Positive behaviour support
Getting it right from the start

Facilitators reference manual
Version 2 (updated September 2009)
Acknowledgements

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Kylie Saunders, Practice Advisor, Office of the Senior Practitioner

Reference material has also been drawn and adapted from the following major resources.
Bloomberg K, & West, D (1999), The Triple C: Checklist of Communication Competencies. Triple C Copyright of SCOPE

Program participants should have some understanding of the following Acts, policies and procedures:
Disability Act 2006
Underpinning knowledge

Person Centred Active Support (PCAS)

Office of the Senior Practitioner

Disability Quality Framework

Residential Services Practice Manual (section 7)

Guide to icons

Throughout this document the following icons have been used.

This icon refers to further references or learning materials that can be found on web pages.

This icon refers to activities that will reinforce the training materials being presented during the session.

This icon refers to suggested responses to the learning activities being presented.

This icon refers to case studies or scenarios for the group to work through.
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Program details

The purpose of this package is for participants to learn about:

- the importance of personal background factors as they relate to a person showing behaviours of concern and subject to restrictive interventions
- the interrelationship of bio-psychosocial factors and behaviours of concern
- why people communicate or show behaviours of concern
- the value of a functional behaviour assessment
- how to provide positive behaviour support
- the importance of self-control strategies.

Participants will be provided with information on how to effectively support the person with a disability who shows behaviours of concern and be supported to consider practical alternatives to restrictive interventions, that is: chemical restraint, mechanical restraint and seclusion.

This training package is based on person-centred principles which encompass positive communication and behaviour support. Staff competency in the application of positive communication and behaviour support is critical in improving the quality of life of people with a disability and in reducing the frequency, duration and intensity of behaviours of concern.

This training is a mandatory pre-requisite before the provision of any protective behaviours training for staff such as Professional Assault Response Training (PART).

| Content summary |
|-----------------|-----------------|-----------------|
| **Day one**     | **Day two**     | **Day three**   |
| What is positive behavioural support? | Communication | Positive behaviour support |
| Rights of people with a disability | • Need for effective communication | • Changing background factors |
| Victorian Charter of Human Rights and Responsibilities 2006 | • Communication continuum | • Skill development strategies |
| Attitudes, perceptions and values | • Augmentative and alternative communication | • Short-term change strategies |
| Rights of disability support workers | Behaviour of concern and challenging behaviours | • Immediate response strategies |
| Getting to know the person: Personal background factors: | Functional behaviour assessment | • General risk minimising strategies |
| • Impact of trauma and attachment | Mistaken and alternative interpretations of behaviour | Maintaining self-control |
| • Syndrome specific characteristics | Behaviour recording | |
| • Medical conditions | STAR charts | |
| • Mental illness | Motivation assessment tool | |
Learning outcomes, assessment and achieving competency

Successful completion of this training package requires you to attend the three day program and competently complete homework requirements provided at the end of Day 2. The program facilitator will tell you if you have met the requirements.

The program, however, does not lead to achievement of a formal accredited competency. If you wish to seek formal recognition for the skills and knowledge you have acquired through this program, the following guidelines will assist you.

The content, activities and homework tasks contained in this package should enable you to meet the following learning outcomes:

• Demonstrate understanding of the influence and purpose of behaviour
• Assess problem behaviour
• Develop multi-element support plans to meet individual needs
• Develop an individual response plan
• Monitor effectiveness of response plan
• Complete documentation

These learning outcomes are contained in the unit of competency entitled Plan and provide advanced behaviour support (National code: CHCICS404A)

This unit of competency forms a compulsory unit in Certificate IV in Disability (National course code: CHC40308), and an elective unit in the Advanced Diploma of Disability (National course code: CHC60108).

Both these courses are contained in the Community Services Training Packages CHC08, which are nationally recognised qualifications relevant to this industry.

If you are seeking formal recognition of competency for this unit, you will need to approach a registered training organisation (RTO) that delivers the relevant courses. An RTO is the only organisation type that can provide formal recognition of competency. This includes TAFEs and private providers. The RTO will explain the process, fee and evidence they require to assess your knowledge and skills against this competency. If the RTO is satisfied you have produced adequate evidence, you will be formally given the unit of competency.

It is recommended the following evidence be provided to the RTO:

• The learners manual including the completed activities
• The homework completed at the end of Day 2 (all participants should have a copy)
• The RTO will also ask seek additional evidence to see that you have applied the knowledge and skills in your workplace.

The individual RTO will instruct you according to their own requirements, policies and procedures.

Your regional Learning and Development co-ordinator may be able to suggest an RTO to approach.
The context of the learning program

This training package has been developed to reflect the Disability Act 2006 (the Act) which came into effect on the 1st of July 2007. The Act provides the framework for a whole-of-government and whole-of-community approach to enable people with a disability to actively participate in the life of the community.

The Act is guided by the principles of human rights and citizenship and provides substantial reform to the law for people with a disability in Victoria.

The Act also created the role of the senior practitioner who is responsible for ensuring that the rights of people who show behaviours of concern and who are subject to restrictive interventions and compulsory treatment are protected.

For the context of this training package behaviours of concern are defined as:

‘...behaviour of such intensity, frequency and duration that the physical safety of the person or others is placed or is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to ordinary community facilities, services and experiences’ Emerson 1995

Key Terms

Restrictive intervention (RI) refers to any intervention that is used to restrict the rights or freedom of movement of a person with a disability and includes:

• seclusion – for example, a room with a locked door/area and windows the person cannot open from the inside
• mechanical restraint – for example, a device used to prevent, restrict or subdue a person’s movement
• chemical restraint – for example, medications used for the primary purpose of behavioural control
• social restraint – for example, the use of verbal interactions, which might reasonably be construed by the person to whom they are directed as intimidating or potentially abusive, which rely on eliciting fear to moderate a person’s behaviour

If a restrictive intervention is to be used the option chosen should be the least restrictive possible in the circumstances (The Disability Act 2006 s 140 (b)).

The use of restrictive interventions by registered disability support providers must be reported monthly to the senior practitioner via the Restrictive Intervention Data System (RIDS).

People with a disability who show behaviours of concern and are subject to restrictive intervention must have a behaviour support plan (BSP) that is reviewed and submitted to the senior practitioner at intervals not more than 12 months, (The Disability Act 2006 s 142 1 (a)).

A behaviour support plan refers to a plan which specifies a broad range of strategies used in supporting the needs of the person and includes proactive strategies that build on the person’s strengths and supports the learning of skills such as general life skills, coping skills and effective communication.

The Act defines a behaviour support plan as:

‘a plan developed for a person with a disability which specifies a range of strategies to be used in managing the person’s behaviour including proactive strategies to build on the person’s strengths and increase their life skills’
The development of a behaviour support plan should involve the person with a disability and those who know the person well. Of equal importance is ensuring that the behaviour support plan is based on functional behaviour assessment conducted no more than five years ago. Other highly relevant assessments include; communication skills, risk assessments, sensory assessments and neuropsychological assessments.

The behaviour support plan must describe the use of the restrictive intervention. The inclusion of the restrictive intervention must be explained to the person with a disability by an independent person.

It is the role of the authorised program officer (APO) to approve the strategies in a behaviour support plan before it is submitted to the senior practitioner.

Refer to the Office of the Senior Practitioner website www.dhs.vic.gov.au/ds/osp for more information on:
- role of the senior practitioner
- restrictive interventions
- Restrictive Intervention Data System
- behaviour support plan
- independent person
- authorised program officer.

Describe the difference between:
- seclusion
- mechanical restraint
- chemical restraint
- social restraint.

Provide examples of each type of restraint.

**Seclusion** – a room with a locked door/area and windows that the person cannot open from the inside

1. a person in a wheel chair being moved into their bedroom against their will as a punishment for their behaviour
2. A person being moved into a room and the door shut and locked from the outside

**Mechanical restraint** – device used to prevent, restrict or subdue a person’s movement,

1. arm splints being used for non therapeutic purposes
2. being strapped into a chair as a method of behavioural control

**Chemical restraint** – medications used for the primary purpose of behavioural control

1. the use of valium or other drugs as a method of behavioural control

**Social restraint** – the use of verbal interactions, which might reasonably be construed by the person to whom they are directed as intimidating or potentially abusive, which rely on eliciting fear to moderate a person’s behaviour.
Day one
What is positive behaviour support?

Positive behaviour support (PBS) is not a simple answer to the complex reasons why people show behaviours of concern. The PBS approach includes the systematic gathering of relevant information, conducting a functional behaviour assessment, designing support plans, implementation and ongoing evaluation. Immediate response strategies for the management of serious episodes of the behaviour are also addressed, but there is a belief that the best behaviour support happens when the behaviour is not happening; hence the strong emphasis on proactive strategies.

PBS is based on decreasing behaviours of concern and improving the person’s quality of life. Positive behaviour support planning tells us the best way to work with an individual who shows behaviours of concern and gives us ways to improve the quality of life for the person and does not just deal with behaviour.

This approach places an emphasis on the need for responsiveness to a person’s feelings and needs and has the following defining features:

• valuing the person, deliberately building a sense of self-worth, and acknowledging all attempts at positive interaction
• creating situations where the person is placed at their best advantage
• acknowledging and trying to interpret what the person is communicating via the behaviour
• analysing the functions of the behaviour
• teaching the person other ways to meet their need or communicate their feelings
• gently supporting and leading the person to a calmer state
• providing encouragement and feedback about personal successes along with aspects of difficult situations the person may have handled well.

In groups develop a definition of what positive behaviour support means to you.

What does positive behaviour support mean to the people you support?

Group definitions should include:

• PBS is not a simple answer or a quick fix.
• The PBS approach includes the systematic gathering of relevant information, conducting a functional behaviour assessment, designing support plans, implementation and ongoing evaluation.
• PBS is based on decreasing behaviours of concern and improving the person’s quality of life.
• PBS has a strong emphasis on proactive strategies.
The following model is a brief guide to staff to remind staff of key things to think about when planning positive behaviour support for a person showing behaviours of concern.

### Positive Intervention Framework

#### Proactive strategies
What to do to prevent the behaviour

#### Immediate response strategies
What might help when the behaviours occur; beginning with least restrictive strategies?

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| Gathering relevant personal background information that leads to:  
  • increased opportunities for access to a variety of activities  
  • “balanced lifestyle”  
  • predictable environment  
  • consistent routines  
  • improved interactions and realistic expectations | General skills development  
  (e.g. teaching person to do more things for self)  
  Useful communication strategies that promote effective communication  
  (e.g. teaching the person to sign when seeking social interaction)  
  Coping skills  
  (e.g. teach the person what to do when feeling angry) | To support the learning of new skills such as:  
  • reinforcing specific behaviour  
  • avoiding things you know upsets the person  
  • strategies to increase engagement |

#### Redirection
(e.g. ‘distract’ the person by offering another activity)
- Talk to the person and find out what the problem is
- Work out what the person’s behaviour is trying to communicate
- Responding to early signs of the behaviour
- Responding to serious episodes of the behaviour

In groups develop a brief snap shot of a person you work with. This snap shot should identify major strengths and interests of the person as well as clear examples of any of the behaviours of concerns that are displayed.

This snap shot will be further developed and expanded over the course of the next few sessions.

This snap shot should cover all key quality of life areas and be written focussing on the strengths and interests of the person concerned.

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Where does positive behaviour support come from?

The origins of positive behaviour support can be found in the movement towards inclusion, applied behavioural analysis and person-centred values which have as a primary goal enhancing the quality of life of a person with a disability.

Positive behaviour support is a multi-element approach which provides a clear values base, a defined process and a sense of how to work with a person who displays behaviour/s of concern.

It promotes:
- a comprehensive lifestyle change
- a lifespan perspective
- environmental changes
- stakeholder participation
- social validity
- multi-component intervention
- emphasis on prevention.

For positive behaviour support to be successful it requires:
- team work
- seeing the person’s strengths and being committed to the person
- seeing the person and seeing the behaviour
- an appreciation that all behaviours have a purpose
- being positive.

Positive behaviour support: Assumptions and possible outcomes

Positive behaviour support is based on the assumption that people with a disability require different levels of support as they learn to self-regulate their feelings and behaviour as by nature they are likely to feel more anxious or stressed than others.

People with a disability can rely on support professionals to acknowledge their feelings and the message communicated via their behaviour. Support professionals will provide the personal support and affirmation required and gives specific acknowledgement for behavioural learnings.

Support professionals support the person with a disability to understand what to do and provide feedback on what has been done well and leads the person with a disability towards more appropriate ways of interacting.
Possible consequences and outcomes of the consistent implementation of positive behaviour support strategies

The person may learn:

• that their feelings will be noticed and acknowledged
• where and when behaviours are appropriate and valued
• how to manage situations and emotions that have previously led to difficult situations
• that considerate and cooperative behaviour is acknowledged, gets things achieved and leads to good feelings
• that they can make a difference by influencing others in ways that are mutually pleasing and positive.

Describe how the person you have identified above displays signs of stress
Describe how the person you have identified shows signs of anxiety
Describe how the person you have identified shows when they are tired or unwell
Describe how the person you have identified shows happiness
Describe how the person you have identified shows boredom

Is there a place for behaviour modification?

We have come a long way since the days of ‘behaviour modification’ which was used extensively in the 1960s and 1970s.

Behaviour modification did not try to understand why a person showed certain behaviour: it was enough to know what the behaviour was. There was an almost exclusive reliance on using consequences to change behaviour that is, reinforcing or rewarding desired behaviours while punishing undesired behaviours.

The use of aversive management techniques (restraint, seclusion, punishment) often laid the foundations for further behaviours; that is teaching the need to interact with others in an aversive way. Aversive techniques are usually at best unethical and frequently dangerous. Aversive techniques also have the potential to place support professionals at high risk of both emotional and physical injury.

Behaviour modification: Assumptions, strategies and possible consequences

Behaviour modification is based on the assumption that support professionals are responsible for:

• teaching people with a disability how to control their feelings and behaviours, to become well behaved
• teaching people with a disability what they should do
• controlling some people until they develop self-control skills.
Based on these assumptions strategies such as rewards and punishments have been used, that is:

- positive and negative consequences for inappropriate behaviour (limiting access to community, withholding personal items, using threatening or intimidating language)
- withdrawal of attention (time out, seclusion, ignoring)
- avoiding opportunities for recognition and acknowledgment.

As a consequence to these strategies the person with a disability:

- learns to do whatever the adult tells them
- learns that those with difficult behaviours are less worthy
- are more likely to develop a self-concept of being ‘bad’
- may learn that they can gain more power and influence with inappropriate behaviour
- may learn to use similar ignoring, excluding, punishment and reward approaches with others.

**Self-reflection:**

Think about the ways you were disciplined when you were younger. How has this impacted on how you act with your own or others children or how it impacts on the support that you provide people with disabilities?
Rights of people with a disability

People with a disability who show behaviours of concern have the right for their dignity and respect to be upheld as any other citizens of the community. This should be kept in mind even more so when we intervene in their lives as part of providing behaviour support.

Behaviours of concern do not indicate an illness to be treated. It is an indicator of a much more complex situation involving more than just the person with a disability. There is an emphasis on the responsibility of those providing support to also change, to better meet the person’s needs, rather than emphasising the need of the person alone to change, to fit in with their support service or network.

When planning to provide behaviour support the Act, the Victorian Charter of Human Rights and Responsibilities 2006, the Convention of the Rights of Person’s with a disability and the Communication Bill of Rights require us to consider the way we support people with a disability, particularly in setting the scene for any planned intervention, by ensuring that the interventions selected enable the person’s basic human rights to be upheld.

In July 2008 Australia became a signatory United Nations Convention of the Rights of Person’s with a Disability. The purpose of the convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

The convention marks a ‘paradigm shift’ in attitudes and approaches to persons with disabilities. Persons with disabilities are not viewed as ‘objects’ of charity, medical treatment and social protection. Rather, people with a disability are viewed as ‘subjects’ with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society.

The convention gives universal recognition to the dignity of persons with disabilities.
Communication Bill of Rights

Communicate and be listened to,
Be treated as an equal participant in conversations,
Choose his or her individual method of communication,
Express his or her feelings,
Request information, objects, events or actions,
Reject or refuse unwanted objects, events or actions,
Be included in social interaction,
Be communicated with in ways that are dignified and meaningful,
Be communicated with in ways that are culturally and linguistically appropriate,
Live and work in an environment that offers opportunities, promotes and supports their communication.

Without upholding a person’s basic human rights, knowing the person and addressing the underlying reasons for the behaviour, long-term change is virtually impossible.

In groups identify how many of the above communication rights are held or experienced by the people you support.

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2. These rights have been compiled from the following sources:
   - Information provided by people with disabilities who participated in the community consultations on complex communication needs, September 2000.
   - The Communication Bill of Rights produced by Severe Communication Impairment Outreach Projects (SCIOP).
Victorian Charter of Human Rights and Responsibilities 2006

The charter is enforceable with respect to Victorian laws and public institutions. It prohibits any person, any entity or public authority from limiting or destroying the human rights of the person.

The following human rights are enshrined in the Victorian Charter of Human Rights and Responsibilities 2006:

**Freedom**
- Freedom of movement, assembly, expression and association.
- Rights to liberty and security including due process and protections in the context of individual contact with the legal system (fair trial, ‘double jeopardy’ and prohibitions on retrospective criminal laws).
- Freedom of thought, conscience, religion and belief.
- Property rights.

**Respect**
- Right to life.
- Protection of families.
- Protection of children.
- Cultural rights.

**Equality**
- Equal recognition before the law.
- Entitlement to enjoy rights without discrimination.
- Equality before the law and protection from discrimination.
- Entitlement to participate in public life (including voting).

**Dignity**
- Prohibition on torture and cruel, inhuman or degrading treatment.
- Prohibition on forced work.
- Protection of privacy and reputation.
- Humane treatment when deprived of liberty.
- Appropriate treatment of children in the criminal process.
In applying the *Victorian Charter of Human Rights and Responsibilities 2006* with respect to people who show behaviours of concern we have a responsibility to ask ourselves the following questions when considering whether to subject the person to restrictive interventions.

- Which right is to be limited? Is the right very important in international law? (e.g. freedom from torture)
- Is the purpose for wanting to limit the human rights very important to society?
- What sort of limitation is being imposed? How could it infringe human rights?
- Is the limitation likely to achieve the purpose? Is the limitation excessive or out of proportion to its purpose?
- Are there any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve?

For more information refer to the Human Rights Commission website [www.humanrightscommission.vic.gov.au](http://www.humanrightscommission.vic.gov.au)

**Applying the Victorian Charter of Human Rights and Responsibilities 2006 to the following case studies**

*Please consider:*

1. Which right is being limited?
2. Is the purpose for wanting to limit the human rights very important to society?
3. What sort of limitation is being imposed: How could it infringe human rights?
4. Is the limitation likely to achieve the purpose? Is the limitation excessive or out of proportion to its purpose?
5. Are there any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve?
6. How can we adjust our work practices?
7. What impact will the adjusted work practices have on the lives of the people I support?

**Scenario one**

John is a young man with autism who speaks occasionally in short phrases. He lives with three other men in shared supported accommodation, two of the men are dependent on activities of daily living. John requires a moderate level of supervision in most activities of daily living (e.g. how to prepare a meal). He is subject to chemical restraint, Respiradone, for his autism.

There is a pattern of unauthorised leave described by staff as ‘absconding’. At times he ‘disappears’ overnight and is usually found by the police. However when he returns there is no evidence of injury and he appears safe. He has absconded many times before and has returned safely.
Freedom
• Freedom of movement, assembly, expression and association.

Equality
• Entitlement to enjoy rights without discrimination.
• Entitlement to participate in public life (including voting).

Dignity
• Prohibition on torture and cruel, inhuman or degrading treatment.

While these rights are not the only ones being infringed discussion should also include is John being placed at harm while he is away? Is John really absconding? Where is he going to and why? Is there a plan in place to ensure John can access help if need be, mobile phone, communications book? What is the pattern?

Scenario two
Miriam, Sarah and Mary all have severe to profound levels of intellectual disability and histories of aggression. All had lived in institutions.

Miriam has a history of physical and verbal aggression. No recent documentation of aggression noted. She is subject to chemical restraint polypharmacy and has been on psychotropic medication for many, many years. Her aggression occurs around the context of food when she wants more, she takes it from others.

Mary is 19 years old with vision impairment. She is described as having no communication skills. She grunts and vocalises. She spits, punches and bites staff. The aggression tends to occur when she is assisted to undress for a shower or before her favourite leisure activity, swimming. She takes other residents’ clothes when she is near these things and hides them in her cupboard. She uses a wheelchair.

Sarah will drink anything and has been found to drink from the toilet bowl. She will aspirate when drinking thin fluids. Like the others she is on a high level of psychotropic medication.
Freedom
• Freedom of movement, assembly, expression and association.
• Rights to liberty and security

Equality
• Equality before the law and protection from discrimination.
• Entitlement to participate in public life (including voting).

Dignity
• Prohibition on torture and cruel, inhuman or degrading treatment.
• Protection of privacy and reputation.
• Humane treatment when deprived of liberty.
• Appropriate treatment of children in the criminal process.

While these rights are not the only ones being infringed discussion should also include when was the last time the medications were checked? Are there communication systems in place and being used by staff?

Scenario three
A mechanical restraint, Velcro straps on the body and left arm, is applied on Luke, a 17-year old with cerebral palsy. It is not reportable because the restraints are for therapeutic reasons to maintain postural stability. The restraint is applied during mealtimes and when he is using an electronic voice output device (VOCA). For safety reasons, his wheelchair is ‘clamped down’ while he is on his own, such as while waiting to be picked up. Luke spits, scratches and attempts to throw punches at staff during these times when the restraint is applied. His Dynavox (type of VOCA) is taken off him for safety reasons and because it is an expensive device. The Dynavox is often kept in the cupboard.

Freedom
• Freedom of movement, assembly, expression and association.
• Freedom of thought, conscience, religion and belief.
• Property rights.

Equality
• Entitlement to participate in public life (including voting).

While these rights are not the only ones being infringed discussion should also include the concepts of social restraint. Why is his Dynavox really being removed? What safety reasons are being considered? How long is Luke kept waiting?
Attitudes, perceptions and values

Disability support professionals who understand their own motives for working with people with a disability are less likely to be cynical and pessimistic about providing positive behaviour support. Often cynicism, pessimism and other destructive staff attitudes can contribute to people with a disability needing to show behaviours of concern.

- Describe why you decided to work in the disability field?
- Why do you continue working in the disability field?
- Who is responsible for change when you are supporting people who show behaviours of concern?

Key words and phrases should include
- Support
- Making a difference
- Value
- Social justice

Attitudes

*Attitudes* -

‘... a settled opinion or way of thinking, behaviour reflecting this, a bodily posture.’

Oxford Dictionary

It is important to know yourself and where you are coming from (value base) and how that may impact on your perceptions and, subsequently, on your interactions with people who have a disability.

Hints to consider before taking action

Whatever the nature of the behaviour, there are some hints to consider before taking action.

1. Ensure you are operating from definitions of what is and is not behaviour of concern.
2. Definitions of unacceptable behaviour are usually based on personal standards and values of those viewing the behaviour and therefore open to interpretation.
3. Question the need to change a person’s behaviour.
4. Many behaviours occur as a result of interactions with people.
Perceptions

Perception

‘… a way of seeing or understanding things’

1. We all see the world differently:

   because of our education, socialisation, upbringing, different experiences, class, background
   and so on.

2. Our perceptions are a result of a complex interaction of internal and external factors:

   how we feel at the time, the situation we are in, our socialisation experiences, and interactions
   with others (for example, if I am feeling negative there is nothing my partner can do right).

3. We generally accept our perceptions and the interpretations we make based on them,
   as a true representation of reality:

   everything in our past and about us tells us that what we see and know is correct. This is how
   we make sense of the world categorising and matching with our memories of our experiences.
   This can be a problem when we come up against other individuals who believe they also have a
   true representation of reality.

How to check perceptions of behaviours

• Involve the person, support professionals, parents and advocates in deciding whether a
  behaviour is a problem.

• Be consistent with what is generally considered as normal for living situations, for example,
  think of living with five people, think of the people living with you and the confrontations you
  have in daily living.

  Don’t deny the reality of shared living. Situations where people live together are characterised
  by frequent difficulties and disagreements and occasional periods of stress. These dimensions
  are part of normal daily life and as natural for people with disabilities living together as they are
  for others.

• Whatever the reason, the efforts of support professionals to provide people with tranquil
  lives by eliminating all conflict are not only unreasonable, but they can be perceived and
  experienced by support professionals as oppressive.

• Be flexible and open to different perspectives.

• Continually change your own motives and methods in supporting people who show
  behaviours of concern.

• As support professionals, we have an unusual degree of power in that we can easily, in
  our position, curb behaviour which does not personally fit in with our values. We should
  be conscious of this when interacting with clients and be conscious of our behaviour,
  such as body language, tone of voice and expectations.
Values

Values

‘...one’s principles or standards, one’s judgement of what is valuable or important in life.’
Oxford Dictionary

are the standards by which a person directs his actions and defines, interprets, and judges all social phenomena.

What are values?

• Values are learned beliefs.
• Individuals learn them from their culture, their family, religion, peers, educators and from experience.
• Values are part of our personalities and how we behave and think.
• Values are evidenced by attitudes, and these vary by race, age, sex, religion, income and education.

It is important to examine our own values because:

• our values provide us with direction/a guide both in and outside work
• values influence our behaviour, attitudes and decisions
• when we communicate with people we interpret their messages using our own value base
• every decision we make has some basis in our values
• we need to be conscious of our own values and how they influence the way we work with people
• values determine whether we view behaviours as appropriate or not and whether we decide to intervene or not
• it is necessary to be aware of how your own values and attitudes may impact on how you see and define behaviours.

Read the article extract by Royce Millar Trouble in Kew (appendix 1)

• Identify the main key stakeholders in this article.
• What are the attitudes of each of the stakeholders?
• What are the perceptions of each of the stakeholders?
• What are the values of each of the stakeholders?
• Whose attitudes, perceptions and values are the most important?
• What message is this article sending in relation to clients with behaviours of concern?
Complete the attitude questionnaire and begin to examine how some of your attitudes may be impacting on your ability to provide effective support to people who show behaviours of concern.

**The attitude questionnaire**

"*Without the right attitude, no matter how good the behaviour support plan looks on paper, it won’t work.*"

Negative attitudes block people’s ability to carry out a positive behaviour support genuinely and with integrity. The following set of questions will help you to analyse your own attitudes. Each of them is about the things you actually do and may give you insight into your own underlying attitudes.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Sometimes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you introduce the person to visitors?</td>
<td>✔️</td>
<td>❌</td>
</tr>
<tr>
<td>2. Do you talk in front of the person about them as though they can’t hear or understand what you’re saying?</td>
<td>✔️</td>
<td>❌</td>
</tr>
<tr>
<td>3. Where possible, do you offer choices to the person in a way that is meaningful?</td>
<td>✔️</td>
<td>❌</td>
</tr>
<tr>
<td>4. Do you search for enjoyable, stimulating and fulfilling things for the person to be involved in that is based on their preferences?</td>
<td>✔️</td>
<td>❌</td>
</tr>
<tr>
<td>5. Do you include the person in decision making about the things that have an impact on their lives?</td>
<td>✔️</td>
<td>❌</td>
</tr>
<tr>
<td>6. Do you strive to actively support the person in the flow of activities that happen every day?</td>
<td>✔️</td>
<td>❌</td>
</tr>
<tr>
<td>7. Do you talk to the person with the same level of respect you show towards people without a disability?</td>
<td>✔️</td>
<td>❌</td>
</tr>
<tr>
<td>8. Are you polite in the way you talk with the person?</td>
<td>✔️</td>
<td>❌</td>
</tr>
<tr>
<td>9. Do you knock on the door of the person’s room before entering?</td>
<td>✔️</td>
<td>❌</td>
</tr>
<tr>
<td>10. Do you ensure the person is provided with privacy when helping them with personal care activities?</td>
<td>✔️</td>
<td>❌</td>
</tr>
<tr>
<td>11. When visitors come to the house do you take them on through the house, including the person’s bedroom?</td>
<td>✔️</td>
<td>❌</td>
</tr>
<tr>
<td>12. Do you think about how the person might be feeling and acting on these thoughts? (do you wonder whether they are cold or hot? Disappointed? Angry? Sad? Jealous? Confused? Unwell? Scared?)</td>
<td>✔️</td>
<td>❌</td>
</tr>
<tr>
<td>13. Do you often wonder what it must be like to live in a shared supported accommodation?</td>
<td>✔️</td>
<td>❌</td>
</tr>
<tr>
<td>14. Do you ever put yourself in the person’s shoes or try to imagine the world through their eyes?</td>
<td>✔️</td>
<td>❌</td>
</tr>
</tbody>
</table>
15. Do you stick up for the person even when it creates a level of discomfort and anxiety for you?

16. Do you thoughtfully challenge people, including your workmates, when they display disrespect towards the person?

17. Do you create opportunities during the day to interact with the person?

18. Do you show patience with the person?

19. Do you spend time trying to find out what the person is good at and likes doing?

20. Do you put personal effort into learning alternative communication methods like manual signing so you can communicate with the person in a way that is meaningful?

21. If you work with the a person who has high support needs, do you make efforts to help the person feel comfortable (for example, changing them if they have been incontinent, making sure their clothes fit properly, shooing flies way from their face or applying repellent)?

Reflecting on your attitudes

Spend some time reflecting on your own attitudes and beliefs. If there are some attitudes and beliefs you have identified which may be impeding your relationship with the residents, spend some time thinking about how you can alter these. You may like to write some personal goals for yourself!

After completing these questions, you may have discovered that there are some attitudes you have, that you may like to change.

TIPS for changing attitudes

Consciously try to change the things you say to yourself by:

- regularly focussing on the thoughts and beliefs that are going through your head
- having an internal debate about these beliefs by asking yourself questions like:
  - Is it helpful to the person for me to think that?
  - What evidence do I have for thinking this?
  - Is this a belief I want to continue to hold and rule how I act?

Substituting other more positive thoughts and beliefs and rehearsing these like:

Adam is a feeling human being, just like me, and deserves the time and patience I would expect when I’m going through a rough patch.

Sue has every right to want to be treated like an individual.

Rex is a person just like the people I meet in the street. It just happens to be the case that he also has a disability.
Before and while doing the things you habitually do at work, ask yourself whether this is how you would act if you held positive beliefs and values about people with a disability. If you find it is not, then try changing the way you act in accordance with more positive attitudes.

At first this may seem out of character for you and unnatural, but with a commitment to doing this, with time it will become part of your natural style and your attitudes will change too.

For further ideas on reflective practices try googling the key terms:

- reflective practices
- reflective learning
- plan, act, reflect, do
Rights of disability support workers

The Victorian Charter of Human Rights and Responsibilities 2006 is one important law that sets out our freedom, rights and responsibilities. This formal recognition of our rights protects all people from injustice and allows everyone to participate in and contribute to society. Disability support professionals therefore have the right to work in a safe and supportive environment.

Psychological injury resulting from work-related stress is a priority health and safety issue for the Department of Human Services and, so far as is practicable, is supported by the department’s core values of:

• client focus
• professional integrity
• quality
• collaborative relationships
• responsibility.

Stress is a term used to describe the feelings that some people have in response to pressures they face in their lives. Stress is not always harmful, and what may be stressful for one, is not always stressful for another. In some cases stress can be experienced as a ‘challenge’ and can produce positive effects, such as the maximisation of output and creativity. However stress that is prolonged or intense (distress) can result in psychological and physical harm.

A range of work-related factors have the potential to cause distress. Distress can result when people have work demands and pressures that are not matched to their knowledge and abilities and which challenge their ability to cope. This may arise when demands and pressures are considered to be unrealistic or unreasonable, or when an individual’s skills and abilities are not well matched to their role. Distress is likely to result in a decline in functioning and performance, and in overall levels of wellbeing.

well@work is the department’s strategy to promote psychological wellbeing and prevent and manage psychological injury that results from work-related stress.

Disability support professionals have the right, especially when supporting people who show behaviours of concern and are subject to restrictive interventions, to:

• adequate information and training in positive behaviour support
• be actively involved in the assessment process and not just be informed of what to do
• receive appropriate ongoing professional development
• access debriefing following a stressful workplace incident.

Refer to the Residential services practice manual for more information on the Employee Assistance program and Critical Incident Stress Management

Positive behaviour support: Getting it right from the start

Positive behaviour support: Personal background factors

Getting to know the person

Behaviours of concern rarely occur for no reason nor can behaviour be explained by a single factor or attributed to a single reason or cause.

In this section we will discuss a range of factors that need to be considered when supporting a person who shows behaviours of concern. An awareness of these factors and an appreciation of their impact is essential when providing positive behaviour support.

Areas to think about:

- Impact of trauma and attachement
- Importance of syndrome specific characteristics
- Mental conditions
- Mental illness
- Medications
- Communication
- Knowing the person’s preferences and abilities
- Human relations and sexuality
- Sensory impairments

Impact of trauma and attachment

Having a disability can increase one’s vulnerability to all three forms of abuse: emotional neglect, physical and sexual abuse. Many people with a disability who have been institutionalised from early childhood into old age may have experienced some form of abuse whilst in institutionalised care such as not having seen parents since admission, multiple care givers, loss of a carer and sudden changes to their environment.

These forms of abuse can have a short and long term impact on the person. In fact some behaviour, such as difficulties interacting with other people, can be traced back to situations where an individual has been abused. For people without effective communication skills the behaviour is often an expression of that trauma.

Whilst we are all born with the need and ability to form close relationships or attachments, the most critical developmental period is between birth and the age of three. Children who have experienced early problems with bonding with their primary carer due to abuse and neglect can go on to develop a variety of physical, emotional and social difficulties. These difficulties may result in the child developing a set of thoughts, feelings and behaviours that will influence how they interact with others (make attachments) and how they think about themselves and others.

3. Office of the Senior Practitioner, Positive Solutions in Practice, Trauma and Attachment for people with an intellectual disability, Kylie Saunders, Practice Advisor
There are four types of attachment styles which include:

1. **Secure** (usually confident)
   and three other insecure attachment styles
2. **Avoidant** (dismissing)
   - Here the person may think positively about themselves but have a negative view of the world and may avoid social interactions. They may have a tendency to avoid seeking help and do not like strong, emotionally-involved relationships.
3. **Anxious** (ambivalent/preoccupied/resistant)
   - Here the person may think negatively about themselves and think other people are good. They lack confidence in their own abilities and often prefer for others to make decisions for them.
4. **Disorganised** (Fearful/disorientated/unresolved)
   - Here the person may have a negative view of themselves and others, low confidence, fear of being rejected by others and are unable to adequately express how they are feeling.

People with an insecure attachment style, may exhibit a range of behaviours of concern including problematic ways of interacting with those around them. It is important to remember that they have developed a traumatic belief about themselves, other people and their environment, which influences their relationships, feelings and interactions and often are not aware of why they feel or act the way they do.

**How does trauma impact on attachment?**

A traumatic event can affect a person’s ability to cope with stress and makes them feel overwhelmed. Sometimes the effects are delayed by weeks and in some cases even years. Often people with an intellectual disability may not be able to fully understand why something has happened the consequences for themselves and others, how to problem solve or know what coping strategies to use. As a result people with an intellectual disability are more likely to show behaviours of concern when they feel that their personal safety is threatened.

**Case study**

Terry was physically abused when he was a child and now he gets scared if he hears someone yelling. Terry may misread the person’s tone of voice and body language as a potential threat and become fearful. He might suddenly lash out aggressively as part of an automatic response to keep himself safe.

In groups identify some potential strategies that you could put into place to support a person with an intellectual disability to establish positive relationships with others.

Why do you think these might work?

It is important to note that not all people who have experienced trauma will go onto develop significant attachment problems. Generally people who are social, confident, have effective communication skills and strong relationships with others are better able to cope with trauma.
General strategies for establishing positive relationships with others

1. Getting to know the person overall and in particularly about any traumatic experiences that may have occurred in the person’s life.

2. Interacting with the person in a way that is meaningful and respectful; using natural gesture and key word sign.\(^4\)

3. Assisting the person to make their own choices, and gain a sense of control and ownership over the things in their own environment.

4. Influencing the person’s daily experiences, engaging the person using a positive intervention framework and person-centred practices.

5. Ensuring a safe and predictable environment with opportunities to experience a range of activities.

6. Sensory and movement activities such as walking, drawing, painting, puzzles.

7. Taking care of a pet.

8. Teaching the person, through role modelling, how to problem solve, make choices and use relaxation techniques.

9. Providing grief counselling. In relation to bereavement, people with a disability should have access to counselling or therapy to help them cope with their loss. If access to counselling is not sought the person is more likely to suffer more atypical and longer grief.

10. Providing support and guidance in the areas of human relationships including problem solving, concepts of personal space, relaxation techniques, assertive communications training.

11. Modelling appropriate ways of interacting with others and managing emotions.

12. Using person centred active support to identify the person's like and dislikes and ways they can be included in tasks and activities at home and in the local community.

13. Being mindful of how you react to the person you support.

Please remember that for many people getting them to understand the reasons why they are reacting in a particular way towards others may not be useful, as often they not aware of their own beliefs about themselves and others.

It is also worth remembering whilst a person is at a time of crisis and feeling distressed it may not be helpful to discuss the reasons why they are feeling this way, this is explained further in the section on Immediate Response Strategy plan: phases 1 to 5.

Importance of syndrome specific characteristics

While it is important not to label a person with a disability or use terms such as a ‘disabled person’ it is important to acknowledge that some types of disabilities have common characteristics. This section focuses on the commonalties of some disabilities and is not meant to label or generalise people with a disability. The information here should be used as a guide only, with the realisation that every person is different and therefore may behave or interact in different ways.

Remember the person always comes first.

Particular types of syndromes have common characteristics. Although some links exist between certain syndromes and behaviours of concern often the behaviours occur as a result of people not having been supported to learn skills in particular areas, such as appropriate social interaction.

Understanding particular syndromes and the associated characteristics can be useful when trying to learn more about a person with a disability especially if they show behaviours of concern and have complex communication needs.

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\(^4\) A manual signing approach that combines speaking and signing and produced in English word order (Grove and Walker 1990)
Examples of common features

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Common features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prader Willi</td>
<td>Irresistible urge to eat and drink, difficulties with short-term memory, often difficulties with effectively using speech to communicate and/or understanding of spoken information</td>
</tr>
<tr>
<td>Lesch Nyhan syndrome</td>
<td>Self-injury behaviour (lip and finger biting), aggression</td>
</tr>
<tr>
<td>Fragile X syndrome</td>
<td>Repeating words, hand flapping, eye gaze avoidance</td>
</tr>
<tr>
<td>Cornelia de Lange syndrome</td>
<td>Loud vocalisations almost ‘cat like’, often visual and hearing impairments, gastro-oesophageal reflux</td>
</tr>
<tr>
<td>Autism Spectrum disorder</td>
<td>Stereotypical behaviour, hand flapping, toe walking, self-injury (e.g. hand biting) anxiety, difficulties with communication, literal interpretation of words</td>
</tr>
<tr>
<td>Down syndrome</td>
<td>Communication difficulties, early onset dementia (early to late fifties)</td>
</tr>
<tr>
<td>Angelman Syndrome</td>
<td>Hand flapping, communication difficulties, hyperactive behaviour marked by impulsivity, difficulties paying attention</td>
</tr>
<tr>
<td>Rett's Syndrome</td>
<td>Wringing of hands and constant clapping, teeth grinding, severe difficulties with expressive communication</td>
</tr>
<tr>
<td>Smith-Magenis</td>
<td>Hyperactivity, anxiety, self-injury</td>
</tr>
<tr>
<td>Williams Syndrome</td>
<td>Short attention span, persistent social intrusion</td>
</tr>
</tbody>
</table>

On page ten you described in some detail a person you support. Using this person as an example answer the following.

- Has the person you support been officially diagnosed with any type of disability or syndrome?
- If so what is it?
- What are some of the common characteristics of this disability or syndrome?
- How do these characteristics present in their interactions with others?
- How does it affect thinking and reasoning skills?
- How can I adjust my work practices to better support this person?
- Add this information to your previous summaries.

Refer to the Better Health Channel for further information on specific disabilities and support groups.

www.betterhealth.vic.gov.au

Other web sites of interest

Medical conditions

A thorough knowledge of the person’s medical history and the impact of any medical conditions is imperative. This is especially the case if the person shows behaviours of concern and has difficulties effectively expressing their needs and feelings.

Often people with a disability have a number of co-existing medical conditions; such as epilepsy, constipation, gastro-oesophageal reflux, poor oral health, and if the person does not have a means of communicating, the person may show behaviours of concern to communicate pain and discomfort.

For the person mentioned above answer the following:

• Does the person you support have any co-existing medical conditions that have been officially diagnosed?
• If so what are they?
• What signs or symptoms does the person display in relation to this diagnosis?
• How do these characteristics potentially effect their interactions with others?
• How does it affect their thinking and reasoning skills?
• What signs does the person display to show they are not well?
• How can I adjust my work practices to better support this person?
• Add this information to your previous summaries.

Consider the development of a personal communication dictionary that identifies how the person communicates the following:

• Happy, sad, sick, uncomfortable, thirsty, hungry, sleepy, cold, hot, want to be alone

Emphasis of a personal communication dictionary should also show staff how they should respond to the people they support including key word signs that staff will use with the person concerned.

An ‘All about me book, also known as communication passports could also include information about any medical conditions that are relevant for the person the personal communication dictionary is developed for.


Other web sites of interest:
www.betterhealth.vic.gov.au
Mental illness

People with an intellectual disability have a much higher prevalence of mental illness. Some researchers have estimated that people with a disability are approximately 40 per cent more likely to have a mental illness than the general population.

Mental illness is commonly overlooked or misdiagnosed in people with a disability. This is because they often show signs in ways that are hard for others to understand and interpret. People with severe communication difficulties will often show behaviours of concern; however it is important to avoid the assumption that all severe aggressive behaviour indicates a mental illness.

If people with a disability have higher rates of mental illness than the rest of the population and knowing that these are more difficult to diagnose in people with a disability due to cognitive and communication difficulties, it is important for disability support professionals to gain information on whether:

• there is a family history of a mental illness, as mental illnesses such as schizophrenia or mood disorders can be inherited

• the person is showing behaviours that may be symptomatically consistent with a mental illness.

In groups identify what common features or behaviours may be a characteristic of the people you support having or at risk of having mental health issues.

In identifying whether a person is showing symptoms consistent with a mental illness it is important for disability support professionals to document behaviour/s that are out of character for the person.

For example, signs that may indicate a mental illness:

• withdrawn behaviour

• irritability

• aggression directed towards others that has no clear warning signs or triggers

• boisterousness

• uninhibited behaviour

• hallucinations and paranoia

• refusing to eat

• withdrawal

• weight change, loss or gain.

It is important to work in conjunction with a qualified mental health worker or your BIST team to help devise appropriate strategies.
It is not the role of staff to diagnose mental illness; this is the role of the GP or other health professionals. Staff should:

- promote good mental health in the people they support
- be alert to changes in the behaviour of people they support
- arrange a visit to the GP if a person develops signs that may indicate a mental illness.

Refer to the *Residential services practice manual* Chapter 5.1.3: Promoting mental health and wellbeing

Other web sites of interest:
- www.betterhealth.vic.gov.au
- www.cddh.monash.org/
- www.vdds.org.au/

### Medications

Many people with a disability are often on a combination of medications for the treatment of medical conditions such as epilepsy, constipation or gastro-oesophageal reflux. Commonly psychotropic medication is prescribed to enable the treatment of a diagnosed mental illness or for the primary purpose of behavioural control.

When psychotropic medication is used for the primary purpose of controlling the behaviour of the person it is called chemical restraint and is one type of restrictive intervention. Psychotropic medication includes the use of antidepressants, anti-anxiety, anti-convulsant and anti-psychotic medications.

As all medications have possible side effects a general awareness of the side effects associated with prescribed medication is encouraged.

It is important for support professionals to have a general understanding of:

- what medications the person has been prescribed
- why a person is prescribed those medications
- what medical conditions or diagnosis the medication is treating
- whether any attempt to reduce or remove medication has occurred as a way of checking to see if the previously presenting condition has subsided.

An awareness of the side effects would enable support professionals to recognise symptoms associated with side effects that should be documented for discussion with the treating medical practitioner (general practitioner, psychiatrist, neurologist).

Some common side effects associated with psychotropic medication include:

- extreme restlessness in the legs that may result in excessive pacing
- extreme thirst
- extreme hunger
- hand tremors
- difficulties with eating, drinking and swallowing (dysphagia)
• constipation
• sedation
• tiredness
• difficulties controlling saliva
• shuffling gait
• difficulty beginning a motion
• facial grimacing
• mask like face
• involuntary tongue protrusion at rest.

For the person you support identify the following:

• A list of the medications the person is prescribed
• The purpose of these medications
• The possible side effects of these medications
• How it will be monitored?

Add this information to your client profile.

Refer to the *Residential services practice manual* Chapter 5.8: Promoting mental health and wellbeing

Refer to the *Residential services practice manual* Chapter 5.6: Medication

Other web sites of interest


and search for more information on:

• Practice Advice: Important information about medications used for the primary purpose of behavioural control
• Positive Solutions in Practice: What is Chemical Restraint?
• Office of the Senior Practitioner: Medications and RIDS

For further ideas on medications, common side effects of medications and general health tips try googling the key terms as identified above.
Importance of knowing the person’s preferences and abilities

As you complete each activity you are building up a profile of the person you support. This information is important when developing a positive behavioural support plan.

For the person you support identify the following:

• How would you use PCAS to provide the right support for experiencing success?
• What are the person’s likes and dislikes?
• What are the person’s strengths and weaknesses
• Can the person you support make choices – if so how do they show this?
• How does the person you support recognise and express their emotions?
• What is the person’s personality type?
• Are they assertive?
• Do they have a high self-esteem?
• Are they motivated?
• What social skills does the person have? Can they initiate a conversation? Take turns in a conversation? Do they have the language to maintain a conversation?

Add this information to your client profile.

As a group think about the best way to collect and present this information. Ideas could include developing an ‘All about me book’ or communication passports to document the person’s preferences and abilities.

Human relations and sexuality

People with developmental disability have the same sexual desires and needs as the rest of the community. There are many myths surrounding the sexuality of people with an intellectual disability. They are often seen as either asexual or childlike and in need of protection, or conversely as oversexed and in danger of becoming promiscuous and perverted.

There are differences, however, but these have more to do with different life experiences and opportunities to learn, rather than the individual’s inherent sexuality. It is by acknowledging and acting upon these differences that people with a developmental disability can be best assisted to develop their full potential.

Most information about sexuality and relationships is acquired through life experiences. People with a disability:

• tend to be overprotected by others, or be limited due to their level of disability
• often have difficulty learning and generalising abstract social rules and patterns of behaviour or they learn them in a rigid and literal manner
• sometimes learn inappropriate behaviours from others (both with and without disabilities).

Sexuality and disability is often considered a ‘Pandora’s Box’ of complex and never ending problems. It is important to:

- treat the person with the same amount of respect and dignity as you would a person with no disability
- be respectful, not only of the person but also of their disability
- be aware of myths and stereotypes
- consider what the function of purpose of the behaviour is.

Case studies

Scenario four
Mike is a 22 year old man with a moderate intellectual disability and poor communication skills. He does not really get along with the other people who live in his house and won’t even eat dinner with them. He often displays aggressive behaviour towards them, especially when he doesn’t get his own way. He spends a lot of time in his room masturbating, but CRU staff don’t think he is achieving ‘satisfaction’ and that he is getting ‘frustrated’, they also think that some of his aggressive behaviour may be due to this.

- What is the problems?
- Who is it a problem for?
- What are you going to do?
- How are you going to do it?

Problems could be

- the attitude of staff
- medically based, does Mike have a current CHAPS assessment
- referral, has Mike been referred onto services such as family planning
- what is Mikes behaviour really saying?
- does Mike have an up to date and relevant method of communicating?
- what is Mike gaining out of this behaviour?

6. Case studies provided by Ms Jenny Butler, Practice Advisor, Office of the Senior Practitioner.
Scenario Five

John is an 18-year-old man with a mild intellectual disability. He lives in a CRU with three other people. He works part-time as a factory hand. When he is not at work he likes to masturbate. He has recently been caught stealing silk nighties from the clothesline and wearing them in his bedroom whilst he masturbates. He then places the soiled nightie back on the clothesline hoping no-one will notice. When questioned about his behaviour he says that the nighties feel ‘sexy’ and nice against his skin. He also has a collection of ‘bras’n’things’ catalogues and stolen Playboys which are hidden under his mattress and in his pillow case. He is not allowed to buy them because staff don’t like them and will throw them out.

- What is the problem?
- Who is it a problem for?
- What are you going to do?
- How are you going to do it?

Problems could be

- the attitude of staff
- referral, has John been referred onto services such as family planning
- what is John’s behaviour really saying?
- does John have an up to date and relevant method of communicating?
- what is John gaining out of this behaviour?
- what are the legal implications of John’s behaviour?
- why are the staff throwing out John’s personal property?
- whose rights are being overlooked?
- does John have things to do at home apart from masturbating?
- is John’s behaviour “bad” or “dirty” or part of normal development?

Scenario six

Keeping in mind client confidentiality and relevance for the person you have been writing about, discuss any issues that this person may have in relation to human relations and sexuality. Summarise these issues into two or three paragraphs and then answer the following questions.

- What is the problem?
- Who is it a problem for?
- What are you going to do?
- How are you going to do it?

Refer to the Residential services practice manual Chapter 4.6

Other web sites of interest

Sensory impairment

The presence of a sensory impairment (hearing or visual impairment, tactile defensiveness) and the impact on a person's ability to communicate, interact and take part in daily activities needs to be considered.

Having a hearing impairment can result in the person with a disability having further difficulty in processing and understanding speech. Often hearing aids amplify all noise and therefore in a noisy room the person may be receiving an overload of sound.

People with disabilities with vision impairment may be limited in their interactions with people and objects around them and this may impact on their desire to communicate.

A person who is tactile defensive, that is, overly sensitive to touch, may experience great distress in daily living. Even the most subtle sensations can be perceived as extreme irritation or even painful and often over sensitive systems do not accommodate to the sensations no matter how much exposure the person has. This explains why some people may dislike light touch, but tolerate firm touch; or hate clothes tags and haircuts. People who are tactile defensive may feel bombarded by dozens of unpleasant sensory experiences on a daily basis and may respond in a reactive way such as grimacing, physically withdrawing or showing behaviours of concern.

As a support worker you will be better able to support a person with a disability with a visual or hearing impairment or tactile defensiveness, if you understand the nature and degree of their sensory impairment.

**General strategies to use with people who are deaf or hearing impaired**

1. Find out what communication mode the person prefers or is most effective.
2. Be sure that you have the person’s attention.
3. Make sure that you are standing in front of the person so they can see your face.
4. Try not to cover your face or mouth.
5. Use other visual modes of communication. These may include sign language, natural gestures, photos or pictures, as well as speech to assist the person's understanding.
6. Tactile sign language (where the words are signed into the person’s hand, body, or hand over hand) may be required for those who are deaf and blind.
7. If a person uses AUSLAN or a keyword signing for communication, it is important that all support staff learn and use these.
8. Try to reduce background noise, or if it is unavoidable perhaps suggest that the person have their hearing aid turned down or off. Be aware that hearing aids amplify all noise and therefore in a noisy room the person may be receiving an overload of sound.

**General strategies to use with people who are blind or vision impaired**

1. Understand the nature and degree of the person’s visual impairment
2. Make sure you introduce yourself before approaching the person. Introduce anyone else who is nearby or joins in the conversation by saying the person’s name.
3. When you are leaving the room let the person know, as talking when no one is there may embarrass them.
4. To encourage and promote communication, make sure the person has numerous chances to interact with people and objects in their environment.
5. Other senses such as smell should be used to interact with the person and provide them with information about their environment.

6. Always provide verbal warnings (where needed) in conjunction with object symbols, raised symbols or touch cues, to warn the person about what is going to happen next.

7. Always talk to the person and tell them what you are doing and what is happening.

8. Be explicit in giving verbal directions to a blind person. Pointing or saying ‘over there’ is of no help.

9. If you notice a visually impaired person heading for danger, give the immediate short command to STOP. (Do not say ‘watch out’, as they won’t know whether to stop, duck or back up.) Then explain the danger.

10. If the person has trouble processing and understanding speech, use a range of tactile cues to assist the person. For example, if something is unique to you (such as a bracelet that you wear) introduce yourself and direct the person’s hand to your bracelet.

General strategies to reduce sensory overload (including tactile defensiveness)

1. Use a quiet calm voice.

2. Set aside an uncluttered room where people can relax.

3. Engage people in an activity that calms them (you may need a sensory assessment to find this out).

4. Be aware that some people have their own calming techniques and are not trying to be difficult, e.g. sitting on the floor rather than climbing the stairs, taking empty packages out of the rubbish bin as they need something to scrunch to calm themselves.

5. Inform people when something that disturbs them is going to happen, e.g. bus arriving home, noise from maintain work, you are going to touch their hands to cut their nails.

6. Help people to feel in control and if possible facilitate people to do thing for themselves.

7. Reduce noise levels in the room.

8. Reduce visual clutter, e.g. check to see that there are not too many pictures on the wall.

9. Use a firm touch rather than a light touch.

For the person you have been developing a profile on discuss the following areas and how they may impact on their daily routines and identify suitable strategies to use.

- Hearing levels or ability
- Visual ability
- Tactile defensiveness issues

Add this summary information to your client profile.
Day two
Communication

Communication is about two or more people sharing a message. It is the exchange of information, thoughts and opinions between people. Communication may involve the use of conventional or unconventional signals and may occur by spoken and non-spoken modes.

Communication is a very complex activity, with two major processes:
• **Expressive communication** – The sending of a message
• **Receptive communication** – The receiving and interpreting of a message

Below is a simplified diagram of what happens when two people communicate a message.¹

The diagram above shows in a simplified way an example of a successful interaction. The two-way process of communication is not always successful and not always that simple.

Complex communication needs²

People who are unable to communicate effectively using speech alone may benefit from using augmentative or alternative communication (AAC) systems either temporarily or permanently. Hearing limitation should not be considered the primary cause of complex communication needs. Many people with a disability have complex communication needs. Often a significant proportion will show behaviours of concern as they are unable to effectively use speech or the attempts they make to communicate are difficult for their communication partners to understand. This is particularly true for people who find the usual methods of communication difficult or impossible.

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¹ Diagram modified from Disability Services Queensland Certificate III workbook.
² Disability Services Division definition following feedback provided by people with disabilities who participated in the community consultations on complex communication needs, September 2000.
For example, a person who isn’t feeling well and is unable to communicate may show behaviours of concern when it is their turn to do the washing up. If the behaviour brings about a response from others that meets the person’s need they may use that behaviour again and again to get the same response (desired outcome).

**Communication is a shared responsibility**

‘A communication disability does not just belong to the individual. It belongs to the entire environment of which the person is the focal point’ Sandwell, Communication Aids Centre United Kingdom

A collaborative approach looks not only at the person with complex communication needs and their communication skills, but at the strategies that COMMUNICATION PARTNERS need to use to help make communication successful. Communication partners can support people with complex communication needs more effectively if they are familiar with augmentative communication strategies and know how to use them.

We all share the responsibility for:

- valuing each person’s unique way of communicating
- understanding how each person communicates
- being responsive to people’s communication
- learning how to communicate more effectively with people with complex communication needs
- allowing people the opportunity to have their say
- assisting people to participate in social interactions and activities and be included in the community.

**How can you model these responsibilities in the workplace?**

**The need for effective communication**

Helping people to communicate improves their quality of life. It improves their opportunities, education, social life, friendships and independence.

People with disabilities show great differences in their ability to communicate. Some may have functional speech with a good grasp of language forms. Some may be limited in their use of grammatical structures and have a small but useful vocabulary. These people will use spoken communication as their main form of communication.

The majority may use only the odd word or two or may use gestures and vocalisations. These people may need assistance in developing other forms of communication, such as using signs, symbols or a communication board. These other forms of communication are collectively known as augmentative and alternative communication (AAC).
Frustration and loneliness caused by the inability to communicate effectively may lead some people to behave in a disruptive manner. Other people may withdraw from any attempt at communication. These reactions limit their opportunities to form friendships and develop social skills.

In fact, some people will have become so frustrated that they appear to have given up trying to communicate. They may resist attempts to engage them in conversation or misbehave when people try to use other forms of communication with them. Without support these people become more and more isolated and limited in their participation in the community.

However, most people will try to influence their environment through some form of communication. Those with poor speech may make more use of gestures or sounds (rather than words, signs or symbols). Some may have learned that a loud shout can be more effective than persistent, pleasant requests.

Some may become physically expressive by grasping and through bodily contact. These acts can be communicative, but where physical assertion is intense the acts are often misinterpreted as aggression.

Your first impression may be that a particular behaviour (e.g. head banging) has nothing to do with communication. Perhaps it hasn’t. However if you see a person striking his head and you have never observed this before, then you should at least consider the likelihood that the person is trying to convey some message, such as *I have a headache*, *I am bored* or *I am angry*.

Unfortunately this behaviour can become habitual and its correlation with communication diluted, if in the past people have not responded sensitively to these attempts at communication. Behaviour which may have started out as a communicative act merely becomes a troublesome habit for those who live with the person.

So much depends on how familiar you are with the person, your knowledge of their preferred methods of expressing feelings and your ability to interpret.

People with profound and multiple disabilities often express emotion, pain or boredom in non-conventional ways. Some people who are non-speaking may turn in on themselves and communicate by what appears to be self-absorbed behaviour (hand waving, teeth grinding or rocking). Others express themselves more outwardly (throwing objects, damaging furniture and hitting out at other residents).

So called disruptive behaviour and various inappropriate behaviours may be an attempt to initiate social contact or gain attention. It may also be a reaction and response to what is happening (such as when expectations are unreasonable or not understood).

People with developmental disabilities will sometimes have confused or conflicting feelings. Like everyone else in this situation they will have difficulty expressing themselves clearly because they are not sure what they are trying to convey. Understanding the ‘communicative intent’ of the behaviour requires understanding the person’s communicative ability (whether they are intentional or unintentional communicators) a functional behaviour assessment and the systematic introduction of appropriate AAC systems that are linked to the function of the behaviour.
Strategies used by effective communication partners

- Know the person’s level of communicative ability—what it means if the person is an intentional or unintentional communicator or if the person has basic literacy. Knowledge and understanding of the person’s communicative ability will help ensure communication with the person is meaningful.

- Remove any distractions before talking to the person (e.g. turn down the volume on the television or radio).

- Get the person’s attention (e.g. using a touch cue, making eye contact with the person).

- Use clear simple language, but don’t be condescending.

- Keep instructions specific and positive. Talk to the person about what to do, not what not to do. For example, ‘Tom walk beside the pool’ instead of ‘don’t run by the pool’. Avoid saying ‘We will go for a coffee later’ give the person a time ‘We will go for a coffee after lunch’.

- If you have broken down the instruction and the person is still experiencing difficulty processing it, model or demonstrate to the person what you are saying.

- Break down complex instructions into separate steps. For example, if providing a three part instruction, provide one part of the instruction at a time.

- Be careful that your body language and facial expressions don’t send conflicting messages: for example, having a grumpy look on your face when your message does not have an angry or grumpy tone.

- Always use environmental cues. For example be in the kitchen when talking about making dinner.

- Use natural gestures or key word signing when talking with the person. Remember always to speak and sign.

- Supplement spoken messages with visual cues such as the real object, photo, line drawing that is being talked about to help the person understand what is happening next or what you are talking about. Remember to find out what visual cues are most meaningful to the person, as not all people are able to understand photographs or line drawings.

- Allow the person time to respond. People with disabilities may not only take time to communicate their message but may also require time to listen to their communication partner, formulate and communicate a response.

- If the person has difficulty with time concepts, use times of the day they know, or provide the person with visual ways to mark time.

- Use visual systems to help the person process and respond in times of stress or illness. For example an AAC system such as a social story will support the person to remember how to relax and react in a stressful situation. This also provides the person with ways to control and support themselves independently.

- If you have broken down the instruction and the person is still experiencing difficulty processing it, model/demonstrate what you are saying.

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• Increase the rate of providing choices and other communication opportunities to people with complex communication needs.

• Respond to all attempts at communication made by the person. Be sure to update the person's personal communication dictionary regularly.

• Initiate and expand on any social or communicative behaviour made by the person, this will help the person learn new skills over time.

Describe the expressive language of the person you are supporting.
Describe the receptive language of the person you are supporting.
Describe any form of AAC system your client uses or relies on.

Communication development

Pre-requisites for intentional communication

From the time we are born we are developing the skills or pre-requisites for intentional communication. Initially our communication is unintentional and consists of crying when we are uncomfortable or hungry and our parents have to interpret what we want. As we develop, so does our ability to understand our environment and the power our behaviours or actions have on those around us – The power of intentional communication.

While our first words are often not spoken until about 12 months, we have already developed a number of skills and are clearly communicating.

To get to the point where we are communicating intentionally we have to develop certain cognitive skills or pre-requisites skills. These cognitive pre-requisite skills to intentional communication are:

• Being able to pay attention

To learn about the world around us we need to be able to attend to the stimulus that is occurring; not only visually, but through all our senses of hearing, taste, touch and movement.

• Understanding cause and effect

Cause and effect is an important skill for communication development as we begin to learn that our behaviours/actions have an effect on the objects and more importantly people around us. The key to communication is I do or say something and the other person will react in some way, hopefully with what I wanted.

• Understanding object permanence

Object permanence is the term used to describe knowing that something still exists even though we cannot see it. Having developed the skill of object permanence means that a person can communicate about things they cannot see as they realise that they still exist. People without an understanding of object permanence may only communicate about concrete things they can see in the here and now.
• The ability to imitate

Imitation is a skill that we develop very early. During our communication development we are imitating the actions, sounds and eventually words of the people around us.

Does the person you support have intentional communication skills?
Give examples that support your view.

The Communication continuum

In order to identify a person’s communicative abilities we need to think of the development of communication as occurring on a continuum: from an unintentional stage through to an intentional symbolic stage. As we are all developing and learning to communicate we progress through this continuum.

We learn that by communicating we can have an effect on the people in our environment, and can use them to obtain what we want and need (cause and affect).

For example: Sally does not use speech to communicate and she is in a wheel chair. Sally wants her favourite song turned up louder, but she can’t reach, so she claps to gain the attention of Fred and points at the stereo. Fred asks Sally what she wants and she again gestures by pointing in the direction of the stereo. Fred turns up the music. Sally has learnt the link between communication and manipulating her environment.

Some people with a disability have not yet developed all of the prerequisite skills needed to be an intentional communicator. Others have, but are not yet using symbols to communicate. In order to support the communicative needs of people and develop effective support plans we must have an understanding of where the person’s communication skills are on the continuum.

A tool such as the ‘Checklist of communication competencies’ can be used to help you determine this and best plan for the support required.

Triple C Copyright of SCIOP
## The communication continuum

<table>
<thead>
<tr>
<th>Assessments to use</th>
<th>Unintentional</th>
<th>Intentional</th>
<th>Intentional-symbolic</th>
<th>Basic literacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use Triple CCC to identify person’s communicative ability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Communication skills

- **Unintentional**
  - The person doesn’t use communication as a tool, to obtain a goal.
  - Person has not yet developed the cognitive pre-requisite skills for intentional communication.

- **Intentional**
  - The person uses communication as a tool to obtain a goal.
  - Person has developed the cognitive pre-requisites for intentional, but means of communication are not easy to understand.

- **Intentional-symbolic**
  - The person uses formal symbol systems to communicate their message and obtain their goal.

- **Basic literacy**
  - The person has effective communication skills with over 50 words/signs in their vocabulary. Is able to read simple words or phrases.

### Example

- **Unintentional**
  - The person looks at a desired object but does not look at another person. The person may cry/scream, laugh/smile with no apparent purpose.

- **Intentional**
  - The person looks at or points to a desired object/activity while looking at a person in the room. The person may take someone’s hand and lead them to a desired object/activity.

- **Intentional-symbolic**
  - The person uses photographs, line drawings, objects, to communicate their message.

### Role of communication partner

- **Unintentional**
  - The communication partner assigns the intent and meaning to the communication.

- **Intentional**
  - The communication partner reads/interprets the intent and meaning and responds.

- **Intentional-symbolic**
  - The communication partner decodes the message and responds.

### About the Checklist of Communication Competencies

The Checklist of Communication Competencies is also known as the Triple C. It is an observational screening tool designed to ascertain the approximate stage at which a person is communicating and is designed for use with adolescents and adults who have complex communication needs. It is a useful tool for assessing early communication skills that act as building blocks for effective communication. The checklist can be filled in by anyone who knows the person well and often it is useful for different support professionals from the same and different environments to complete separate checklists and compare findings.

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Triplet Copyright of SCIOP
The checklist is not designed for use with children or for people who use speech or other formal communication systems competently as their main form of communication. The checklist may not be useful for some people with autism, where there are communication skills that may be masked by learned helplessness (that is, when others pre-empt the individual’s need to communicate; when others communicate on behalf of the person or when the individual’s attempts to communicate are not listened to).

**Useful tips for completing a Checklist of Communication Competencies**

- Involve as many people as you can, who know the person well.
- If you are unsure if the person can perform a particular skill, set up the situation and observe how the person responds.
- Make sure you have placed the person at their best advantage; that is observing the individual when they are most alert.
- Set up the situation a few times to allow the person an opportunity to demonstrate their skills.
- Don’t forget to fill in details on the front page; the person's name, the date and who helped complete the checklist.
- Review the Checklist of Communication Competencies regularly (e.g. yearly) to evaluate progress.

If you are undertaking or completing the Triple C Checklist for the first time, support and guidance from a speech pathologist or experienced practitioner should be sought. They will also be able to help if you are not sure how to interpret the results and what to do next after completing the checklist.

**Differences between intentional and unintentional communicators**

<table>
<thead>
<tr>
<th>up</th>
<th>ua</th>
<th>ii</th>
<th>sb</th>
<th>se</th>
</tr>
</thead>
<tbody>
<tr>
<td>preintentional</td>
<td>intentional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>unintentional</td>
<td>intentional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>non-symbolic</td>
<td>symbolic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Symbolic means you can understand and use photos, words and signs

Triple C stages

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12. This information sheet was taken directly from the interAACtion manual (2004) *InterAACtion© Strategies for Intentional and Unintentional Communicators.* InterAACtion Copyright of CRC Bloomberg K, West, D & Johnson, H (2004),
up – Unintentional passive communication

The communication of adolescents or adults who are assessed as being at stages 1 or 2 may seem quite passive. There may be physical or sensory problems that affect the person’s ability to be involved in some events or activities. Health issues may impact on their quality of life. All interactions are based on the communication partner’s awareness of the person’s needs and observations of the person’s behaviour. (InterAACtion page 21)

ua – Unintentional active communication

Some people who communicate unintentionally are more active than others. They are much more likely to reach out for things that attract their attention and interest. If they are able to physically, they may walk. All interactions are based on the communication partner’s awareness of the person’s needs and observations of their behaviour. (InterAACtion page 35)

ii – Intentional informal communication

The person at the intentional informal stage of communication knows that other people can be useful. The person understands that for communication to occur, the attention of a communication partner is required. (InterAACtion page 55)

sb – Symbolic (basic) communication

A person is able to communicate symbolically when they understand what words, pictures, or signs can be used to communicate about a real object or events. The person is also able to communicate a range of intentions or functions through pictures, gestures, single words or vocalisations. (InterAACtion page 73)

se – Symbolic (established) communication

By this stage the person is communicating at an established symbolic level. They can recognise a large number of pictures, photos and line drawings and are more likely to use these to initiate interactions with familiar people. Photos, pictures and line drawings may also be incorporated into a range of different communication aids including electronic communication devices, boards, books and wallets. The person may put signs, pictures or words together to make simple two-word phrases. The person may use their communication skills to comment, chat, request or reject something. They also have a reliable way of indicating yes and no to simple questions. If something is missing, they may seek help from others or try to remember where they last saw it. (InterAACtion page 89)

Alternative and augmentative communication

Some people find communication difficult because they have little or no clear speech. The idea behind AAC is to use the person’s abilities, whatever they are, to compensate for their difficulties and to make communication as quick, simple and effective as is possible when speech alone does not work.

Although we all use aspects of AAC from time to time (e.g. waving goodbye instead of saying it, pointing to a picture or gesturing to make yourself understood in a foreign country) some people may rely on ACC all of the time.

Augmentative communication refers to any approach designed to support or enhance the communication of individuals who have speech skills which are limited or ineffective.

Alternative communication refers to communication systems for people with no oral communication skills whatsoever.
Augmentative and alternative communication can be divided into two groups:

<table>
<thead>
<tr>
<th>UN-AIDED AAC options (Requires no equipment)</th>
<th>AIDED options (Requires equipment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Crying</td>
<td>• Object symbols</td>
</tr>
<tr>
<td>• Self-injury</td>
<td>• Partial objects</td>
</tr>
<tr>
<td>• Aggression</td>
<td>• Raised symbols</td>
</tr>
<tr>
<td>• Vocalisations</td>
<td>• Logos</td>
</tr>
<tr>
<td>• Intonation</td>
<td>• Photographs</td>
</tr>
</tbody>
</table>
| • Facial expression                       | • Line drawings Communication symbols, COMPIC
| • Touch                                    | • Written word                    |
| • Eye gaze                                 | • SMS text messaging               |
| • Gesture, pointing                        |                                   |
| • Manual signs eg: AUSLAN, key word signing|                                   |
| • Speech                                   |                                   |
| • Individualised communicative behaviours  |                                   |

Useful AAC strategies for unintentional and intentional communicators

<table>
<thead>
<tr>
<th>Unintentional (non-symbolic)</th>
<th>Intentional symbolic (symbolic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘All about me’ book</td>
<td>Chat books</td>
</tr>
<tr>
<td>Communication passports</td>
<td>Community request cards</td>
</tr>
<tr>
<td>Personal communication dictionary</td>
<td>‘Who’s here today’ board</td>
</tr>
<tr>
<td>Activity sequence schedule using object symbols</td>
<td>Talking mat</td>
</tr>
<tr>
<td>Multi-sensory environments</td>
<td>Activity sequence schedule using photographs and line drawings</td>
</tr>
<tr>
<td>Touch cues</td>
<td>Social stories</td>
</tr>
<tr>
<td></td>
<td>Feelings board</td>
</tr>
</tbody>
</table>

What symbols can I use with the person?

‘A symbol (visual cue) is a device or action that can be used to represent something else because it has qualities that can be associated with the original device or action. These symbols can represent places, people, activities, feelings and objects’. (Bloom 1997)

There are many different types of symbols we all use throughout our daily life. **Not all people with complex communication needs will be able to interpret, understand and use symbols.**

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14. COMPIC© Communication Resource Centre, SCOPE, Victoria, Australia.
15. For more information refer to the interAACtion manual (2004) InterAACtion© Strategies for Intentional and Unintentional Communicators. InterAACtion Copyright of CRC Bloomberg K, West, D & Johnson, H (2004),
Some symbols are easier to interpret than others: the more concrete the symbol the easier it is to understand. In order to interpret and use a symbol, a person has to be able to decipher what the symbol is and link it to the real object or activity. Some of the things that make some symbols easier than others to interpret include: dimension 2D, 3D, iconicity (they closely look like what they represent). For example, giving a person that cannot read, a written word or sentence is like you trying to read something written in a language you don’t understand.

Expecting a person to use a symbolic system that they cannot interpret can lead to a great deal of frustration for the person as well as compromise the success of an intervention plan. A speech pathologist can assist in identifying what symbolic system is the most appropriate for the person.

Arrange symbols on a continuum from most concrete to the most abstract.

- Line drawing (COMPIC or Picture Communication Symbols)
- Real object
- Written word
- Part of the real object
- Photograph
- Spelling
- Logo

Most concrete
- Real object
- Part of the real object
- Logo
- Photograph
- Line drawing (COMPIC or Picture Communication Symbols)
- Spelling

Most abstract
- Written word
## Using AAC appropriately with intentional and unintentional communicators

<table>
<thead>
<tr>
<th>Skills of the person at this level</th>
<th>Unintentional passive (UP)</th>
<th>Unintentional active (UA)</th>
<th>Intentional informal (II)</th>
<th>Intentional symbolic basic (SB)</th>
<th>Intentional symbolic established (SE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>UP – All interactions are based on the communication partner’s awareness of the person’s needs and observations of the person’s behaviour.</td>
<td>The person knows that other people can be useful. The person understands that for communication to occur, the attention of a communication partner is required. The way person communicates may be hard for others to understand.</td>
<td>A person is able to communicate symbolically. The person communicates a range of intentions or functions through pictures, gestures, single words and/or vocalizations.</td>
<td>The person is communicating at an established symbolic level. He or she can recognise a large number of pictures, photos and line drawings and is more likely to use these to initiate interactions with familiar people. Photos, pictures and line drawings may also be incorporated into a range of different communication aids including electronic communication devices, boards, books and wallets. The person may put signs, pictures or words together to make simple two-word phrases. The person may use their communication skills to comment, chat, request or reject something. They also have a reliable way of indicating yes and no simple questions. If something is missing, they may seek help from others or try to remember where they last saw it.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UA – The person is much more likely to reach out for things that attract their attention and interest. All interactions are based on the communication partner’s awareness of the person’s needs and observations of their behaviour.</td>
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</tbody>
</table>

### What symbols to use?

<table>
<thead>
<tr>
<th>Visual cues/ symbols to use with the person</th>
<th>Non-symbolic</th>
<th>Symbolic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real objects: the actual object must be used when communicating with the person or making up communication boards or books.</td>
<td>Person cannot understand spoken language alone, photos and line drawing (e.g. COMPIC, Boardmaker PCS)</td>
<td>Person can understand simple 1-2 step instructions and can use photos and line drawing (e.g. COMPIC, Boardmaker PCS for communication)</td>
</tr>
<tr>
<td>Real objects: the actual object must be used when communicating with the person or making up communication boards or books.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Real objects: the actual object must be used when communicating with the person or making up communication boards or books.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Real objects: Line drawings (COMPIC or P.C.S) must be used when communicating with the person or making up communication boards or books.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Real objects: Line drawings (Boardmaker, COMPIC and possibly familiar word) must be used when communicating with the person or making up communication boards or books.</td>
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</tr>
</tbody>
</table>

### General strategies used by effective communication partners

Refer to page 33 of this reference manual for general strategies used by effective communication partners. Key word signing to be used by all communication partners regardless of the person’s level of communication. Consistent use of key word sign by communication partners will assist the person to understand what is happening or what is expected of them. With consistent use some people may learn to use key word signing to express themselves.

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16. A manual signing approach that combines speaking and signing and produced in English word order (Grove and Walker 1990).
Behaviours of concern and challenging behaviours

Every behaviour, regardless of form is communicating a message

People do not behave randomly and in fact behaviour is often predictable
All behaviour is potentially functional for the individual

It is not always easy to work out what the message is!

Some important principles to remember are:

- There is a reason behind everything we do, for example, if I:
  - scratch my arm it is probably because it is itchy
  - am sweating it probably means I am hot
  - start playing with my hair it probably means I am bored
  - If I begin pulling at or hitting my ears, I may have an ear ache
  - cross my arms and tap my foot, it probably means I am angry.

People will use the quickest, easiest and most effective way to communicate a message. For people with speech the quickest way to tell someone they are annoying them and to go away, to say they would like to have a conversation or to tell someone they are in pain, is by using speech.

However when we are confused, sick or affected by medication, speech is not always easy or a quick way to communicate. What about people with little or no speech and limited access to other forms of communication? How will they tell you these things?

People need to communicate for a variety of reasons. Often we take for granted our ability to effectively express ourselves in a way that others understand.

<table>
<thead>
<tr>
<th>Some common reasons for communication are:</th>
<th>Common reasons for behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Greet people</td>
<td>Some of the most common reasons are:</td>
</tr>
<tr>
<td>• Answer questions</td>
<td>• Gaining social interaction</td>
</tr>
<tr>
<td>• Make requests</td>
<td>• Escape or avoidance of demands</td>
</tr>
<tr>
<td>• Comment on situations</td>
<td>• Gaining access to referred activities or tangible objects</td>
</tr>
<tr>
<td>• Acknowledge the presence of others</td>
<td>• Sensory feedback (eg hand flapping, eye poking)</td>
</tr>
<tr>
<td>• Show something to others</td>
<td>• Pursuit of power and control over own life</td>
</tr>
<tr>
<td>• Form relationships</td>
<td>• Reduction of arousal and anxiety.</td>
</tr>
<tr>
<td>• Give information</td>
<td></td>
</tr>
<tr>
<td>• Describe/define ourselves</td>
<td></td>
</tr>
<tr>
<td>• Refuse or protest</td>
<td></td>
</tr>
<tr>
<td>• Express our imaginations/fantasies</td>
<td></td>
</tr>
<tr>
<td>• Express feelings</td>
<td></td>
</tr>
<tr>
<td>• Seek goods, services, information</td>
<td></td>
</tr>
<tr>
<td>• Exert some control over the environment</td>
<td></td>
</tr>
<tr>
<td>• Pain or discomfort.</td>
<td></td>
</tr>
</tbody>
</table>

17. Pat Mirenda, PH.D. Presentation 1994 "Communication Approaches to Challenging Behaviour".
Individually list examples of how and why you communicated today.

As a group identify the how and why the person you support communicated on your last shift.

Are they different and why?

**About behaviours of concern**

Between five and 15 per cent of people with an intellectual disability show behaviours of concern which can present a significant challenge to both the person and those involved in providing support.

Of these only between two and 20 per cent of people in need of positive behaviour support, actually receive any kind of behavioural support. Fifty to 60 per cent of people with a disability showing behaviours of concern will be subject to the restrictive intervention of chemical restraint, which is psychotropic medication, typically antipsychotics, used for the primary purpose of behavioural control.

Behaviours of concern can be defined as:

> ‘...behaviour of such intensity, frequency and duration that the physical safety of the person or others is placed or is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to ordinary community facilities, services and experiences’. Emerson 1995

Examples include:
- aggressive behaviour
- self-injurious behaviour
- property destruction
- fire lighting
- withdrawn behaviour.

The term ‘behaviours of concern’ implies that a higher standard and quality of services is required than those ordinarily provided to people with an intellectual disability. The behaviours that the term covers set a challenge to services to improve the way they do things. The term was first used to encourage service providers and the community to develop better services, supports and attitudes to address the behavioural difficulties demonstrated by some people with a disability. (Toogood, Bell, Jacques, Lewis, Sinclair and Wright, 1994).
What are challenging behaviours?

‘Challenging behaviours’ differs from ‘behaviours of concern’ in that it relates to annoying or inappropriate behaviours.

Examples include:

- repetitive questioning
- playing loud music
- refusing to eat particular meals prepared
- vocalising loudly
- non compliance.

List the behaviours that you believe are behaviours of concern for the person you support. Clearly describe each behaviour.
Functional behaviour assessment

‘It is not a matter of what causes self injury or what causes aggression or what causes stereotyped or repetitive movements but for each of these difficult forms of behaviour, what does it do for the individual, what purpose does it serve for them in life?’

Brown and Brown 1994

A functional behaviour assessment aims to identify which particular needs of the person are met through their behaviour. This means trying to work out what message or purpose the behaviour is serving for the person. Determining why the behaviour is occurring is an important starting point in selecting positive behaviour support strategies to be included in a behaviour support plan.

Without conducting a functional behaviour assessment it is very easy to jump to inaccurate conclusions of why a person is behaving in a certain way. In turn this can result in the selection of inappropriate strategies that will not address the person’s needs or have positive effects on the behaviour.

Inappropriate strategies can often make the behaviour worse, lead to an increase in the frequency, intensity and duration of the behaviour and give rise to new and even more problematic behaviours. There is also a risk that it can bring about serious harm to the person and others involved.

For further information refer to the Office of the Senior Practitioner website www.dhs.vic.gov.au/ds/osp for Positive Solutions in Practice; Getting It Right from the Start, the value of a good functional behaviour assessment.
Mistaken and alternative interpretations of behaviour

<table>
<thead>
<tr>
<th>Common misinterpretations</th>
<th>Examples of Alternative Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attention seeking</strong></td>
<td>Initiating relationships – they want friends</td>
</tr>
<tr>
<td>For example: people follow staff or family members around the house, touch others inappropriately, attempt to pass objects at seemingly inappropriate times; tease others; interrupt others or act in a way that is found to be ‘annoying’.</td>
<td>Seeking company – they are lonely</td>
</tr>
<tr>
<td></td>
<td>Seeking reassurance – they are scared</td>
</tr>
<tr>
<td></td>
<td>Seeking help or support – they lack skills or confidence</td>
</tr>
<tr>
<td></td>
<td>Personality issues</td>
</tr>
<tr>
<td><strong>Self-stimulating</strong></td>
<td>Bored, overwhelmed or over stimulated and may need to calm</td>
</tr>
<tr>
<td>For example: people rock, twist or play with their fingers and toes; slap their face or their legs persistently; twirl around; poke at their eyes; hum or sing inappropriately.</td>
<td>Unable to identify or initiate an alternate activity</td>
</tr>
<tr>
<td></td>
<td>Syndrome specific behaviours, possibly related to neurological problems</td>
</tr>
<tr>
<td></td>
<td>Health and medical needs</td>
</tr>
<tr>
<td><strong>Self-injuring</strong></td>
<td>Nervous</td>
</tr>
<tr>
<td>People pick at their skin, cut themselves with sharp objects, place objects in their body cavities, pull their hair out, eat or drink to excess.</td>
<td>Anxious</td>
</tr>
<tr>
<td></td>
<td>Depressed</td>
</tr>
<tr>
<td></td>
<td>Psychiatric issues</td>
</tr>
<tr>
<td></td>
<td>Bored/Boredom</td>
</tr>
<tr>
<td><strong>Non-compliant</strong></td>
<td>Not interested</td>
</tr>
<tr>
<td>People do not do things as they are asked to do them, when they are asked, or do not finish things they start.</td>
<td>Not understanding</td>
</tr>
<tr>
<td></td>
<td>Not being asked the right way</td>
</tr>
<tr>
<td></td>
<td>Not having sufficient skills</td>
</tr>
<tr>
<td></td>
<td>Not having sufficient stamina (tired)</td>
</tr>
<tr>
<td></td>
<td>Recalling bad memories of a past experience</td>
</tr>
<tr>
<td><strong>Disruptive</strong></td>
<td>Frightened</td>
</tr>
<tr>
<td>People talk or make noises at inappropriate times, yell, interfere with the work or activities of others or break things.</td>
<td>Scared</td>
</tr>
<tr>
<td></td>
<td>Stressed</td>
</tr>
<tr>
<td></td>
<td>Lacking understanding of the situation</td>
</tr>
<tr>
<td><strong>Aggressive</strong></td>
<td>Not knowing what is expected of them</td>
</tr>
<tr>
<td>People throw objects or hit out at others.</td>
<td>Frustrated or even threatened</td>
</tr>
<tr>
<td></td>
<td>The requirements of the current situation exceed their skill or level of tolerance</td>
</tr>
<tr>
<td></td>
<td>Other attempts to communicate are not responded to</td>
</tr>
</tbody>
</table>

Behaviour recording

Key steps in completing a functional behaviour assessment

**Step 1:** Defining the behaviour of concern

Need to write the behaviour in a way that the actual behaviour of concern can be easily understood by others and that then can be used to gain reliable documentation on when and when it does not occur.

**Step 2:** Finding out as much information as possible about the behaviour, which is information on:

- What happens before the behaviour?
- What happens during the behaviour?
- What happens after the behaviour?

*This will require the use of recording forms such as STAR Charts or questionnaires like the, Motivational Assessment Scale.*

**Step 3:** From information collated via the recording forms/questionnaires, come up with an idea (hypothesis) about why the behaviour is occurring, that is what purpose/function does the behaviour appear to be serving for the person. Some of the most common reasons why behaviours of concern occur:

- Gaining social interaction
- Escape or avoidance of demands
- Gaining access to referred activities or tangible objects
- Sensory feedback (hand flapping, eye poking)
- Pursuit of power and control over own life
- Reduction of arousal and anxiety.

**Step 4:** Test your idea (hypothesis) by systematically introducing strategies such as environmental changes, skill development strategies and planned responses to behaviours. These strategies must be linked to why the person is using the behaviour. The introduction and consistent implementation of these strategies should result in a reduction to the frequency and intensity of the target behaviour and over time, an increase in the person’s quality of life.

**Step 5:** Regularly monitor, evaluate and review the effectiveness of the strategies: *Thinking about what worked and what needs to change.* Ongoing data collection will be required to monitor or check that your ideas about the behaviour are correct.

---

19. Motivation Assessment Scale Durand and Crimmins 1992
Completing a functional behaviour assessment

Step 1. Clearly defining the behaviour of concern

This is often referred to as an ‘operational definition’ of the behaviour. Having a clear and concise definition of the behaviour is essential when conducting a functional assessment. As a functional assessment may consider observations/records/ideas from more than one person, it is important that everyone has exactly the same behaviour in mind. A good operational definition may also serve as a helpful reference for others involved in providing support to the person.

Behaviours should not be written in a way that is vague or subjective or broad. The definition needs to be specific. A good operational definition of the behaviour is one that is written in a way that:

1. can be visualised
2. frequency can be counted
3. is agreed on by different observers regarding its occurrence and absence.

Three examples of client behaviours are written below.
Identify which one is written objectively and rewrite the others according to the above guidelines.

1. Mario has a long history of aggression. When Mario gets upset he will often kick staff and co-residents and at times will throw items such as chairs and cups at others.
2. Sally will hit her head against walls in her bedroom on a daily basis and this becomes more frequent at the end of each month.
3. Terry often presents with withdrawn behaviour and on occasion he does not comply with staffs requests. Sometimes Terry will also pick at his bottom and rub his genitals when staff members tell him what to do.

Watch snippets from the Australian movie The Black Balloon. After viewing one or two snippets describe the behaviours observed.

Review all the information you have collected on your focus person.
As a group describe three behaviours that are of concern.
These behaviours will become the focus of the next few activities.
Step 2: What happens, before, during and after the behaviour?

Now that we know what the behaviour is, we need to gather as much information as possible about the behaviour.

- What happens before the behaviour? (Setting events: triggers and warning signs)
- What happens during the behaviour? (Action: What did the person actually do? What did it look like?)
- What happens after the behaviour? (Results: What is the person getting from the behaviour?)

It is not necessary here to be able to identify exactly what triggered the incident. This is sometimes difficult. Our task is to take careful note of relevant events that preceded the episode. By doing this we will often be able to uncover patterns in the behaviour. As mentioned earlier, behaviour is often predictable: that is if A happens B will follow.

Setting events, triggers and warning signs

In identifying setting events it is important to consider possible background factors. What was happening in the environment? Where did the behaviour occur? Who was there at the time?

General setting events

The following events may influence whether the behaviour occurs.

<table>
<thead>
<tr>
<th>Factors external to the person</th>
<th>Factors internal to the individual</th>
<th>Warning signs that the individual displays to indicate that something is not quite right</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Staff changes</td>
<td>• Pain</td>
<td>• Person withdraws</td>
</tr>
<tr>
<td>• Level of structure in the environment</td>
<td>• Hunger</td>
<td>• Repetitive questioning</td>
</tr>
<tr>
<td>• Activity levels in the environment</td>
<td>• Stress</td>
<td>• Facial expression changes</td>
</tr>
<tr>
<td>• Level of stress or tension in the environment</td>
<td>• Tension</td>
<td>• Mood changes</td>
</tr>
<tr>
<td>• Isolation</td>
<td>• Depression</td>
<td>• Pacing</td>
</tr>
<tr>
<td>• Noise levels.</td>
<td>• Frustration</td>
<td>• Over activeness</td>
</tr>
<tr>
<td></td>
<td>• Medical factors (medical conditions, medication and side effects).</td>
<td>• Difficulty attending to task.</td>
</tr>
</tbody>
</table>

Action

Describing what the person actually did? What did the behaviour look like?

Examples:
- Person used left fist to hit co-resident Mary on the head twice.
- Banged back of head on wall five times.
- Picked up television with both hands and threw it towards the window. The window did not break.
- Person picked up chair with both hands and threw it across the kitchen towards staff member.

Results: Identifying the result or outcome is about developing an understanding of what the person is getting from the behaviour that motivates them to do it again and again that is what happens following the behaviour that achieves an important result for the person.
<table>
<thead>
<tr>
<th>What did the person get?</th>
<th>How did the staff react?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Tangible pay-offs (food, preferred items)</td>
<td>What steps did you take to de-escalate the person?</td>
</tr>
<tr>
<td>• Social interactions (others’ reactions)</td>
<td>What strategy did you employ? (Active listening, relaxation, redirection, negotiation?)</td>
</tr>
<tr>
<td>• Escape from undesired or feared situations</td>
<td></td>
</tr>
<tr>
<td>• Expressed emotions</td>
<td></td>
</tr>
<tr>
<td>• Sensory feedback (light, noise, smell, touch, taste)</td>
<td></td>
</tr>
</tbody>
</table>

Chose one of the behaviours listed above.

Identify the setting events, triggers and warning signs.

Answer the following two questions:

• What did the person get?
• How did the staff react?
Setting, trigger, action, result (STAR) chart

<table>
<thead>
<tr>
<th>Date and time</th>
<th>Who is completing the form</th>
<th>Setting</th>
<th>Trigger</th>
<th>Action</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Where? Who was there? What was happening?</td>
<td>What happened immediately before the incident?</td>
<td>What did the person do? Describe the incident?</td>
<td>Describe precisely what happened. What did the behaviour look, sound and feel like? Describe who was with the person and what they were doing, or not doing at the time. Was the person’s routine disrupted? Was the person unwell? Was the person attempting to communicate and need or want? What steps did you take to de-escalate the person? What strategy did you employ? (e.g. active listening, relaxation, redirection, negotiation).</td>
</tr>
</tbody>
</table>

Tips for completing a STAR chart

- Record only what you observe yourself.
- Record only those behaviours that are on the agreed list of target behaviours.
- Record the target behaviour as soon as possible after it was observed by you.

For the behaviour you have identified, summarise this information in a STAR Chart.

Chose one of the behaviours listed above.
Complete the Motivation Assessment Scale (MAS) in relation to this behaviour. This will be provided by your trainer.
Motivation assessment scale

The MAS consists of 16 items describing various behaviours which a respondent (family member or staff) is required to rate on a six-point scale according to how they believe the person would behave in a variety of different situations. The results are tallied according to four theoretical categories said to suggest the possible motivation underlying a person’s behaviour. Like any assessment tool, the MAS should be used regularly to check if your ideas about why the behaviour is occurring are correct.

Name: ____________________________ Rater: ____________________________

Date: ____________________________

Description of behaviour (be specific):

Instructions: The MAS is a questionnaire designed to identify those situations where an individual is likely to behave in specific ways. From this information, more informed decisions can be made about the selections of appropriate replacement behaviours. To complete the MAS, select one target behaviour. Be specific about the behaviour. For example ‘is aggressive’ is not as good a description as ‘hits other people’. Once you have specified the behaviour to be rated, read each question carefully and circle the one number that best describes your observations of this behaviour. The column with the highest score indicates the reason why the behaviour is occurring.

---

Example of MAS tool

**Motivation Assessment Scale**

By V. Mark Durand and Daniel Grimmins

<table>
<thead>
<tr>
<th>Name</th>
<th>Johnathan</th>
<th>Today's Date</th>
<th>06/01/08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rater</td>
<td>Dan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior Description</td>
<td>Hand biting - anytime his teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>touch his hand</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ITEM

1. Would the behavior occur continuously, over and over if this person was left alone for long periods of time? (For example, several hours.)

<table>
<thead>
<tr>
<th>ITEM</th>
<th>RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Never</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

2. Does the behavior occur following a request to perform a difficult task?

<table>
<thead>
<tr>
<th>ITEM</th>
<th>RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Never</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

15. Does this person seem to do the behavior to get you to spend some time with him or her?

<table>
<thead>
<tr>
<th>ITEM</th>
<th>RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Never</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

16. Does this behavior seem to occur when this person has been told that he or she can’t do something he or she had wanted to do?

<table>
<thead>
<tr>
<th>ITEM</th>
<th>RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Never</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

### SCORING

**Sensory**  4  **Escape**  20  **Attention**  10  **Tangible**  15

**Total Score** = 40

**Mean Score** = 100 500 250 375

**Relative Ranking** = 4 1 3 2
Step 3: What message is the person communicating via the behaviour of concern?

Behaviours of concern serve a function or purpose for the person. The most common reasons people show behaviours of concern are often the same as why all people communicate. An analysis of the behavioural recording will have generated some ideas (hypotheses) about the function of the behaviour that is any patterns to the behaviour. Hypotheses regarding the function or relationship between the behaviour and the individual’s environment can lead to identifying positive behaviour support strategies. Be aware however that a single behaviour of concern may serve more than one function.

The function that a behaviour serves has direct implications for how we respond to the behaviour. For example it could be decided to ignore a person who is engaging in the behaviour of head banging. In the long term this may lessen the behaviour in a person who head bangs exclusively to gain social interaction. However the exact same strategy could worsen the behaviour for another person who bangs because they prefer to stay alone, since this response may reinforce the behaviour that ‘I bang my head and people leave me alone’.

In the above scenarios both people are communicating through their behaviour, that they would like more or less attention and it is important to listen to this. However one must try and respond in a way that is not simply a direct reaction to the head banging.

The following are some of the most common messages being communicated via behaviours:

- Gaining social interaction
- Escape or avoidance of demands
- Gaining access to preferred activities or tangible objects
- Sensory feedback (e.g. hand flapping, eye poking)
- Pursuit of power and control over own life
- Reduction of arousal and anxiety.

Analysing the information you have collected using the STAR chart and the MAS; what messages do you think your focus person is trying to communicate.

Why?

Analyse the STAR charts below, do you agree with the assessment of the function of the behaviours identified?

What else could these behaviours be communicating?

Why?
### Bob

<table>
<thead>
<tr>
<th>Setting (background factor)</th>
<th>Trigger (setting event)</th>
<th>Action (actual behaviour)</th>
<th>Result (outcome achieved)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very few stimulating activities and interactions with others</td>
<td>Someone walks in</td>
<td>Bob throws a chair</td>
<td>Staff tell Bob to pick up the chair and physically assist him to do so when he refuses</td>
</tr>
</tbody>
</table>

**Function of behaviour:** Bob gets access to interaction with others in an otherwise boring environment.

**Message communicated via behaviour:** *‘I am bored – spend some time with me’*

### Mary

<table>
<thead>
<tr>
<th>Setting (background factor)</th>
<th>Trigger (setting event)</th>
<th>Action (actual behaviour)</th>
<th>Result (outcome achieved)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling sick</td>
<td>Being asked to clear table</td>
<td>Mary swipes plates off the table with her forearm</td>
<td>Mary is told to leave the table and return only when she can behave properly</td>
</tr>
</tbody>
</table>

**Function of behaviour:** Mary avoids doing something she finds mundane when she’s already not feeling well. The behaviour expresses her emotion.

**Message communicated via behaviour:** *‘I feel sick and don’t want to do it’*

### Step 4: What skills can we support the person to learn to use instead of the behaviour?

The Positive Intervention Framework can assist in planning positive behaviour support. The framework contains a range of components that require attention under four major headings and includes:

- Changes to the environment:
- Teaching skills
- Short term change strategies.
- Immediate response strategies
1. Changes to the environment
This involves an understanding of relevant environmental factors that may be contributing to the behaviour of concern. An analysis of the STAR charts will have identified possible factors which may include undiagnosed medical conditions or possible side effects to medication. In addition we need to plan how we will change the environment to ensure a ‘smooth’ fit between the individual and where they live and work.

2. Teaching skills
This involves selecting and implementing skill development strategies, that is, skills the person can be supported to learn, instead of using the behaviour of concern. Skill development strategies need to be linked to the reason why the person is showing the behaviour of concern and the skills taught need to be as effective as if the person was using the behaviour of concern.

3. Short-term change strategies
These may be required for a short period of time to produce a rapid change in behaviour. These strategies are used to facilitate a more immediate change to the behaviour.

4. Immediate response strategies
These strategies are used to minimise risk to the person and others by planning responses aimed at de-escalating or managing a serious episode of the behaviour. These strategies provide all involved with a plan for immediately responding to the behaviour as it occurs. These strategies do not promote long-term behaviour change; they are only intended to manage a serious episode of the behaviour.

Putting what you have learnt into practice
Over the past two days you have covered topics including
- human rights
- the importance of background factors and their potential impact on the people you support
- the importance of getting to know the people you support well and how this may affect they way they interact or behave on a daily basis
- stages of communication development
- definitions of behaviours of concern
- functional behavioural assessment
- the recording of STAR charts
- Motivation Assessment Scale

As a team you have focussed on one person you all support and identified at least three behaviours of concern in relation to that person.

On your return to your work it is important to practice what has been covered. It is expected that by the beginning of day 3 of this program you will have completed as a staff team step 1 to 4 of a functional behaviour assessment.

Refer to Appendix 2 for details
Day three
## Positive behaviour support

**Positive Intervention Framework**

<table>
<thead>
<tr>
<th>Proactive strategies</th>
<th>Immediate response strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>What to do to prevent the behaviour</td>
<td>What might help when the behaviour occurs; beginning with least restrictive strategies?</td>
</tr>
</tbody>
</table>

### Change the environment

<table>
<thead>
<tr>
<th>Teach skills</th>
<th>Introduce short term change strategies for rapid change to behaviour</th>
<th>Aim: To de-escalate and/or manage serious episodes of the behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim: To gather relevant information about the person and use the information to identify areas for improvement</td>
<td>Aim: Skill/s we can support the person to learn to use instead of behaviour</td>
<td>Work out what the person’s behaviour is trying to communicate</td>
</tr>
</tbody>
</table>

### Personal factors –

- Medical conditions
- Medication and side effects
- Hunger
- Sensory impairments
- Communication difficulties

### Need for changes to environment

- Increased opportunities for access to a variety of activities
- ‘Balanced lifestyle’
- Predictable environment and consistent routines
- Improved interactions & realistic expectations
  - Activity Level
  - Delivery of information in a way that is meaningful
  - Likes and dislikes
  - Create opportunities for control and choice
- Conflict tension

<table>
<thead>
<tr>
<th>Based on the person’s strengths</th>
<th>To support the learning of new skills may need to consider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>General skills development (e.g. teaching person to do more things for self)</td>
<td>reinforcing specific behaviour</td>
</tr>
<tr>
<td>Useful communication strategies that promote effective communication (e.g. teaching the person to sign)</td>
<td>avoiding things you know upsets the person</td>
</tr>
<tr>
<td>Coping skills (e.g. teach the person what to do when feeling angry)</td>
<td>‘dos and don’ts’ lists</td>
</tr>
<tr>
<td>Strategies to increase engagement</td>
<td>Trigger control</td>
</tr>
</tbody>
</table>

### Least restrictive

- Mechanical restraint
- Seclusion
- Chemical restraint

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## Changing the environment

<table>
<thead>
<tr>
<th>Positive Intervention Framework</th>
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<td>Proactive strategies</td>
</tr>
<tr>
<td>What to do to prevent the behaviour</td>
</tr>
</tbody>
</table>

### Change the environment

- **Teaching skills**
- **Introduce short-term change strategies for rapid change to behaviour**
  - Offer choices
  - Positive interactions with person
  - Predictability

There are many factors within a person’s environment that may directly impact on their behaviour. These include:

### Settings and materials:
Being exposed to a setting which doesn't promote and encourage meaningful and enjoyable activity; not having enough space; not experiencing a rich variety of settings; living in places that are not personalised, pleasant and comfortable; not having equipment available which the person can use to pursue their interests; or just being overcrowded or exposed to too much noise.

### Human environment:
Having few positive interactions with others; people holding low expectations about the person; people not treating the person with respect; people equating the person with their problem behaviour; people not feeling a strong sense of commitment to the person; people failing to recognise the person strengths; being exposed to lots of others with difficult behaviours and being exposed to high levels of conflict and tension.

### Something to say:
Communication skills are developed when the environment is stimulating, interesting and where the developing communication skills are supported and encouraged. Often for people with disabilities decisions are made for the person that results in the person losing control over their life.

### The desire to communicate:
The environment plays a pivotal role in developing a person’s desire to communicate. Often a person’s needs are anticipated without any action on their part. Activities need to be created which provide opportunities to request items.
Some means of communication:
In order to communicate a person needs to have a means of communication. If the person does not have speech, it is very important to learn the meaning behind the person’s unique methods of communication and systematically introducing AAC systems.

Someone to communicate with:
Although this appears quite obvious, often people with complex communication needs seldom have a person who really takes the time to chat. Communication may be slow or the person may prefer not to communicate rather than experience frustration or failure. It is therefore important for positive relationships to be established as a means of ensuring the person becomes confident with their communication attempts.

Make choices:
This should be a routine part of all daily activities. By having constant opportunities for decision-making and choice a person is encouraged to do things for themselves.

Activities:
Not having much to do that is personally enjoyable and based on the person’s strengths, doing things which are not very functional, not being taught in ways which set the person up to succeed.

Predictability:
Not being able to predict activities or what is happening next in their day.

Delivery of instructions
Information is conveyed in ways that the person finds hard to understand, e.g. support staff relying primarily on spoken language.

Some key points to remember about the processing and interpreting of messages:
• Speech only is very difficult to process and interpret.
• People with a disability have varying levels communicative ability and it important to know where on the communication continuum the person is.
• Some people may be able to follow simple one stage commands, information in the here and now, the first or last thing that was said. Others may be processing information at a conversational level but having difficulty with abstract concepts such as humour, or taking everything that was said literally—are concrete thinkers.
• Some people are very good at seeming like they understand everything that is being said, when in fact they are only processing bits of information and relying heavily on your non-speech cues and may misinterpret the intent of your message.
• The ability to process and interpret messages can change depending on the person’s health and wellbeing, emotional state and number of distractions in the environment.
• Some people may have difficulty processing information:
  - that is presented in the negative—for example, ‘Don’t run’ or ‘You don’t like bananas do you?’
  - that is related to time, day or date (temporal relationships)
  - about who, what, where, when and why questions.
## Changing background factors

<table>
<thead>
<tr>
<th>Possible background factors</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal</strong></td>
<td></td>
</tr>
<tr>
<td>The person appears to no longer be able to do the things they once could</td>
<td>Document skills the person can no longer do and discuss with the medical practitioner</td>
</tr>
<tr>
<td>The person has a urinary tract infection</td>
<td>Medical treatment</td>
</tr>
<tr>
<td>The person has been on high doses of psychotropic medication for over three years</td>
<td>Refer to psychiatrist for a medication review</td>
</tr>
<tr>
<td>The person has a large appetite and only gets to eat at main meal times</td>
<td>Provide the person with nutritious meals through the day</td>
</tr>
<tr>
<td>The person does not see other people as a source of enjoyment (based on many failed experiences and much criticism in the past)</td>
<td>Build rapport with the person by offering things that they like</td>
</tr>
<tr>
<td>Person is non-speaking and has no communication skills</td>
<td>Complete a checklist of communication competencies to identify person's level of communication</td>
</tr>
<tr>
<td>Person has recently began to head bang, withdraw from others and avoid eye contact</td>
<td>Document new behaviours and discuss with medical practitioner</td>
</tr>
<tr>
<td>Person's methods of communication are hard to understand</td>
<td>Complete a personal communication dictionary</td>
</tr>
<tr>
<td><strong>Environmental</strong></td>
<td></td>
</tr>
<tr>
<td>The person has few opportunities to exercise choice</td>
<td>Increase the number of choices available to the person</td>
</tr>
<tr>
<td>Staff have low expectations of what can do and so don’t provide her with many opportunities</td>
<td>Provide training to staff on recognising the strengths of service users, and then get them to build a strength list for the person</td>
</tr>
<tr>
<td>The person lives in an overcrowded and unstimulating house</td>
<td>Improving the person’s accommodation by internal modifications, or by adding a flat and fitting it out with materials of the person’s choosing</td>
</tr>
<tr>
<td>The BSP does not focus on positive behaviour support strategies and instead focussed on the restrictive interventions</td>
<td>A functional behaviour assessment needs to be completed to identify the functions of the behaviour</td>
</tr>
<tr>
<td>The person does not interact with others much</td>
<td>Increase the number of interactions the person has with others by encouraging a hobby which will act as a springboard for interaction</td>
</tr>
<tr>
<td>The atmosphere in the person’s support service is tense because of simmering disputes between staff</td>
<td>Introduce a grievance process</td>
</tr>
<tr>
<td>There is a lack of predictability in the activities of the day from the person’s point of view</td>
<td>Introduce an activity sequence chart</td>
</tr>
</tbody>
</table>
### Teaching skills

<table>
<thead>
<tr>
<th>Positive Intervention Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Proactive strategies</strong></td>
</tr>
<tr>
<td>What to do to prevent the behaviour</td>
</tr>
<tr>
<td><strong>Change the environment</strong></td>
</tr>
<tr>
<td>General skills</td>
</tr>
<tr>
<td>Replacement skills</td>
</tr>
</tbody>
</table>

People with disabilities often require more time to learn new skills than others. As there are an infinite number of general skills that anyone would benefit from learning, select general skills to teach that are of interest to the person and based on the person’s strengths.

Use person centred active support to assist the person to engage in meaningful activity.

#### Teaching replacement skills

Once we know the function that the behaviour serves for the person we need to figure out how they can achieve the same through using an alternative skill. It is important that whatever the replacement skill is, it must be more efficient in performing the function than the behaviour does. Otherwise there will be no point for the person to use the replacement skills instead of the behaviour.

In considering replacement skills it is important to think about the following factors:

- **Effort involved**
  The replacement skill being taught must require less effort than the behaviour (asking for a break takes less time than breaking a chair, making a full meal when you are hungry is more effort than stealing food).

- **Impact on the environment**
  The replacement skills needs to impact on the environment in the desired way more often than the behaviour.

- **Time for a result**
  The replacement skill should lead to a desired result more often than the behaviour (telling staff that you have lost something will probably lead to finding it quicker than crying and withdrawing to your room or asking “can you please talk to me?” will be easier way of getting interaction than pinching staff who may perceive the behaviour as a form of aggression.

- **Response match**
  The replacement skill must match the function of the behaviour it is meant to replace.
- Response mastery
The replacement skill must be based on a person’s skill base and they must be able to successfully achieve the behaviour requested effectively and efficiently.

-Response acceptability
The replacement skill is something that is socially acceptable and in accordance with social conventions.

Three types of replacement skills

1. Communication skills
When thinking about a more appropriate and efficient way the person can communicate the same message as the behaviour, consider whether the person is an intentional or unintentional communicator. It is important to choose a way of communicating that builds on the person’s current communication strengths and will be relatively easy for the person to learn.

Let’s go back to our scenario with Bob. What positive behaviour support strategies can we support Bob to learn?

<table>
<thead>
<tr>
<th>Setting (background factor)</th>
<th>Trigger (setting event)</th>
<th>Action (actual behaviour)</th>
<th>Result (outcome achieved)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very few stimulating activities and interactions with others</td>
<td>Someone walks in</td>
<td>Bob throws a chair</td>
<td>Staff tell Bob to pick up the chair and physically assist him to do so when he refuses</td>
</tr>
<tr>
<td>Function:</td>
<td>Bob gets access to interaction with others in an otherwise boring environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Message:</td>
<td>‘I am bored – spend some time with me’</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive behaviour support strategies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental change</td>
<td>Get Bob involved with more stimulating activities and increase his positive interactions with others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Replacement communication skill</td>
<td>Get Bob, who is non-speaking, to approach staff with his chat book when he wants to spend some time with staff</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Independence

Some people will show behaviours of concern as a means of getting an object, activity or sensory experience. When this is the case, we can teach the person to independently, but appropriately get these things.

**Simone**

<table>
<thead>
<tr>
<th>Setting (background factor)</th>
<th>Trigger (setting event)</th>
<th>Action (actual behaviour)</th>
<th>Result (outcome achieved)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simone disliked being in large groups</td>
<td>Simone and everyone else completed breakfast and personal hygiene tasks and were waiting in the lounge room</td>
<td>Hitting, biting and scratching co residents</td>
<td>Staff sat outside with Simone on the front bench until the taxi arrived</td>
</tr>
</tbody>
</table>

Function: Simone got to go outside

Message: *Let me out, I want to be alone*

Positive behaviour support strategies

**Environmental change**

All staff are made aware that Simone wants to sit outside and wait for her taxi rather than waiting inside

**Replacement independence skill**

Simone was taught to let herself out the front door using her own key and wait on the front bench for her taxi

3. Coping skills

Sometimes people show behaviours of concern because they are frustrated, disappointed, angry or scared and this provides them with some relief. It could be that the behaviour helps the person cope with a bad situation (others may comfort the person, give them something else to do or speed up their access to something they have been denied). On the other hand just performing the behaviour may help the person calm down because it allows them to vent their feelings.

**John**

<table>
<thead>
<tr>
<th>Setting (background factor)</th>
<th>Trigger (setting event)</th>
<th>Action (actual behaviour)</th>
<th>Result (outcome achieved)</th>
</tr>
</thead>
<tbody>
<tr>
<td>John dislikes strangers in his environment</td>
<td>A new maintenance man is fixing a broken doorknob in John’s room when John arrives from work</td>
<td>John takes the maintenance man’s toolbox and throws it out the door</td>
<td>The maintenance man yells at John and tells him he will pay for everything that is broken</td>
</tr>
</tbody>
</table>

Function: Expression of anxiety at having a stranger in the house

Message: *I don’t know who you are, ‘go away’*

Positive behaviour support strategies

**Environmental change**

Staff to let John know when a stranger/or someone new is coming

Staff develop a ‘who’s here today’ board

**Replacement independence skill**

John was taught:
- to place a picture on the who’s here today board to remind John when someone new is coming
- to introduce himself to strangers invited into the house and to ask them their name and purpose of being there.
Short-term change strategies

<table>
<thead>
<tr>
<th>Positive Intervention Framework</th>
<th>Proactive strategies</th>
<th>Immediate response strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What to do to prevent the behaviour</td>
<td>What might help when the behaviour occurs; beginning with least restrictive strategies?</td>
</tr>
<tr>
<td>Change the environment</td>
<td>Teaching skills</td>
<td>Introduce short-term change strategies for rapid change to behaviour</td>
</tr>
<tr>
<td>AIM: To produce a rapid change in behaviour</td>
<td>- Changing setting events, triggers</td>
<td>- Incentive programs</td>
</tr>
<tr>
<td>- Situational control</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Changing the environment and teaching skills can take some time to have an impact on the behaviour displayed by the person. It is often useful to take some practical steps to promote short-term change that will give you and others some respite from the person’s behaviour and build some hope for the future.

Reducing or changing setting events and triggers –

This consists of setting the occasion for positive behaviour by increasing the events that produce desired behaviour. For example:

• providing the person with greater access to preferred activities
• providing the person with clear instructions
• giving the person more time to spend with favourite staff
• placing a tray with books on the lap of a person when you know this inhibits them from breaking the bus windows.

*It also consists of decreasing or eliminating setting events that trigger the behaviour. Some examples include:*

• Reducing the number of demands made.
• Giving instructions in a way that is not directive (for example, ‘The table is ready to be set when you’ve got a chance’) if assessment reveals that directive instructions act as triggers.
• Providing the person with a room of their own.
• Slowing down the morning routine if you know the bus will be late and waiting has been shown to act as a trigger.
• Often putting together a Do’s and Don’ts lists to ensure staff consistency.
Incentive programs

These provide the person with some very strong incentives to stop the person needing to use behaviours of concern.

Example: Bruce

Baseline data collected by staff revealed that on average Bruce engaged in the behaviour once every twelve hours. This meant that Bruce should be rewarded if he can go for six hours without engaging in the behaviour.

For convenience, Bruce’s day was divided into three intervals:

1. From when he woke up until lunch time
2. From lunchtime until tea time
3. From tea time until bed time.

A simple chart was developed with each of these intervals clearly marked on it. After each interval passes without Bruce engaging in the target behaviour staff sign their initials on his chart. Staff members involve Bruce in this and praise him.

When Bruce is not successful, staff don’t spend time telling him off. Instead they leave the chart blank and encourage him to try again in the next time interval.

Because the program hasn’t been going for very long Bruce needs to earn two consecutive initials to get an incentive from his incentive menu. The rewards chosen for Bruce’s incentive menu were all things that Bruce did not get before the program started.

The incentives used included:

- playing his favourite music video tape that staff bought him specifically for this program
- a three-minute call to his brother who he usually only sees or talks to every now and then
- hiring a fishing video tape
- getting to choose the channel on the TV for the evening
- having a cappuccino with a staff member
- getting breakfast in bed
- having sections of the newspaper read to him.

As the program progresses the length of time Bruce is expected to go without engaging in the behaviour will be gradually increased.

When Bruce reaches his program objective the rewards from his incentive menu will be available to him unconditionally on an informal basis.
The steps involved in setting up an incentive program

1. Select the target behaviour.
2. Select the time interval without displaying the target behaviour (half the average time between incidents).
3. Select the incentives. These should be:
   - ordinary
   - age appropriate
   - added to the person’s life
   - available non-conditionally after the program.
   You should ensure that the maximum number of rewards available is less than the person would seek given free access to it. The best way to do this is to construct an incentive menu.
4. Develop a system for monitoring the person’s performance (for example, signature chart).
5. Provide positive feedback paired with access to an incentive when the person goes for a whole interval without displaying the target behaviour.
6. When a target behaviour occurs, simply leave the space on the chart blank. Do not criticise the person, but simply encourage them to try to go for the next interval without displaying the target behaviour.
7. As the person’s behaviour improves, extend the amount of time they need to go before earning a reward.
8. When they have reached the program objective, make sure the person can still access the incentives on an informal basis. This will, in effect, enrich the person’s life and help to prevent behaviours from recurring.

Situational control

Situational control strategies are for behaviours that are OK as long as they occur at the right time and in the right place. They consist of teaching the person in what situations it is appropriate to engage in the behaviour, and in what situations it is not.

Situational control can be used for behaviours like:
- Complaining
- Masturbation
- Spitting
- Nose picking
- Dressing up in clothing of the opposite sex.

The following situational control was set up to deal with Andrea’s excessive complaining.

Andrea
Andrea was told that she could have the undivided attention of staff every evening for ten minutes where she could complain about the things that went wrong for her that day.
Every evening at 8.30 pm the staff member on duty said, ‘Andrea, it’s our discussion time. Come into the staff room and let me know what went wrong today.’ Then in a caring and genuine way, staff listened to what Andrea had to say. They always arranged the seats in a certain way and turned off the main light and turned on a reading lamp. At the end of ten minutes (if it was fair to end at this point) staff praised Andrea for sharing her complaints with them.

If Andrea made complaints during the day which didn’t need to be acted on then, staff would say ‘Andrea, remember that one for our discussion time tonight.’

Steps involved in setting up a situational control program

1. Select the target behaviour
2. Select an incentive to establish situational control (this may simply involve giving positive feedback).
3. Select a signal that the behaviour is OK now (select one which you control).

Immediate response strategies

<table>
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<tr>
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<tr>
<td>Introduce short-term change strategies for rapid change to behaviour</td>
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</table>

Rather than waiting for incidents to occur, it’s much wiser to be prepared. This is where immediate response strategies come in.

Before these strategies can be planned, it is imperative that the warning signs (precursors) to incidents of behaviour are identified. The warning signs are the behaviours that the person engages in during the lead up to the actual behaviour (as opposed to triggers that are the setting events that occur immediately before the behaviour).

Reactive strategies should be planned in a ‘hierarchical manner’, that is, there should be a series of steps incorporated into the plan, which match the level of escalation that the person is displaying at any particular time. Steps should always reflect the principles of the ‘least restrictive alternative’ ranging from the least to the most restrictive strategies. If a restrictive intervention is to be used the option chosen should be the least restrictive as possible in the circumstances (s 140 (b) Disability Act 2006).
As mentioned earlier, restrictive intervention refers to any intervention that is used to restrict the rights or freedom of movement of a person with a disability and includes:

- **seclusion;** e.g. a room with a locked door/area and windows that the person cannot open from the inside
- **mechanical restraint;** e.g. a device used to prevent, restrict or subdue a person’s movement
- **chemical restraint;** e.g. medications used for the primary purpose of behavioural control

People with a disability who show behaviours of concern and are subject to restrictive intervention must have a behaviour support plan that is reviewed and submitted to the senior practitioner at intervals not more than 12 months.

### Two functions of immediate response strategies

1. To de-escalate a potential episode of the behaviour and manage serious episodes of the behaviour.
2. To minimise damage to people, property and the person’s reputation.

They are not set up to promote long-term behaviour change. This is done through changing background factors and positive programming.

### Examples of common immediate response strategies

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Example of how it may be used</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Using space</strong></td>
<td>When Cheryl appeared agitated, Carol moved a little closer towards her.</td>
</tr>
<tr>
<td></td>
<td>When Sam began pacing and mumbling, Alex gently placed his hand on his shoulder.</td>
</tr>
<tr>
<td><strong>Inject humour</strong></td>
<td>When Simone glared at Jacqui after she knocked her accidentally at the dinner table, Maureen used a playful, joking manner.</td>
</tr>
<tr>
<td>(Use with caution as this method may be wrongly construed as ridicule or sarcasm)</td>
<td></td>
</tr>
<tr>
<td><strong>Instructional control</strong></td>
<td>When Fred began masturbating in the lounge, he was discreetly told that he should do that in his bedroom.</td>
</tr>
<tr>
<td></td>
<td>When Megan saw James running to Alice to hit her, she yelled, ‘James, take out the rubbish bins!’ – a request that he is known to follow reliably.</td>
</tr>
<tr>
<td><strong>Encouraging communication</strong></td>
<td>Steve was crying while he did the dishes. Jeremy grabbed his feelings book and said, ‘Steve, you look upset. Tell me what’s wrong.’</td>
</tr>
<tr>
<td></td>
<td>Jane had her period, and yelled when asked if she could please go to work now. Cathie gently led her to a lounge chair and said, ‘Jane, don’t you feel good? Is your stomach hurting?’</td>
</tr>
<tr>
<td><strong>Active listening</strong></td>
<td>Roy was pacing and appeared to be getting more and more upset as dinner approached. Wendy said, ‘You seem hungry Roy. Come with me and we’ll make a snack while we’re waiting for tea.’</td>
</tr>
<tr>
<td></td>
<td>During a lull in Stephanie’s outburst, Jenny calmly said, ‘Hey Steph, you sure are upset that mum didn’t visit. It must be hard to take.’</td>
</tr>
</tbody>
</table>
Strategy | Example of how it may be used
--- | ---
Encourage relaxation | 1. Acknowledge that the person is upset.<br>2. Instruct the person to calm down.<br>3. Instruct the person in activities that promote relaxation (Soles of the feet, deep breathing, music, etc).<br>4. Leave the situation, if necessary, where they can remain undisturbed.<br>5. When they arrive, try to help them to get comfortable and relaxed. Encourage the person throughout.

Do something completely unexpected | Sing a song loudly.
Response is usually only momentary but allows time to evade.<br>The surprise will wear off if it is used repeatedly.

Inter-positioning | Paul, who weighs about 90kg, rushes towards a staff member with his hands in the air. The staff member positions herself behind a table and uses ‘active listening’.<br>Barry runs from the kitchen table towards the front door of his house which fronts a busy street. Staff position themselves between him and the door and speak loudly enough to distract his focus.

Example immediate response strategy plan

These strategies are designed to defuse or de-escalate a potentially serious episode of the behaviour when the warning signs are apparent, or to manage a serious episode when it occurs. Reactive strategies are NOT designed to bring about long-term behaviour change.

The diagram below is commonly known as the stress or anger cycle. It represents a series of phases that can be observed as people escalate in the degree of aggressive or agitated behaviour. Following is a list of the known activities and situations that trigger the person’s behaviour, and also those behaviours or warning signs that can at times be seen prior to a serious episode occurring. This list aims to provide people supporting the person with an observation strategy that enables them to intervene as early as possible in the behaviour cycle.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Triggering event</td>
<td>Escalation (warning signs)</td>
<td>Crisis</td>
<td>Recovery</td>
<td>Post crisis depression</td>
</tr>
</tbody>
</table>
Phase 1: Triggering event - a perceived threat (others may agree or disagree that a real threat existed.) Triggering events fall into two general categories:

a) Fear,

b) Frustration

Phase 2: Escalation - The person’s mind and body prepare to do battle with the cause of the triggering event, muscles become increasingly tense and active.

Phase 3: Crisis

Phase 4: Recovery - The muscles become progressively more relaxed as the mind and body return to normal.

Phase 5: Post-crisis depression - The physical and emotional symptoms of fatigue and depression dominate the behavioural pattern until normal responses can be restored.
Case study: ROSIE TYLO

*A clear description of the behaviours of concern is required*

Hitting others with a closed fist (using her right hand), usually to the upper body.

**Possible triggers for the behaviour:**
- New staff
- Noisy environments
- Staff changes
- Tiredness
- Constipation
- Headache

**Possible warning signs that the person may display:**
- Red-faced
- Excessive pacing
- Muttering under her breath.
- Using threatening language
- Erratic behaviour that does not settle
- Avoids eye contact

**Remember: potentially difficult situations may be avoided if you minimise these possible triggers (see do’s & don’ts list)**

**Phase 1 Response:** Rosie is red-faced and paces excessively

**Strategy:** Encourage communication, for example, 'What's wrong?/Can I help you?'

If R positively, encourage Rosie to engage in problem solving as per Problem Solving Program, This should be done in a quiet area, without interruptions.

**Phase 2 Response:** Rosie continues pacing plus muttering under her breath.

**Strategy:** Encourage relaxation in her bedroom as per Relaxation Program.

Provide as much assistance to Rosie with this program as she requires.

Check with her as to whether she wants you to stay with her or be left alone.

If she chooses to complete the program alone, check in periodically without disturbing her.

If Rosie refuses to engage in relaxation, but the precursor behaviours cease, provide positive reinforcement in the form of verbal praise for her calming down. Continue to observe her from a distance for a period of 15 minutes.

If Rosie refuses to engage in relaxation, and the precursor behaviours continue, encourage her to complete an alternative, preferred activity (see Rosie’s menu of activities). Continue to observe her from a distance for a period of 15 minutes.

If Rosie refuses to engage in relaxation and attempts to, or actually succeeds in, carrying through with the target behaviour, proceed to Phase 3.

**Phase 3 Response:** Rosie engages in target behaviour: Hitting others with a closed fist (using her right hand), usually to the upper body.

**Strategy:** PRN VALIUM.

a) Redirect Rosie to another room (away from other clients). Instruct her to sit down. One staff member should stay with Rosie (at a safe distance, that is, on the other side of a table but not engage in conversation with her).

b). The second staff member should attend to the person who was target of Rosie’s aggression. If the person was a staff member, they should not be the one to stay with Rosie, but be allowed some time away from the person.

c). Once 15 minutes has passed with no precursor or target behaviours being displayed, usual activities should be resumed.

Staff should ensure that the individual needs of both clients and staff are met.

Staff should not, at this time, enter into discussion with Rosie about the behaviour that she has displayed. When the time comes to fill out her incentive chart, Rosie and staff will discuss her behaviour across the whole day.

Talking to Rosie about the episode whilst in Phase 4 Recovery, can actually escalate Rosie’s behaviour.
Using the Positive Intervention Framework identify strategies or ideas that you could implement to change or modify the behaviours of concern.

**General risk-minimising strategies**

Staff members who are prepared to respond to behaviour of concerns before they enter the working environment are less likely to injure or be injured during a serious episode of the behaviour. The fully prepared staff member has a good understanding of the person, is appropriately dressed and has adequate mobility, well-practised observational skills and an organised plan for self-control.

<table>
<thead>
<tr>
<th>Knowledge of the person</th>
<th>Rate your knowledge of the person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abilities and independent skills</td>
<td>1= little 2= some 3= lot</td>
</tr>
<tr>
<td>Preferences</td>
<td></td>
</tr>
<tr>
<td>Know how to speak to person in a way that is meaningful</td>
<td></td>
</tr>
<tr>
<td>Know the meaning of person’s unique ways of communicating</td>
<td></td>
</tr>
<tr>
<td>Person’s warning signs</td>
<td></td>
</tr>
<tr>
<td>Triggers</td>
<td></td>
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</table>

| How am I dressed?                        | Look at the way you are dressed from head to toe and assess your attire in terms of risk it might present during a serious episode of the behaviour | L low risk S some risk H high risk |
|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| **Earrings:** Do earrings present a risk of tearing or cutting?                                                                 |                                                                                                                                  |
| **Glasses:** Are frames or lenses likely to break?                                                                                                                                   |                                                                                                                                  |
| **Necklaces:** Do necklace, ties, scarves etc provide an opportunity for choking?                                                                                                      |                                                                                                                                  |
| **Accessories:** Can ring, bracelets, watches or fingernails catch or tear skin?                                                                                                       |                                                                                                                                  |
| **Clothing:** Will my clothing keep me from jumping, running, bending and kneeling?                                                                                                     |                                                                                                                                  |
| **Shoes:** Do my shoes interfere with my ability to move quickly? Do my shoes present a risk of injury to others or myself?                                                            |                                                                                                                                  |
| **Keys:** Does the way I carry my keys pose a risk of injury to myself or others?                                                                                                         |                                                                                                                                  |
| **Emotional attachment:** If my clothing or jewelry were damaged would I be upset?                                                                                                         |                                                                                                                                  |
Maintaining self-control

A plan for self-control

When you believe you are being threatened with physical injury, your body will prepare to reduce or eliminate the potential threat. This is a normal reaction and is necessary for survival. Stress caused by repeated experiences of ‘fight or flight’ arousal is cumulative in its effects.

Maintaining self-control in difficult circumstances is one of the hallmarks of professional behaviour. Therefore developing a series of planned techniques for maintaining (or regaining) control is very important in reducing this stress and restoring emotional balance.

Critical features of an effective plan for maintaining self-control

1. **Self-assessment**: taking a moment to check your own physical state.

2. **Know your limits**: having a clear picture in your mind of how far you might go when you lose your temper.

3. **Regaining self-control**: knowing how you feel and what you don’t want to do is a good start. To be truly effective at self-control, you need to take specific steps to counteract the *fight or flight* response. For example if you find that you breathe very rapidly when you are frightened, your self-control plan would include a conscious effort to breathe slowly and deeply.

4. **Restoration and healing**: being threatened or physically injured creates emotional stress. Since emotional stress makes it more difficult for you to stay calm and controlled, it is important for you to plan methods for restoring your emotional balance after an episode. Talking with a trusted friend is one of the most common ways of beginning to restore emotional balance. Since we are each unique individuals, no one way of emotional restoration will work for every individual. It is important for you to understand what you can do to make yourself feel better after a stressful incident. Emotional balance is essential for good professional performance.

Complete the plan for self-control
Activity: Plan methods for reducing this stress and restoring emotional balance.

Knowing your limits

<table>
<thead>
<tr>
<th>If I failed to regain self-control and over reacted what would I be doing?</th>
<th>If I failed to gain self-control and under reacted what would I be doing?</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

What habits do I display under stress that might make the situation worse?

<table>
<thead>
<tr>
<th>Breathing</th>
<th>Vision</th>
<th>Speech</th>
<th>Thinking</th>
<th>Emotions</th>
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</table>

Practical methods for maintaining self-control

You have completed your self-assessment and find that you are going into either ‘fight or flight’ response. What can you do to keep your behaviour within professionally acceptable limits?
Methods for restoring balance and a sense of wellbeing

<table>
<thead>
<tr>
<th>Immediately after the incident I will do these things to restore my sense of wellbeing:</th>
</tr>
</thead>
<tbody>
<tr>
<td>When I have been threatened or attacked at work, I will do these things after work to restore my sense of wellbeing:</td>
</tr>
<tr>
<td>Because I have a job where there is a real possibility of being threatened while performing my duties, I have developed the following habits or patterns of activity to keep myself emotionally balanced:</td>
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</table>
Importance of monitoring, evaluating and reviewing the effectiveness of the positive behaviour support strategies

As stated earlier positive behaviour support is not the simple answer to a complex question. A functional behaviour assessment can significantly assist in uncovering the purpose that the behaviour is serving for the person which can guide the selection of appropriate strategies; changes to the environment, teaching new skills, immediate response strategies. These strategies will require consistent implementation and a concerted effort from all those involved.

There is little point in persisting with strategies if after a reasonable period of time there does not appear to be any change in the behaviour nor an improvement in the person's quality of life. This is in turn can have a negative effect the person with a disability and on the enthusiasm of staff and their feelings of hope for the future.

The importance of regularly monitoring the implemented strategies can not be understated. Consideration needs to be given to what strategies have worked and what strategies may need to change. This will often require interval data recording using STAR charts to identify any changes to the frequency of the behaviour and whether ideas formulated following the functional behaviour assessment about why the behaviour is occurring are still correct.

In reviewing the selected strategies according to the Office of the Senior Practitioner, Behaviour Support Plan Practice Guide it is important to consider:

- the results of the positive interventions; that is what worked well in reducing the behaviours of concern and what doesn't work well to reduce the behaviours of concern and,
- the results of the restrictive interventions; that is what was the effect of the restrictive intervention on the behaviour of concern and what was the effect of the restrictive intervention on the person's quality of life.

For people who are subject to restrictive interventions the need for monitoring and evaluation is crucial given the dangers associated with subjecting the person to restrictive interventions. These dangers include:

- repeated traumatic experiences
- the re-emergence of older behaviours
- emergence of new behaviours
- irreversible side effects associated with psychotropic medication (e.g. tardive dyskinesia)
- physical injury to the person and even death in others.
Decision-making model for responding to behaviours of concern

1. Identify behaviour to be changed.
2. Ensure behaviour(s) are important to be changed.
4. Identify interim reactive strategies.
5. Analyse appropriateness of environment. Specify settings and triggers.
6. Form a hypothesis about the function of the behaviour.
7. Change background factors
8. Compare new level of behaviour with original level.
9. Is the program effective?
   - Yes: Continue program.
   - No: Review immediate response strategies
         Change background factors
         Teach skills
         Short term change strategies
         Continue program.
         Return to step 5.
Appendices
Appendix 1: Article modified from ‘Trouble in Kew’
Royce Millar The Age December 13 2008

DOROTHY Jones loves trees. Loves touching them and even giving them a hug from time to time. She always has. Loving trees was never an issue, until now.

Dorothy (not her real name) has lived at Kew Cottages most of her life. But her parkland home is not what it was. More than a century after it opened, the oft-criticised institution for intellectually disabled Victorians is being transformed into an upmarket $400 million residential estate.

Dorothy is one of just 100 former Kew Residential Services (KRS) residents who remain on site in 20 houses known as community residential units.

The new-look Kew Cottages was to be a "flagship" housing project for the Bracks/Brumby Government – a model of environmental sustainability and deinstitutionalisation where disabled residents would blend seamlessly into the wider community. So far however, the 27-hectare Kew Cottages makeover is more battleground than flagship.

The first 50 of more than 500 new households have moved in after paying up to $1.8 million for the privilege of "lifestyle" on a hill in leafy Kew. Despite the enviable setting, there are real problems. Tensions have come to a head in recent weeks as residents have tackled the Government and its development partner, the Walker Corporation, over gripes ranging from leaking roofs and missing steel girders in their homes, to the absence across the estate of footpaths and promised environmental features.

They are now engaged in a bitter row with the State Government and the NSW-based Walker over what they claim are broken promises and contracts. Caught in the crossfire are the remaining Kew Cottages residents, the behaviour of some of whom is also under scrutiny…

…In the wider public domain, some footpaths marked on plans don't exist and little thought seems to have been given to car parking. All residents complain that traffic is a nightmare in the tightly packed neighbourhood.

As part of its design, Walker insisted that there be no fences, including on the community residents' units. Lack of fences is increasingly identified as a flaw, especially given the inclination of some KRS residents to wander.

But most troubling for all involved are the complaints now being made by newcomers about the behaviour of KRS residents. No one involved will discuss the behaviour issue, on the record at least. It is just too sensitive. Healey says the behaviour of the KRS residents simply should not be an issue. "This was their property and should never have been sold out from underneath them."

But it was and the tensions are real.

A letter to Walker Corp from the new resident committee complains of KRS residents relieving themselves in public, wandering the streets and into neighbours’ homes with little or no supervision, screaming loudly late at night, throwing food and garbage and even scissors into a neighbour’s property.

The complaints have raised the most thorny of questions about deinstitutionalisation, especially at Kew.
Some homebuyers have complained to The Age that they were never briefed about the reality of living next to intellectually disabled residents. Others say there was no mention of disabled neighbours at all.

There is an argument, of course, that homebuyers should not expect to be even notified of the presence of intellectually disabled neighbours because to raise it is discriminatory in itself. But for some with long involvement in caring for the disabled, being as frank and up front as possible about living cheek by jowl with intellectual disability is the only way. They say tensions now developing were inevitable. The Government was warned.

"I think Walker under the guidance or direction of the Department of Human Services was encouraged to underplay the behaviours of the residents," says one professional saddened that the KRS residents are the subject of controversy on their own turf.

One resident, for instance, has long struggled with his pants slipping down. Like Dorothy and her trees, he continues to behave as he always did at Kew. It’s the world around him that has changed. His parkland home is now a smart housing estate. With narrow streets, no fences, and missing footpaths, close contact with his new neighbours was always on the cards.

Says one source familiar with the KRS residents: "What were they (the Government) thinking, that all of a sudden because you put him in a house there that his pants would stop slipping down?"

A well-placed source says that in light of complaints about the KRS residents, it has been made clear to carers that the residents should be less conspicuous. "Don’t do anything that might upset the local community," is how the source summarised the message…

…There is a real fear that an experiment that tore down institutional barriers may yet lead to the saddest of paradoxes at Kew. "It’s the worst thing I could imagine," says a seasoned Kew local. "There’s a handful of KRS residents who have lived on there forever; great characters who wander around the site which is their home. It would be an absolute tragedy if the limited freedom they have is taken from them."

Royce Millar is an Age investigative reporter.
Appendix 2: Workplace tasks to be completed by Day 3 of Positive Behaviour Support Training program

Date of day 3:

Names of participants:

Please note: These completed tasks could be used in addition to notes from your learners manual as evidence of competency for the unit entitled Plan and provide advanced behaviour support (National Code: CHCICS404A). This may assist you in obtaining recognition of current competency from a registered training organisation delivering Certificate IV in Disability and / or the Advanced Diploma of Disability.

Tasks to be completed as a staff team by beginning of day 3 of this program

Objective: Complete a functional behaviour assessment (Steps 1 to 4) using information in your learner’s manual from Day 2.

Instructions
1. Complete Team Action Plan in table below before you leave day 2 of training
2. List clearly at least two behaviours of concern for your focus person (Step 1 of functional behaviour assessment)
3. Undertake MAS assessment in relation to two of the behaviours. Assessment form will be distributed by trainer. (Step 2 of functional behaviour assessment)
4. Complete STAR charts for at least one of the behaviours for the period of one week (Step 2 of functional behaviour assessment)
5. Develop a hypothesis about why the behaviour is occurring (Step 3 of functional behaviour assessment)
6. Test your hypothesis by developing and trialling at least one environmental and one skill development strategy (Beginning of Step 4 of functional behaviour assessment). Identify the strategies chosen and provide a brief description on how these strategies were implemented and the outcome.
### Task 1 – Team Action Plan

<table>
<thead>
<tr>
<th>Objective</th>
<th>Tasks/steps to be undertaken to meet objective</th>
<th>How</th>
<th>Who</th>
<th>By when</th>
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<tbody>
<tr>
<td>2. Clearly describe at least two behaviours of concern for your focus person</td>
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<tr>
<td>3. Complete a MAS assessment in relation to two of these behaviours</td>
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<tr>
<td>Objective</td>
<td>Tasks/steps to be undertaken to meet objective</td>
<td>How</td>
<td>Who</td>
<td>By when</td>
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<tr>
<td>4. Complete STAR charts for at least one of the behaviours for the period of one week</td>
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<tr>
<td>5. Develop hypothesis about why the person is using the behaviour of concern</td>
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<td></td>
</tr>
<tr>
<td>Objective</td>
<td>Tasks/steps to be undertaken to meet objective</td>
<td>How</td>
<td>Who</td>
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<tr>
<td>6. Test your hypothesis by developing and trialling at least one environmental and one skill development strategy. Identify the strategies chosen and provide a brief description on how these strategies were implemented and the outcome.</td>
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</table>

2. List clearly at least two behaviours of concern for your focus person

3. Undertake MAS assessment in relation to two of the behaviours (ie: two assessments)
4. Complete a STAR chart for at least one of the behaviours, over a one week period

<table>
<thead>
<tr>
<th>Setting (background factor)</th>
<th>Trigger (setting event)</th>
<th>Action (actual behaviour)</th>
<th>Result (outcome achieved)</th>
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</thead>
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</table>

5. Develop a hypothesis about why the behaviour is occurring

6. Test your hypothesis by developing and trialling at least one environmental and one skill development strategy. Environmental strategy should include things that you can change in the environment that will increase consistency and predictability. Skill development strategy should identify a skill the person can learn to replace the behaviour of concern.

Identify the strategies chosen and provide a brief description on how these strategies were implemented and the outcome.
Appendix 3: Overview – Person Centred Active Support

PCAS is now the required approach to service delivery in Disability Accommodation Services (DAS). The department has embraced PCAS in order to increase the participation of people with a disability in everyday tasks and activities and tackle associated issues such as:

- Problems with under-activity
- Behavioural issues
- Physical health problems
- Depression.

The role of staff is to constantly look for opportunities to involve people in the things happening around them, so they gain more control over their lives, become more included in their community, pursue their own interests and gain independence.

The Person Centred Active Support (PCAS) approach is about:

- Increasing the levels of everyday engagement and interactions between staff and people with disabilities living in group homes and documenting this via a planning process which records and monitors activities, allocates staff time to ensure activities occur, and regularly reviews a person’s progress.
- Ensuring people with a disability enjoy spending time participating in different activities.
- Challenging disengagement which sometimes happens to people with a disability where staff do most things for them and they become non-participating spectators in their own lives, resulting in a loss of skills, confidence and motivation.

The approach provides a model in which staff map participation in activities within group homes and the local community, ensuring the support people require is planned, provided and regularly reviewed.

The approach includes the following components:

- Staff proactively planning opportunities for and with people.
- Staff documenting the activities to be pursued, their responsibilities and allocating time to support activities.
- Staff supporting participation (where required) by supplementing verbal instruction with gestures or physical prompts, demonstrating how to undertake the tasks or activity, providing physical guidance, etc.
- Staff regularly monitoring and reviewing the opportunities provided.

PCAS is based on a premise that all of us enjoy spending time participating in different activities. Generally, we do not like doing little or nothing for most of the time.

The amount of time spent participating in social, personal, household, leisure or other pursuits typical of everyday living, as opposed to having little to do, being passive or engaged in aimless activity, is a measure of quality of life.

PCAS is not concerned with forcing or coercing people to undertake chores or household tasks they do not want to be involved with, but involves gathering information about the activities they wish to pursue (at home and in the local community), and having in place a structured way to ensure engagement with such activities occurs.
Participation in activities can vary from undertaking the activity to full independence or with a variety of support levels. For example, some people may require hand-over-hand support or need to be shown or guided to participate in activities. Others may be able to perform tasks relatively independently. People do not have to ‘pass’ an activity by doing it independently. Rather, with support they can enjoy an activity, do it regularly over time and have other activities of choice introduced.

Decisions concerning the PCAS opportunities to pursue within group homes and the local community should be made in consultation with the person. Ideally, this should occur one-on-one or as part of a small group and be planned, documented and reviewed via Active Support documentation – Activity and Support Plans, Monthly Opportunity Recording Plans and Learning Logs.

PCAS is for all people, irrespective of the degree of disability or presence of other issues such as behaviours of concern.

Further information regarding PCAS is available from the PCAS Project Officer, Wellbeing and Practice Improvement Team, Disability Services Division – 9096 0229.