



Mindfulness, Behaviour Support and Carer Wellbeing

An evidence-informed guide for carers, support workers, allied health professionals and behaviour support practitioners

Open Circle · Behaviour Support Practice Resource

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Why this matters

Supporting a person through repeated distress or behaviours of concern can be demanding. Mindfulness-based approaches may help carers and support workers notice their own reactions, respond more deliberately and sustain wellbeing. Some practices have also been studied as self-regulation skills for people with intellectual and developmental disability.

The key boundary

Mindfulness is an adjunct to good behaviour support - not a replacement for functional assessment, environmental change, communication support, medical or mental-health care, or an agreed crisis and safety plan. It should never be relied on as the sole strategy for keeping a dangerous situation safe.

Evidence position

The strongest programme-specific findings come from Mindfulness-Based Positive Behavior Support (MBPBS) and Meditation on the Soles of the Feet. Results are promising, including randomised trials, but much of the evidence comes from one research group. Evidence for SOBER Breathing Space and Surfing the Urge is preliminary. Broader mindfulness research with children and adolescents shows small average effects.

About this resource

This guide translates the referenced mindfulness and behaviour-support literature into a concise resource for carers and multidisciplinary teams. It focuses on practices that may be useful in real support settings, while keeping the strength and limits of the evidence visible.

It is written for family carers, paid support workers, allied health professionals and behaviour support practitioners. Some practices can also be taught to a person as a self-regulation skill when they are suitable for that person and taught within an appropriate support framework.

Use this guide to

- Understand where mindfulness may fit alongside Positive Behaviour Support (PBS).
- Support carers and staff to notice automatic reactions and respond more deliberately under pressure.
- Consider evidence-informed self-regulation practices such as Meditation on the Soles of the Feet.
- Distinguish better-supported approaches from practices that remain preliminary.
- Plan implementation, monitoring and review without over-claiming what mindfulness can achieve.

At a glance

1. Mindfulness is deliberate, present-moment attention with a non-judgemental stance; in practice, it is intended to create space between a trigger and an automatic reaction (Singh et al., 2020).
2. MBPBS combines mindfulness training for carers with streamlined, function-based positive behaviour support. Several studies report reductions in carer stress and in restrictive or emergency responses, but the evidence base is concentrated within one research programme (Singh et al., 2015; 2016; 2019; 2021; 2023).
3. Meditation on the Soles of the Feet (SoF) has the most developed evidence among the individual self-regulation practices reviewed, largely from single-case designs plus one small randomised trial (Singh & Hwang, 2021).
4. SOBER Breathing Space and Surfing the Urge are promising but each is supported by very limited direct evidence in this population (Singh & Hwang, 2021).
5. General mindfulness programmes for children and adolescents produce small average effects, and effects are smaller when compared with active control conditions (Dunning et al., 2019).
6. Mindfulness should be used to support regulation, thoughtful responding and wellbeing - not instead of understanding why behaviour occurs or changing the conditions around the person.

What the evidence supports

The literature in the reference documents includes programme trials, single-case studies, feasibility studies and a broader meta-analysis. These designs answer different questions. The summary below deliberately separates the strength of evidence from the attractiveness of the idea.

How to read the evidence labels

The labels below are an Open Circle synthesis of the literature referenced for this resource. “Supported but concentrated” means there are multiple studies, including stronger designs, but replication is largely from the same research group. “Promising” means there is a consistent signal but important design or replication limits remain. “Preliminary” means evidence is too sparse for confident generalisation.

Approach	Evidence in supplied literature	Reported outcomes	Practice position
MBPBS for carers and support staff	Multiple studies including randomised trials	Reduced caregiver stress; fewer restrictive/emergency responses; improved engagement reported	Supported but concentrated - independent replication remains important
Meditation on the Soles of the Feet	Multiple single-case studies + one small RCT; some independent replication	Reduced verbal/physical aggression and destructive behaviour in studied participants	Promising targeted skill; suitability and teaching competence matter
SOBER Breathing Space	One multiple-baseline study in autistic children	Aggression reduced in the reported study, with generalisation	Preliminary
Surfing the Urge	One small study in autistic adolescents	Aggression reduced in the reported study	Preliminary
Mindfulness for children/adolescents generally	Meta-analysis of 33 RCTs, 3,666 participants	Small positive effects overall; smaller against active controls	Modest average effect; not specific evidence for behaviours of concern
MBSR / self-compassion / mindful parenting	Feasibility and programme literature	Potential wellbeing, stress and quality-of-life benefits	Useful adjacent approaches; not stand-alone behaviour treatments

A key caution

Most MBPBS studies were conducted by the programme developers or closely related research teams. Singh (2020) explicitly calls for direct, systematic and independent replication before broad rollout. Parent- and staff-reported outcomes also create a risk of expectancy and observer effects. These limitations do not erase the findings, but they should temper claims of certainty.

Mindfulness in behaviour support

Mindfulness is commonly defined as deliberate awareness of present experience without immediately judging or reacting to it. In the MBPBS literature, the practical target is not “being calm” at all times. It is noticing what is happening in the carer, the person and the environment early enough to choose a more useful response (Singh et al., 2020).

From automatic reaction to chosen response

Under pressure, carers and support workers can become pulled into familiar cycles: prompting too quickly, repeating instructions, matching intensity, arguing, withdrawing or escalating control. MBPBS treats the carer-person interaction as reciprocal. A change in the carer’s attention, pacing and emotional regulation can alter the interaction, while the behaviour support plan provides the practical structure for what to do next.

Mindful caregiving in practice

Practice	What it can look like
Observe	Notice what is actually happening before interpreting it. Separate direct observation from expectation or yesterday’s incident.
Pause	Allow a brief gap before the next prompt, instruction or response. The pause is useful for both people.
Attend	Notice body tension, urgency, frustration or fear in yourself. These cues can be early warnings of automatic responding.
Choose	Return to the agreed support strategy rather than improvising under pressure.
Reinforce	Notice and respond to the person’s communication, coping, engagement and replacement skills with the same care given to behaviour of concern.
Review	After the event, use data and team reflection rather than self-blame or assumptions.

Practice principle

Mindfulness is most useful when it improves implementation of a well-formulated support approach. The strongest component trial in the supplied literature found the combined mindfulness + PBS programme produced larger gains than mindfulness alone or PBS training alone (Singh et al., 2021).

Carer and support-worker wellbeing

The source literature begins from a practical reality: people can care deeply about the person they support and still become stressed, emotionally exhausted or depleted. Repeated exposure to high-intensity incidents can narrow attention and make reactive responding more likely. Carer wellbeing is therefore relevant both in its own right and because it can affect the quality and consistency of support.

A sustainable starting practice

The MBPBS programme uses regular meditation practice to strengthen attention and reduce automaticity. Its formal training is intensive, but carers do not need to recreate the whole programme to begin practising present-moment attention for their own wellbeing. A simple starting point is to sit comfortably, notice the natural breath, and gently return attention whenever the mind wanders. The published MBPBS programme progressively builds practice time and treats repetition as essential (Singh et al., 2020).

Do not turn “dose” into a rule

Some MBPBS studies used 20-30 minutes of daily meditation and long training periods. Those doses belong to the studied programmes; they should not be presented as a universal requirement or as a guarantee of benefit. A realistic practice that is actually sustained is more useful than an ambitious schedule that increases pressure.

Self-compassion after difficult moments

Mindful Self-Compassion describes three elements: self-kindness rather than harsh self-judgement, common humanity rather than isolation, and mindful awareness rather than becoming overwhelmed by the experience (Germer & Neff, 2020). For carers, this can be particularly relevant after a difficult incident or when support did not go as planned.

A brief self-compassion pause

1. Acknowledge the moment: “This is difficult.”
2. Remember that strain is not unique to you: other carers and workers have difficult moments too.
3. Use a kind, practical statement: “What would help me respond well from here?”
4. Return to the agreed support plan, seek debriefing or support if needed, and avoid using the mindfulness exercise to minimise a genuine safety or workload problem.

The source literature also notes that mindfulness or self-compassion can bring difficult feelings or memories to the surface. If practice repeatedly increases distress, stop and seek appropriate professional support (Germer & Neff, 2020).

Mindfulness-Based Positive Behavior Support (MBPBS)

MBPBS combines mindfulness practice for carers with a simplified form of function-based positive behaviour support. The central idea is practical: a carer who is less reactive still needs a clear, evidence-informed plan; and a technically sound plan is difficult to implement if the carer is overwhelmed or responding automatically under pressure (Singh et al., 2020).

The behaviour-support component

Element	What it means in practice
Understand	Describe the behaviour clearly, when and where it occurs, what tends to happen before and after it, how the person communicates, and what the person is trying to obtain, avoid, communicate or regulate.
Prevent	Adjust setting events, triggers, routines and environments where feasible.
Teach	Build communication, coping, tolerance and other replacement skills that can meet the same need more safely or effectively.
Respond	Use agreed, safe response strategies that reduce escalation and do not rely on aversive methods.
Improve life	Include longer-term supports and quality-of-life outcomes, not only reduction of behaviour.
Review	Collect enough data to know whether the plan is helping and revise it when circumstances change.

Stepped support, not delayed support

The MBPBS literature describes stepped care: observe and make low-intensity adjustments first when appropriate, then increase support intensity when the problem persists or risk increases. This is not a reason to delay specialist assessment where behaviour is severe, dangerous, rapidly escalating or poorly understood.

Australian practice note

Where a person has an NDIS Behaviour Support Plan, mindfulness practices should sit within the person's broader support arrangements. They do not replace required risk management, restrictive-practice processes, clinical care or practitioner review. This note reflects practice context rather than a finding of the mindfulness evidence review.

Meditation on the Soles of the Feet

Meditation on the Soles of the Feet (SoF) is the most developed individual self-regulation practice in the reference literature. It is intended to help a person notice rising anger or arousal and deliberately shift attention to a neutral, concrete body sensation before choosing what to do next (Singh & Hwang, 2021).

The core sequence

1. Stand or sit in a natural posture with both feet supported.
2. Notice the first signs of anger or escalation - thoughts, tension, faster breathing or an urge to act.
3. Shift attention deliberately to the soles of the feet.
4. Notice concrete sensations: toes, socks, shoes, pressure, temperature and contact with the floor.
5. Keep breathing naturally and stay with those sensations until the intensity begins to settle.
6. Then choose the next action: move away, communicate a need, ask for help, or respond calmly according to the person's support plan.

Important teaching point

Published studies typically taught the skill through instruction, modelling, practice while calm, prompts in real situations and gradual fading of support. Parents and teachers were commonly asked to practise the method themselves before teaching it. Where a person cannot imagine or recall a past situation, the reference literature describes adapting rehearsal rather than assuming the practice is unsuitable (Singh & Hwang, 2021).

What the evidence can - and cannot - say

Across the reviewed studies, SoF was associated with substantial reductions in aggression and destructive behaviour for some people with intellectual and developmental disability, including autistic adolescents. The evidence includes repeated single-case designs, long follow-up in some studies, a small randomised wait-list trial and some independent replication. This is encouraging, but it is not evidence that SoF will work for every person or that it should be taught without individual assessment.

For behaviour support teams, SoF is best treated as a possible replacement or coping skill to be taught, prompted and monitored - not as a universal de-escalation instruction.

Two promising but preliminary practices

The source literature also describes SOBER Breathing Space and Surfing the Urge. Both are plausible mindfulness-based self-regulation strategies, but the direct evidence for behaviours of concern is much thinner than for SoF.

SOBER Breathing Space

Step	Prompt
S - Stop	Pause when you notice the first sign of anger or an urge to react.
O - Observe	Notice body sensations, thoughts and feelings without immediately acting on them.
B - Breathe	Bring attention to a few natural breaths.
E - Expand	Widen attention to the situation, the other person and the likely consequences of different actions.
R - Respond	Choose the next action deliberately rather than from habit.

Evidence position: one multiple-baseline study in autistic children reported reductions in verbal and physical aggression with maintenance and generalisation. The review authors explicitly caution that a single study is not enough to establish general utility (Singh & Hwang, 2021).

Surfing the Urge

This practice treats an urge as temporary: notice where it is felt in the body, observe it without judgement, return attention to the breath, and allow the urge to rise, peak and fall without acting on it. The published training uses repeated rehearsal so that the person learns the sequence before it is needed in a difficult moment (Singh & Singh Joy, 2021).

Evidence position: the supplied review describes one small study in autistic adolescents. That is preliminary evidence only (Singh & Hwang, 2021).

Do not overstate early evidence

A memorable technique can spread much faster than the evidence supporting it. SOBER and Surfing the Urge may be useful options for some people, but they should not be described as established treatments for aggression or behaviours of concern.

Choosing and teaching a practice

Mindfulness-based strategies are not one-size-fits-all. Fit depends on the person's communication, cognitive skills, sensory preferences, trauma history, motivation and ability to notice internal cues. The person's willingness to practise also matters.

Questions for the team

Question	What to clarify
Purpose	What problem is this practice intended to help with - carer reactivity, the person's anger, an urge to act, general stress, or something else?
Fit	Can the person understand and use the steps? Are body-focused exercises comfortable or aversive for them?
Function	Is the practice addressing a relevant skill gap, or is the behaviour primarily being shaped by environmental conditions that need to change?
Teaching	Who will model, practise, prompt and fade the skill? Has that person practised it themselves?
Safety	What is the agreed response if risk escalates? The mindfulness skill must not be the safety plan.
Measurement	What simple outcome will show whether the strategy is helping - use of the skill, recovery time, intensity, incidents, distress ratings, or participation?
Review	When will the team decide to continue, adapt or stop?

Teaching principles reflected in the literature

- Practise the skill while calm before expecting use during escalation.
- Use modelling, simple language and prompts matched to the person.
- Support generalisation across people and settings rather than assuming it will occur automatically.
- Fade prompts as independence develops.
- Collect simple data so the team can distinguish improvement from impression.

Professional scope

A carer can use mindfulness for their own regulation. Teaching a person a structured coping practice should be coordinated with the relevant support team when behaviours of concern are significant. If behaviour is dangerous, complex or unresolved, specialist behaviour support and other relevant clinical input should guide the intervention.

A practical implementation pathway

1. Clarify the target. Decide whether the goal is carer wellbeing, better implementation under pressure, or a self-regulation skill for the person.
2. Check the broader formulation. Confirm that health, communication, sensory, environmental and functional contributors are being considered. Do not use mindfulness to fill a gap in assessment.
3. Choose the least complex suitable practice. Start with one practice rather than several competing techniques.
4. Teach and rehearse while calm. Use the person's preferred communication style and adapt the steps only where the core process remains understandable.
5. Plan prompts and support. Decide who prompts, when, and how prompts will be faded.
6. Define safety separately. Keep crisis and risk procedures explicit. A mindfulness practice is not an emergency-response plan.
7. Measure something useful. Track practice use and one or two meaningful outcomes.
8. Review after a defined period. Continue only if the practice is acceptable, feasible and associated with useful change.

Simple practice and review log

Date	Practice used	When / context	What happened next	Anything to change?

Suggested review questions

- Is the person or carer actually using the practice?
- Does the practice reduce reactivity, shorten recovery, improve engagement or support more consistent implementation?
- Is the strategy acceptable to the person and feasible for carers or staff?
- Are changes better explained by environmental changes, medication, staffing, health, sleep or other setting events?
- Is there any sign that practice is increasing distress or being used to delay a needed review?

Safety, limits and when to stop

Mindfulness is often presented as inherently benign. The reference literature is more cautious. Practices can surface difficult emotions; a strategy may be a poor fit; and an appealing self-regulation exercise can become unsafe if people rely on it instead of assessment, crisis procedures or clinical care.

Stop or seek additional support when

- The person or carer becomes reliably more distressed during or after practice.
- Trauma-related memories or intense emotional reactions emerge and do not settle.
- The practice is being used instead of a needed medical, mental-health or behaviour-support review.
- Someone is relying on the practice as the main way to keep a dangerous situation safe.
- The person does not understand, tolerate or want the practice.
- There is no useful change despite reasonable teaching, practice and review.

Limits of the evidence

1. Concentration of research: much of the MBPBS and individual-practice evidence comes from one research programme, so independent replication is limited (Singh, 2020).
2. Design limits: several studies use small samples, single-case or pre/post designs. Stronger randomised trials exist for MBPBS, but not for every practice.
3. Measurement limits: carer stress and some behaviour outcomes rely on self-report or on carers who also received the intervention.
4. Generalisation limits: the evidence does not establish that findings apply to every disability group, age, support setting or level of cognitive/communication ability.
5. Broader mindfulness evidence: a large meta-analysis with children and adolescents found small effects overall and smaller effects when compared with active controls (Dunning et al., 2019).
6. Australian context: the supplied evidence does not specifically test these programmes within the Australian NDIS workforce or NDIS behaviour support system.

Bottom line

Mindfulness-based approaches are best viewed as potentially useful adjuncts: they may support carer wellbeing, improve the quality of moment-to-moment responding and, for some people, provide a teachable self-regulation skill. They should be selected on fit, taught carefully, monitored with data and kept within a broader person-centred behaviour support framework.

Key takeaways for different readers

For family carers

- Your wellbeing matters in its own right. A brief, sustainable mindfulness practice may help you notice stress and create a pause before reacting.
- You do not need to “stay calm” perfectly. The practical goal is to notice sooner, recover more quickly and return to the support approach you have agreed with the team.
- If a practice makes you more distressed, stop and seek support.

For support workers and providers

- Mindfulness training is not a substitute for adequate staffing, training, debriefing, supervision or a workable behaviour support plan.
- Use mindfulness to support implementation quality: observation, pacing, prompting, communication and consistent responses.
- Do not introduce a self-regulation technique for a participant as an isolated staff idea when risk is significant; coordinate it with the relevant team.

For allied health professionals

- Mindfulness may complement work on communication, interoception, emotional regulation, sensory supports and participation, but evidence strength varies by technique.
- Help the team distinguish a coping skill from a functional explanation. The presence of a useful mindfulness strategy does not explain why behaviour occurs.
- Where fit is uncertain, contribute discipline-specific assessment rather than assuming body-focused practice is neutral for every person.

For behaviour support practitioners

- Treat mindfulness as a possible proactive, replacement-skill or implementer-support strategy within a broader formulation.
- Make the intended mechanism explicit: what cue will trigger the skill, what does the skill help the person or carer do, and what outcome should change?
- Monitor implementation and social validity as well as incident counts.

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