date:**

	Indicator	In Place + Not in Place -	Action
1.	**Personal Plan:** Score a + if the person has a personal plan which has been developed with the person, their circle of support and is based on the person's Life Vision including what is important to and for the individual for example in each of these areas; home, work, leisure, learning(skills), health, family, friendships.		Personal Plan (Person centred plan and personalised care and support plan) for person centred living.
2.	**Wheel of Optimal Living or Using Your Environment(UYE) (or other person centred quality of life tool):** Score a + if the Wheel of Optimal Living or UYE or other has been completed with the APIE documented for a behavioural support need or to prevent a behavioural support need		Interview with Individual, family, extended family
3.	**A Written Plan:** Assessment, Plan, Implementation and Evaluation (APIE) has been used: Score a + if the person has an individualised plan including a PBS approach, based on APIE at step 1 using the Wheel of Optimal Living (and/or USING YOUR ENVIRONMENT or other person-centred quality of life tool) or Step 2 a clinically valid assessment and a PBS or a MEBS plan or Step 3 Multi-Element Model is used.		APIE completed and a written plan Is present
4.	**Non-aversive and Non-restrictive Practices:** Score a + if there are no aversive or restrictive practices in place.		Restrictive Practices Check
5.	**Collaborative, Integrated and Multi-Discipline Approach:** Score a + if the person has access to, (as required) other professionals e.g., an SLT, OT, GP, Social Worker, Score N/A if not required.		Evidence of Referral to x, with consultation note and recommendations available.
6.	**Measuring Outcomes:** Score a + if the effectiveness of Positive Behaviour Support is measured by reviewing the desired increase in the person's optimal functioning and quality of life; the removal (reduction) of any aversive or restrictive strategies; the reduction in the behavioural support need as well as the other outcomes on a quarterly basis.		Evaluation evident as part of the personal plan review minutes.
7.	**Incident Management, Risk Assessment and Safeguarding Support:** Score a + if Incident Management, Risk Assessment and/or Safeguarding policies have been adhered to for this person and all necessary supports are in place or N/A if not applicable.		Incident review, Risk Assessment Review and Safeguarding supports review inform practice.
8.	**Individual Checklist:** Score a + if this Individual checklist has been completed for this individual at least once every 12 months, note, when PBS has been required.		Individual checklist completed and verified by…
	Total:	**/8**	

Actions	
1.	4.
2.	5.
3.	6.

Completed by: _____

Appendix 5: Service Checklist for Positive Behaviour Support

	Standard	Yes	No	Comment
1	On interview staff can describe what a 'behavioural support need' is.			
2	On interview staff can describe Positive Behaviour Support and what restrictive practices are?			
3	On interview staff can describe the 5 pillars and the 3-step approach for PBS services?			
4	There is an accessible leaflet/video for individuals and families on Positive Behaviour Support.			
5	There is a written policy 'Positive Behaviour Support' which staff can locate and talk about.			
6	There is a plan in place to support the Positive Behaviour Support policy in the area in question, day or residence, as evidenced in meeting minutes.			
7	Individual records show evidence of APIE and a Plan for each individual (if required) which has been developed and reviewed and is/ part of the personal plan linked to the individual's Life Vision.			
8	Individual records show evidence of multi-discipline (as required), individual and family involvement in decision making and consent processes in relation to PBS.			
9	Individual Personal plans have been updated in the last 12 months and are in line with this policy, HIQA standards and best practice in PBS.			
10	Behaviour report forms / Adverse Incidents / Risk Assessments are analysed and inform the strategy plan as outlined by the PBSC as they implement this policy.			
11	Person Centred Approach Policy informs the development of the Personal Plan which includes the Person-Centred Plan and the Personalised Care and Support Plan. The individual's Personal Plan is in line the PCA Policy.			
12	Staff have attended induction on the PBS policy with access to training/practice support in PBS as evidenced by the training record, as required.			
13	Staff have attended training in how to safely support and respond to a behavioural support need including de-escalation and supports and intervention techniques as evidenced by the training records.			
15	Restrictive practice (Restraint) data is collated, reviewed, and reported on to HIQA and the Local Quality and Safety Committee.			
16	Positive Behaviour Support Committee is active with meeting minutes and reports shared with the Regional Director and Quality and Safety Committee annually.			
	Total	**/16**	**/16**	

Appendix 6: Positive Behaviour Support Committee Terms of Reference Guidance

1. **Terms of reference guidance:**
   - Complete a Local Operating Procedure to aid implementation of this policy, if required, in collaboration with the PPPG Committee.
   - To promote a Positive Behaviour Support (PBS) culture, for example, info share, visuals/posters, workshops on PBS, flow charts, facilitate positive feedback.
   - To collate and use available data to identify individuals requiring Positive Behaviour Support and liaise with the relevant clinician/MDT as required.
   - To collate and use available data to develop and advise on a staff training and support plan as evidenced by needs of individuals supported and liaise with the Human Resource Department and manager(s) as appropriate.
   - To use information from available data sets to monitor and plan for the behavioural support needs within the service for example, behaviour report forms, behaviour incident forms, risk assessment (on Risk Register), NIRF/NIMS, restrictive practices to inform how best to meet behavioural support needs for the service.
   - To request a summary/feedback from HIQA inspections/internal PQS audits in relation to Positive Behaviour Support and Restrictive Practices (in relation to behavioural support needs) and use these to inform an implementation plan for the subsequent 12 months.
   - To monitor or have oversight of the data on restrictive/restraint practices used for behavioural support (physical, mechanical, environmental and medication used as a restraint) and respond appropriately. (It is acknowledged that each regions local procedure will specify their structure and process for Restrictive Practice Governance.in accordance with the Restraint Reduction Policy)
   - To support persons in charge in standardising reporting to HIQA in relation to notifiable incidents for restrictive procedures
   - To liaise with other committees where appropriate for example, Equality Human Rights Committee, Quality and Safety, Safeguarding, Risk Management, Restrictive Practices in relation to strategic use of data /themes in relation to behavioural support.
   - To share a report on the work of the committee in regard to analysis of data, trends and recommendations with the Chair of the Clinical Governance/Quality and Safety Committee annually.

2. **Membership: Director will nominate a committee with the necessary skills:** The committee should be made up of people (minimum of 6- maximum 10) with experience/expertise in PBS, specifically the MEBS model. The chair is a person with expertise in the MEBS model of PBS, where possible:
   - Chair (Senior Clinician with ongoing MEBS/PBS responsibility)
   - Occupational Therapist (Senior)

- Clinician, with a key role/responsibility for PBS (using MEBS) (for example, CNS, Behaviour Risk Coordinator, Psychologist)
- At least one staff member in a senior leadership role from day and residential services. (Persons in Charge/Supervisors/Day Service Coordinator/ Programme Manager)
- CPI Trainer
- Other Senior MDT members as required.

3. Roles and Responsibilities of the committee:

- The committee meets on at least 6 occasions in a 12-month period.
- Quorum: minimum of 4, one of which is the chair.
- Minutes/notes are available for each committee meeting.
- Relevant committee members are responsible for following up on agreed actions.
- Members are responsible to attend scheduled meetings.

4. Accountability and Reporting Relationships

- The committee is operationally accountable to the Local Director/General Manager/Management Team

5. Reports

- PBSC issues a report annually to the Quality and Safety committee and/or the Director of Service or Designee.

Appendix 7: Sample List of Interventions as part of a MEBS plan (proactive and reactive)

PROACTIVE STRATEGIES			*REACTIVE STRATEGIES*
Environmental Adaptations ***(Physical, Interpersonal, Programmatic and Sensory)***	***Skills Teaching***	**Focused or Direct Supports**	***Reactive Strategies*** (De-escalation and Resolution)
Picture/Object Schedule Chat-time Access to drinks, snacks, food. An enjoyable daily routine A job Friend-time Family time Decorate my… bedroom Things to do… hobbies, chores, etc. Things to look forward to Sensory based- dim lights Activity Sampling	General Skills/ Fun skills: baking an apple tart; painting a flowerpot. Functionally Equivalent Skills: e.g. (Communication skills and supports) 'no', 'I want' 'break' 'finished' 'help' 'sad' 'happy' Functionally Related Skills e.g., Choice making. Coping and Tolerance Skills: e.g., Relaxation based strategies; Breathing and calming exercises Self-regulation: Mindfulness, Cognitive based; emotional literacy. Therapy/Counselling Social/Scripted Stories	Reduce triggers (things that may cause a behavioural support need) e.g., noise, light, inactivity. Increase things, events, access to people/activities that bring enjoyment. Praise Reward Contracts, guidelines, and rules Self-monitoring Satiation Stimulus based strategies Cooperation training	Active Listening Capitulation (intuitive Strategies, functional based) Redirection to a preferred activity, object, person Facilitative strategy (prompts to use a communication skill and supports, emotional literacy and attunement, a relaxation skill etc.) Use of positive touch. Stimulus change to a person, activity. Proxemics- change person, space Inter-positioning Self-protective. Remove un-necessary demands/requests

Appendix 8: Guidelines for Reactive Strategies (de-escalation and resolution) as part of a MEBS Approach, a MEBS Plan and the MEBS Model for all steps of the policy

Reactive strategies must always reflect:

1. There is a functional understanding (bio-psycho-social-environmental) of the individual's behavioural support need. This is stated as 'the message' of the behavioural support need.

2. Functionally based and non-functionally based strategies (including Functionally Informed)

3. The use of non-aversive, non-restrictive strategies to respond to and support a behavioural support need.

4. The reduction of the episodic severity of each behavioural support need by responding to the function of the behavioural.

5. Their use in the context of a functionally equivalent /communication skill and as part of a suite of proactive strategies (environmental, skills and direct interventions)

6. On occasion an intervention which is considered non-aversive and non-restrictive may escalate a behavioural support need. If this occurs, the intervention should be discontinued immediately.

7. Strategic Capitulation: This intervention forms the basis of a MEBS (approach, plan and model) reactive strategy and it identifies that 'if you know what the individual needs /wants and what would calm the individual down then provide it immediately' (providing access to a preferred item/event will reduce the episodic severity).

8. In the absence of a MEBS plan it is ethical and consistent within a Human Rights Based Approach to respond functionally and use non-aversive approaches to de-escalate and resolve the behavioural support need. A referral for Positive Behaviour Support can be made, if required.

9. The application of the 9 ADM guiding principles with the individual are evidenced in the decision-making process for all supports and interventions. This ensures good practice in relation to consent.

10. Should a restrictive practice be recommended, the individual's participation in the decision-making process on the 'restrictive practice' is evidenced including the consent process. MEBS is responsible to reduce and remove the restrictive practice.

    1. There is a 'frequency of review' noted, including how the individual will be included in this.

    2. Equality and Human Rights Committee is accessed to ensure a due process review has been afforded.

Appendix 9: Sample List of Interventions that make up a Reactive Strategy (for de-escalation and resolution) in a MEBS Approach, MEBS Plan and the MEBS Model

The following reactive strategies can be used when responding to a behavioural support need within the MEBS model; these interventions are non-aversive and non-restrictive.

1. **Strategic Capitulation:** If you know what the person wants/needs and what would calm the person down, then provide it immediately (providing access to a preferred item/event reduces the episodic severity).

2. **Redirection or diversion** to a preferred activity/object.

3. **Active listening:** An empathetic response involving identification of the communicative intent of behavioural, verbal feedback allowing the person to further discuss any issues, e.g., stimulus naming (identifying and naming the trigger, emotion, e.g. 'I can see you're tired', 'I can see you are annoyed'), positive framing and affirmation/confirmation of the person.

4. **Facilitative Strategy:** Prompts to use coping skills, relaxation skills, communication skills and supports, move to calm place, breathing skill, (NB: Not forced to).

5. **Stimulus change:** Introduction of a completely different and preferred stimulus e.g., person, place, object, activity, humour, quietness.

6. **Diversion** to compelling activity (diversion to an activity that the person is typically compelled to do, really enjoys doing or wants to do).

7. **Proxemics:** Awareness/modifications of personal space intrusions.

8. **A change** in non-verbal, body language, tone of voice, personal style, and verbal behavioural protocol, in response to early indicators of behavioural escalation.

9. **Ignore**: Respond to person as if behavioural support need has not occurred. This can also include use of Positive Leading. Note: This is not extinction and should not be included if the behavioural support need is communicating 'please interact with me' /in order to elicit attention. May ignore the physical (topographical) behavioural need not the function.

10. **Remove** un-necessary demands or requests.

11. **Self-protective**, for example, blocking a strike, holding a cushion to block a strike;

12. **Inter-positioning:** Placing an object between the physical act of aggression, for example a table, a cushion.

13. Use of **Physical Prompts or Positive Touch:** At times it may be supportive to use a gentle touch on the arms, hands, shoulders, or upper body (back) of an individual. This touch is used to calm an individual, to get an individual's attention and is always done gently and if at any time the individual's behavioural support need increases as in the individual becomes distressed, resists, and moves away, as a result of this touch, it should be discontinued immediately. The use of physical prompts or positive touch is used with the following guidelines

    - The person gives permission to be touched on the arm, hand, shoulder, or upper body (back). The individual shows no resistance, and no pressure is used.
    - The touch is used to reassure and support the person to calm and to address the function of the behavioural support need. The touch is used to enable access to a 'right', so serves the purpose of honouring a right, be it accessibility, participation for example.
    - If touch is used to assist a person who is resisting, this may be a form of physical restraint and as such requires authorisation by an appropriate professional and written consent from the individual (or decision support). This intervention must be consistent with the policy guidelines on physical restraint. (SJOGCS Restraint Reduction Policy)

Each of these strategies can be used as a reactive strategy to any behavioural support need. They are non- restrictive, and for most people are non-aversive. Should any of these strategies result in an increase in a behavioural support need, this would mean they are aversive for the person and should be discontinued immediately.

For these strategies to be most effective they should be used as part of a PBS approach, which could include a behavioural assessment and a Positive Behaviour Support Plan or Multi-Element Behaviour Support Plan. If these strategies are used on an on-going basis the APIE is required at the appropriate step. Reactive strategies as part of PBS approach and in particular in the MEBS model can be functionally based, non-functionally based and/or functionally informed, but are always, non-restrictive, and non-aversive.

- **Functionally based:** The reactive strategy is based on the function of the behavioural support need e.g. If an individual hits another individual and the function is 'to leave the room', then the reactive strategy is to support the person to leave the room.

- **Non-functionally based but functionally informed (function known, so functionally informed):** e.g., when an individual hits another individual to 'leave the room' and the individual is affirmed, and the message is acknowledged by saying "I know you want to leave the room. However," (redirection is used, a non-functionally based intervention (yet functionally informed), while the staff member waits for a colleague to return) "can you help me with this first until 'staff member' comes back and I can leave the room with you".

- **Non-functionally based (function not known):** e.g., when an individual hits another individual and the function is not known. In this situation, the staff member offered the individual a new movie on their iPad, which the individual agreed with. (Redirection is used, a non-functionally based intervention) with the staff engaging in reflective practice as they complete the behaviour report form.

Note: in the example, if a peer was involved or indeed experienced distress, a safeguarding report as per the Safeguarding Policy is required.

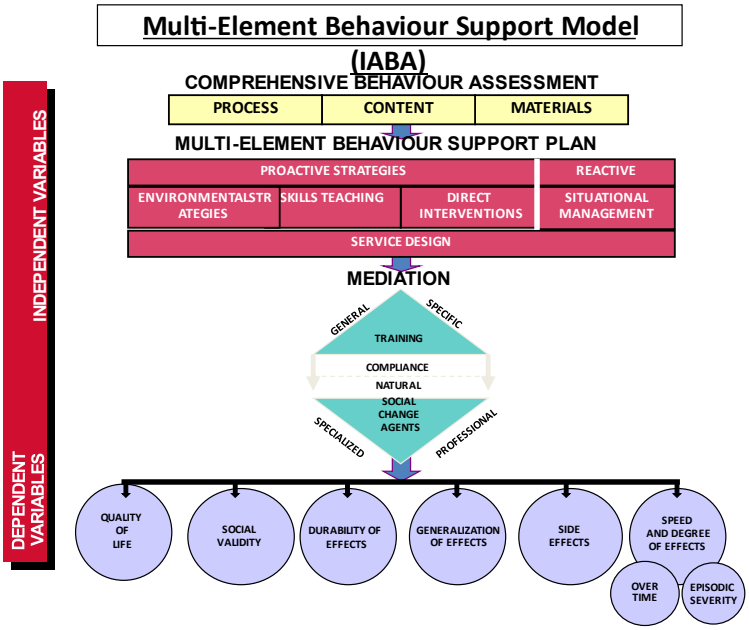
Appendix 10: Glossary of Terms and Definitions

Disability: The Convention on the Rights of Persons with Disabilities adopts a social model of disability, and defines disability as,

'Recognizing that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others'.
(United Nations, 2006)

In adopting this definition this policy conforms to the social model of disability and a Human Rights Model of disability recognising the interaction and responsiveness of the environment to the needs and rights of the person.

Multi-Element Behaviour Support Model: Multi-Element Behaviour Support (MEBS) Model is a comprehensive and structured model of Positive Behaviour Support. The uniqueness of this model lies in the comprehensiveness of the assessment (process, content, and materials), the development of a MEBS plan (which meets clear criteria, including the use of functionally based and/or non-functionally based, non-aversive and non- restrictive reactive strategies.), implementation and monitoring using the Periodic Service Review and evaluation across 6 outcome measures.



Optimal Living: This is best understood as the most favourable or desirable life as identified by and with the individual.

Person Centred Planning: 'Person Centred Planning' may be defined as a way of discovering:

- how a person wants to live their life and
- what is required to make that possible.
- See SJOGCS Person Centred Approach Policy: 2021

he overall aim of Person-Centred Planning is "good planning leading to positive changes in people's lives and services" (Ritchie et al, 2003, cited in NDA, 2006:12).

Area of concern of imminent risk of serious harm: any conditions or practices or situations which are such that a danger or risk exists which could reasonably be expected to cause death or serious physical/psychological harm to an individual(s) immediately or before the imminence of such danger/risk can be reduced or eliminated. For example, falling out of bed; choking; eating non-edibles; leaving home without adequate support; to participate in a medical procedure; physical harm to self or another; postural/positioning for breathing etc.

Unplanned /Emergency use of a restrictive practice when responding to a behavioural support need. In cases of an emergency or crisis, it is incumbent on staff to evidence a commitment to the use of non-aversive and non-restrictive interventions. On saying this, it is noted that it may become necessary to physical hold/restrain a person in order prevent imminent risk of serious harm, for example, 'take hold of an individual's arm to pull them out of oncoming traffic' or to support the safety of others or to facilitate a person receiving urgent medical care, (with due regard to any advance healthcare directive which the person has in place.) In such circumstances, staff may require CPI training and PBS input and supervision in using unplanned restrictive practices.

Appendix 11: Legislation / other related Policies

This policy is informed by Health Act 2007 (Care and Support of Residents in Designated Centres for persons - Children and Adults - with Disabilities), the Regulations (2013) of the same act, and the Health Information and Quality Authority's (HIQA, 2013b) National Quality Standards for Residential Settings for Adults and Children with Disabilities and the Assisted Decision-making (Capacity) Act, (2016). The United Nations Convention on the Rights of People with Disabilities (UNCRPD) and 'A Rights Based Approach to Behavioural Support Guiding Principles' Guiding Principles Subgroup Policy: Provision of Behavioural Support – Schedule V no. 5 Health Care Act 2007, Regulations 2013. Version 1. Approved by the Independent Governance Review Group HSE July 23, 2020.'

It is also informed by the following Saint John of God policies:

- SJOGCS 11 Policy on Equality and Human Rights (Promotion and Protection) 2020 or update
- SJOGCS 39 Policy on Equality and Human Rights for Children (Promotion and Protection) 2021
- SJOGCS 4 Supports Policy for Individuals with an Intellectual Disability (Admission/Entry/Transition/ Transfer/Discharge/Exit) 2022 or update
- SJOGCS 13 Policy on Using a Total Communication Approach (2022) or update
- SJOGCS 16 Restraint Reduction Policy (2019) or update
- SJOGCS 17 Policy on Stakeholder Feedback and Complaints in line with HSE "Your Service Your Say" (Intellectual Disability and Mental Health Services) 2022
- SJOGCS 18 Integrated Risk Management Policy and Standard Operating Procedure 2021
- SJOGCS 19 Incident Management Policy and Procedure 2021
- SJOGCS 30 Person-Centred Approach: A Policy on the development of Personal Plans which include a Person-Centred Plan and a Personalised Care and Support Plan for Intellectual Disability Services 2020
- HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures 2014 or update
- SJOGCS 41 Policy on the Prevention and Management of Work-Related Aggression and Violence 2018 (HSE) Standard Operating Procedure including the Protection of Staff working in intellectual disability and mental health services in Saint John of God Community Services clg 2022
- SJOGCS 42 HSE Child Protection and Welfare Policy 2019: SJOGCS Standard Operating Procedure 2022
- Department of Children and Youth Affairs (2015) National Strategy on Children and Young People's Participation in Decision-making, 2015 – 2020.

Appendix 12: Extract from Statutory Instruments. S.I. No. 367 of 2013. Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013

1. 'The Person in Charge shall ensure that staff have up-to date knowledge and skills appropriate to their role to respond to behaviour that is challenging and to support residents to manage their behaviour.
2. The Person in Charge shall ensure that staff receive training in the management and support of behaviour that is challenging including de-escalation and intervention techniques.
3. The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his/her representative, and are reviewed as part of the personal planning process.
4. The registered provider shall ensure that where restrictive procedures including physical, chemical, or environmental restraint are used, such procedures are applied in accordance with national policy and evidence-based practice.
5. The person in charge shall ensure that where a resident's behaviour necessitates intervention under this regulation-
   (a) every effort is made to identify and alleviate the cause of the resident's challenging behaviour.
   (b) all alternative measures are considered before a restrictive procedure is used and
   (c) the least restrictive procedure, for the shortest duration necessary is used.

   that where an individual's behavioural support need requires support every effort is made to:
   - identify and alleviate the cause of the individual's behavioural support need using PBS.
   - all alternative measures are considered before a restrictive procedure is used and the least restrictive procedure, for the shortest duration necessary is used in keeping with the SJOGCS Policy on Restraint Reduction.'

Appendix 13: Members of the Policy Working Group (with active consultation with SLT)

<table>
<tr><td colspan="2">Members of the Policy Working Group:</td></tr>
<tr><td>

Elaine Fitzsimons, Principal Clinical Psychologist, DSE
Cathy Hayes, Principal Counselling Psychologist, Liffey Region.
Gary Luckie, CNS in Behaviour, ANP Candidate, NES.
Ann O Brien, CNS in Behaviour, Liffey Region
Christina Doody, Behaviour Specialist, Callan Institute.
Gillian Martin, Behaviour Specialist, Callan Institute.
Jane Fitzgerald, Risk and Behaviour Management Coordinator, Kerry Services.
Caryn Almgrengleason, Risk and Behaviour Management Coordinator, Kerry Services.
Eucemia O’Leary, Senior Occupational Therapist, DSE

</td><td>

Moyna Noble, Speech and Language Therapy Manager, DSE.
Noel Hannan, Consultant Psychiatrist, DSE /Liffey Region.
Ashika Bridglall, Senior Psychologist, Liffey Region.
Aisling Ryan, Senior Clinical Psychologist, DSE
Sharon Hardiman, Senior Clinical Psychologist, DSE
Zafar Iqbal, Clinical Psychologist, Liffey Region.
Liz McGuinness, CNM, Liffey Region.
Louise Buckley, CNS Dementia, Liffey Region.
Claire O Dwyer, General Manager, Kerry Service.

Caroline Dench (Chair) Coordinator, Callan Institute.
</td></tr>
<tr><td colspan="2">Policy document reviewed by SLT in SJOGCS (Disability Services)

Moyna Noble, (DSE) Leigh Hagan, (DSE) Sorcha Lannoye (DSE), Christina Cannon, (Liffey Region) Polly Walsh (Liffey Region) and Amy Hayward (NES)

</td></tr>
<tr><td colspan="2">Minutes and Draft Policy was shared with the following staff post each meeting.

Emma Potter, Occupational Therapist, Kerry Services
Edwin Ndubi, Senior Occupational Therapist, NES
Christine Melrose, Quality Manager, PQS Department.
Gyan Bharti, Senior Occupational Therapist, Liffey Region.
Maria Kennedy, Occupational Therapist, DSE,
Nita Desai, Senior Occupational Therapist, Kerry Services
Audrey Carroll, Programme Manager, Day services, DSE

</td></tr>
<tr><td colspan="2">Easy Read document on the Positive Behaviour Support Policy was finalised with feedback from individuals supported(adults) in Saint John of God Dublin Southeast and Liffey Services (as a separate document)</td></tr>
</table>

Appendix 14: Local Operating Procedure (If required, can be attached here)

STAFF SIGNATURE SHEET

I have read, understand and agree to adhere to the 2023 SJOGCS Positive Behaviour Support Policy (Children and Adults Intellectual Disability) (SJOGCS 08).

Print Name	Signature	Area of Work	Date