POSITIVE BEHAVIOUR SUPPORT

Can Positive Behaviour Support be implemented in a primary care setting for the homeless/vulnerably housed?

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CAN POSITIVE BEHAVIOUR SUPPORT BE IMPLEMENTED IN A PRIMARY CARE SETTING FOR THE HOMELESS/VULNERABLY HOUSED?

INTRODUCTION

This review is based upon a GP practice working in a city centre providing primary care to the homeless and vulnerably housed within the city. Services include GPs, Nurses, Mental Health Practitioner, Social Prescriber, Addiction Worker, Dentist, Acupunturist, Podiatrist and an administrative team.

The service is highly responsive with patients being able to book same day appointments, longer appointment times are allocated and support provided from registration onwards. Many of our patients have drug and alcohol problems, are living chaotic lives and some can be difficult to engage. The practice is therefore very flexible in missed appointments, late arrivals, and are opportunistic with interventions when a patient presents as we don't know when we will next see them, if ever. However, even with this accessibility/flexibility, there are still times when patients present in an aggressive manner/with challenging behaviour. The Royal College of Psychiatrists 2007 define behaviour as challenging "when it is of such an intensity, frequency or durations as to threaten the quality of life and/or physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion".

Patient's challenging behaviours can be triggered once they are in the practice receiving care, or before they even enter the premises. These incidents often trigger emotional responses within the team which can easily escalate, split the team as to how the situation should be handled and lead to an inconsistent approach with the patient. This has been described in the Personality Disorder Outcomes Programme (www.pdpop.uk) as the Rescue/Blame Seesaw, "people with personality disorder often elicit strong reactions in others. Sometimes this can be experienced as overwhelming feelings of sympathy and a desire to help fix the persons problems ('rescuing'). Other presentations can evoke very negative feelings ('blaming')". Current systems in place in the practice to curb undesirable behaviour is to have "behaviour conversations" or issue "behaviour contracts" and as a last resort, exclusion.

In addition, some patients become very reliant on the practice and are unwilling to move on to a new GP practice once they are stably housed (the practice is aimed at being a brief intervention service whilst people are homeless/vulnerably housed). Patients are therefore asked to re-register with another practice at some point in their care. When doing this the staff team are conscious that this can be a challenge to many of the patients who become reliant/ attached to the team, have built good trusting relationships and have received high levels of support.

In looking at the principles of Positive Behaviour Support (PBS), it was felt that adoption of this approach within the practice would assist in addressing these identified key needs, as well as generally improving both the patient and staff experience.

WHAT IS POSITIVE BEHAVIOUR SUPPORT?

PBS is described within the book "Person-centred active support, A handbook, Bev Ashman, Joh Ockenden, Julie Beadle-Brown and Jim Mansell", as:

"Positive behaviour support involves changing situations and events that people experience in order to reduce the likelihood that challenging behaviours will occur, and increase social, personal and professional quality in their lives."

The International Journal of Positive Behavioural Support, Volume 12, Supplement 1, 2022, describes PBS as "forever evolving, embracing new practices that improve people's quality of life."

BILD: The seven key questions about Positive Behaviour Support 1 Taken from the BILD Positive Behaviour Support Jargon Buster, available at: www.bild.org.uk/pbs describes it as: "An understanding of the behaviour of an individual. It is based on an assessment of the social and physical environment in which the behaviour happens, includes the views of the individual and everyone involved, and uses this understanding to develop support that improves the quality of life for the person and others who are involved with them."

In looking at those descriptors, PBS seems to encapsulate what the practice is trying to achieve. Whilst it is noted that PBS seems to be mainly used with clients with Learning Disabilities and/or Autism, the framework of the approach seem to be flexible enough to design and utilise around existing systems.

IS PBS RIGHT FOR THE HOMELESS COMMUNITY?

In undertaking research into PBS, the parallels on challenges faced by those with learning disabilities and the homeless were striking (https://www.bild.org.uk/resource/pbs-helpline-resources-understanding-behaviour/ - Physical Health Video by S Rogun, Associate Consultant, British Institute of Learning Disabilities). Within this she cites the following challenges for those with learning disabilities:

- Health inequalities
- Premature death
- Services designed for the general population
- Health professionals don't have the skills to meet needs
- Patients may not be able to communicate their health symptoms and assumptions made about their needs
- May have had negative experience previously with support systems
- Less likely to attend preventative programmes to identify problems earlier e.g. cancer screening
- Diagnosis overshadowing
- Pain/distress can be misinterpreted as just the way they are, always like that.

Whilst PBS has not explicitly been recommended for adoption within the homeless community, evidence is clear that the homeless exhibit the same challenges as those with a learning disability (A health needs assessment of the adult street homeless population in Oxfordshire -Dr Isaac Ghinai Public Health Specialty Trainee Oxfordshire County Council.) This is also supported within the homeless support network: Personally Speaking Dec 2013 (homeless.org.uk).

The adoption of PBS therefore would seem to be a good fit with the challenges faced by the homeless community, some of whom will also have a learning disability and/or autism. If we are able to positively engage patients and encourage them to take ownership of their own health, this could make a real impact.

WHAT OUTCOMES HAVE BEEN ACHIEVED BY INTRODUCING PBS?

I was keen to see what successes had been achieved using PBS, particularly on a larger scale, to evaluate the potential for change at the practice. There were notable impacts seen following its introduction at MacIntyre (www.bild.org.uk - Implementing Positive Behaviour Support at MacIntyre A case study showing how BILD is supporting organisations to implement Positive Behaviour Support). Outcomes include 81% of staff's well-being increasing, injuries caused by behaviours of concern dropping by 54% and a drop in physical interventions by 23%.

When PBS was introduced in a forensic setting, outcomes achieved included a reduction in staff turnover, improved staff retention, reduction in the amount and intensity of incidents, restrictive practices reduced and positive feedback received. In addition, feedback received was that there was an improvement of quality of life for both staff and those using the service. (Implementing PBS in a forensic setting – a story of success in the UK Laura Higgins, BILD).

Gloucestershire County Council set up a county-wide PBS approach for those with a learning disability. Outcomes that they saw following its introduction were transitions from residential special schools and inpatient units from outside the county, to local community placement. There was also evidence of better inter-agency working which therefore improved the outcome of individuals. (www.skillsforcare.org.uk - Offering positive behavioural support across Gloucestershire: a county-wide case study).

From these examples of outcomes achieved, it would appear that through the adoption of PBS within the practice we would not only address our key areas for improvement, but would also benefit from better outcomes in other areas.

HOW DO WE INTRODUCE POSITIVE BEHAVIOUR SUPPORT?

In learning from the work undertaken within the learning disability sector, and as discussed on the British Institute for Learning Disabilities website, opportunities to support our patients could include PBS strategies in the following areas:

- The environment. We should consider safety and security, physical comfort, psychological comfort, sensory needs.

- Be aware of how we communicate – does the patient understand what is said, use easy read/pictures, translators, use of gestures, is a referral to a Speech & Language Therapist appropriate.
- Physical health. Undertake a full medical review upon registration and treat not only presenting symptoms, but also look at addressing underlying medical conditions. Not to make assumptions because of drug or alcohol abuse, but to look at the whole and see where support can be given. This could be physical health, mental health, advocacy, sign posting, referrals etc.
- Building trust/rapport. Respectful communication, listening to what the patient is saying, doing what you say you will do.
- Active support. This can be provided at the time of registration for completion of registration forms, understanding what is going to happen next, support within the consultation itself, encouragement to engage in health activities through education/knowledge sharing, assisting with completion of forms, accessing activities, creating plans for things they would like to do, aid understanding of their own behaviour and what they could try to get different results.

It is also key to ensure that the Manager/Practice Leader of the service has knowledge of PBS and takes a lead role. To assist in meeting Practice Leader Competencies, the checklist produced by BILD "Community of Practice and LDAG Subgroup Transforming Care in Wales for People with Learning Disabilities and Challenging Behaviour March 2018" appears to be a very good resource/roadmap.

NHS England have also compiled a competency based action plan for organisations to use, broken down into actions by the person having direct contact, the manager and the organisation. (www.england.nhs.uk – Positive Behaviour Support, A Competence Framework - Positive Behavioural Support Coalition March 2015). Through the adoption of this framework, PBS can truly be embedded into a practice wide approach.

In introducing PBS, we also need to consider challenges that can be faced. It has been cited that the introduction of PBS is resource intensive at the beginning in terms of the physical environment and recruitment and training of staff, there needs to be consistency of staff approach, resistance to change and a fear of increased risk by introducing PBS principles.

(Implementing PBS in a forensic setting – a story of success in the UK Laura Higgins, BILD). This view was further endorsed by Caswell Clinic, Medium Forensic Unit, Wales (Introducing Positive Behavioural Support (PBS) Within a Medium Secure Forensic Mental Health Service - Dr. Bronwen Davies John Griffiths) where they noted the challenge of staff attitude when introducing PBS, with some staff believing that they were rewarding challenging behaviours, or they felt they were being 'manipulated' by the service users.

HOW DO WE EVALUATE THE INTRODUCTION OF POSITIVE BEHAVIOUR SUPPORT?

BILD cite that "good PBS practice should include robust and effective ways to measure and evaluate the outcomes of a person's goals. This helps us know if we are making a difference, whether the impact of PBS results in improvements for the person in quality of life, increases in new skills, and reductions in behaviours of concern. PBS uses several data methods, from direct recording, structured checklists/questionnaires, and indirect methods (e.g., incident reports), each with benefits and limitations."

In order to evaluate success, therefore, as a first step we need to be clear on the goals/standards/outcomes (these should be specific, measurable, attainable, realistic and timed – SMART) that we are looking to achieve at the outset and how these will be measured. Leaders can be assigned to each target area to aid ownership and attainment against goals measured on a monthly basis. If we are not achieving our goals, as a team we can constructively discuss what we can do to unblock this through Peer Support Review (Peer support occurs when people provide knowledge, experience, emotional, social or practical help to each other – Wikipedia).

Within each goal area, data methods should be selected at the outset. In addition to those outlined in "How to we introduce Positive Behaviour Support?" above, examples of additional tools that could be used are the Motivational Assessment Scale (MAS; Durand & Crimmins, 1988, 1992; Haim, 2002)) and BILD's Subjective Quality of Life Tool.

CONCLUSION

Within this report the goal was to explore whether the use of PBS could assist us in supporting patients who presented as challenging and also building their knowledge and confidence to enable them to move-on from our practice once they were stably housed.

There is extensive evidence of the impact of PBS and the positive outcomes that can be achieved through its adoption and of note CQC have utilised this as an example of best practice. (Brief guide: Positive behaviour support for people with behaviours that challenge.) Whilst PBS has mainly been utilised with people with a Learning Disability and/or Autism, it would appear that the principles of PBS can be readily applied to other settings (Implementing PBS in a forensic setting – a story of success in the UK Laura Higgins, BILD).

From the evidence and outcomes observed following the introduction of PBS in other organisations it would seem that the adoption of PBS within the practice would certainly reduce challenging situations and enhance patient experience and staff well-being. Whilst the writer could not find evidence of PBS being introduced within homeless services or primary healthcare, it would appear that the concept of PBS is one that can be used in various settings and environments.

Whilst the benefits of introducing PBS are clear, it is also important to recognise that its introduction will be time intensive and could also meet with resistance. A team wide supported approach therefore is essential to ensure its success. Indeed, within the International Journal of Positive Behavioural Support, Volume 12, Supplement 1, 2022, it states that there is a danger that "the indiscrimate use of PBS risks prompting a backlash against a perception that PBS is trying to be the answer to all things." It would be important therefore to not think that by introducing PBS within the practice, that this will be the only intervention required.

(Word Count including headings and references quoted above 2,237).

In addition to cited documents in the report, additional documents referenced:

Personally speaking Dec 2013.pdf (homeless.org.uk) –

draft-guideline (nice.org.uk)

Integrated health and care for people experiencing homelessness: NICE guideline DRAFT (October 2021)

Periodic Service Review (**LaVigna** et al, 1994)

Homelessness: applying All Our Health - GOV.UK (www.gov.uk)

positive behaviour suppo rt - YouTube

10_things_PBS_HLPE.pdf (bild.org.uk)

www.bild.org.uk – video on health

PBS helpline resources: Understanding behaviour | bild

Positive BehaviourAL Support (england.nhs.uk)

Understanding Challenging Behaviour - YouTube