

# A practitioners' definition of Positive Behaviour Support

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## Abstract

**Purpose** – *The purpose of this article is to provide a definition of Positive Behaviour Support (PBS), developed by a group of practitioners of PBS, in the United Kingdom (UK).*

**Design/methodology/approach** – *The definition was developed through a series of online meetings with a group of practitioners, and through reference to the existing research.*

**Findings** – *A definition is presented in the form of 9 defining characteristics. These include a specific underpinning philosophy (functional contextualism), a focus on promoting quality of life, rights, relationships, the use of Applied Behaviour Analysis, functional assessment to inform function-based strategies, the provision of multielement support, collaborative working and implementation support.*

**Originality/value** – *There are numerous pre-existing definitions of PBS. However, this article seeks to present a definition specifically from the perspective of practitioners in the United Kingdom.*

**Keywords** *Positive Behaviour Support, Applied Behaviour Analysis, Intellectual disability, Autism, Behaviour that challenges, Human rights*

**Paper type** *Conceptual paper*

(Information about the authors can be found at the end of this article.)

## Introduction

There are numerous definitions of Positive Behaviour Support (PBS) (Fernández-Mateos *et al.*, 2022). PBS has been described varyingly as Applied Behaviour Analysis (ABA) in support of people who display behaviour that challenges (LaVigna and Willis, 2012), or as combining the principles and procedures of ABA with the values of person centred planning (Toogood, 2012). Whereas there is disagreement regarding the populations that PBS can be used to serve, there appears to be a consensus that PBS is predominantly intended for people who display behaviour that challenges. The exception would be where PBS is implemented through a systems-wide approach. In such circumstances, universal strategies (such as honouring communication preferences) would be provided to all individuals receiving support.

## *Positive Behaviour Support in the United Kingdom*

In the UK, the most recent definition is that of Gore *et al.* (2022), which is an updated version of the definition proposed nearly a decade earlier (Gore *et al.*, 2013). One of the most noticeable changes was the reduced emphasis on the role of ABA. It can be argued that this change is incongruent with the view put forward by Hastings *et al.* (2013, p. 11) who stated that PBS “lives or dies with ABA”, that put forward by Gore and Baker (2017, p. 20) who stated that PBS is “informed primarily by the use of ABA”, but is also at odds with the history and development of PBS (e.g., Dunlap *et al.*, 2008; Toogood, 2012; LaVigna and Willis, 2012; Gore *et al.*, 2013). A further addition was a discussion of the concept of “neurodiversity” and a description of who PBS is for. Gore *et al.* (2022) stated that PBS is

not intended for individuals who identify as neurodivergent, but do not have an intellectual disability. Whereas the authors went on to explain that the PBS framework that they outlined may be relevant for populations other than individuals with an intellectual disability, their comments appear to have been interpreted by some to mean that PBS should not be used with autistic people under any circumstances (e.g., [Culture of Care, 2025](#); [Neurodiverse Connection, 2025](#)). It is important to acknowledge that there are examples of poor practice within the respective fields of PBS and ABA (e.g., [Quinn, 2025](#); [Anderson, 2022](#)). However, [Schuck et al. \(2022\)](#) provide a different perspective regarding neurodiversity and behavioural intervention for autistic people, and outline that, provided it is focused upon improving quality of life (QoL) and delivered respectfully, neurodiversity advocates are often in favour of behavioural intervention. This highlights an important issue, that neither the autism community, nor practitioners of behavioural science, collectively hold the same views. What is important to acknowledge, is that discourse between professionals who support autistic individuals and members of the autism community, is beneficial in increasing mutual understanding ([Bowring, 2025](#)).

### *The need for a practitioners' definition*

The concept of developing a practitioners' definition was initially discussed in the context of increasing criticism of PBS and ABA from some neurodiversity advocates, as well as anecdotal reports of confusion amongst stakeholders regarding what does, and does not, constitute "training in PBS". The practitioners involved in the development of this definition did not feel that the criticisms being raised regarding PBS, were representative of their views, values, or practice. However, they also felt that in some forums the response to such criticisms was either to downplay, or deny entirely the role of ABA within PBS, presumably in an attempt to distance PBS from the controversies regarding the use of punishment and/or aversive practices in the field of ABA (see [Fernández-Mateos et al., 2022](#) for a discussion regarding distancing PBS from ABA; see [Allen et al., 2024](#) for a discussion of controversies relating to the field of ABA). To the practitioners involved in the development of this definition, several issues arise from such an approach. Firstly, to deny the role of ABA within PBS could appear to either dismiss (by circumventing), or invalidate, concerns raised by members of the autistic community regarding ABA (e.g. [Anderson, 2022](#)), or the role of ABA within PBS. It is crucial that such concerns are approached as opportunities for reflection and learning. Secondly, this could result in the misconception that practitioners of PBS do not need a thorough understanding of the underpinning science of behaviour (ABA), to be competent, reflective practitioners.

[Gore et al. \(2022, p. 4\)](#) highlight that in 2013, the special edition of the *International Journal of Positive Behavioural Support* aimed to provide a "marker in the sand" to ensure that those stating they were implementing PBS, were describing the same approach. The same authors go on to say that the need for such a marker has reduced with time. However, as guidance increasingly advocated the use of PBS to support a variety of populations (e.g. [Department of Health, 2014](#); [Department of Health, 2015](#)), organisations being able to "say" that they were implementing PBS was increasingly incentivised. Concerns have been raised that poor quality services simply state that they are using PBS, without making any changes to practice (e.g. [Gore et al., 2022](#); [Culture of Care, 2025](#)). Tokenistic applications such as this were highlighted in the Care Quality Commission's review of the use of restraint, seclusion and segregation with autistic people, and people with a learning disability in secure hospitals. Within this review, 91% of individuals were found to have a "PBS plan", however, the quality of these plans was described as "poor" and the review also noted unsuitable physical environments, service cultures focused upon containment rather than support, as well as a lack of suitable assessments, support for communication and access to meaningful activity ([Care Quality Commission, 2020](#), pp. 13–16). This suggests that PBS often exists in such services, in name only. Concerns regarding tokenistic applications of

PBS were also raised by [Fernández-Mateos \*et al.\* \(2022\)](#) in their review of the history of ABA and PBS. The same authors also identify numerous issues that arise from attempting to create too great a division between the fields of ABA and PBS, including confusion amongst stakeholders, unclear training requirements for those delivering PBS services, and service providers only accessing short, commercially available PBS courses that do not address fundamental aspects of PBS. It can be argued therefore, that there is a disparity between the landscape described by [Gore \*et al.\* \(2022\)](#) and the practical reality of delivering PBS in the UK, in particular that the need for a marker in the sand, remains.

## ***Aims***

The aims of the present article were to provide a definition of PBS from the perspective of practitioners and to discuss key issues affecting applications of PBS within the UK context, including which populations PBS can serve, criticisms of PBS and ABA, the relationship between PBS and restrictive practices, and common barriers to implementation.

## **Method**

The definition was developed by a group of PBS practitioners (initially with a core group invited by the lead author, and latterly with an extended group who responded to an open invitation sent out via the PBS Special Interest Group of the UK Society for Behaviour Analysis; UK-SBA), through a series of online meetings, written submissions and reflection and feedback on drafts. Contributors discussed key characteristics of PBS within the UK, as well as topics that required further consideration. Once defining characteristics were agreed, each contributor wrote at least one section of the article. Sections were then shared with the lead author who coordinated contributions and developed a draft manuscript. This was shared with all contributors for further discussion, refinement and amendment.

## ***Scope of the definition***

The scope of the definition is “current practice within the UK” but was shaped with reference to the existing research. As outlined by [Gore \*et al.\* \(2013\)](#), PBS can be implemented by individual practitioners, multidisciplinary teams or as part of an organisation-wide approach. PBS is not limited to a particular setting, however, there may be additional barriers and challenges dependent on service type.

## ***Author demographics***

All contributors met the standards for Higher-Level Behaviour Specialist ([PBS Academy, 2017](#)) and all were registered with the UK-SBA. Several had additional postgraduate qualifications in autism studies, language sciences and psychology, one was a Registered Learning Disability Nurse and one was a trainee Clinical Psychologist. Contributors had worked with a diverse range of populations (i.e. autistic individuals with/without co-occurring intellectual disabilities, individuals with intellectual disabilities, mental health conditions, dementia and/or individuals with no formal diagnosis) and in a diverse range of settings (e.g. family homes, schools, children’s homes, Children and Adolescent Mental Health Services, adult community homes, supported living, mental health hospitals and forensic settings).

Four contributors were neurodivergent (40%), including three who were autistic (30%), and four were parents/stepparents to neurodivergent children (40%). Representation of different ethnic groups was limited, with eight contributors identifying as white British (80%). One contributor identified as white British/Polish, and one as Sri Lankan.

## *A practitioners' definition of Positive Behaviour Support*

The defining characteristics of PBS can be seen in [Table 1](#).

### *Underpinning philosophy (epistemology)*

As explained in [Table 1](#), PBS follows a functional contextualist philosophy. Within a functional contextualist philosophy, the term “behaviour” refers to everything people think

**Table 1** Defining characteristics of Positive Behaviour Support

<i>Defining characteristic</i>	<i>Description</i>
Underpinning philosophy	PBS follows a functional contextualist philosophy (an extension of radical behaviourism). This philosophy places a focus upon the function, or purpose, that behaviours serve, but also recognises the importance of context in influencing behaviour. The term “behaviour” refers to all human activity, including our thoughts. PBS also incorporates elements of person-centred planning, and therefore, prioritises and values the “lived experience” of the person receiving support
A focus on promoting the quality of life of the person receiving support	The predominant focus of PBS is upon improving the life of the person receiving support. It is acknowledged that “personal values” influence different people’s conceptualisation of quality of life. Therefore, what constitutes a good quality of life, will be dependent on the person receiving support’s unique experiences and perspective
Rights	PBS is delivered in accordance with human rights. This means that support is provided in accordance with the relevant legal framework, and that consent and assent, are addressed in all stages of support. PBS does not involve harsh, punitive, or intentionally aversive strategies, as these would be incongruent with a rights-respecting approach
Relationships	Relationships are both a mechanism of behaviour change, and an outcome within PBS. Unconditional positive regard is a fundamental aspect of every stage of support and is not contingent on behaviours that are seen as desirable, or undesirable, by supporters. The development of meaningful relationships is dependent on establishing mutuality and reciprocity between supporters, and the person receiving support
Applied Behaviour Analysis	PBS predominantly uses the principles and procedures of ABA to define, assess and support behaviour change. PBS is focused upon the context in which support is delivered. “Behaviour change” therefore, refers to organisational behaviour, and staff / caregiver behaviour, and not only that of the person receiving support
Functional Behaviour Assessment to inform function-based strategies	As with all our behaviour, behaviours that challenge develop and are influenced by the person’s biology, environment, and learning history. These “behaviours” are recognised as serving important purposes for the person (including reflexive behaviours, such as trauma responses, which serve an evolutionary purpose). The purpose(s) of behaviours that challenge (function) are determined through careful assessment, and data is used to ensure decisions are based upon evidence. Function-based strategies are developed that provide alternative ways for the person’s needs to be met
Multielement support	It is recognised that human experience is complex, and that numerous factors affect our behaviour. Strategies to support the person are not focused upon changing the person’s unique characteristics but are focused upon changing the context in which support is provided. Strategies may include those which develop understanding of the person’s needs, removing sources of distress, increasing the person’s opportunities to exercise choice and autonomy, increasing engagement in preferred activities, as well as building skills such as those which aid communication and independence
Collaborative working	PBS is not the prerogative of one person, or discipline, alone and requires collaborative working. This may include the person receiving support, family members, staff / caregivers and other professionals. PBS involves the use of other evidence-based approaches (e.g. person-centred active support, occupational therapy, speech and language therapy, acceptance and commitment therapy) in accordance with the person’s needs
Implementation support	PBS is not a “quick fix”, nor a universal panacea. It is a long term, constructional approach that works through developing an understanding of the person’s unique needs and a focus upon promoting meaningful improvements in the person’s quality of life. This requires ongoing implementation support for staff and caregivers, that may include training, coaching, monitoring and review, and practice leadership

Source(s): Authors' own work

and do (Harris, 2009). This philosophy emphasises the purpose (function) that behaviours serve but also recognises the importance of the environment and overall context in influencing behaviour. People's emotional experiences are recognised as influencing (and being influenced by) observable behaviour (e.g., McGill *et al.*, 1996; Gore and Baker, 2017). This in turn means that behaviour is determined by a complex interplay between a person's biology (including neurodevelopmental difference), environment and history of learning experiences. The conceptual framework underpinning PBS, therefore, is biopsychosocial in nature (Hastings *et al.*, 2013; Bowring *et al.*, 2019). However, as outlined by Gore *et al.* (2022), this is not a departure from the functional understanding of behaviour (i.e. a functional contextualist view), rather it is a clarification of the nature of the conceptual framework underpinning PBS, as described by Hastings *et al.* (2013) nearly a decade earlier.

PBS incorporates elements of person-centred planning (Toogood, 2012) and therefore, prioritises and values the "lived experience" of the person receiving support. Within PBS, the difficulties or challenges experienced by an individual are situated not within the person themselves, but within the context where these behaviours occur (Carr, 2007). This is consistent with a social model of disability (Oliver, 1986) which recognises that the barriers experienced by disabled people are predominantly created by society failing to accommodate their needs.

### *A focus on promoting the quality of life of the person receiving support*

As stated by Osgood (2019), it is the role of services to deliver QoL. This is also the predominant focus of PBS. However, QoL is a subjective construct (Schalock, 2000), and conceptualisations of QoL can be interpreted through a normative lens (Quinn, 2025). Different QoL conceptualisations and scales can be focussed upon remediation, rather than socially valid features of human experience, such as belonging (Milton and Sims, 2016) or acceptance (Cooper *et al.*, 2017). There are numerous guiding conceptualisations of QoL that may be used within PBS (e.g., O'Brien, 1992; Schalock, 2000; Seligman, 2011). Application of these models requires recognition that there is no single truth for all cultures, contexts and neurotypes, and that QoL is influenced by personal values (Felce and Perry, 1995).

There is a well-established relationship between behaviour that challenges, and impoverished QoL (McGill *et al.*, 2020). People who display such behaviour(s) are at risk of responses which sustain poor QoL (e.g., restrictive practices, out of area placements). The main concern within PBS, therefore, is identifying where attention is required to improve a person's QoL, and how to avoid, or disrupt, a cycle in which behaviours that challenge are met with restrictive and/or aversive responses, resulting in diminished QoL, and an increased likelihood of further occurrence of behaviours that challenge.

### *Rights*

PBS is a rights-based approach and as such, any support provided must be focused on the rights, dignity and autonomy of the person being supported. Human rights principles are integrated within the design and delivery of interventions, and the person is treated as an active participant in their support. As a minimum, this means tailoring the support to the individuals' preferences and goals (Gore *et al.*, 2013). Where people cannot make informed decisions about their life, their right to assent (or withdraw assent) to the support that is provided is acknowledged.

In line with a rights-based approach, PBS does not involve harsh, punitive or intentionally aversive strategies, as these would be incongruent with a rights-respecting approach. Whilst it is important to recognise that a PBS approach cannot result in the elimination of all restrictive practices (e.g., a seatbelt is technically a form of mechanical restraint), or

aversive situations (sometimes learning to tolerate an aversive situation may be an important goal of the person receiving support), within a PBS framework, it is recognised that everyone has the right to live a life free from abuse, neglect, and exploitation.

### *Relationships*

It is essential that we acknowledge the harm caused by practices “done to” people in the name of behavioural intervention and commit to ensuring these mistakes are not repeated (Carr *et al.*, 2002; Morris and Peterson, 2022; Graber and Graber, 2025). It is vital in this respect, that those receiving support are recognised as active partners in their support (Osgood, 2019). Their needs, aspirations and preferences are the primary focus of PBS (Gore *et al.*, 2022); therefore, relational security and psychological safety are also essential. Human behaviour is best understood in the context of relationships and the overall social context, and not just through a focus upon the person receiving support (Toogood, 2012; Hastings *et al.*, 2013).

Across a range of psychological therapies, it has been recognised that therapeutic alliance is the greatest predictor of positive outcomes (Baier, Kline and Feeny, 2020). As highlighted in Table 1, the relationship between supporters and those supported, is also paramount for PBS to be successful. Behaving compassionately and with flexibility is an essential part of modern ABA and PBS (Hanley, 2020; Ghaemmaghami *et al.*, 2024). Developing warm and harmonious relationships, and embedding unconditional positive regard within support, are integral to the implementation of PBS.

### *Applied Behaviour Analysis*

PBS is a multicomponent framework, the underlying science of which, is ABA (Gore *et al.*, 2013). ABA is the science in which strategies derived from the principles of behaviour are applied to achieve socially significant changes in behaviour (Cooper *et al.*, 2020). As with other natural sciences, ABA is neither inherently “good” nor inherently “bad”; rather, its value is determined by how it is used, and the goals it aims to achieve.

ABA is recognised as an evidence-based practice for autistic individuals (Allen *et al.*, 2024). However, the science of ABA is not specific to one population and is used with people within the neuromajority, in addition to people with various diagnoses including ADHD, OCD, dementia, intellectual disabilities, mental health conditions and Tourette’s syndrome (Cooper *et al.*, 2020). ABA has been used to support behaviour change with regard to a diverse range of issues including aviation safety, reducing littering, breast cancer detection, fire safety, gender-based violence and phobias (Cooper *et al.*, 2020).

### *Functional assessment to inform function-based strategies*

Behaviours that challenge serve meaningful purposes (functions). These are not limited to intentional actions but also include reflexive behaviours (such as trauma responses that occur to a great extent as a result of our biology). Within PBS, all behaviour is considered to have meaning, whether it is intentional communication or an automatic neurobiological response.

The primary focus of PBS is not upon reducing the occurrence of behaviours that challenge, but upon understanding why these occur (Weiss and Knoster, 2008). This understanding is developed through a process called functional behaviour assessment (FBA). FBA involves systematic observation and data collection, to gather evidence about what the behaviour may communicate; but also seeks to understand the person’s history, characteristics and preferences. FBA, therefore, is focussed upon seeing behaviour in context through examining the person’s internal state, sensory experience, communication needs, trauma history and neurological differences, alongside environmental and relational factors.

Completion of an FBA results in the support provided being more effective (Hanley, 2012), but is also in essence an act of empathy (McClean, 2024), as it seeks to identify why the outcomes of a particular behaviour are important to the person. Function-based strategies are developed, not to suppress behaviour, but to provide alternative ways for the person's needs to be met.

### *Multi-element support*

PBS adopts a non-linear approach to behaviour which necessitates a multi-element (or multicomponent) approach (LaVigna and Willis, 2012). Individualised Behaviour Support Plans are focussed upon proactive support that minimises exposure to antecedents which result in distress or discomfort, increases understanding of the person's needs and experience, improves the person's QoL, promotes engagement in meaningful activity, and teaches new skills that provide the person with alternative ways to meet their needs (Gore *et al.*, 2022).

Reactive strategies may be included, which are focussed upon keeping the person, and those around them, safe when behaviours that challenge occur (LaVigna and Willis, 2012). These are developed in accordance with the person's needs and preferences, and non-restrictive options are prioritised.

### *Collaborative working*

The involvement of stakeholders (family members, friends, staff/caregivers), is emphasised within assessment, goal development and the delivery of support (Carr *et al.*, 2002). PBS, therefore, is not the prerogative of a single professional or discipline, and involves collaboration with stakeholders and other professionals.

Multidisciplinary input may include a range of evidence-based disciplines including healthcare, mental health, and education professionals (Gore *et al.*, 2013). Such input is required to establish "capable environments" (McGill *et al.*, 2020) and deliver genuinely person-centred support. Multidisciplinary teams (MDTs), however, can be subject to a diffusion of responsibility, and a "wait and see" inertia (Doornebosch *et al.*, 2025). It is vital therefore, that open communication and shared decision-making are established. Conflict between collaborators will have a detrimental effect, and it is important that collaboration is approached with humility and sensitivity.

### *Implementation support*

PBS is a long-term, dynamic process that requires deliberate investment in people. Staff and caregivers serve a pivotal role in shaping the environment of those they support. They are responsible for translating strategies into compassionate and person-centred practice (Allen *et al.*, 2013). Staff/caregiver wellbeing and competence will significantly affect the QoL of those they support (Beadle-Brown *et al.*, 2016). Effective delivery of PBS, therefore, relies on effective implementation support which will include a combination of theory and competence-based training, coaching, modelling and feedback (McGill *et al.*, 2018). Suitable organisational culture, effective training and the correct systems to support implementation, are all needed to support consistent and competent practice (Allen *et al.*, 2013).

## Discussion

### *Values*

PBS is a values-led framework with human rights at its core (Gore *et al.*, 2022). It was not felt, however, that the "values" of PBS could be separated from the characteristics included in this definition. Rather, values are integral to, and reflected within, each characteristic. The

values of PBS arose from the disability rights, self-determination and anti-aversives movements (Bambara *et al.*, 2025) but continue to evolve in response to the values of the groups practitioners serve, and include the neurodiversity perspective (McTiernan and Bowring, 2024). Core values within PBS include being person-centred, constructional, proactively focussed and compassionate (Gore *et al.*, 2013). That is, PBS is always adapted to a person's individual needs and adopts a strengths-based approach (McTiernan and Bowring, 2024).

### *Who is Positive Behaviour Support “for”?*

The science of ABA is not specific to, or practised by, a single population. It is argued here that PBS also, is not “for” any single population. As an ideographic/person-centred approach, PBS must always be adapted to the needs, preferences and circumstances of the person being supported. The evidence-base for PBS is strongest in support of people with intellectual disabilities; however, PBS has been successfully implemented with a range of populations including with individuals who are autistic (Carr *et al.*, 2002; LaVigna and Willis, 2012; Gore *et al.*, 2013; McClean, 2024; Davies *et al.*, 2019).

### *Criticisms of Applied Behaviour Analysis and Positive Behaviour Support*

Contemporary scepticism towards ABA stems substantially from its association with the historical employment of unethical and aversive methodologies. This relates particularly to practices implemented in institutional settings in the USA, in the mid to late 20th century (Bernal, 2025). The field must acknowledge this harmful legacy (and cannot simply side-step such issues through minimising or diminishing the role of ABA within PBS). These approaches, while legally permissible within the prevailing paradigm of disability management at the time, bear little resemblance to current person-centred practice (Bernal, 2025). Understanding this historical context is crucial: the methodologies pioneered by Lovaas and contemporaries represent a historical phase that modern ABA and PBS have moved beyond, yet this transformation has not been adequately communicated to broader audiences.

Some criticisms reflect legitimate concerns regarding poor practice standards or coercive applications (e.g. Quinn, 2025). However, many critiques appear to conflate behavioural intervention with broader systemic issues that represent ubiquitous societal phenomena. These include medicalisation, institutional ableism, exclusionary practices, and the privileging of “neurotypical” behavioural norms. For example, concerns have been raised regarding systemic racism within the application of PBS in the UK (Culture of Care, 2025). On closer inspection however, the evidence provided regarding this, relates to black individuals being more likely to be detained under the Mental Health Act. Whereas this highlights systemic inequality, it is not directly relevant to the field of PBS. That is not to say however, that practitioners of PBS are immune from the social contexts within which they operate. Racism, sexism, ableism and other forms of discrimination persist within the UK. It is vital therefore, that those implementing behavioural interventions are both humble and self-reflective, such that they are continually illuminating and challenging their own implicit biases (Allen *et al.*, 2024). The discourse regarding PBS in the UK is increasingly at risk of being mischaracterised as a straightforward “for” versus “against” debate. Whilst it is important that the voices of marginalised groups are heard (Fletcher-Watson, 2022), the difficulty with a binary view of the discourse relating to PBS, is that this can prevent meaningful dialogue. As stated by a neurodivergent parent regarding their views of PBS:

It's an uncomfortable truth that those of us who have benefited from ABA have our voices shouted down and our experiences ignored. There are people who are autistic who get shouted down and abused for supporting this (Learning Disability England, 2025).

## ***Positive Behaviour Support and restrictive practices***

“Restrictive practice” is an umbrella term used to explain approaches that prevent a person from doing something they would otherwise do (Restraint Reduction Network, 2019). Restrictive practices are not a defining characteristic of PBS, as they are neither constructional, nor evidence-based (McDonnell *et al.*, 2023). It is recognised, however, that there are occasions where restrictive interventions may be incorporated into an individualised Behaviour Support Plan to prevent harm to the person receiving support, or those around them (LaVigna and Willis, 2012). It is also important to acknowledge that the use of restrictive interventions can impact on a person’s human rights. They should only be used therefore, with a clear focus on preserving the person’s rights and supporting the least restrictive (and aversive) approach (Ridley and Hopes, 2022). Within PBS, the use of such interventions is minimised, and where they are required, they are implemented as part of a broader, collaborative, rights-based approach.

## ***Barriers and challenges to delivering effective Positive Behaviour Support***

Despite a strong evidence-base underpinning PBS (Gore *et al.*, 2022), its implementation can be undermined. One significant issue is the persistence of power imbalances and rigid hierarchical structures across health and social care (O’Shea *et al.*, 2019) which can limit the collaborative ethos central to PBS (Gore *et al.*, 2013). Such issues are likely to be particularly difficult obstacles, in settings where those receiving support are detained against their will.

High staff turnover can also be a barrier to the implementation of PBS (Kearney *et al.*, 2020), as inconsistent staffing disrupts relationships and the continuity of care. Frequent staffing changes, inadequate training and/or implementation support, can all prevent PBS being embedded into practice. PBS, therefore, requires organisational commitment and effective management oversight to be successful (Allen *et al.*, 2012). Service culture can present further barriers. Organisational norms and implicit biases may create expectations of ideal service user behaviours or characteristics that alienate minority groups (Desai *et al.*, 2021). Broader cultural stigma can prevent a truly person-centred approach, even where individual staff attitudes are more progressive (Bracke *et al.*, 2019). Without organisational commitment to address such cultural and structural barriers, the adoption and sustainability of evidence-based frameworks such as PBS will be compromised.

## ***Limitations***

It is acknowledged that there was limited input from different disciplines when developing this definition, however, the aim was to provide a definition specifically from the perspective of UK-based practitioners. As the article is presented from this perspective, it is focussed predominantly on support for individuals, rather than systemwide applications of PBS.

The ethnic and social backgrounds of contributors were relatively homogenous, although, it is worth reiterating in this regard, that authors were self selecting. It is also likely that there is a disparity between the ethnic and social backgrounds of those working in direct support roles (where minority groups are overrepresented; Skills for Care, 2022), and those working in practitioner roles. It would, therefore, be highly beneficial for employers and higher education providers to consider how they can promote diversity and inclusivity within recruitment and staff development programmes.

## ***Directions for future research***

Through the process of developing this definition, several areas for further research were identified:

- The values and processes of PBS should be influenced by the populations that it serves (McTiernan and Bowring, 2024). Further research should be conducted regarding PBS in the UK, to gain and incorporate the views of different stakeholders (including those who are critical of PBS).
- As highlighted by Hastings *et al.* (2013), reductions in the occurrence of behaviours that challenge are not sufficient for PBS. Further longitudinal research concerning QoL outcomes within the UK would be beneficial.
- As highlighted by Bowring (2025), the prevalence of neurodivergence amongst professionals within the field of ABA/PBS in the UK is currently unknown. It would be helpful to explore this further.
- This article has focussed upon providing a definition of PBS developed by UK-based practitioners. Further work providing case study examples of how the definition appears in practice would be beneficial.

### *Calls to action*

There is a need to ensure the quality and consistency of PBS in the UK. One of the greatest risks to the field is that any professional or service can “say” they are delivering PBS. Despite research indicating that training in PBS alone, does not significantly affect practice (Hassiotis *et al.*, 2018), a multitude of brief training courses which purport to confer a title upon those who attend (e.g., “Practitioner” or “Coach”), remain widely available. There are also training courses delivered under the banner of “PBS”, that upon closer inspection are predominantly focussed upon physical intervention. Organisations and services must be actively discouraged from adopting a tokenistic approach to the implementation of PBS. There are several calls to action arising:

- Practitioners of PBS (including those delivering training in PBS) should be accountable and transparent regarding their qualifications and experience, and should be committed to an ethics code. For practitioners in the UK, this means being part of the UK-SBA professional register.
- Practitioners must practice within their own area(s) of competence (UK-SBA, 2024). This means ensuring that they have a thorough knowledge of the needs and views of the populations they serve.
- Those practising PBS should have a thorough understanding of issues relating to diversity, and exercise cultural humility within their practice.

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