

Impact of Legislated Quality Assurance Measures on Interventions and Challenging Behaviour in Adults with Intellectual Disabilities

Retombées des Mesures d'assurances de la qualité prescrites par la loi sur les interventions et les comportements problématiques chez les adultes ayant une déficience intellectuelle

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Abstract

Persons with intellectual disabilities (ID) are at risk for challenging behaviour (e.g., self-injury, aggression, destruction) and several evidence-based interventions exist. Ontario recently mandated Quality Assurance Measures (QAMs) governing the design and implementation of Behaviour Support Plans (BSPs) for challenging behaviour in individuals with ID receiving government funded adult residential and day supports. This study evaluated the impact of QAM-compliant BSPs on challenging behaviour and staff use of intrusive procedures in 14 adults living in community group homes. Challenging behaviour, PRN (as needed) medication and restraint use decreased over a 12-month period. Staff viewed the new BSPs favourably. These preliminary findings support the value of legislated measures to improve interventions for adults with ID and challenging behaviour.

Résumé

Les personnes ayant une déficience intellectuelle (DI) sont à risque de présenter des comportements problématiques (p. ex., automutilation, agression, destruction). À cet égard, plusieurs interventions fondées sur les données probantes existent. L'Ontario a récemment mandaté des Mesures d'assurance de la

qualité (MAQ) régissant l'élaboration et la mise en œuvre de plans de soutien au comportement (PSC) pour les comportements problématiques chez les individus ayant une DI bénéficiant d'un soutien, en centre résidentiel ou de jour pour adultes, financé par le gouvernement. Cette étude évalue les retombées des PSC conformes aux MAQ sur les comportements problématiques et l'utilisation de techniques d'ingérence par le personnel auprès de 14 adultes vivant en foyer de groupe dans la communauté. Les comportements problématiques, l'utilisation PRN (au besoin) de médication et de la contention ont diminué sur une période de 12 mois. Ces résultats préliminaires attestent de l'importance des mesures prescrites par la loi afin d'améliorer les interventions auprès d'adultes ayant une DI et des comportements problématiques.

Mots clés: Adultes ayant une DI, comportements problématiques, plan de soutien au comportement, techniques d'ingérence, mesures d'assurance de la qualité.

Introduction

Persons with intellectual disabilities (ID) have an increased risk of challenging behaviours (e.g., self-injury, aggression, property destruction) across the lifespan (Feldman, Atkinson, Foti-Gervais, & Condillac, 2004; Sturmey, Lindsay, & Didden, 2007; Wachtel & Hagopian, 2006). Prevalence rates hover around 18% (Bowring, Totsika, Hastings, Toogood, & Griffith, 2017; Feldman et al., 2004; Lunqvist, 2013). Historically, behavioural challenges often were treated with intrusive measures (Feldman et al., 2004; Lundstrom, Antonsson, Karlsson & Graneheim, 2011; Sturmey, 2009b). Intrusive procedures include psychotropic medications, physical and mechanical restraint, and confinement time-out/seclusion (Ministry of Community and Social Services [MCSS], 2008). While intrusive measures may suppress behaviour, they are not effective in increasing desirable replacement behaviours (Cooper, Heron, & Heward, 2007) and often cause unwanted side-effects, such as injuries to clients, and staff and client death (Sturmey, 2009a; Williams, 2010).

Function-based Positive Behavioural Interventions

Function-based positive behaviour interventions based on applied behaviour analysis (ABA) decreases challenging behaviour and caregiver stress, increases skills, and individual and caregiver quality of life (Didden, Duker, & Korzilius, 1997; Feldman, Condillac, Tough, Hunt, & Griffiths, 2002; Feldman & Werner, 2004; Heyvaert, Maes, & Onghenal, 2010; McClean et al., 2005; Williams, 2010). Coupled with a biopsychosocial assessment that considers predisposing conditions to challenging behaviour (Griffiths & Gardner, 2002), function-based positive behavioural interventions identify the environmental consequences (functions) of challenging behaviour and then teach the individual functionally equivalent appropriate behaviours (e.g., communication skills) to obtain the same consequences as the challenging behaviour (Carr et al., 2002; Feldman et al., 2002).

Government Policies on Behavioural Interventions

Several jurisdictions have developed policies regarding behavioural interventions, focusing on the use of restraints and other intrusive procedures (Deveau & McGill, 2009; Phillips, Wilson &

Wilson, 2010; Lundstrom et al., 2011; Romijn & Frederiks, 2012; Rotholz, Moseley, & Carlson, 2013; Søndena, Dragsten, & Whittington, 2015). A Behaviour Support Plan (BSP) provides a written prescription of the least intrusive strategies caregivers should use to treat challenging behaviour (Phillips et al., 2010). Without direction, caregivers may choose more reactive intrusive methods of behaviour control, mainly because they can be effective in stopping harmful behaviour quickly (Feldman, 1990; Hastings & Remington, 1994; Peterson & Martens, 1995; Griffiths & Gardner, 2002). In an Ontario-wide study of 948 quasi-randomly selected persons with ID, Feldman et al. (2004) found a high use of psychotropic medications (in the absence of a psychiatric diagnosis) and other intrusive procedures to control challenging behaviours. In total, 55% of non-medical interventions and 30% of intrusive procedures were “informal” (lacking a written plan with input from a professional, data collection and implementation training and monitoring). The authors raised concerns about the “low levels of intervention accountability, training and supervision” (p. 60) in the development of and provision of behavioural interventions in the community for persons with ID.

For a variety of reasons, including group home abuse cases reported in the media, the Ontario government recognized the need for legislated standards on behaviour interventions for persons with ID and challenging behaviour supported by government-funded community agencies (persons living with family members were excluded). Therefore, the *Ontario Regulation 299/10, Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act* (2008), included *Part III: Quality Assurance Measures (QAMs) for Behaviour Interventions for Challenging Behaviour*. The QAMs and subsequent Policy Directives (MCSS, 2012) and BSP reference guide (MCSS, 2015) reflect a set of values and procedures that promote quality of life, social inclusion, autonomy, and the right to the least intrusive, most effective behavioural treatment for individuals with ID. Professional practice requirements for behavioural assessment and intervention, and BSPs are consistent with the *Ontario Association for Behaviour Analysis Standards of Practice* (Ontario Association for Behaviour Analysis, 2010) and the Behaviour Consultant Certification Board’s (BACB) *Professional and Ethical Compliance Code for Behaviour Consultants* (BACB, 2014).

The QAMs (MCSS, 2008) for behaviour intervention state that “each service agency shall develop an individual behaviour support plan (BSP) for each person...who has challenging behaviour” (18[1], p. 13) and “shall ensure that positive behaviour interventions and intrusive behaviour interventions are used as outlined in the BSP” (19[2], p. 13). The BSP should be based on a written functional [behavioural] assessment informed by biopsychosocial factors, and include “positive behaviour interventions, and if necessary, intrusive interventions” (15[2, 3], pp. 10-11). The implementation of any behaviour support plan requires informed consent by the client or their legal guardian, must include risk and benefit considerations, training of all individuals in contact with the person (including volunteers) and methods to monitor BSP implementation and effectiveness. The intervention plan must promote the utilization of positive behaviour strategies over intrusive ones, and any BSP with intrusive procedures must be reviewed by a qualified professional at least twice a year. While professionals with behavioural expertise (e.g., Board Certified Behaviour Consultants) are usually involved in conducting assessments, writing the BSP, training staff and the reviews, the QAMs make clear that the residential and day support agencies are responsible for BSP implementation by their staff and volunteers. Government compliance officers routinely check randomly chosen files.

Study Purpose

The QAMs have challenged Ontario ID support service agencies to change their practices to meet these standards (Select Committee on Developmental Services, 2014). Several questions remain about agency capacity to adhere to mandated standards in implementing the least intrusive, but most effective behavioural interventions, train staff, monitor BSP implementation and obtain low levels of challenging behaviour and intrusive procedure use. The purpose of this study was to conduct a preliminary clinical outcome evaluation on the impact of introducing QAM-compliant BSPs on challenging behaviour, use of intrusive measures, and staff acceptance in community group home settings.

Methods

Participants and Settings

This study was cleared by the Brock University Research Ethics Board. The participants were a convenient sample recruited from one agency. The participants were living in five community group homes and were considered to have the most challenging behaviour by the residential agency. They totaled 14 persons (10 males) with ID and low frequency but high intensity challenging behaviours (and other problem behaviour). Table 1 presents pertinent information about each participant. The mean age was 37.29 years ($SD = 17.01$; range: 19-66) and their ID ranged from severe to mild. Target behaviours for each participant are listed in Table 1 and covered both QAM-defined challenging behaviours (physical aggression, self-injury, property destruction) and problematic behaviours (theft, elopement, repetitive behaviours, verbal outbursts, non-cooperative behaviour, and inappropriate social and sexual behaviours).

Table 1. *Participant information (all have ID No.)*

ID No.	Group Home	Age	Sex	Target Behaviours	Comorbid Diagnoses	Medications for Challenging Behaviour	BSP Interventions (PRNs in Medication column)
1	A	19	M	inappropriate touch (IT), verbal aggression (VA), property destruction (D), physical aggression (PA), self-injurious behaviour (SIB)	Epilepsy (E)	Lorazepam, Methylphenidate PRN - Olanzapine (5 mg)	Non-contingent attention (NCA), First/then (F/T) contingencies, social skills training (SST), physical restraint (PR)
2	A	24	M	verbal aggression (VA), PA, D	E, intermittent explosive disorder (IED), Oppositional Defiant Disorder (ODD), Conduct Disorder, ASD	Risperidone (4mg), Olanzapine (5mg)	Tolerance training (TT), replacement Skill Teaching (RST), SST, PR

3	A	33	M	PA, repetitive behaviours (RB)	Bipolar disorder (BD), ASD	PRN - Lorazepam (1mg)	NCA, differential reinforcement of alternative behaviour (DRA), SST, choice Training (CT), PR
4	B	20	M	VA, PA, D, SIB	Cerebral Palsy, E, ASD	PRN's - Lorazepam 1mg), Quetiapine (25mg)	CT, TT, functional communication training (FCT), PR
5	B	45	M	PA, D, SIB	Schizophrenia (SZ), ASD	PRN - Olanzapine (10mg)	CT, NCA, RST, F/T.PR
6	B	20	M	PA	GDD, ADHD, ASD	PRN's - Lorazepam (1 mg), Risperidone (1 mg)	CT, high-P requests, FCT, PR
7	B	40	M	PA, SIB	ASD	PRN - Lorazepam (2mg)	NCA, DRA, TT, PR
8	B	21	F	VA, PA, SIB, IT, Elopement	SZ, E, ASD	Pimozide (2x daily) PRN - Olanzapine (5mg)	CT, TT, FCT, PR
9	B	38	M	VA, PA, D	Down syndrome, schizoaffective disorder, IED, hypothyroidism, ASD		CT, NCA, self-management training (SMT), PR
10	C	28	F	PA	BD, ASD, ADHD, ODD	PRN - Lorazepam (1mg)	SMT, FCT, DRA, PR
11	C	66	M	PA	BD, SZ, E		NCA, FCT, hygiene skills training, PR
12	D	62	F	SIB	ID, ASD	PRN - Lorazepam (2mg)	Social Narratives (SN), SMT, DRA, PR
13	D	41	F	SIB	PTSD, major depression, ASD		SN, TT, PR
14	E	65	M	PA, D	SZ, ASD	PRN - Lorazepam (1mg)	NCA, CT, FCT, PR

All participants had pre-QAM BSPs in place before the start of the study. Table 2 presents information about each group home. The agency required all full-time staff to have a two-year community college diploma in a related field (e.g., Developmental Service Worker) or a university degree and be trained in agency-approved crisis intervention techniques that included de-escalation and physical restraint protocols for severe challenging behaviour.

Table 2. *Information about each participating group home*

Home	Setting	Total Residents	No. Residents in Evaluation	Full Time Staff	Part Time Staff	No. Staff Typically on Shift (approx.)	Staff to Resident Ratio
A	rural	7	3	14	3	5	0.71
B	rural	6	6	14	7	6	1.00
C	suburban	5	2	7	4	3	0.60
D	suburban	2	2	2	3	1	0.50
E	suburban	5	1	6	8	4	0.80
	mean	5.00	2.80	8.60	5.00	3.80	0.72
	SD	1.87	1.92	5.27	2.35	1.92	0.19

We were unable to obtain individual staff demographic information, but they appeared typical of most Ontario group home staff in approximate age and gender ratio. The evaluators were five Behaviour Consultants with Masters' degrees who were Board Certified Behaviour Consultants (BCBAs) from an external community behaviour support service. Three Behaviour Consultants wrote the BSPs being evaluated, trained staff and analyzed residential staff collected data, and two Behaviour Consultants provided clinical supervision and oversight.

Design

A longitudinal design evaluated the ongoing impact of the QAM-compliant BSPs on staff use of intrusive measures and client challenging behaviours in a 3-month baseline followed by four sets of three-month data collection for 12 months after introduction of QAM-compliant BSPs. The Contextual Fit Feedback Survey (Horner, Salentine, & Albin, 2003) measured staff acceptance of each BSP.

Measures

Functional Behaviour Assessment Measures.

The Questions about Behavioural Function (QABF; Matson & Vollmer, 1995) was an indirect assessment of behavioural function for challenging behaviours. Staff who knew the individual well rated 25 items as to how often the item applies - 0 (never) to 3 (often) or "does not apply." Behavioural functions (attention, tangible, escape, physical and non-social) of each target behaviour were rank ordered according to item scores. The QABF has acceptable psychometric properties (Zaja, Moore, van Ingen, Rojahn, 2011) and emerging evidence suggests that its identification of behavioural function corresponds to the "gold standard" experimental functional analysis (Healy, Brett, & Leader, 2013; Watkins & Rapp, 2013). Nonetheless, Watkins and Rapp recommended that the QABF be used with other functional behavioural assessment methods.

In addition to the QABF, possible behavioural functions were identified using Antecedent-Behaviour-Consequence (ABC) narrative recordings. The Behaviour Consultants trained the direct-care staff to record ABCs. When a target behaviour occurred, the date, time and events

occurring just before and just after the behaviour were tracked. While the Behaviour Consultants completed ABC's during their visits (if they witnessed a target behaviour), the direct-care staff completed most of the recordings over a 4 to 8-week period before implementing the QAM-compliant BSPs.

Use of intrusive procedures

Staff completed agency Medication Administration Records (MAR) sheets for each use of a PRN and an incident report form for each use of physical restraint (mechanical restraint and seclusion were not used).

Target behaviour observations.

Before the assessment and baseline phases, the Behaviour Consultants trained direct care staff to record the frequency of the participants' target behaviours using either a check mark system or clicker. These data were transferred to a recording sheet and summarized as number of each target behaviour per day. Interobserver agreement of these observations was not collected due to the ongoing daily demands of working within the group home setting and lack of resources to hire additional staff to solely conduct agreement checks.

Contextual Fit Survey

A Contextual Fit Survey was used to measure staff acceptance of the QAM-compliant BSPs (Horner et al., 2003). This survey consisted of 16 statements that were rated on a Likert scale from 1 to 6: strongly disagree, moderately disagree, barely disagree, barely agree, moderately agree, and strongly agree. Statements from the survey were categorized into five key domains: (1) staff skills and knowledge (four statements); (2) consistency of the BSP with personal values (four statements); (3) availability of resources to implement the BSP (five statements); (4) effectiveness of the BSPs (two statements); and (5) staff stress related to implementing the BSPs (one statement).

QAM-Compliant BSP Checklist

To assess QAM-compliance of each BSP, the researchers developed a 16-item BSP checklist (see Table 3).

A trained independent reviewer rated the pre- and post-QAM BSPs. Item-by-item interrater agreement of the checklist was independently assessed by a second, trained reviewer for four pre- and four post BSPs selected randomly while ensuring one pre and post BSP were obtained from the same client. Both reviewers were blind to the purpose of the study and the pre- or post-status of the BSP. Agreement for pre-QAM BSP Checklist scores was 94% (range 85% to 100%) and 87% (range 85% to 92%) for post-QAM BSP Checklist scores.

Table 3. *QAM-compliant BSP Checklist*

Behaviour Support Plan Components	Yes/No
1. Challenging behaviour is defined - i.e., self, injury, physical aggressions and/or property destruction.	
2. Biopsychosocial variables discussed.	
3. Rationale for addressing behaviour discussed.	
4. Functional behaviour assessment completed that includes direct observation and data analysis.	
5. Intervention strategies focus on development of positive behaviour, skills (e.g., communication, social) and environmental modifications (e.g., visual schedule, removing triggers).	
6. The BSP conforms to the least intrusive model.	
7. Intrusive procedures are clearly described.	
8. Statement of how intrusive procedures will be faded and/or eliminated.	
9. Debriefing procedure of individual and witnesses to physical restraint and seclusion/confinement time-out described.	
10. Risks and benefits of interventions are outlined.	
11. Measurable anticipated outcomes of BSP are described.	
12. Recommendations/procedures provided on how to monitor effectiveness on client behaviour (e.g., data collection).	
13. Recommendations/procedures provided on how to monitor BSP adherence.	
14. BSP has been signed off by a psychologist, a physician, a psychiatrist or BCBA	
15. BSP signed by a representative of the residential/day support agency.	
16. BSP has evidence (e.g., signature) that it has been reviewed and approved by the client and/or the substitute decision maker.	

Procedure

Functional Behaviour Assessment (FBA)

QAM requires that a BSP be based on a FBA. Behaviour Consultants met with staff and conducted observations to operationally define the target behaviours. The FBA consisted of the QABF and narrative ABCs, as described above. Experimental functional analyses were not employed given the potential increased risk of harmful behaviours occurring during the functional analysis sessions (Feldman et al., 2002). Narrative forms of ABCs show reasonable correspondence to functional analysis (Lanovaz, Argumedes, Roy, Duquette, & Watkins, 2013). The Behaviour Consultant reviewed the assessment results and derived hypotheses about likely functions of the target behaviours that were used to design the function-based positive behaviour intervention strategies in the BSP.

Baseline

While the BSP was being prepared, staff collected baseline data 24 hours a day, seven days a week, as described above, for three months.

BSP development, format, training and implementation

Once the function for all target behaviours were surmised, the Behaviour Consultants collaborated with each participant's primary staff person to write a BSP. The BSP consisted of a brief description of the person and their history and (per QAM) a biopsychosocial summary of factors that may be related to the challenging behaviours (e.g., ID syndrome, acute and chronic medical conditions, history of trauma, current living environment). The BSP then defined the target behaviours to decrease and replacement skills to increase (cf., Feldman et al., 2002) and measurable objectives that specified clinically meaningful decreases in challenging behaviour and increases in replacement skills by a specified time (e.g., 3, 6 months). The next section was a summary of the QAM-required FBA and other behavioural assessments (e.g., reinforcer preference test) and an accompanying rationale for the behaviour support interventions to be subsequently described. The behaviour support section was divided into three sections: (1) prevention and antecedent strategies, (2) reinforcement and skill building strategies, and (3) behaviour management strategies (i.e., what to do when the target behaviour occurs). See Table 1 for the list of each participants' BSP strategies. A QAM required section described the debriefing protocol for the person who received restraint and/or seclusion/confinement time-out, as well as witnesses. The other sections of the BSP dealt with data collection, evaluation, adherence, and roles and responsibilities. There was a signature page for the client or substitute decision-maker (only three participants were cognitively capable of providing their own consent), agency manager and Behaviour Consultant to sign for consent.

After the BSPs were completed and signed, the staff and supervisors were asked to read the QAMs and the Behaviour Consultants provided didactic instruction on the QAM components. Then the Behaviour Consultants conducted from one to three behavioural skills training sessions, consisting of instructions, modeling, rehearsal and feedback (Miles & Wilder, 2009), to train staff and supervisors in BSP implementation, in the context of the QAM. The amount of staff training depended on complexity of the BSP and staff's ability to demonstrate competence implementing strategies when monitored using adherence check observations completed by the Behaviour Consultants. Supervisors were given additional training to complete the adherence checks to monitor BSP implementation and provide ongoing positive and corrective feedback to staff. Once all staff were trained to an 80% level of BSP adherence on the floor, the BSP was implemented, data collection continued and BSP implementation monitored by the Behaviour Consultant and supervisor for 12 months. Ongoing staff training was provided, as needed, if staff were observed to incorrectly implement the BSP.

Results

Formal measures of target behavior, PRN and restraint continued to be counted for all participants. The mean percentage of correct QAM-compliant items increased from 39% (range 15% to 62%) on the pre-QAM BSPs to 89% (range 85% to 93%) on the post-QAM BSPs. Figure 1 shows the total monthly frequency of target behaviour and PRN and restraint use across the 14 participants over the 3-month baseline and then every three months up to 12 months after baseline.

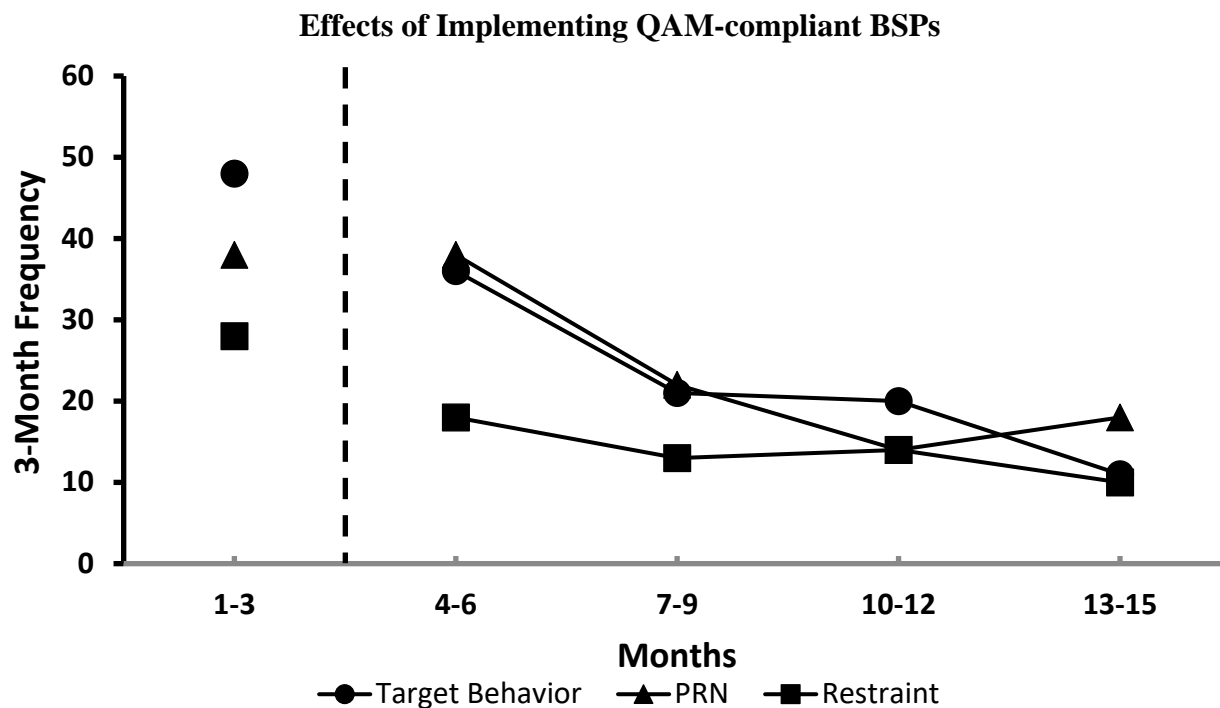


Figure 1. Three-month total frequency of the 14 participants' target behaviours, and PRN and restraint use, before and after the introduction of QAM-compliant BSPs

As can be seen in Figure 1, by 12-month post-QAM BSP (month 15 of the study), across all participants, target behaviours, PRNs and restraints decreased by 77%, 53% and 64%, respectively, from baseline. There was considerably variability in baseline scores. Baseline 3-month totals ranged from 0 to 18, 0 to 21, and 0 to 18 for target behaviour, PRN and restraints, respectively. Variability was reduced after the introduction of the QAM-compliant BSPs; the final 3-month totals post QAM-compliant BSP ranged from 0 to 2, 0 to 6, and 0 to 5 for target behaviour, PRN and restraints, respectively. Given the small sample size and variability that increased risk of Type II error, no dependent *t*-tests between the pre- and 15-month post scores were significant at $p < .05$. One-sample Cohen's *d* effect sizes from baseline to 15 months for total target behaviour, PRN and restraints were 0.47, 0.35, 0.39, corresponding to small-medium effect sizes, respectively. Nonetheless, the results appear to be clinically significant as by 12-months after the introduction of QAM-compliant BSPs, 13 of the 14 participants had met their BSP objectives and had been discharged from the behaviour support service (seven participants

reached their objectives and were discharged within the first three months and maintained the objectives for the remainder of the study). Staff continued to measure target behavior, PRN and restraint use on all the participants even after discharge from the behaviour support service. Therefore, the data presented in Figure 1 and the statistical analyses reflect all 14 participants at each point in the study.

Staff Acceptance

A total of 110 anonymous Contextual Fit Surveys (Horner et al., 2003) were completed for the 14 participants in this study to determine staff acceptance and opinions of the new QAM-compliant BSPs at least 2 months after BSP implementation. Note that most staff completed more than one survey as they worked with several of the participants. Across all domains, mean ratings ranged from 4.66 to 5.46 out of a total possible score of 6. Staff were most likely to feel that they had the skills and knowledge to implement the plans (mean = 5.46). Their personal values were consistent with the components of the BSPs (mean = 5.26). They generally felt they had the resources and support they needed to implement the plan (mean = 4.97). They felt that the BSPs were moderately effective (mean = 4.87) and did not find it stressful to implement the BSPs (mean = 4.66, higher scores indicate less stress).

Discussion

This preliminary evaluation of legislated quality assurance measures governing the design, implementation and monitoring of BSPs for persons with ID and challenging behaviour living in community group homes suggested that agency attempts to comply with the QAMs (including working with external behaviour consultants) may be related to a subsequent reduction in challenging behaviours and intrusive interventions. These results contrast with Phillips et al. (2010) who found no consistent improvement in the quality of BSPs following legislation regulating BSP content in Australia. One important difference between the current study and Phillips et al. is that in the current study the BSPs were designed and staff trained by certified Behaviour Consultants whereas in Phillips et al. unqualified direct-care staff designed the BSPs. The implementation of a restraint reduction policy for the treatment of challenging behaviour in persons with ID in Norway resulted in a paradoxical increase in restraint use (Søndena et al., 2015). Unlike the Norwegian law that focused entirely on restraint use, the Ontario QAM emphasizes staff training and supervision in function-based positive behavioural interventions that have been repeatedly shown to decrease challenging behaviour and need for intrusive procedures (Williams, 2010).

While the external behaviour support service had been providing behavioural consultation to the community agency for many years, it was not until the QAMs (and accompanying Policy Directives) were introduced and government compliance checks started that the agency took serious measures to implement effective BSPs. The external Behaviour Consultants worked closely with residential staff and supervisors in all aspects of BSP development and implementation. This partnership arrangement may have influenced BSP adherence and favourable BSP ratings by staff. Legislation that regulates the use of intrusive interventions and promotes the use of positive, evidence-based support strategies for individuals with ID allows

governments to play a key role setting clinical standards of practice that has the potential to improve the quality of life of individuals with ID and the direct support staff working with them. Furthermore, governments and the agencies they fund should ensure that adequate resources are available for certified behavioural professionals to develop and monitor BSPs that when implemented consistently can reduce the use of intrusive procedures for challenging behaviour (Williams & Grossett, 2011). Behavioural support consultation models for persons with ID can significantly decrease challenging behaviour, prevent hospital placement and are more cost-effective than placement in hospital units (Chartier & Feldman, 2015; McClean et al., 2007; Rudolph, Lakin, Oslund, & Larson, 1998).

Several limitations that often plague service evaluation research are noted, including a small number of participants; no control group; and no interobserver agreement (IOA) on staff-recorded behaviour observations, use of intrusive procedures and BSP adherence tracking. Any potential conflict by the evaluators or group home supervisors may have been somewhat mitigated through the completion of BSP compliance checks prior to the evaluators having knowledge they would be part of an evaluation study. Future evaluations should use experimental designs with larger samples across agencies, IOA and adherence measures (implementation checks) completed by someone external to the research team, additional social validity measures (e.g., quality of life) and over a longer follow-up period to determine the impact of regulations for behaviour interventions for challenging behaviour.

Conclusion

The findings of the present study suggest that legislated quality assurance measures governing the design and implementation of BSPs for challenging behaviour may lead to decreases in challenging behaviour and the use of intrusive interventions with persons with ID living in community residences.

Key Messages from this Article

People with disabilities: If you are experiencing some behavioural difficulties, the government has asked agencies that support you to offer positive supports to help you reduce your distress.

Professionals: This study showed that a partnership between behaviour support and residential services to design and implement behaviour support plans that follow the Ontario Quality Assurance Measures for Behaviour Interventions may reduce challenging behaviour and use of intrusive procedures.

Policymakers: This preliminary study suggests that community agency adoption of the Ontario Quality Assurance Measures for Behaviour Interventions may result in the implementation of cost-effective behaviour support plans that reduce reliance on intrusive procedures.

Messages clés de cet article

Personnes ayant une incapacité: Si vous éprouvez des difficultés comportementales, le gouvernement a demandé aux organismes qui vous accompagnent d'offrir des soutiens positifs afin de vous aider à diminuer votre détresse.

Professionnels: Cette étude démontre qu'un partenariat entre les services de soutien au comportement et résidentiels visant à élaborer et mettre en place des plans de soutien au comportement conformes aux Mesures d'assurance de la qualité de l'Ontario pourraient diminuer les comportements problématiques et l'utilisation de techniques d'ingérence.

Décideurs: Cette étude préliminaire suggère que l'adoption des Mesures d'assurance de la qualité de l'Ontario par les organismes communautaires pourraient permettre la mise en place de plans de soutien au comportement efficaces qui diminuent le recours aux techniques d'ingérence.

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