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Positive behaviour support in Irish residential services: Perspectives of frontline staff, management and clinicians on implementation challenges

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ABSTRACT

Background: The current study explored the perspectives of staff working with adults with intellectual disabilities and behaviours that challenge. We sought insight into their understanding of procedural fidelity and challenges faced when implementing behaviour support.

Method: We interviewed 15 staff members supporting adults with intellectual disabilities in residential settings. Participants included five front-line staff, five residential managers, and five clinicians. Interviews were transcribed and thematic analysis conducted.

Results: Issues identified by the participants related to four main themes: (1) Organisational and environmental constraints; (2) Understanding and monitoring of procedural fidelity; (3) Theory versus practice; (4) There's nothing positive about behaviour support.

Conclusion: Across staff groups, lack of understanding of fidelity emerged, as well as minimal accountability regarding behaviour support. Front-line staff felt isolated and under pressure. Greater emphasis on partnership, practice leadership, and positive feedback may give front-line staff the support needed to use behavioural interventions with high fidelity.

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Positive Behaviour Support (PBS) is a multi-component approach combining goals of reducing the risk of behaviours that challenge displayed by people with intellectual disabilities, while increasing skills, opportunities, and environments that support quality of life (Gore et al., 2022). PBS has increasingly been endorsed internationally as an approach of choice (e.g., NICE, 2015). Multiple demonstrations of the effectiveness of PBS have been provided in direct work with individuals who display behaviours that challenge (e.g., Hassiotis et al., 2009), through staff training (e.g., MacDonald et al., 2018) and when applied on a setting-wide basis (e.g., McGill et al., 2018). At an individual level, PBS is often implemented through the development of a behaviour support plan (BSP) that guides frontline staff in the strategies to be used with an individual to reduce behaviours that challenge and support quality of life. Many such plans incorporate both proactive components relating to the prevention of behaviours that challenge through the provision of high-quality support and environments and the development of functional skills together with more specific reactive strategies to be used in the event of the occurrence of behaviours that challenge (e.g., LaVigna et al., 2022).

Previous studies have highlighted a number of difficulties in the successful implementation of PBS plans. Fisher et al. (2022) reported that, while staff find PBS plans useful, they are often lengthy and difficult to implement due to lack of support. Albin et al. (1996) discussed the fact that the separation between clinicians and frontline staff may have an impact on the level of accuracy with which plans are implemented. They suggested that plans can often be written in technically-proficient language, but may not be compatible with the resources, values, and needs of the service in which they are to be implemented.

Procedural fidelity refers to the implementation of a behavioural intervention as intended (Ledford & Gast, 2014). It is considered as a major factor in behavioural research, listed as one of the six standards for single-case research by Horner et al. and included in a list of essential features for special education research by Gersten et al. (2005). However, Wolery (2011) highlighted that there is little evidence that frontline implementers of behavioural interventions can and do deliver interventions as intended without significant support from researchers. There is little research into improving procedural fidelity in adult services for individuals with intellectual disabilities despite their huge financial cost

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for governments and organisations. For instance, in Ireland, the Action Plan for Disability Services 2024–2026 has allocated over €2 billion to the provision of adult residential disability services (Department of Children, Equality, Disability Integration and Youth, 2023).

It has been argued that the failure of human services to consistently deliver quality-of-life outcomes and interventions delivered with high fidelity lies within the organisational processes underpinning frontline management and leadership practices (Mansell & Beadle-Brown, 2012). Most community residential services in Ireland work within a three-tier staffing structure to deliver frontline behavioural interventions. The three tiers include frontline staff members, clinicians, and frontline residential managers (National Disability Authority, 2018). However, a systematic review conducted by Brady et al. (2019), which focused on procedural fidelity of behaviour interventions in intellectual disability service provision, identified that previous research focused solely on frontline staff members' training and experience of implementing interventions. It is important to consider the range of influences operating on different groups of staff and how they might support or act as barriers to fidelity.

Regulatory bodies involved in ensuring quality and safety in services provide one set of influences. In Ireland, for example, residential disability services for individuals with intellectual disabilities have been subject to regulation by the Health Information and Quality Authority (HIQA) since 2013. The Irish government has committed to moving people from congregated settings to community-based settings within a 7-year period and is committed to creating organisational and culture change across the disability sector (HSE, 2011). The standards outlined by HIQA have a basis in Irish law with eight key domains identified, which include: person-centred care and support; effective care and support; safe care and support; better health and wellbeing; leadership; governance and management; workforce; and resources. The effective care and support domain lays particular emphasis on good quality behaviour support, guided by evidence-based practices. While these standards aimed to improve and bring consistency to services provided, they have been established in a top-down manner, with organisations being required to conform within a set time period or risk not being registered as a service provider or being shut down.

While additional regulation may have been necessary, a 2019 overview report by HIQA (Health, Information and Quality Authority, 2019) highlighted its sometimes-negative impact on service provision. Service users reported that increased paperwork was preventing frontline staff from being able to spend time

with them, and the rules and regulations in place made their home environment too restrictive. A focus on administrative activities at the cost of interaction with service users has been previously reported in intellectual disability research (Mansell & Elliott, 2001). Such factors are likely to have an impact on procedural fidelity by reducing the time staff spend with service users to teach new skills, support them in new environments, or deliver other recommended interventions. It should be noted that this report also highlighted a number of benefits of the new regulations, including increased safety and autonomy and better standards of living across services.

The behaviour of frontline staff is also heavily influenced by the organisations in which they deliver services. Bigby and Beadle-Brown (2018), in a review of factors influencing quality of life outcomes, identified a range of influential organisational characteristics including but not limited to management practices, enabling and less institutional cultures, clarity and understanding of organisational mission, and good governance. Mostly, such organisational features have their impact through their influence on frontline staff practices.

Bigby and Beadle-Brown (2018) also acknowledged the role played by the external environment and the importance of this being congruent with an organisational mission that is centred on quality-of-life outcomes for the people receiving the service. More individual factors, such as staff background and previous training histories, likely also play a significant role, as do the personal values, attitudes, and perceptions of one's own role of the staff required to carry out the interventions (Lewer & Harding, 2013). While the new HIQA requirements mean all frontline staff in Ireland must have a minimum Level 5 qualification in social care, there are different levels of staffing including personal assistants, care assistants, nurses, and social care workers, meaning that qualifications can vary significantly. Social care workers are required to hold an undergraduate degree in social care and be registered with the National Health and Social Care Registration Board (CORU); and nurses must hold nursing degrees and be registered with the Irish Medical Council. It is likely that the differences in qualification and experience required for frontline positions will impact each individual staff member's perspective and focus in their role.

Staff training systems have been developed to improve the quality of support delivered to service users. A review by Konstantinidou et al. (2023) identified nine studies that reported results of staff training within a PBS framework. These studies included "train the trainer" methods and an Organisational Behaviour

Management (OBM) framework, which resulted in positive overall outcomes for service users. However, difficulties were highlighted in the reporting of results, in that the main measurable outcome was the reduction of behaviours that challenge, with little focus on service user quality of life. Additionally, the reviewed studies included little information about how training systems could be replicated, leaving it uncertain how procedural fidelity of support plans developed after the trainings could best be monitored and maintained.

The current study aimed to further explore staff perceptions of how interventions around behaviours that challenge (especially those associated with PBS) are implemented day-to-day and their understanding of factors that influence the perceived fidelity of these interventions. The study included three different groups of staff based in Ireland: clinicians, frontline managers, and frontline staff, to investigate and compare perceptions from the different roles involved in developing and implementing behaviour support plans.

Method

Design

Qualitative, semi-structured, face-to-face interviews were used because of their ability to gather extensive and relevant data while allowing for exploration of interviewees' experiences and own perspectives (Creswell & Clark, 2011). This method also ensures that certain topics are addressed consistently in the interview process, while allowing some degree of freedom to gather information specific to the individual participant (Rabionet, 2014).

Participants and recruitment

Participants were recruited in groups of three from each organisation: one clinician, one house manager, and one frontline staff member. All members of each triad were involved in working with the same service user to enable the researcher to compare their perspectives of the process involved in implementing the same behaviour support plan. A total of 15 participants (i.e., five triads) were recruited from five adult disability services in Ireland. A database of 20 organisations, based in Leinster, Ireland, which described their behaviour support as PBS, was compiled. All organisations were contacted via email by the researcher. Five organisations responded to the research request and these were included in the current study. Organisations provided study details (e.g., purpose and participant involvement) to residential house managers, who were asked to volunteer if they were interested in the research. The first manager that

volunteered in each organisation was selected to take part in the study. Following this, the participating manager's front line staff team were provided information and interested participants were asked to volunteer to take part. The first team member to volunteer and provide a consent form to their manager was selected for the study. Clinicians associated with the residential house were then provided with information about the study. All clinicians associated with the identified residential teams provided consent to take part in the study. Demographic information was gathered by questionnaire prior to interviews. Summary information is provided to protect participant anonymity; all names reported in the results are pseudonyms. Eleven females and four males took part. The average age of participants was 39.25 years (range 25–56), and the average duration they had been working with people with behaviours that challenge was 15.1 years (range 7 months – 25 years). All participants had a minimum qualification of a Bachelor's degree. Five participants were frontline social care workers, two participants were clinical nurse managers, and three were social care workers with the title "Person in Charge". Three clinicians were clinical psychologists and two were Board Certified Behaviour Analysts. Thirteen participants were full time employees of their organisations and two clinicians were contracted to work within their organisations.

Measures

Semi-structured interviews were designed to focus the participant on five key topics in their work with individuals who display behaviours that challenge: the participant's experience working with individuals with behaviours that challenge; experience and understanding of the development of behaviour support plans; understanding of procedural fidelity; opinion on the level of procedural fidelity in their day to day practice; and perceived barriers to achieving high procedural fidelity in their practice.

Procedure

Ethical approval was obtained through the University of Kent in addition to organisational ethics committees where relevant (requested by two services as an addition to university ethical approval). Service managers within the organisations that had agreed to participate were contacted via email with a brief description of the study to assess their interest in participating. Consent was obtained by the service manager from the service user (someone who lived in the residential home, has a behaviour support plan in place for behaviours that

challenge, and has regular contact with a behaviour support specialist) for the researcher to speak with their support staff. The manager was given a participant information sheet and consent form, written in an accessible format. All service users were considered able to provide consent under the Ireland Assisted Decision Making (Capacity) Act (2015). When consent was given by the service user, the researcher approached the frontline staff and clinician to explain the study and gain their consent. All participants then took part in individual semi-structured interviews that had an average duration of 28.5 minutes (Range: 25.3–38.6 minutes). Interviews were conducted in person in head offices of four organisations and in one residential facility for the fifth organisation. All interview times were organised around the participants' convenience. All participants were presented an information sheet about procedural fidelity prior to the interview, which explained the term in jargon-free language to ensure that they were familiar with how it was relevant to their jobs.

Data analysis

Interviews were audio-recorded and later transcribed. Transcripts were analysed using Reflexive Thematic Analysis, a qualitative method emphasising the “researcher’s reflective and thoughtful engagement with their data and their reflexive and thoughtful engagement with the analytic process” (Braun & Clarke, 2019, p. 594). This method acknowledges that no two researchers will interpret the data in identical ways. The researcher followed Braun and Clarke’s (2006) six step guide to analysing data. Initially, the researcher became familiar with the data. This involved transcribing the data and then reading while making some notes. During transcription, all identifying details of participants were removed from the transcript and all service users who were discussed were given pseudonyms. Following this, the researcher began to develop initial codes. During this phase, the researcher examined transcripts in four groups: all transcripts together; clinician transcripts only; manager transcripts only; and frontline staff transcripts only.

The researcher then began to generate themes from the identified codes. The researcher developed a thematic map, using this map for the fourth and fifth phase of the analysis where themes were reviewed with the rest of the research team, defined, and named. During these phases, overlapping themes were identified and reorganised into overarching themes, each containing sub-themes. Finally, the researcher engaged in phase six, writing the report.

While, as described above, it was initially anticipated that there would be significant differences between the perspectives of each staff group, it became apparent that the differences between the groups were less than expected. As such, the analysis primarily focused on the 15 interviews as a single sample, while drawing out identified differences in group perspective or understanding where apparent.

Reflexivity

The first author is aware that her own personal preconceptions may have affected the design of interview questions and the analysis or interpretation, or both, of data. The first author has worked in organisations similar to those of participants, as a frontline staff member, frontline residential manager, and behaviour specialist, and was aware that personal experiences could produce leading questions or a focus on similar experiences during the interviews. To avoid this as much as possible, key questions were designed to maintain a structure and these were developed with the research team. The researcher listened to each interview within 3 days and wrote a reflective account, while the transcription process took a number of weeks. The reflective accounts were then used to discuss the analytic process with the rest of the research team. While this is not an essential part of the Reflexive Thematic Analysis process, it was considered valuable to discuss and compare interpretations of three interviews in reaching “a richer more nuanced reading of the data” (Braun & Clarke, 2019, p. 594).

Results

Overarching themes and sub-themes are listed in Table 1.

Theme 1: Organisational and environmental constraints

This theme reflects participant reports regarding the structure and policy of the organisations they worked in. Participants discussed the difficulty of being powerless to change environments due to senior management decisions and highlighted a clear hierarchical divide between clinicians, managers and frontline staff: the three people who need to be working together to ensure success of support plans. All participants shared similar experiences and perspectives of the structure of the service they were working in.

Table 1. List of identified themes and sub-themes.

Theme	Sub-theme
Organisational culture and environmental constraints	<ul style="list-style-type: none"> • Inappropriate housing placements • Power divide between frontline staff and clinicians • Priorities of organisation governed by outside body
Understanding and monitoring of procedural fidelity	<ul style="list-style-type: none"> • Clinicians aren't accountable • Levels of behaviours that challenge as a measure of procedural fidelity • Consistency is important but can't be sure it's happening
Theory vs practice	<ul style="list-style-type: none"> • Different perspectives of stakeholder involvement in support plan development • Inconsistencies in narratives from different staff about training and implementation of plan • Functional analysis is best practice, but we're not doing it • Regular reviews are a great idea
There's nothing positive about behaviour support	<ul style="list-style-type: none"> • Feedback in a crisis • Frontline staff under pressure • Behaviour centred plans • Focus on restrictive practices

Inappropriate housing placements

Eleven participants noted that service users were placed in settings that were completely unsuitable for them, where they were unhappy and unable to engage. They highlighted the difficulty of a PBS plan being successful in an unsuitable environment:

But you see, there's no point again if the environment isn't right. I mean staff can't follow a plan that needs a quiet space and low lighting if the person lives with six other people and they all love rock music. You know? (Clinician 1)

Participants also discussed how living in communities and with people with whom you did not choose to live and may not get along with can have a major impact on behaviour and motivation to take part in the house community:

So, the problem is a parent, her mam dies. She's isolated (in her community) and there's going to be problems. She's not going to be able to live independently on her own. She finds it very hard to cope living with other people, but, unfortunately, she has to be supported here for safeguarding reasons. (Frontline manager 4)

Participants reported sometimes successfully advocating for individuals and challenging the organisation's policies:

When I started Emma was living with a couple of other people and we felt that her tolerance of other people was pretty low and that wasn't going to change. You know?

And so, we would have very strongly advocated for changes to the service design and we've been very lucky in that and strategic in how we went about things. So, we kind of refuse to get involved unless certain circumstances happen, unless we're given a certain level of resources and that kind of commitment for the service to change. So yeah that was hard initially, but once we had a suitable environment it was always going to be easier for the plan to be implemented. (Clinician 1)

Power divide between frontline staff and clinicians

The language used by participants to describe the relationship between clinicians and frontline staff was notable. The terms pass "up" to clinicians and "down" to frontline staff were frequently employed:

Well, they (clinicians) come *down* to see us and tell us the plan. When we give feedback to the PIC [person in charge] it goes back *up* and then they send out the finished plan. (emphasis added, Frontline staff 2)

The clinicians might not come out after an incident, but they will usually send some suggestions *down* to us after we send an incident report *up* to the psychology department. Usually pretty quickly. (emphasis added, Frontline manager 3)

Participants also commented on the struggle between clinicians who wrote the report and frontline staff who implemented it. Frontline staff knew the person very intimately and may have had a different view to what will work than the clinicians:

If people aren't in agreement with them, they're not going to implement them. (Frontline manager 3)

During three of the interviews there was a suggestion that frontline staff would face negative consequences if they chose to disagree or not implement the plan as directed by a clinician. One clinician described quite a punitive accountability system:

I'm not the only clinician and we aren't the only clinicians to have found that support plans were being put in place and staff were going "that'll never work, I'm not doing that". And unfortunately, then they wouldn't be followed and then sometimes you would find that people hadn't even read them. And that was a problem. So that's why we instituted this very kind of harsh process. (Clinician 4)

Priorities of organisation governed by outside body

Participants from all three groups discussed the pressure of ensuring HIQA standards were met. Such standards focussed on fire safety, medication management, financial audits, and other aspects of the day-to-day running of supported accommodation. While such matters are

clearly important, participants described how the associated paperwork would take away from time that could be spent with service users implementing proactive strategies from their PBS plans:

I don't know if it's because we have a manager who is hugely focused on the paper work and no matter what happens, it's HIQA, HIQA, HIQA, HIQA. And I've never worked with that before. And he's a very good manager. But the pressure of that is huge. (Frontline manager 2)

One clinician noted the importance of remembering that there is a person at the centre of each support plan and that it is not just an exercise in complying with outside standards.

It's really around putting the person at the centre of that, and trying to be as true to them as possible, you know, so that you're not designing something for HIQA or for external bodies or for people to come in and say, "oh, that looks great." You're actually saying, "it's for this person, and this is what they genuinely need." (Clinician 3)

All participants from one organisation discussed the difficulty of having to wait for funding decisions from an external body (The Health Service Executive, HSE) and how this had a major impact on their ability to deliver effective services.

She needs the funding from the HSE for the staff and that's the piece we're waiting for. (Clinician 5)

Theme 2: Understanding and monitoring of procedural fidelity

During each interview, participants were asked what their understanding of procedural fidelity was. Ten participants said they did not know and the five clinicians who responded gave an incorrect response:

It's a bit like a person-centred process like their quality of life. (Clinician 2)

Following these exchanges, the researcher gave a definition of procedural fidelity and its application in research and clinical practice. All participants agreed that procedural fidelity is important, but differences were highlighted in how it could be achieved and who should monitor it.

Clinicians aren't accountable

This sub-theme drew on information taken only from the clinicians who took part in the interviews. All five participants discussed how, once they had written a plan, they had no real way of monitoring if the plan was being correctly implemented. When asked how

they knew staff were following the plan accurately, their responses suggested a lack of accountability:

I'm not sure I can answer that. A PIC (person-in-charge) is much better placed. They're on the ground. They know if they are following through or not. I can go to a meeting and they can all say, oh we did exactly what the guidelines said. But I don't know whether they did. (Clinician 2)

Two clinicians distanced themselves from the responsibility for monitoring procedural fidelity since they were contracted in by the organisation and not permanent staff members:

Given the particular position I am in here ... I don't have any great input into policy ... I don't have any power, executive power. (Clinician 4)

Levels of behaviours that challenge as measure of procedural fidelity

All 15 participants reported that staff testimony and levels of behaviours that challenge were enough to determine if a plan was being implemented accurately and decisions about changes to the evidence-based plan could be made based solely on this:

(The support plan) is reviewed on the basis of the support workers' input and staff saying this isn't working any more or that doesn't make any sense any more, or we have to put in a restrictive practice. So, a restrictive practice is put in. (Clinician 2)

All participants, despite having just received an explanation that procedural fidelity was the accuracy of implementation of plan, discussed how the number of behaviours that challenge incidents could be used as a measure of procedural fidelity:

We wouldn't have many ABC (Antecedent-Behaviour-Consequence) incidents recorded. So, to me I think that was obviously a way of showing everybody's doing the same thing and that the plans are working. (Frontline staff 1)

Consistency is important but can't be sure it's happening

All participants agreed that consistency of implementation of behaviour support plans was essential. However, they also stated that there is no way to know if this was happening. Due to shift working, some staff may not see other staff for two weeks at a time, people work alone and do not get any feedback on how they are getting on:

I'm not working with someone for two or three weeks and people are different – they might not implement it the same way, they might think they are, but they're

not, you know. So, not at the moment, there's not, not really a way to monitor implementation. (Frontline staff 1)

Theme 3: Theory versus practice

There were some notable differences between the perspectives of clinicians and the other groups in this theme. In a manner consistent with the material on power divide above, there was some suggestion that clinicians perceived the development of a support plan as more consultative than did frontline staff. Similarly, manager and frontline staff accounts suggested that support plans were not always implemented in the way expected by the clinician, with perceived failures (unacknowledged by the clinician) in the staff training and implementation process.

Different perspectives of stakeholder involvement in support plan development

In the accounts of how support plans were developed and monitored in three different triads, there were direct contradictions of the role of the different staff members. When asked how they developed a support plan, the clinician, manager, and frontline staff member from the same team provided different responses. The following descriptions are taken from one triad to illustrate the conflicting reports and experiences of the same process;

I would come to a staff meeting and we would talk through how Steven is presenting, how they're getting to know him. And then we would design a positive behavioural support plan. (Clinician 2)

There would have been observing staff interactions with Steven, and also there would have been observing Steven's behaviour. And then it would have been a collation of E-forms which would, anytime there's an incident of challenging behaviour one of the forms would be completed by the staff and it would outline everything that's done, and the behaviours that were presented and ... the forms go up to [the psychologist] and we would sit down and we would discuss the plan, as a multi-disciplinary team, so it would be myself, it would be psychologist, and it would be his key worker then as well. (Frontline manager 2)

[The house manager] would have had a huge part in that. It would have been X at the time. And then there would have been the psychologist. Yeah, and then we were given the plan. (Frontline staff 2)

Inconsistencies in narratives from different staff about training and implementation of plan

In some of the accounts of the training and implementation process of the plan, there were direct

inconsistencies in staff recall of events. When asked about whether training on implementation of the plan was provided, one triad of participants provided conflicting responses. The clinician reported that careful training and implementation occurred, but the manager and staff quotes show a gradual dilution of this. The manager discussed the practice of providing frontline staff with an unsanctioned summary version of the plan, while the frontline staff member reported they needed to do the best possible at the time:

There's absolutely no point in handing somebody a plan and saying do that. So, you sit down with staff, you work out what's practical ... then it's about running through it with them and making sure they're happy with it and reviewing it on a regular basis. (Clinician 4)

Basically, the plan, well it was the multi-disciplinary process. The clinicians are the ones who design the plan and then sent it over to us. But what we might do sometimes, because what we use in the front line, we would have our own support really, just a summary ... we made that yes. (Frontline manager 4)

Well, it was the best staff could do here at the time because it would be so busy, and things like that are kicking off at the time they're saying "OK read this and see what you think about it". (Frontline staff 4)

Functional analysis is best practice, but we're not doing it

Each organisation that took part in the study had a behaviour support policy that outlined functional analysis (a systematic approach to identifying the antecedents and consequences of behaviours that challenge) as best practice; however, only one clinician mentioned the functional assessment process when developing the support plan:

We would have developed the functional assessment and the behaviour support plan. (Clinician 1)

There was a consensus among four of the triads, including the clinicians, that data collection and reports (i.e., providing information about likely antecedents and consequences of behaviours that challenge) were not being followed up on by the clinician:

There was loads of incident report forms, like, you know, behaviour challenge report forms regarding these kinds of behaviours, but, like, they're still in the file. No one has read them. (Frontline staff 3)

I don't do it (review ABC forms) officially, but I know I should. I suppose the best way to know if the plan is being followed is by the outcomes. (Clinician 1)

One clinician also disputed the importance of consequences of behaviour when writing a support plan and felt that antecedents were all that was needed for a successful support plan despite the organisation's PBS policy stating that a full functional assessment should be completed:

You really have to focus on the antecedents. What is causing the behaviour. There's little point doing anything about it once it's happened ... a functional assessment is incredibly important but focusing on the setting events and the antecedents. I'm not too bothered about the consequences. (Clinician 4)

Regular reviews are a great idea

Participants had different understandings of the appropriate length of time between reviews of support plans with suggested periods ranging from 6 months to 2 years:

I think it varies. I don't really get into that process per se. I just come when asked. But it's usually once a year I think, maybe two years. (Clinician 4)

There was general consensus that regular reviews were very important and beneficial to the behavioural support process, but they seemed to be more likely after a crisis or some sort of incident. If things were going well, reviews were pushed back as the individual was no longer a priority:

She contacted me about getting it reviewed and then I said to the manager, and she said "Oh well, you know, the review meetings – like, if we don't need to have a meeting then we don't have to because it's hard for, you know, time and money reasons." (Frontline staff 5)

You're asked to come over and the whole thing has fallen apart, and you go, if you'd only called me in a little bit sooner, we could have tweaked a few things, so I think we maybe need to build in some kind of periodic review. (Clinician 4)

Theme 4: There's nothing positive about behaviour support

All participants were focused heavily on crisis intervention and the stress and pressure that the behaviours that challenge caused in their work life. Rather than being positive and person-centred, it appeared that the focus of many of the PBS plans and staff discussion was quite negative and behaviour-centred. Participants also reported that the behaviours that challenge they faced did not seem to improve over time despite the behaviour support process.

Feedback in a crisis

All frontline participants reported that the main way to feedback information about the behaviour support plan to the clinician was through incident report forms and it was these that prompted the clinician to get in touch. When asked about support from the manager and clinician, frontline staff said this would happen after a behaviours that challenge incident:

Well, if an incident was to occur. (Frontline staff 1)

Frontline staff under pressure

Frontline staff commonly reported being frightened by some of the behaviours with which they were confronted:

We're on our own on night shifts. So, if Laura's extra heightened, you can feel a bit like, oh my God, I wish there was someone else there. (Frontline staff 3)

Manager and clinician participants showed empathy for the sometimes-frightening experiences of frontline staff and acknowledged the difficulty of their job and the impact it might have:

Sometimes for the frontline staff it's mentally draining ... you need a break because she exhausts you. (Frontline manager 5)

There was also an acknowledgement that staff might not follow through on guidelines as challenging the service user or saying "no" would take up a lot of time or cause a scene when out in public:

It's just, it's that it might be easier to give in sometimes. (Frontline manager 2)

The repetitiveness and unrelenting nature of some of the behaviours can be exhausting for frontline staff to work with and participants highlighted the need to take this into account when developing support plans to avoid staff burnout:

It's a long shift when you're putting in a shift with her. (Frontline staff 1)

Behaviour-centred plans

Participants were concerned that individuals who displayed behaviours that challenge may not have access to the same opportunities as those who did not. Review meetings and conversations tended to focus on their behaviours that challenge rather than more positive goals:

It would be great to get out there and engage more positively and get some opportunities you know? But I don't know, we're very focused on managing her behaviour

so we need to focus a bit more on the positive things.
(Frontline staff 1)

Another concern was that people with long histories of behaviours that challenge became infamous within the organisation, so staff met them with a negative perception:

They're difficult, and "Oh God, you worked in that house? Oh no, that must have been terrible" ... We're trying to get away from that kind of ... people with big labels and heavy hitters or whatever. (Clinician 2)

Focus on restrictive practices

All groups of staff tended to focus more on the restrictive practices in place as part of support plans rather than the accompanying proactive strategies such as skills teaching:

So, some restrictions would have had to be put in place ... (Frontline manager 4)

We got okayed to lock the doors ... (Frontline staff 3)

Participants talked about restrictive practices as the defining components of support plans, following directions to the letter of how long doors could be locked, how many behaviours should be displayed before medication should be given, etc.:

So, if you lock the door, you're locking it for 15 minutes and you open it up. A few inches, OK. You feel after 15 minutes it still needs to be locked, you justify and record. It's all reported and monitored, safeguarded. (Frontline manager 2)

There was no mention of skill building across the 15 interviews and developing methods to reduce the use of restrictive practices for service users.

Discussion

Semi-structured interviews were used in this study to explore the experiences of staff involved in designing and implementing behaviour support plans in residential services for adults with intellectual disabilities. They also sought to identify any barriers to high fidelity of implementation and other challenges within the organisations. Reflexive thematic analysis of interview transcripts led to the identification of a number of key themes. Staff identified the main barriers to faithful implementation of PBS plans to be: organisational and environmental constraints; lack of understanding and monitoring of procedural fidelity; challenges related to the development of support plans, their quality, implementation and review; and finally, the reactive and restrictive nature of the support plan process that

neither supported frontline staff under pressure nor the skills and quality of life of service users. A novel contribution of this study is the exploration of the perspectives of three different staff groups: frontline staff, managers, and clinicians. While there was perhaps surprisingly broad agreement across these three groups about the issues and challenges faced, differences did emerge in respect of the role played by frontline staff in the development of behaviour support plans and the rigour of the implementation process, and these are considered further below.

Limitations

Before the implications of the results are discussed it is important to highlight the limitations of the study. All 15 participants were recruited from urban areas in the East of Ireland with no representation from services in other geographical areas or in rural settings. It is possible that participants recruited elsewhere may have had different perceptions and experiences of implementing behaviour interventions. The study focused on frontline staff, frontline managers, and clinicians. However, none of these staff groups were directly responsible for funding, resourcing, or training. It may have been valuable to also gain insight from a higher level of management such as "service managers" to get a clearer overall picture of implementing behaviour interventions in residential services and the challenges and barriers to this.

Another limitation of the study was that most of the data gathered related to the overall process of implementing PBS, rather than procedural fidelity specifically. Staff discussed challenges and barriers in very broad terms and did not focus specifically on any particular elements of support plans that were difficult to implement properly. This may reflect the overall lack of understanding and awareness of procedural fidelity that was displayed by all participants. While a definition of procedural fidelity was provided in the information sheet, a more thorough discussion before beginning the interviews may have allowed participants to provide responses more directly related to fidelity. However, in practice, it is likely that participants would still have had difficulty in commenting on actual fidelity since none of the organisations employing participants had mechanisms for collecting fidelity information. Therefore, participant responses inevitably reflected their perceptions of barriers to, and facilitators of, likely fidelity.

Finally, it is important to acknowledge that a possible limitation of the study was that participants were not fully engaged in providing what may be considered competent behaviour support. Previous research has

highlighted that problems with implementation are common (Hassiotis et al., 2018), suggesting that the group of participants in the current study were by no means atypical of others. Despite these limitations, a number of themes were apparent across the 15 interviews.

Organisational and environmental constraints

Archaic institutional hierarchies from the days before modern disability policy and practice appear to continue to have some impact on current human services. People continue to be placed in congregated settings without any choice over where they live or who they live with (Joint Committee on Disability Matters, House of the Oireachtas, 2023). These issues were apparent in the current study where many participants identified the difficulty of implementing PBS when individuals' housing placements had not been chosen by them and may have been inappropriate. These findings are similar to those of Jackman-Galvin and Partridge (2022), who highlighted hierarchical systems of management preventing person-centred care being delivered effectively. Their staff and service user participants also noted that the concept of "choosing where I live" was "tokenism" and not a value that was acted upon or given priority in the service.

Another legacy from the institutions is the perception that clinicians are very separate to frontline staff and do not fully understand the challenges involved in supporting individuals on a daily basis. Clinicians typically work across a number of locations, with their office based in a separate area of the company. Lines of authority can be blurred as the clinician does not report to the house manager or service manager directly, leading to confusion about who is responsible for monitoring delivery of support plans and who has the authority to lead frontline practice. In fact, psychologists and behaviour specialists usually have no authority over any staff other than those in their direct clinical teams and they occupy a support role with respect to frontline staff. These issues may contribute to clinicians being viewed as difficult to approach and more important than frontline staff. Similar perceptions of powerlessness were identified by Quilliam et al. (2018), whose frontline staff participants highlighted that they "knew the person best" but were often overruled and not listened to in relation to major decisions related to the individuals. Within our current study, the terms "pass up" to clinicians and "down" to frontline staff (employed a total of 23 times throughout the 15 interviews), strongly suggested an ongoing power imbalance within the organisations.

Such problematic structures are likely to create tension between frontline staff and clinicians, preventing information being shared, which in turn will interfere with the development and implementation of a successful support plan. Collaborative practices with key stakeholders have been identified as a key underpinning value of PBS (Gore et al., 2022). Results of the current study suggests that, even in settings avowedly using PBS, true partnership is sometimes limited and traditional roles of clinicians "prescribing" and frontline staff administering (or not) the "prescription" remain influential. This is despite the development of effective other models in which frontline staff and managers take a much greater role in developing PBS plans (e.g., McClean et al., 2005; MacDonald et al., 2018).

Outside regulatory and funding bodies (HIQA and HSE) continue to heavily influence care provider policy, so person-centred plans and supports must fit in with larger, national policy and guidelines. However, such a one-size-fits-all approach may be very difficult to implement given the diversity of those supported in adult disability services. The focus on reactive and restrictive approaches around behaviours that challenge that emerged in the fourth theme was, perversely, likely to reflect HIQA standards on health and safety. Staff were so concerned about what they should do, if the behaviour occurred, to keep the person, themselves and others safe, that they may have lost sight of ways to prevent the behaviour or teach alternatives. Such a focus on risk avoidance rather than positive risk taking, independence, and human rights has previously been discussed by Seale et al. (2013) in the context of more general services for children and adults with intellectual disabilities.

Understanding and monitoring of procedural fidelity of behaviour support plans

In the organisations where the research was carried out there was a clear lack of identifiable accountability for monitoring and evaluating the procedural fidelity of behaviour support plans. This is very concerning as major decisions are made as a result of the success or failure of these plans such as implementing restrictive practices, using medication and reducing access to different amenities or opportunities (Vollmer & Slocan, 2008). As discussed above, the current study found an emphasis on restrictive practices in the behaviour support plans involved. It is likely that the lack of understanding of procedural fidelity and accountability for the plan contributed to this. As PBS plans are not being monitored for fidelity, if or when they do not provide positive outcomes, the plan is blamed and more

restrictive procedures put in place. People may be stuck with locked doors, given PRN (as required) medication, and denied access to areas of their own homes, when the more proactive plan in place may not actually be being implemented at all. It would seem natural that the author of a plan would be responsible for monitoring its implementation; however, this did not appear to be the case in the current study. Unfortunately, due to the organisational structure and divides between different groups of staff, this key element of behavioural support seems to have been neglected.

There was agreement among all participants that measuring procedural fidelity of a behaviour support plan is something that should be done. One participant had positive experience of using the periodic service review (LaVigna et al., 1994), but this did not go as far as monitoring accuracy of implementation. For many reasons, at least in the current study, procedural fidelity has been overlooked as a necessary part of the PBS process and the success of plans is determined by the level of behaviours that challenge after the plan is written. This is in line with findings by Gresham (2004), who identified that this was how clinicians were monitoring their plans and making life changing decisions. A more structured and accountable support system would allow practice leadership (Beadle-Brown et al., 2015) to be at the centre of PBS. This would ensure that frontline staff and managers have access to training, feedback, and ongoing discussions to maximise procedural fidelity. Further exploration of how to implement Organisational Behaviour Management systems within disability services would be useful to facilitate more accountable and measurable application of support plans.

Theory versus practice

Dunlap et al. (2010) highlighted that, while a huge amount of effort has been put into developing the procedures of PBS, considerably less is known and understood about how to put these procedures into practice. When speaking with all participants in the current study, there was a clear consensus about what is best practice. All participants were well trained in behaviours that challenge, had received training in PBS, and the social model of disability and had lots of experience working in disability services. Therefore, it was presumed that participants had knowledge and skills in the core principles of PBS, although they were not “experts” in PBS. All organisations had clear behaviour support policies that each staff member had read and signed off. Clinicians were aware that frontline staff know the service users best and should be included in

the development of the plan; however, this was not being done consistently across services. Managers knew that regular reviews of behaviour support plans were important to their monitoring and success, yet they allowed review meetings to slip when things were going well in order to prioritise resources elsewhere. Wiese (2015) highlighted a similar, more general disconnect between the rhetoric of PBS and actual practice. Such a disconnect may also reflect the contingencies operating on managers, especially from their own manager and external regulators. For example, meeting frontline staff regularly and collecting data on plan implementation was not a priority in HIQA standards and perhaps, therefore, not a priority for the relevant staff. As noted by Thompson (1995), practitioners adjust their behaviour to meet the goals specified by their organisations.

It was also interesting that across five different triads of staff, from five different organisations, there was no agreement about how often review meetings should be held. The recommendations ranged from “constantly” to “every two years.” HIQA standards are extremely vague on this also, simply stating that “interventions are reviewed on a regular basis” (HIQA, 2019, p. 82). It may be valuable to explore a quality standard for how often reviews should occur and in what format. For example, do reviews need to be carried out regularly with a multidisciplinary team or would it be sufficient to have the clinician and key worker managing the review? The second issue is, what exactly is being reviewed? Staff testimony and incident forms are reportedly the only methods to review the effectiveness of a plan. As discussed above, with no record of how accurately plans are being implemented and limited data being gathered on their impact on desired outcomes, it could be suggested the reviews risk being carried out with incomplete evidence.

There’s nothing positive about behaviour support

Staff perceptions of behaviours that challenge play a huge role in staff interactions and support for service users. Staff confronted with behaviours that challenge may respond in ways that are not recommended because, no matter their long-term consequences, such responses stop the behaviour from happening and enable them to escape what are often highly aversive situations (Oliver, 1993). As staff report only receiving feedback after an incident of behaviours that challenge, there will often be no monitoring of the extent to which such “off-plan” approaches are being used.

The apparent lack of positive reinforcement and feedback for staff and service users who are following plans and making progress is a clear contradiction of what PBS is about. As attention is only focused on these individuals and staff teams when something is going wrong, the perception that the work is negative and aversive is strengthened.

The current study has highlighted a focus on restrictive practices and an absence of prioritising skill building and environmental factors, which are key to successful PBS interventions. This is a common finding across services (National Guideline Alliance, 2016) and is extremely concerning due to the growing evidence base that restrictive practices can have a detrimental psychological impact on the individual, their staff, and the therapeutic relationship between the two (.). The described how, despite mounting evidence that restrictive practices increased the likelihood of behaviours that challenge, staff were able to justify restrictions on people's access to food, personal care, and movement as a regularly required "duty of care". This suggests the need to ensure that all staff understand the importance of proactive strategies within PBS and these are encouraged through clear and easy-to-follow guidelines.

There was acknowledgement from one clinician that there should be more of a focus on teaching new skills, but as a team, they tended to only think of behaviour management. This has been highlighted previously by Hoole and Morgan (2011) as service users with PBS plans felt they were excluded from activities and learning opportunities due to their label. The fear and burnout reported by participants in the current study may have contributed to reduced motivation to carry out the more positive aspects of the PBS plan, such as skills teaching. Without being taught the necessary skills that might replace their behaviours that challenge using techniques such as functional communication training, progress towards a better quality of life will be limited.

Conclusion

The need for more understanding of the importance of procedural fidelity of PBS interventions is clear. To enable this to happen, more input and support needs to be provided to enable frontline staff and managers to follow guidelines accurately. A more structured and accountable support system would ensure that frontline staff and managers have access to training, feedback, and ongoing discussions to maximise procedural fidelity. The implementation of an accountable structure of recording interactions and feedback sessions

would improve communication between clinicians and frontline staff, allowing challenges to be dealt with as they arise, and ensuring that appropriate decisions can be made in due course about the effectiveness of PBS plans and any necessary adjustments to intervention approaches.

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Conflicts of interest

All the authors declare no conflicts of interest.

Data availability statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

All authors listed have contributed to, seen and approved of the manuscript and have agreed to the order of authors as listed on the title page.

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