Positive practice framework
A guide for behaviour support services practitioners
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ISBN 978-0-7311-6358-8

Authorised and published by the Victorian Government, 50 Lonsdale St, Melbourne.

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November 2011 (0270911)

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Foreword

I am pleased to introduce the Positive practice framework for behaviour support practitioners in Victoria.

This framework reflects Disability Services’ continued commitment to ensuring that people with a disability access quality services that are both evidenced based and informed by contemporary approaches to service delivery.

The framework’s primary goals of maximising quality of life and reducing behaviours of concern are consistent with and reflect the principles outlined in the Disability Services Act 2006.

As the framework brings together current research, knowledge and practice strategies, it will enable the department and behaviour support practitioners to articulate a clear practice model and pathway and at the same time, provide flexibility for practitioners to integrate their knowledge and skills within the organisational context.

I would like to acknowledge the significant contribution of the Behaviour Support Services Advisory Group, Positive Practice Framework Working Group and the Specialist Services managers in shaping the content of the document and in ensuring its relevance for behaviour support practitioners.

I am confident that behaviour support practitioners and the newly established Behaviour Support Services Practice Advisory Group will support the translation of the guidance provided within this document into effective practice and positive outcomes for people with a disability.

[Signature]

Arthur Rogers
Executive Director
Disability Services
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Executive summary

The Positive practice framework (PPF) is an online resource for behaviour support services (BSS) practitioners. It presents a practice model that brings together current research, knowledge and practice strategies and reflects the legislative requirements of the Disability Act 2006.

The Department of Human Services funds a range of services, including BSS for children, adolescents and adults with a disability. These services are delivered by departmental regions, community service organisations (CSOs) and private practitioners.

A comprehensive practice framework was a key deliverable for the BSS Improvement Project undertaken by the Disability Services Division (DSD). The project aimed to deliver service improvements and improve outcomes for people with a disability presenting with behaviours of concern. Key to achieving these aims is delivering timely and quality BSS that are underpinned by evidence and contemporary approaches.

In addition to presenting a practice model, the PPF will also support practitioners to exercise professional judgement within an organisational context and complements professional supervision and development. It will assist practitioners to promote and inform people about their role and services they provide.

As well as ensuring the practice model is underpinned by evidence, a set of practice principles were developed in consultation with stakeholders to ensure the integrity of the model over future revisions and to guide ethical and effective practice.

The practice model is based on positive behaviour support and promotes a person-centred approach to responding to people with emerging or presenting behaviours of concern. It relies upon a comprehensive assessment and analysis of the meaning of behaviour for the person within a whole-of-life context and provides for a person with a disability to exercise their human rights in an appropriate manner and to live in, be included in and participate in the community.

The PPF includes: background information and context; an overview of the practice model and principles; practice pathway strategies and advice; standards and supporting templates; and references. The practice pathway has been designed to assist practitioners to implement the practice model and offers practice advice about key stages of the practice pathway such as assessment, intervention, support and review.

The PPF has been developed as an online practice framework to ensure easy navigation, review and update in line with developments in practice.

DSD is committed to effective governance and will utilise a range of mechanisms including, for example, the Behaviour Support Services Advisory Group, which will bring together key stakeholders to oversee priorities for building a strong behaviour support system in Victoria and also consider emerging practice guidance and advice on its application to the PPF.

The PPF applies to BSS delivered by departmental regions. Funded CSOs and private practitioners are encouraged to use this manual.

The PPF is a compendium document and should be read in conjunction with the BSS policy (Appendix 1). The BSS policy is intended for service providers and presents a role statement and service requirements for regions.
Part A: About the *Positive practice framework*

1  Purpose

The *Positive practice framework* (PFF) is an online resource for behaviour support services (BSS) practitioners. It presents a practice model that brings together current research, knowledge and practice strategies and reflects the legislative requirements of the *Disability Act 2006*.

The Department of Human Services funds a range of services, including BSS for children, adolescents and adults with a disability. These services are delivered by departmental regions, community services organisations (CSOs) and private practitioners (Appendix 6).

In addition to ensuring the practice model is underpinned by evidence, a set of practice principles were developed in consultation with stakeholders to ensure the integrity of the model over future revisions and to guide ethical and effective practice.

BSS practitioners are specialists, preferably with tertiary qualifications in relevant disciplines such as nursing, psychology, special education, speech pathology, occupational therapy and social work, and/or staff with relevant behavioural training and experience. BSS managers are responsible for managing the multidisciplinary teams.

To manage and prevent behaviours of concern BSS practitioners:

- conduct comprehensive assessments relevant to the person’s presenting needs and circumstances
- develop and implement evidence-based behaviour support programs, which might be delivered in the form of multi-systemic interventions and/or individual therapy
- deliver training and consultation to staff and carers, based on contemporary practice and professional standards
- promote environments that support and maintain positive behaviour.

The goals of the PPF are to ensure that BSS practitioners:

- deliver evidence-based services that are consistent with a contemporary human rights approach to the support of people with disability
- demonstrate accountability to the person with disability, their support network and the disability service system
- deliver consistent standards of services statewide while taking into account local and individual client circumstances.
2 Format of the practice strategies

The PPF presents background information/context, standards, principles, an overview of the practice model, key practice strategies and advice and supporting references/templates.

Each phase of the practice pathway contains hyperlinks that take the reader to additional supporting information including references, templates, suggested assessment/planning tools and additional advice.

The practice strategies are presented in the following format.

<table>
<thead>
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<tr>
<td>Process</td>
<td>The method for achieving the task</td>
</tr>
<tr>
<td>Outcomes</td>
<td>The outcome to be achieved by the BSS practitioner (practice strategies) or the BSS manager (quality assurance)</td>
</tr>
<tr>
<td>Standard</td>
<td>The standard to be supervised by the BSS manager</td>
</tr>
<tr>
<td>Sample proforma</td>
<td>Where applicable</td>
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</table>

The PPF should be read in conjunction with the BSS policy (Appendix 1). The BSS policy is intended for service providers and presents a role statement and service requirements for regions.

The PPF supports the BSS policy in that it:
- promotes a positive approach to responding to people with emerging or presenting behaviours of concern that reflects best practice and is person centred and outcome focused
- relies upon a comprehensive assessment and analysis of the meaning of behaviour for the person within a whole-of-life context
- provides for a person with a disability to exercise their human rights in an appropriate manner and to live in, be included in and participate in the community.

3 Definitions

3.1 Target group

The Positive practice framework is for those within the target group for services from Disability Services. The Disability Services access policy 2009 (Appendix 2) states that to access disability services funded by the Department of Human Services, a person must:
- be considered to require supports from the disability services system
- be within the target group as defined in the Disability Act (Appendix 2)
- be considered a priority for access.

The Department of Human Services funds a range of services, including BSS for children, adolescents and adults with a disability.
The *Positive practice framework* addresses the needs of:

- people receiving services delivered by the department or CSOs funded or managed under the Disability Act
- families, carers and service providers
- other services integral to the implementation of BSS.

Carers are those who provide care, support and assistance to people with a disability. A carer can be a parent, sister, brother, husband, wife, partner, foster parent, grandparent, son, daughter, or anyone else who supports a person with a disability in their home.

### 3.2 Access

The following urgency criteria should be considered when determining urgency for access to services:

- an individual whose behaviours present immediate and serious consequences for their care and safety, or for the safety of the community
- children and young people and other individuals whose family is at crisis point and imminent family breakdown is likely unless support is provided
- an individual who is in jeopardy of being excluded from services, employment or school and the behaviours of concern are presenting barriers to other significant needs being met
- individuals at risk of entry into the criminal justice service system
- an individual who is undergoing a significant ‘transition period’, for example, admittance to a hospital, leaving ‘out-of-home care’ or entry to community accommodation.

### 3.3 Disability

*Disability* is not simply a quality or attribute inherent in an individual person that requires treatment or cure. Rather, disability comes about as a consequence of the complex interaction between biological, psychological and social factors, including physical, economic and attitudinal barriers to participation at home, in education, at work, or in the community generally (McVilly and Newell, 2007).

The legislative definition of disability is set out in section 3 of the Disability Act. For a discussion and related references regarding the requirements of meeting target group criteria to access disability supports see section 3.1 ‘Target group’, above.

A key principle of positive behaviour support is that it is a non-categorical process (that is, strategies, interventions and decisions are not based on any particular category of behaviour, impairment or disability). Therefore, the framework aligns itself with a *social model definition of disability* (Appendix 3), which is supported by the World Health Organization (WHO) *International Classification of Functioning Disability and Health* (Appendix 4) and the United Nations (UN) *Convention on the Rights of Persons with Disability* (Appendix 5). The process must address ethical issues and priorities (managing risk, duty of care to provide effective interventions and prevention of abuse) as outlined in *The Victorian Charter of Human Rights and Responsibilities* (Appendix 5) and the *UN Convention on the Rights of Persons with Disability* (Appendix 5).
The WHO International Classification of Functioning, Disability and Health is a biopsychosocial framework that informs the PPF. It covers:

- body functioning associated with the integrity of the person’s body structures and functions (including the nervous system and cognitive functioning)
- activities and participation known to effect health and wellbeing (including communication, learning, domestic activity, social and community participation)
- environmental factors that can facilitate or impede the person realising their full potential (including physical, social and political factors).

Figure 1 presents a diagrammatic representation of factors that predispose, precipitate or maintain mental ill-health and/or behaviours of concern.

**Figure 1: Factors that predispose, precipitate or maintain mental ill-health and/or behaviours of concern**

Adapted from Holland and Jacobson (2001) (cited in McVilly, 2002).
3.4 Behaviours of concern

Behaviours of concern are socially constructed, an outcome of the person–environment interaction. Therefore, such behaviours are a ‘challenge’ to service systems.

Reinforcing the social model of disability, behaviours of concern may be a reaction to an inappropriate environment and/or a method of communicating a lack of autonomy, lack of stimulation, frustration at not being understood, or over stimulation. A more inclusive social model definition incorporates intrinsic factors such as the nature and severity of impairment and contextual factors such as the attitudes of others, the extent to which the environment is enabling or disabling and wider critical social and economic issues. Behaviours of concern may represent ‘protest or resistance’ when the environmental responses are neglectful, socially and morally unacceptable, abusive or restrictive, particularly when human rights are violated. In other words, it is system attitudes, practices and structures that are disabling, not necessarily facets of the person.

The department’s Behaviour support services policy (Appendix 1) places emphasis on promoting a positive approach to responding to behaviours of concern and recognises the need to build a behaviour support system that will more effectively promote and maintain environments that support positive behaviour support.

For the purpose of this document, behaviours of concern are defined as:

*Any behaviour that is a barrier to a person participating in and contributing to their community (including both active and passive behaviours) that undermines, directly or indirectly, a person’s rights, dignity or quality of life, and poses a risk to the health and safety of a person and those with whom they live or work.*

This definition of behaviour of concern has been adopted by the Australasian Society for the Study of Intellectual Disability (ASID) and the Australian Psychological Society (Budiselik et al., 2010).

This definition is:

- tangible – behaviours can be observed and measured
- dynamic – social and interactive elements are identified.

The definition guides practitioners in addressing person factors, environmental factors and human rights.

3.5 Scope of services

BSS broadly include the following:

- *An intervention that is provided directly with the person, or via carers or staff.* This form of service delivery requires assessment, intervention and support strategies. These strategies may be delivered simultaneously rather than sequentially.

- *Consultation and skills building that is designed to build systemic capacity.* This form of service delivery involves the application of clinical knowledge and skills to enhance service policy and procedures, as well as the knowledge and skills of those who provide direct support to people with disability.
Part B: Positive behaviour support

4 Positive behaviour support

Positive behaviour support is both a philosophy of practice and term to denote a range of individual and multisystemic interventions designed to effect change in people’s behaviour and ultimately their quality of life. Positive behaviour support is the approach that underpins this framework.

Positive behaviour support is applicable to all people; it has been applied to provide support to children and adults, to provide support and intervention for people with and without disability and for people in a range of settings. It is applicable to all people with behaviours of concern, regardless of cognitive functioning or disability.

Positive behaviour support recognises that all people, regardless of their behaviour, are endowed with basic human rights and that any assessment, intervention or support should be respectful of those human rights and foster the exercise and experience of those rights. Positive behaviour support recognises that all human behaviour serves a purpose, including those behaviours that are deemed to be behaviours of concern. In order to bring about adaptive change, it is first important to understand the purpose of their existing behaviours, their aspirations and the range of knowledge and skills they already have. In order to develop effective behaviour change strategies it is important to understand the context in which any behaviours of concern occur and the environments in which the person lives and needs to learn to use more adaptive behaviours.

Positive behaviour support includes the following key aspects:

- It has been defined as: ‘an applied science that uses educational methods to expand an individual’s behaviour repertoire and systems change methods to redesign an individual’s living environment to first enhance the individual’s quality of life and, second, to minimise his or her problem behaviour...’ (Carr et al., 2002, p. 4).
- It is an empirical approach that, in practice, (a) is based on scientific principles; (b) it is subjected to formal research validation tests; and (c) it collects and applies data (Dunlap et al., 2008).
- It expects BSS practitioners to be scientist-practitioners (applying research to solve problems with clients).

Positive behaviour support is based on a functional assessment and is focused on positive behaviour and improved quality of life. It commences with person-centred planning, leads to an individualised service based on effective and ethical practice and produces outcomes that address the person’s wants and needs.

Positive behaviour support is implemented in a partnership approach with the person, carers and a person’s support network and staff who work collaboratively to:

- identify behaviours of concern and goals of intervention
- gather information to identify the factors surrounding the behaviour
- generate, implement and evaluate the intervention.
Positive behaviour support utilises systemic, environmental, educational and other therapeutic strategies to prevent the occurrence of behaviours of concern by:

- engaging systems changes to redesign a person’s living environment (such as making choices, modifying the setting or restructuring curricula)
- teaching, strengthening and expanding a person’s behavioural repertoire to prevent recurrence of behaviours of concern (such as communication and self-management skills).

Positive behaviour support ‘...is a great and worthy idea predicated on the notion that creating a life of quality and purpose, embedded in and made possible by a supportive environment, should be the focus of our efforts as professionals. Our chief concern is not with a problem behaviour and certainly not with problem people, but rather with problem contexts...we must give [people with a disability] and their loved ones the support they need to challenge and reconstruct systems that serve bureaucratic needs rather than human needs’ (Carr, 2007, p. 3).

5 Self-directed approaches

Positive behaviour support is self-directed with particular values, strategies and procedures.

Values include:

- person-centred planning in supporting the perspective, specific needs and goals of the person (rather than staff values)
- self-determination in supporting autonomy to make informed choices or best-interest decision making by those who know and love the person
- wraparound processes in developing behaviour support plans that are needs driven and strengths based rather than service driven and deficits based.

Self-directed strategies aim to:

- place the person in the centre of service design and decision making
- provide individualised supports to the person
- empower the person to achieve his or her own wishes, preferences and aspirations.

Planning procedures:

- help the person work out what he or she wants in their life
- clarify the support needs for the person to pursue his or her aspirations
- bring together people who have a part to play in supporting joint problem solving
- energise and motivate the person
- help direct and shape the contributions made from service agencies to ensure plans are based on what is important to a person from their perspective and so more effectively help people meet their goals
- show service agencies how they can adjust their activities at both operational and strategic levels in order to better support people to achieve their goals.

Self-directed approaches are enhanced by providing flexibility, greater control and better outcomes for Victorians with a disability.
Part C: Context for the practice model

People with disability require a strong set of professional ethical standards and values to underpin BSS and practice principles to protect them against abuse, neglect and disempowerment.

Poorly conducted or limited behaviour support can, at best, result in ineffective intervention and support strategies and can, at worst, cause harm to people with disabilities and their carers.

Best practice strategies are both:
- effective – they work
- ethical – they are the right thing to do.

6 Effective services

Extensive literature searches and meta-analyses have shown that assessments and interventions based on the psychological principles derived from learning theory have been most successful in responding to behaviours of concern. Learning theory includes behavioural assessment and both behavioural and cognitive-behavioural strategies. Effective services are enhanced through a combination of structured staff education, staff coaching conducted in the workplace and the development of organisational policy and procedure. This research informs the PPF. However, BSS practitioners must be cautious in applying contemporary approaches to groups of people with specific disabilities. That is, BSS practitioners must understand the empirical literature and which assessment, interventions and contexts are appropriately applied to particular client groups.

7 Ethical services

Good ethical practice relies upon regular clinical supervision. Each practitioner is responsible for ensuring they are aware of their ethical obligations as contained in professional codes of conduct and legislation as it applies to them. The British Psychological Society notes that professionals ought to be alert to their personal values, the practitioner–client power imbalance and the potential for erroneous assessments and interventions.

Practitioners also need to be cognisant of guidelines for support staff who work directly with the person (McVilly and Newell, 2007).
Part D: About the practice model

To ensure an effective and ethical approach, a model grounded in positive behaviour support is provided so that BSS practitioners know *what* they are doing and *why* they are doing it.

The PPF is a resource that can be utilised by BSS practitioners to promote the services they provide and inform people about the model for service delivery. The model underpinning BSS is positive behaviour support. Positive behaviour support is applicable to all people with behaviours of concern, regardless of cognitive functioning or disability.

PPF guides the BSS. The PPF is based on positive behaviour support. BSS practitioners are supported by practice principles. In turn, these practice principles will determine the person–environment interaction to engage person change and environment change. Quality assurance will ensure BSS practitioners deliver effective and ethical services that meet industry standards.

Figure 2 presents a diagrammatical representation of the BSS practice model.

**Figure 2: BSS practice model**

![Diagram of BSS practice model]

In summary, the practice model is (1) grounded in positive behaviour support, (2) guided by practice principles that will determine the person–environment interaction to engage person change and environment change and (3) supported by quality assurance in line with industry standards. This practice model supports delivery of effective and ethical services.
8 Goals

The primary goal of positive behaviour support is to maximise quality of life (Goal 1) and minimise behaviours of concern (Goal 2). Positive behaviour support aims to *illuminate* understanding of the meaning and purpose of behaviour from the individual’s viewpoint, rather than *eliminate* behaviour by simply extinguishing it (Weiss and Knoster, 2008). The question is: *What can go right in this person’s life?* rather than *What impairments or disabilities are causing this person’s problems?*

8.1 Goal 1: Maximise quality of life

Maximising quality of life will be addressed in this framework. Outcome success maximises quality of life in participating and contributing to the community and realised rights and dignity. Quality of life is multidimensional and includes satisfaction in family life, employment, community inclusion, supported living, social relationships and so on. Quality of life is described as the central ‘dependent variable’ and, although the range of dependent variables addressed is being expanded, positive behaviour support relies on its behavioural roots to insist upon careful measurement and evaluation to determine the effectiveness of an intervention (Dunlap et al., 2008). Impediments to quality of life include behaviours of concern, skills deficits and dysfunctional systems (Carr, 2007).

Proactive behaviour support strategies include changing the environment, teaching skills and implementing short-term behaviour change strategies. These strategies are long term and aim to prevent the problem from occurring through a supportive environment. These strategies may include support through consultation and skills building to support both the person and their environment.

If a person’s needs are met (rather than problem behaviours managed) then his or her quality of life will improve (Goal 1) and this will assist to reduce or eliminate behaviours of concern (Goal 2).

8.2 Goal 2: Minimise behaviours of concern

Minimising behaviours of concern will also be addressed. Outcome success minimises behaviours of concern in reducing the intensity, frequency and/or duration of the risk posed to the person and others, commencing with the least restrictive alternative.

Reactive behaviour support strategies are immediate response strategies to achieve rapid and safe control over high-risk behaviours (including both passive and active behaviours). These strategies feature clear and well-rehearsed reactive plans that identify triggers and behavioural indicators to diffuse and de-escalate the situation if necessary. However, to minimise behaviours of concern is a necessary, but not a sufficient, condition for change.
Part E: Practice model standards

9 About the standards

Practice should meet relevant standards. The department is transitioning to the One DHS Standards (Appendix 7). These standards replace the Industry Standards for Disability Services, the Outcome Standards for Disability Services, the Registration Standards for Community Service Organisations and the Homelessness Assistance Service Standards. Full implementation of the One DHS standards will occur by July 2012.

An interim Behaviour Support Services practice framework standards matrix (Appendix 7) has been developed that matches each key practice task with the Standards for Disability Services in Victoria and the One DHS standards.
Part F: Principles

10 About the principles

Practice principles specify the values that practitioners should strive for in delivering an effective and ethical approach. Practice principles ensure that any future revisions will uphold the integrity of the Positive practice framework. Practice principles based on positive behaviour support complement the industry standards.

The Positive practice framework is based on the following principles (adapted from Carr et al., 2002):

1. **Comprehensive lifestyle change and quality of life**
   Assist people with disabilities and their supporters to improve quality of life – improved social relationships, personal satisfaction, employment, self-determination, recreation and leisure options, community adjustment and community integration.

2. **A lifespan perspective**
   Recognise that achieving change can take years; it is a never-ending systemic processing of different challenges at different stages of life.

3. **Ecological validity**
   Apply science in real-life community settings utilising typical stakeholders (parents, teachers) supporting individuals in typical settings (home, school, workplace) for long periods of time.

4. **Apply the least restrictive alternative**
   Provide reactive short-term strategies to restrict the rights or freedom of movement only for the purpose of preventing serious harm to self and others or the destruction of property.

5. **Stakeholder participation**
   Collaborate with stakeholders as active participants in defining quality of life and in planning assessment and intervention strategies.

6. **Social validity**
   Define success by its objective effectiveness, practicality, desirability, contextual fit and subjective effectiveness (quality of life and behaviours of concern) as viewed by stakeholders.

7. **Systems change**
   Focus on problem contexts, not problem behaviours, through system change that enables change to occur and be sustained; adopt a common vision, clear direction, adequate resources and training and incentives to change.

8. **Multicomponent intervention**
   Recognise that multiple functional and structural variables influence behaviours of concern and require multidimensional strategies.

9. **Emphasise prevention**
   Emphasise proactive skills building and environmental design to produce desirable change.
10. *Flexibility in scientific practice*

Employ a systematic data source to evaluate and guide intervention utilising qualitative data, ratings, interviews, questionnaires, logs, self-reports, correlational analyses, naturalistic observations and case studies for data collection in uncontrolled settings.

11. *Multiple theoretical perspectives*

Recognise that individuals in community settings are interdependent and multicultural and so change is an individual–system balance; change requires reallocation of time, money and political power and behaviour is a continuous process of individual–environment adaptation.

In summary, the framework promotes a holistic and multidisciplinary approach incorporating comprehensive behavioural assessment and implementation of multicomponent interventions in supporting the person, carers and staff.
Part G: Practice model: practice pathway

The following section presents the practice pathway.

Intervention to the client or via carers or staff include assessment, intervention and support strategies.

System consultation and system skills building includes support strategies.

Figure 3 presents a diagrammatic representation of the interface of the BSS pathway and goals.

Figure 3: Interface of the BSS pathway and goals
Part H: Practice strategies

11 Introductory comments

The PPF requires multicomponent assessment and intervention approaches that include skills replacement supplemented by environmental and systems change.

These strategies can be applicable to all people with behaviours of concern, regardless of cognitive functioning or disability. Examples include the ABI Behaviour Consultancy in Victoria, which describes a framework for people with an acquired brain injury and behaviours of concern, including on-site assessment of the environment, behaviour-focused intervention and engagement of the client, staff and family in the change process (Kelly and Parry, 2008) and helpful practices for maintaining a safe environment, improving wellbeing, competence, sensitivities, motivation and so on for people with autism spectrum disorder and behaviours of concern (Clements and Zarkowski, 2000).

Several good practice guidelines for professionals have been released. In the UK, the British Psychological Society published clinical guidelines (Ball et al., 2004) with a revised version that includes psychiatrists and speech and language therapists (Banks et al., 2007). In the US, the Association for Positive Behaviour Support developed standards of practice as a ‘work in progress’ (Anderson et al., 2007). While these guidelines focus on people with an intellectual disability, the professional standards are supplemented throughout the PPF with additional resources. The Professional Association of Nurses in Developmental Disability Areas (Aust.) Inc. (PANDA, 2010) have released a position statement containing statements about nursing in relation to the support of people with a developmental/intellectual disability and their families. The Australian Psychological Society published a practice guide to promote, protect and ensure the full and equal enjoyment of human rights and fundamental freedoms by people with disabilities and to promote respect for their inherent dignity (Budiselik et al., 2010). That is, the Australian Psychological Society guidelines are broader than intellectual disability and are based on the WHO definition of disability resulting in impairment in communication, mobility and/or self-care. The Australian Psychological Society guidelines are designed for all health professionals to foster interdisciplinary collaboration and support systemic improvements.

These guidelines establish best practice standards. Practice strategies presented in the PPF reflect these standards.
12 Format of the practice strategies

Key practice strategies are presented in the following format.

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<tr>
<td>Standard</td>
<td>The industry standard to be supervised by the BSS manager</td>
</tr>
<tr>
<td>Sample proforma</td>
<td>Where applicable</td>
</tr>
</tbody>
</table>

The practice strategies also identify the relevant practice principles where applicable.

Key practice strategies and supporting advice are presented for the following:
- referral
- engage the person
- manage referrals
- assess risk.

**Behavioural assessment**

- Gather information about
  - the person
  - the environment
  - person–environment interaction.
- Develop an initial formulation.
- Undertake systematic observation.
- Undertake re-formulation.
- Conduct systems analysis.
- Provide an assessment report.

**Contemporary interventions**

- BSS behaviour support plans
- Maximise quality of life (Goal 1)
- Environment change strategies
- Skills building
- Short-term strategies
- Planned immediate responses
- Minimise behaviours of concern (Goal 2)
- Environment change strategies
- Skills-building strategies
- Short-term strategies
- Planned immediate responses
Inclusive support
- The person: beyond diagnoses
- Children and adolescents
- Aboriginal and Torres Strait Islanders
- Culturally and linguistically diverse backgrounds
- Carers and staff: values and skills
- Support through consultation
- Support through skills building

Review and exit
- Review
- Exit planning

13 Referral

Practice principle
No. 5 Stakeholder participation
Collaborate with stakeholders as active participants in defining quality of life and in planning assessment and intervention strategies.

13.1 Engage the person

<table>
<thead>
<tr>
<th>Practice strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task</td>
</tr>
<tr>
<td>Process</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Outcomes</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Standard</td>
</tr>
</tbody>
</table>
Although the person (or guardian) has consented to receiving services from Disability Services, the person still needs to be actively engaged in service delivery. Feedback from people with dual diagnosis indicates that they should be involved in planning their own behavioural strategies (see Office of the Senior Practitioner, 2010) (see also Appendix 8).

Advocacy (Appendix 9) ensures the human and legal rights of people with disabilities are promoted and protected so that people with disabilities can fully participate in the community. Via the Office for Disability, Disability Advocacy Program (Appendix 9) funds are provided to a range of disability advocacy and self advocacy organisations. These organisation strongly support advocacy to:

- address discrimination
- empower individuals through information, support and knowledge of their rights
- promote community education
- increase the quality of life of individuals and their families
- make services accountable
- address inequities in service provision.

Advocacy can occur through self-advocacy or through individual, systemic, citizen and group advocacy. One role of an advocate can be to assist the person with a disability to make choices. To make choices, the person needs to have the motivation and capacity ('the will and the way', Birgden, 2004). Four elements found to be necessary to consent to treatment are the capacity to: (1) understand – to understand relevant information, (2) appreciate – to appreciate the nature of the situation, (3) reason – to rationally manipulate information to weigh the costs and benefits of various treatment choices and (4) communicate – to state a choice. The MacArthur Treatment Competence Study (Appendix 10) empirically compared the decision-making capacity of hospitalised individuals with mental illness to those with physical illness and found that those with psychiatric diagnoses could make informed choices. The approach provides gradual and simple disclosure, or 'teaches' the person information in order to maximise informed choices. This approach could be modified for people with disabilities other than mental illness.
### 13.2 Manage referrals

**Practice strategy**

<table>
<thead>
<tr>
<th>Task</th>
<th>Allocate referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process</strong></td>
<td>Practitioner/BIS manager:</td>
</tr>
<tr>
<td></td>
<td>- Considers preliminary referral information (Appendix 11) to ensure the definition of behaviours of concern is met.</td>
</tr>
<tr>
<td></td>
<td>- Considers frequency, duration and intensity of behaviours (McVilly, 2002, p. 46) to assist prioritisation. (Note that forensic clients may engage in high-intensity but low-frequency behaviours such as sexual offending, violent offending and arson.)</td>
</tr>
<tr>
<td></td>
<td>- Discuss referral with referral provider.</td>
</tr>
<tr>
<td></td>
<td>- Manage expectations regarding the outcome of the referral. Provide written feedback to the referral provider (usually the intake worker or case manager) whether the referral is rejected (with referral to an appropriate service) or accepted (and anticipated timeframe for service).</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Timely and documented referral outcome</td>
</tr>
<tr>
<td>Standard</td>
<td>Refer to practice matrix (Appendix 7)</td>
</tr>
<tr>
<td>Sample proforma</td>
<td>NSW Department of Ageing, Disability and Home Care (January 2009) <a href="http://www.adhc.nsw.gov.au">www.adhc.nsw.gov.au</a></td>
</tr>
</tbody>
</table>

### 13.3 Referral: Assess risk

**Practice strategy**

<table>
<thead>
<tr>
<th>Task</th>
<th>Undertake a risk assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process</strong></td>
<td>Practitioner:</td>
</tr>
<tr>
<td></td>
<td>- Conducts a risk assessment screen (Appendix 12) that identifies any immediate areas of risk of harm to self or others, the nature of the risk inherent in the behaviour of concern and the degree of risk to self.</td>
</tr>
<tr>
<td></td>
<td>- Establishes the level of risk to determine any action that needs to be taken in order to develop protective factors and reduce or remove the possibility that harm will occur.</td>
</tr>
<tr>
<td></td>
<td>- Considers the person’s capacity to assess particular risks and to make their own judgments regarding the ‘dignity of risk’ (to self).</td>
</tr>
<tr>
<td>Outcomes</td>
<td>An immediate risk assessment screen has been undertaken and documented to identify any potential serious risk to self or others.</td>
</tr>
<tr>
<td>Standard</td>
<td>Refer to practice matrix (Appendix 7)</td>
</tr>
</tbody>
</table>
## 14 Behavioural assessment

### Practice principles

**No. 5 Stakeholder participation**
Collaborate with stakeholders as active participants in defining quality of life and in planning assessment and intervention strategies.

**No. 6 Social validity**
Define success by its objective effectiveness, practicality, desirability, contextual fit and subjective effectiveness (quality of life and behaviours of concern) as viewed by stakeholders.

**No. 10 Flexibility in scientific practice**
Employ a systematic data source to evaluate and guide intervention utilising qualitative data, ratings, interviews, questionnaires, logs, self-reports, correlational analyses, naturalistic observations and case studies for data collection in uncontrolled settings.

**No. 8 Multicomponent intervention**
Recognise that multiple functional and structural variables influence behaviours of concern and require multidimensional strategies.

### Practice strategy

<table>
<thead>
<tr>
<th>Task</th>
<th>Provide a BSS assessment report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process</td>
<td>Practitioner:</td>
</tr>
<tr>
<td></td>
<td>Conducts an assessment of the person and their environment if intervention is required:</td>
</tr>
<tr>
<td></td>
<td>1. Gather information.</td>
</tr>
<tr>
<td></td>
<td>2. Develop an initial formulation.</td>
</tr>
<tr>
<td></td>
<td>3. Undertake systematic observation.</td>
</tr>
<tr>
<td></td>
<td>4. Undertake reformulation.</td>
</tr>
<tr>
<td></td>
<td>5. Conduct system analysis.</td>
</tr>
<tr>
<td></td>
<td>6. Provide a BSS assessment report.</td>
</tr>
</tbody>
</table>

A BSS assessment report is provided for intervention with the person or via staff.
Behavioural assessment determines why the behaviour of concern occurs. Assessment should be comprehensive and consistent with international best practice standards and determined on the basis of the person’s presenting circumstances.

A person-centred assessment aims to understand the meaning of the behaviour of concern. Assessment is therefore fundamental to intervention, whether directly with the client or via observation or information obtained from carers and staff.

The WHO International Classification of Functioning, Disability and Health emphasises function rather than diagnosis. While special factors and skills related to sensory impairment, autism, acquired brain injury and so on are considered important, it is the response to each person, their life history and personal choices and abilities that matters. Note that few assessment tools have been developed and normed for use with individuals with specific disabilities but are provided where available in the framework.

The process of assessment and formulation is appropriate for all people with behaviours of concern, regardless of cognitive functioning or diagnosis. Assessment is an ongoing process in which re-assessment may be necessary if major life changes occur. Assessment requires a planned, systematic and hypothesis-driven approach to understanding behaviours of concern.

A hypothesis is the proposed explanation for the behaviour. Hypothesis testing involves the systematic collection of the relevant information about a person. It begins with a pre-assessment and then progresses towards more comprehensive information gathering about the person, their environment and the behaviour(s) of concern. Following this, an initial formulation must be conducted that involves generating a preliminary hypothesis about the causal links between the information gathered and how this relates to the behaviour of concern. Once this process has been completed, direct observation must be conducted, following which, reformulation may need to occur. Finally, the assessment process must involve an analysis of the system or environment in which the intervention is to take place.

Assessments based on good practice aim to achieve the following.

- Identify specific questions for the assessment to answer.
- Listen and ask questions: Why are you doing this? Why do you think he or she is doing this? Why is this happening? What are you doing in response to this?
- Utilise diverse user-friendly and validated assessment tools that consider contextual factors.
- Develop initial hypotheses (formulations) about the causal mechanisms and functions of the identified behaviour.
- Undertake direct observation to refute or confirm hypotheses.
- Identify who will act on the information provided by the assessment.
- Expand the process to include stakeholders in a broad range of settings.
Utilise multicomponent, multidisciplinary and multiagency approaches.

Develop a behaviour support plan that maximises quality of life (Goal 1) and minimises behaviours of concern (Goal 2).

It is acknowledged that assessment is not a linear process and may on occasion be simultaneous or cyclical (that is, an intervention may commence while an assessment is being conducted). However, a comprehensive assessment should always be completed in order to guide further re-formulation and subsequent practices for intervention with the person or via carers or staff.

Figure 4 presents a diagrammatic overview of the assessment process.

**Figure 4: Overview of the assessment process**

14.1 Gather information

Assessment must determine the best intervention to maximise quality of life (Goal 1) and minimise behaviours of concern (Goal 2). The aim is to develop the person’s ‘story’ regarding his or her past, present and future life.

The WHO International Classification of Functioning, Disability and Health is a biopsychosocial framework that informs the PPF. Information gathering is therefore required of the:

- person
- environment
- person–environment interaction.

14.1.1 The person health-related domains

The WHO International Classification of Functioning, Disability and Health identifies health and health-related domains in terms of body functioning (the integrity of the person’s body structures and functions including cognitive functioning). Behaviours of concern are often a function of health-related domains. Assessment must rule out any issues regarding person factors that restrain the capacity of the person to maximise quality of life and minimise behaviours of concern.

The following areas must be considered regarding strengths and obstacles to improving quality of life. The method of gathering information regarding the person is through file searches, direct
observation and assessment tools (noting that some tools require minimum standards of education and training). Many of the assessment tools can also be used as pre- and post-measures. The tools are suggestions only and BSS practitioner supervision and training should ensure that the appropriate assessment tools are selected and applied to the appropriate client group. That is, not every area needs to be assessed. Note that diagnoses or types of behaviour are explored within this section.

| Medical and organic factors (including medical examinations) | • Headaches and migraine.  
| • Physical problems (discomfort, pain, malaise, physiological disturbance)  
| • Cerebrovascular and epilepsy-related events  
| • Eyesight problems  
| • Gut-related and dental pain  
| • Urinary tract infections and prostatism  
| • Bone and joint pain  
| • Neoplasms (tumours or growths)  
| • Wounds and fractures  
| • Hormonal changes such as puberty  
| • Current medications  
| • Syndrome-specific health complications |

| Health screening resources (Appendix 13) | • Psychiatric symptoms including personality disorders and some ‘philias’  
| • Atypical or secondary presentation of a mental health problem  
| • Diagnostic overshadowing – the tendency to attribute behavioural patterns to a pre-existing disability and so failure to identify psychiatric symptoms  
| • Underlying cognitive abilities, deficits and preferences  
| • Problems in thinking – problem solving, tightly focused attention, binary thinking, mental/behavioural stuttering (perseveration)  
| • Interaction between mental health problems and behavioural processes  
| • Iatrogenic effect of medication  
| • Trauma such as bereavement, parental rejection, relationship difficulties, poor self-esteem, isolation  
| • Consequence of neuropsychological disorders such as Gilles de la Tourette’s syndrome, attention deficit with hyperactivity disorder, dementia  
| • Personality features influenced by genetics, acquired brain injury or experiences of the early environment such as attachment problems, neglect and abuse  
| • Acquired brain injury – verbal aggression, physical aggression, inappropriate social behaviours, lack of initiation, inappropriate sexual behaviour, wandering/absconding and perseveration |
| Risk assessment tools (Appendix 15) | ● Risk assessment must be conducted for behaviours that pose a serious risk to self or others so that risk may be managed.  
● Risk assessment can be determined through clinical judgment or actuarial assessments or structured clinical judgments.  
● Structured clinical judgement is preferable  
  – assesses the intensity of intervention and support required  
  – assesses dynamic risk factors to be monitored  
  – re-evaluates dynamic risk factors.  
● Risk assessment requires validated or trialled tools.  
● A risk assessment must be based on a file review and staff/carer interviews and preferably includes an interview with the person.  
● Risk assessment should also consider  
  – protective factors such as specific abilities, likes/interests, strengths, motivations  
  – contextual factors such as the skills and abilities of staff and carers  
  – any organisational policy, procedures or resources that are inconsistent with the safe and dignified support of the person. |
| Communication assessment tools (Appendix 16) | ● Communication difficulties such as hearing loss, unclear communication, insufficient vocabulary or means of expression and difficulties understanding others  
● Difficulties in understanding social information  
● Difficulties in understanding language – comprehension, hearing difficulties, slowness of processing, developing more generalised ideas  
● Difficulties in self-expression – awareness of the need to communicate and difficulties in means of communication  
● Communication environment (including communication partners)  
● How communication is utilised in daily life |
| Sensory processing problem resources (Appendix 17) | ● Seeking significant deep pressure or strong tactile responses such as biting self, banging head, throwing body against wall  
● Sensory seeking or high levels of arousal as a way to calm down  
● Sensory processing difficulties resulting in sensitivity to smell, taste, texture of surroundings such as home or school effecting behaviour  
● Personal sensations – problems with sensory modulation and physical and emotional wellbeing |
| Phenotype information (Appendix 18) | ● Self-injurious behaviours linked to particular syndromes such as Lesch-Nyhan syndrome resulting in hand and lip biting  
● Usually very serious regarding risks to the person and carers  
● Can be long-term and highly resistant to behaviour change |
### 14.1.2 The environment

The WHO International Classification of Functioning, Disability and Health identifies health and health-related domains in terms of *activity* and *participation* (that affect health and wellbeing) and *environmental* factors (that impede or facilitate the person realising their full potential). Behaviours of concern are mediated by interpersonal, organisational and environmental settings. Assessment must determine the capacity of the environment to maximise quality of life and minimise behaviours of concern.

The following areas must be considered regarding strengths and obstacles to improving quality of life. Many of the assessment tools can be used as pre- and post-measures. The tools are suggestions only and BSS practitioner supervision and training should ensure that the appropriate assessment tools are selected and applied.

| Physical setting | • Size, crowding, privacy  
| Context tools | • Comfort (heat, light, noise)  
| (Appendix 19) | • Location and home environment  
| | • Visitors and others (visitors, access to community and safety)  
| Interpersonal and organisational setting | • Relationships with staff/carers/co-clients/friends  
| Context tools | • Behaviour of staff/carers/co-clients/friends  
| (Appendix 19) | • Effects of behaviours of concern on staff/carers/co-clients/friends  
| | • Structure – structured vs unstructured, groups vs individual, routines and practices  
| | • Amount and quality of social interaction  
| | • Staff/carer attitudes – expectations, beliefs and responses  
| | • Staff/carer skills and turnover  
| | • Level of resources available  
| | • Organisational/familial culture  
| | • Quality of management/leadership  
| Adaptive behaviour | • Physical/motor abilities  
| Adaptive behaviour scales (Appendix 20) | • Personal care  
| | • Domestic, community and vocational skills  
| | • Social and communication skills  
| | • Sexual behaviours  
| | • Activities that are therapeutic (age-appropriate, purposeful, engaged) rather than anti-therapeutic (age-inappropriate, non-adaptive, disruptive)  

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26 Positive practice framework: A guide for behaviour support services practitioners
Quality of life scales (Appendix 21)

- Independence – attaining and maintaining maximum independence
- Participation – attaining and maintaining full inclusion and participation in all aspects of life
- Ability – attaining and maintaining full physical, mental, social and vocational ability
- Choice – how preference and choice is expressed and how reinforcers may be used to motivate change and teach new skills
- Quality of life measured through daily routine, schedules and social interaction:
  - material wellbeing
  - health and safety
  - social wellbeing
  - emotional wellbeing
  - leisure and recreation opportunities
  - autonomy

14.1.3 Person–environment interaction

The WHO International Classification of Functioning, Disability and Health identifies health and health-related domains in terms of body functioning, activity and participation and environmental factors.

Behaviours of concern are the result of an interaction between the person and their environment; they cannot be separated. Is functional assessment an effective and ethical approach (Appendix 22)? Yes, and therefore a functional assessment of the person–environment interaction is essential for intervention with the person or via carers or staff.

The Australian Psychological Society describes functional assessment as three interrelated processes:

1. Identifies and objectively defines a target behaviour
   - initially obtained from the referral process
2. Describes the relationship between the occurrence (and non-occurrence) of the target behaviour and identifies environmental events or bio-behavioural states
   - obtained from assessment of environment and person factors
3. Generates hypotheses concerning
   a) events that precede the occurrence of the behaviour
   b) contingencies maintaining the behaviour
   c) topography of the behaviour
   - described in this section.

Based on the person and environment information gathering, the following steps are required in a functional assessment.
<table>
<thead>
<tr>
<th>Step</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define the behaviour</td>
<td><em>What is the behaviour of concern?</em></td>
</tr>
<tr>
<td>Measures of behaviour</td>
<td>Develop a clear, observable and measurable operational description of the identified behaviour of concern that includes:</td>
</tr>
<tr>
<td>(Appendix 23)</td>
<td>- form of behaviour – category</td>
</tr>
<tr>
<td></td>
<td>- frequency of behaviour – how often</td>
</tr>
<tr>
<td></td>
<td>- intensity of behaviour – how serious for self and others.</td>
</tr>
<tr>
<td>Determine antecedents</td>
<td><em>What triggers the behaviour of concern?</em></td>
</tr>
<tr>
<td>Functional assessment tools (Appendix 24)</td>
<td>These are the predictors of behaviour in the immediate or past immediate environment and can also be in the person’s physical setting, social setting, activities, scheduling factors, degree of independence, degree of participation, social interaction or degree of choice.</td>
</tr>
<tr>
<td>Determine setting events</td>
<td><em>Where does the interaction happen?</em></td>
</tr>
<tr>
<td>Functional assessment tools (Appendix 24)</td>
<td>Setting events are antecedent events that are removed in time and place from the occurrence of the behaviour but are functionally related to the behaviour because of their powerful influences. The setting events ‘set the scene’ for any triggers that may occur.</td>
</tr>
<tr>
<td>Determine consequences</td>
<td><em>What happened just after the behaviour?</em></td>
</tr>
<tr>
<td>Functional assessment tools (Appendix 24)</td>
<td>This forms an analysis of what supports the problem behaviour and why the identified variables are reinforcing the likelihood of the behaviour occurring.</td>
</tr>
<tr>
<td>Determine protective factors</td>
<td><em>What are the person’s strengths?</em></td>
</tr>
<tr>
<td>Functional assessment tools (Appendix 24)</td>
<td>Determine the person’s preferences, interests and preferred or valued activities and dislikes to identify reinforcers that may be used to motivate change and teach new skills. Determine friendships and other social relationships and integration into community activities and supports. Determine physical, social and psychological wellbeing and a sense of ‘home’.</td>
</tr>
<tr>
<td>Quality of life scales (Appendix 21)</td>
<td></td>
</tr>
</tbody>
</table>

### 14.2 Behaviour assessment: Develop an initial formulation

A formulation is a hypothesis about the nature of behaviours of concern, their causal or functional relationship between variables and events and the behaviour. Formulation is applicable to all people with behaviours of concern, regardless of cognitive functioning or disability. In contrast to a diagnosis, a formulation ‘tells the person’s story’. The formulation must be a collaborative effort between the BSS practitioner, the person and staff and carers from the relevant settings.

When undertaking a formulation, note that it is rare for a person’s behaviour to be explained by a single cause. The behaviour of concern may have originally had a single function but is likely to have escalated to numerous biopsychosocial functions requiring multicomponent intervention.

Ensure that the formulation is adequately documented for future reference and revision.
Figure 5 presents a diagrammatic representation of a formulation template.

**Figure 5: Formulation template**

The assessment of the person, their environment and the person–environment interaction should form the basis of the formulation (Appendix 25).

14.3 **Undertake systematic observation**

Systematic observation generates information about the behaviour by counting and recording defined behaviours in a given setting in order to confirm or refute an initial hypothesis. A number of useful systematic observational tools (Appendix 26) are suggested.

14.4 **Assessment: Undertake reformulation**

Following direct observation; the initial hypothesis is either verified or refuted with a reformulation. Additional information may be drawn from the assessment process by considering common results across the datasets. Reformulation will help to further guide the BSS practitioner’s thinking, inform future observations and assessment needs and contribute to the development of a behaviour support plan, as well as guide the evaluation of its effectiveness.
14.5 **Conduct system analysis**

Given that interventions will usually be carried out by a person’s carers (as mediators), a mediator analysis (Appendix 27) should be conducted to assess strengths and needs. The aim is to achieve the contextual fit between the behavioural intervention plan and the environment (see Goodness of Fit Survey in Appendix 27).

15 **Contemporary interventions**

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**Practice principles**

*No. 1 Comprehensive lifestyle change and quality of life*

Assist people with disabilities and their supporters to improve quality of life – improved social relationships, personal satisfaction, employment, self-determination, recreation and leisure options, community adjustment and community integration.

*No. 2 A lifespan perspective*

Recognise that achieving change can take years; it is a never-ending systemic processing of different challenges at different stages of life.

*No. 3 Ecological validity*

Apply science in real-life community settings utilising typical stakeholders (parents, teachers) supporting individuals in typical settings (home, school, workplace) for long periods of time.

*No. 4 Apply the least restrictive alternative*

Provide reactive short-term strategies to restrict the rights or freedom of movement only for the purpose of preventing serious harm to self or others or the destruction of property.

*No. 5 Stakeholder participation*

Collaborate with stakeholders as active participants in defining quality of life and in planning assessment and intervention strategies.

*No. 9 Emphasise prevention*

Emphasise proactive skills building and environmental design to produce desirable change.

*No. 8 Multicomponent intervention*

Recognise that multiple functional and structural variables influence behaviours of concern and require multidimensional strategies.
Contemporary intervention determines what services are provided. Intervention should be comprehensive and consistent with international best practice standards and determined on the basis of the person’s presenting circumstances.

The WHO International Classification of Functioning, Disability and Health is a biopsychosocial framework that informs the PPF. Intervention is therefore required to address the:

- person
- environment
- person–environment interaction.

Positive behaviour support encompasses the range (and combination) of intervention strategies and modalities. These could include, but need not be limited to, behavioural, cognitive, cognitive-behavioural, insight and mindfulness-based approaches, together with pharmacological interventions. While in some circumstances strategies can be effectively implemented by a sole practitioner, it is more usual and typically more effective when a multidisciplinary team approach is employed, depending on the person’s presenting circumstances and the experience of the BSS practitioners involved.

There must be a direct link between assessment and intervention implementation. Good practice in assessment results in an intervention plan that has a contextual fit between the person and their environment. That is, the intervention needs to meet the values and characteristics of the person and their family, including their social, cultural and organisational environment as well as the resources and constraints of that environment.

<table>
<thead>
<tr>
<th>Practice strategy</th>
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<tbody>
<tr>
<td><strong>Task</strong></td>
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<td><strong>Process</strong></td>
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<tr>
<td><strong>Outcomes</strong></td>
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<tr>
<td><strong>Standard</strong></td>
</tr>
</tbody>
</table>
15.1 BSS behaviour support plans

BSS practitioners must articulate intervention strategies through a behaviour support plan that meets the needs of a person with a disability. A behaviour support plan has primarily a proactive focus followed by a reactive focus if required. BSS practitioners must actively supervise carers and staff implementing the behaviour support plan (Reid and Parsons, 2002).

The BSS behaviour support plan is developed in collaboration with the person and staff/carers to maximise the likelihood that the interventions will be implemented consistently across all environments. The minimum standards (Appendix 28) for behaviour support plans are clearly stated by the Australian Psychological Society.

The BSS behaviour support plan should be developed as part of a multicomponent, multidisciplinary and multiagency collaboration. The BSS behaviour support plan ensures a contextual fit (Appendix 29) within the collaborative team.

A behaviour support plan should involve goal setting (Appendix 30) that aims to enhance self-efficacy or gradual mastery of skills.

The following interventions emphasise proactive and reactive change strategies to maximise quality of life (Goal 1) and minimise behaviours of concern (Goal 2). This model can be used to track BSS practitioner services regarding environment change and skills building and intervention in short-term and planned immediate response strategies.

To reflect the biopsychosocial model, the contemporary intervention section suggests the following structure for ease of application. These interventions are applicable to all people with behaviours of concern, regardless of cognitive functioning or disability. The following structure is an adapted version of the department’s Positive behaviour support: Getting it right from the start resource (Appendix 31) and has been extended to include cognitive-behavioural interventions. In other words, any strategies can be included in the structure, as long as they are effective and ethical. Impediments to quality of life include behaviours of concern, skills deficits and dysfunctional systems (Carr, 2007).

A behaviour support plan should meet the following criteria (Browning-Wright et al., 2009):

- define the problem behaviour objectively
- specify the predictors or triggers
- analyse and describe the functions of the behaviour
- specify environmental changes related to the function of the behaviour
- describe predictors that relate to the function of the behaviour
- describe replacement or alternative behaviours that relate to the function of the behaviour
- include teaching strategies for specific alternative functionally equivalent behaviours
- specify reinforcers for functionally equivalent behaviours
- outline reactive strategies
- clearly specify the goals and objectives that can be used to evaluate progress
- detail coordination strategies
- detail communication strategies among those involved.
Figure 6 presents proactive support strategies and reactive support strategies to maximise quality of life (Goal 1) and to minimise behaviours of concern (Goal 2). The following table is an adaptation of LaVigna and Willis' (2005) multi-element model with the addition of Carr’s (2007) impediments to quality of life (that is, behaviours of concern, skills deficits and dysfunctional systems) and WHO’s biopsychosocial approach.

**Figure 6: Support strategies**

<table>
<thead>
<tr>
<th>Support</th>
<th>Proactive support strategies</th>
<th>Intervention</th>
<th>Reactive support strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment change</td>
<td>Skills building</td>
<td>Short-term change</td>
<td>Planned immediate response</td>
</tr>
<tr>
<td>Social strategies for dysfunctional systems</td>
<td>Psychological strategies for skills deficits</td>
<td>Biological strategies for behaviours of concern</td>
<td></td>
</tr>
<tr>
<td>Physical setting</td>
<td>Behavioural</td>
<td>Reinforcement schedules</td>
<td></td>
</tr>
<tr>
<td>Interpersonal and organisational setting</td>
<td>– teach skills</td>
<td>De-escalating strategies</td>
<td></td>
</tr>
<tr>
<td>Quality of life</td>
<td>– social skills</td>
<td>Counterintuitive strategies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Speech and communication</td>
<td>Biomedical responses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cognitive-behavioural</td>
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<tr>
<td></td>
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<td></td>
<td>Family intervention</td>
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<td></td>
<td>Social stories</td>
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<td></td>
<td>Mindfulness techniques</td>
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</table>

The recommended strategies are overlapping; they are not discrete. BSS practitioner supervision should ensure that the appropriate intervention techniques are selected and applied for the appropriate purpose to the appropriate client group.

### 15.2 Proactive support strategies

Maximising quality of life requires designing and delivering interventions that address the interaction between the internal capacities of the person and the external opportunities in the environment. Primary prevention is preferable because it identifies and develops the skills required by a person to function independently in important natural settings to improve quality of life; these strategies are maintained and generalise in the long term and are also more socially valid and acceptable for carers and staff. Human rights include the right to access services such as appropriate education, employment, leisure activities and accommodation.
Behaviour change strategies aimed at improving quality of life (Appendix 32) include environment change, skills building and short-term change strategies, based on the functional assessment conducted for intervention with the person or via carers or staff.

15.2.1 Environment change strategies

<table>
<thead>
<tr>
<th></th>
<th>Proactive support strategies</th>
<th>Reactive support strategies</th>
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</thead>
<tbody>
<tr>
<td>Environment change</td>
<td>Skills building</td>
<td>Short-term change</td>
</tr>
</tbody>
</table>

Environment change strategies focus on ordinary opportunities and experiences that people without a disability take for granted such as living with the people they choose, doing valued and meaningful activities, joining a club with like-minded others and owning objects and equipment based on their interests. An enriched environment reduces the likelihood of stereotypic behaviours, self-injury and noncompliance. Is relying on environmental strategies alone adequate (Appendix 33)?

Environment change strategies include capacity building in carers and staff and capacity building in the person.

**Physical setting**

- Consider changes to settings (accommodation, respite, day support, educational and/or employment).
- Suggest changes to the person’s placement or setting altogether.
- Recommend a sturdy yet attractive living environment (reinforced walls, unbreakable windows).
- Suggest management of the environment (such as noise, crowding, smells, temperature) and remove dangerous objects (such as knives, loose and heavy furniture).
- Sensory approaches include positive sight, sound, smell and touch.
- Develop alternative environments to promote comfort for sensory-seeking or sensory-avoiding people such as aromatherapy, medicine balls, massage.
- Enhance auditory and visual stimulation or manage auditory or visual over-stimulation (such as ear phones, heavy blankets, sensory boards, vibrating cushions).
- Ensure age-appropriate and contextually appropriate furnishings and decor.

**Sensory environments (Appendix 34)**

- Alter or eliminate identified setting events.
- Modify antecedent triggers – modify curricular, modify instructions and routines, provide choice and control, pre-correction, errorless learning and so on.
- Manage the organisation – create clear expectations and engage the person/carer/staff in change.
- Create a supportive environment with collaborative relationships between the person/carer/staff/co-clients.
- Support staff/carer attitudes towards and knowledge of the behaviour.
- Support an appropriate staff work culture and staffing levels.
- Improve the quality of interpersonal interactions.
- Develop predictable routines (such as devise a daily schedule in a format that the person can understand).
- Modify daily demands across settings so the person can successfully complete tasks.
- Provide low arousal techniques such as moderate interaction styles and minimise demands and situations of potential conflict.
- Assist communication partners to use more appropriate and portable augmentative and alternative communication systems and promote environments that facilitate good communication.
- Apply family systems theory when participation of the familial or care system is indicated (although ensure that the expectations of intervention are agreed).
- Create a supportive environment that builds collaborative relationships between individuals and agencies.
- Engage in multiagency approaches such as disability services and mental health services for people with dual diagnosis.

<table>
<thead>
<tr>
<th>Quality of life</th>
<th>Active support (Appendix 35)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provide choice-making opportunities in everyday living such as collaborating on routines, meal options, social activities, room layouts and privacy.</td>
</tr>
<tr>
<td></td>
<td>Provide choices that are age-appropriate and contextually appropriate opportunities.</td>
</tr>
<tr>
<td></td>
<td>Provide active support to engage in a range of everyday meaningful activities. Enhance appropriate activity levels and community access.</td>
</tr>
<tr>
<td></td>
<td>Address issues regarding attachment and trauma.</td>
</tr>
<tr>
<td></td>
<td>Support autonomy and ensure that ‘programs’ do not override a person’s immediate human needs.</td>
</tr>
</tbody>
</table>

**15.2.2 Skills-building strategies**

<table>
<thead>
<tr>
<th></th>
<th>Proactive support strategies</th>
<th>Reactive support strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment change</td>
<td><strong>Skills building</strong></td>
<td>Short-term change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Planned immediate response</td>
</tr>
</tbody>
</table>

Skills building is a critical but under-emphasised aspect of managing behaviours of concern. Skills-building strategies teach individuals to replace the problem behaviour with a desired behaviour, so the person can achieve the goals they are seeking to obtain quality of life. Is skills building effective and ethical (Appendix 36)? Yes, skills replacement strategies are more effective than changing...
antecedents or contingencies, and multicomponent strategies containing a skills replacement element based on the results of a functional analysis are considered most effective. In children and adolescents, skills training for destructive, self-injurious, stereotypic and inappropriate social behaviour is particularly effective.

Behaviours of concern may be a means of communicating human needs. Interventions should include strategies/procedures/steps to ensure consistency in teaching the alternative behaviour as well building general skills. The behavioural or cognitive-behavioural strategies must be matched to the person’s learning style (including limited understanding of time and contingencies, poor concentration span and memory, impaired problem-solving skills and a degree of egocentricity) and must be provided in the context of the person–environment interaction. Note that skills replacement training is often carried out less consistently than other strategies.

The core BSS intervention approaches are behavioural strategies that can be supplemented with cognitive-behavioural strategies under certain circumstances. Engaging in interventions outside core behavioural interventions is best delivered in collaboration with specialist agencies (such as family therapists, acquired brain injury services, medical management of psychiatric diagnoses, and forensic practitioners). Are cognitive-behavioural strategies an effective and ethical approach (Appendix 37)? The Australian Psychological Society has summarised an increasing number of cognitive-behavioural programs, primarily manualised anger management programs and some depression programs. Cognitive-behavioural strategies include accessible information, experiential tasks such as role-plays, flip charts with thought bubbles and ensuring repetition, practice and support between sessions and after therapy.

Ethical and effective cognitive-behavioural intervention requires that:

- the person has adequate cognitive skills
- the person has adequate communication skills
- the person can tolerate distressing emotional states
- the environment reinforces new skills
- the environment supports self-regulation
- the environment supports self-determination.

Behaviour of concern is an interpersonal issue requiring skills building in social skills. Skills building includes behavioural strategies supplemented by cognitive-behavioural interventions when appropriate.

### Behavioural strategies (required)

<table>
<thead>
<tr>
<th>Teach skills resources (Appendix 38)</th>
<th>Teach regularly and often.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Teach by: ask → instruct → prompt → show → guide (use task analysis).</td>
</tr>
<tr>
<td></td>
<td>Instructional methods address problems proactively (such as pre-instruction, modelling, rehearsal, social stories, incidental teaching, use of peer/buddy, meeting sensory needs, direct instruction, verbal, physical or visual prompting).</td>
</tr>
<tr>
<td></td>
<td>Teach appropriate alternative behaviours that serve the same function or meets the same need as the behaviour of concern.</td>
</tr>
<tr>
<td></td>
<td>Increase the rate of pre-existing positive behaviours that serve the same function, which then increases general positive behaviour.</td>
</tr>
</tbody>
</table>
- Benefits to the person should be maximised (positive feedback) and costs to the person minimised (punishment).
- Apply reinforcement: specifically stated, contingently given, immediate, frequently given, desired by the person and varied with choice.
- Apply reinforcements – physical, verbal, activity-based, tangible (tokens/points/stars/privileges).
- Provide active support (Appendix 35) to learn new skills because motor patterns are laid down more effectively with active ‘doing’ rather than passive ‘receiving’.
- Active support is implemented through a combination of structured staff education, staff coaching in the workplace and organisational policy and procedure.

<table>
<thead>
<tr>
<th>Social skills</th>
<th>Social skills resources (Appendix 39)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Teach cued relaxation.</td>
</tr>
<tr>
<td></td>
<td>Provide intensive interaction (Appendix 39) to facilitate social interaction and communication through interactive games, engaging staff, interactions flowing in time, responding to initiations as significant communications, and contingent responding in following the person’s lead.</td>
</tr>
<tr>
<td></td>
<td>Take into account the person’s stage of psycho-social development regarding cognition, attachment and communication.</td>
</tr>
<tr>
<td></td>
<td>Address sex education and human relations.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Speech and communication</th>
<th>Speech and communication resources (Appendix 40)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provide speech and communication aids.</td>
</tr>
<tr>
<td></td>
<td>Provide ecologically valid communication training embedded into everyday support.</td>
</tr>
<tr>
<td></td>
<td>Develop a personal communication dictionary.</td>
</tr>
<tr>
<td></td>
<td>Teach alternative communication skills to replace behaviours with a functionally equivalent communicative response (such as avoiding a demand by signalling the term ‘break’).</td>
</tr>
</tbody>
</table>
### Cognitive-behavioural strategies (supplementary)

**Are cognitive-behavioural strategies an effective and ethical approach? (Appendix 37)**

<table>
<thead>
<tr>
<th>Attachment and trauma resources (Appendix 41)</th>
<th>Behaviours and life stressors (Appendix 36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The consequences of abuse and traumatic experience can be devastating.</td>
<td>- Awareness of the impact of stress on the family and individual.</td>
</tr>
<tr>
<td>- Children with behaviour problems and intellectual disability are at risk of neglect, physical abuse or sexual abuse.</td>
<td>- The role of family in the development and maintenance of behaviour.</td>
</tr>
<tr>
<td>- Attachment is a human need because it provides safety and obtains food and shelter.</td>
<td>- The importance of family in the development of behaviour.</td>
</tr>
<tr>
<td>- Attachments can be secure (or healthy) or insecure (avoidant, anxious or fearful).</td>
<td>- The role of family in the development and maintenance of behaviour.</td>
</tr>
<tr>
<td>- Disruption of normal development in children may be detrimental to establishing healthy attachments over a lifetime, leading to behaviours of concern.</td>
<td>- The impact of stress on the family and individual.</td>
</tr>
<tr>
<td>- The impact of trauma and attachment problems may result in poor cognitive problem solving and emotion regulation.</td>
<td>- The role of family in the development of behaviour.</td>
</tr>
<tr>
<td>- The appropriate response is for carers and staff to provide a safe, predictable and supportive environment and encourage sensory and movement activities (such as going for a walk or doing puzzles).</td>
<td>- The impact of stress on the family and individual.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family intervention Behavioural and family systems interventions (Appendix 42)</th>
<th>Behavioural interventions can be limited in family settings if a mediator analysis is not conducted. What happens if a family refuses to implement a comprehensive behavioural program? How is a family to progress when dealing with insecure attachment, grief, marital conflict and neglect? How can the special needs of all family members be addressed when attempting to ameliorate behaviours of concern?</th>
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</tr>
<tr>
<td>- While behavioural intervention advocates some change while preserving homeostasis, family intervention advocates a more radical change to interrelationships.</td>
<td>- While behavioural analysis determines the communication function of the behaviour, family analysis determines where the family is ‘stuck’ in its lifecycle, which serves to protect or distract them from challenges; both approaches determine the function of the behaviour.</td>
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<td>- Up until 2003 there were only 11 published studies regarding family therapy directed at a person with disability.</td>
<td>- While behavioural analysis determines the communication function of the behaviour, family analysis determines where the family is ‘stuck’ in its lifecycle, which serves to protect or distract them from challenges; both approaches determine the function of the behaviour.</td>
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<td>- Stepping Stones Triple P is a successful behavioural intervention program for preschoolers with disability and behaviours of concern.</td>
<td>- While behavioural analysis determines the communication function of the behaviour, family analysis determines where the family is ‘stuck’ in its lifecycle, which serves to protect or distract them from challenges; both approaches determine the function of the behaviour.</td>
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**Cognitive-behavioural strategies (supplementary)**

**Are cognitive-behavioural strategies an effective and ethical approach? (Appendix 37)**

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</table>
| Social stories resources (Appendix 43) | Social stories are described as a situation, skill or concept in terms of relevant social cues, perspectives and common responses in a specifically defined style and format ([www.thegraycenter.org](http://www.thegraycenter.org)).  
- Social stories depict a character that the person may identify with and describes his/her behaviours, thoughts and feelings while he or she tries to accomplish the behavioural goals identified in the story.  
- The goal of a social story is to share accurate social information in a simple, patient and reassuring manner; half of all social stories developed should affirm something that the person does well. The goal of a social story is to improve understanding of events and expectations, not change behaviour.  
- Social stories have been used to decrease fear and aggression, introduce changes in routine, teach academic skills and teach appropriate social behaviour in children, adolescents and adults with autism spectrum disorder.  
- Note that little empirical evidence is available to validate its use and that using a sole intervention to address specific social deficits misses the complex and unique needs of people with autism spectrum disorder. Social stories have been found to have questionable effectiveness and may be better suited to addressing inappropriate behaviour than teaching social skills. |
| --- | --- |
| Mindfulness techniques resources (Appendix 44) | Mindfulness techniques are a form of cognitive-behavioural intervention.  
- Mindfulness training leads to a clear, calm mind focused in the present and awareness of both the external environment (such as the behaviour) and what is occurring in the person’s internal environment (as a consequence of aggressive behaviour).  
- Mindfulness can be applied to people with a disability and with carers and staff.  
- Mindfulness training:  
  - determines triggers to verbal or physical aggression  
  - meditates – soles of feet on floor, breathe normally, think of what led to feeling angry, shift focus to feet and wait until calm  
  - helps walk away from the situation without anger.  
- However, this technique is yet to be subject to systematic research. |
### 15.2.3 Short-term change strategies

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<tr>
<th></th>
<th>Proactive support strategies</th>
<th>Reactive support strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment change</td>
<td>Skills building</td>
<td>Short-term change</td>
</tr>
</tbody>
</table>

Short-term change strategies shape more adaptive behaviours to achieve quality of life. Are short-term strategies effective and ethical? Yes, if they are based on reinforcement, not punishment (Appendix 45).

Short-term change strategies include the following.

- **Reinforcement schedules**
  - Non-contingent reinforcement
  - Antecedent control
  - Instructional control strategies
  - Stimulus satiation
  - Differential reinforcement of
    - alternative behaviour
    - incompatible behaviour
    - zero rates of behaviour
    - lower rates of behaviour
  - Extinction

- **De-escalating strategies**
  - Distraction
  - Diversion to a reinforcing/compelling event (strategic capitulation)
  - Verbal commands to reassure or calm the person
  - Verbal commands to stop the identified behaviour

- **Counterintuitive strategies**
  - Apply strategies that are counter to control and dominance of behaviour to avoid situations that would otherwise lead to restrictive practices.
  - Maintain a high density of non-contingent reinforcement.
  - Avoid natural consequences.
  - Do not ignore behaviours under certain conditions.
  - Do not punish.

- **Biomedical responses**
  - Medication adjustment
  - Dietary changes
15.3 Reactive support strategies

Planned immediate response strategies focus on early intervention if the behaviour is about to occur. These strategies are clear and well-rehearsed reactive plans that identify triggers and behavioural indicators with an aim to diffuse or de-escalate the severity of the situation. Reactive methods are primarily used to address the communication function embedded in the behaviour of concern and to interrupt the behaviour for the protection of the person and/or others. These strategies are not intended to affect or reduce the problem behaviour in the long term. Immediate response strategies must aim to be least restrictive (not restricting opportunity, choice and participation in the life of the community) and least intrusive (do not intimidate, ignore, override or directly negate the needs, intentions and feelings of the person by simply further disempowering or subjugating the individual). Human rights include the right to not be subjected to unlawful restrictive practice.

Behaviour change strategies aimed at managing behaviours of concern require planned immediate responses.

15.3.1 Planned immediate responses

<table>
<thead>
<tr>
<th>Action</th>
<th>Reactive Support Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment change</td>
<td>Skills building</td>
</tr>
</tbody>
</table>

- Planned immediate responses

- Planned immediate responses resources (Appendix 48)

- Develop reactive plans that avoid restrictive practices.
- Use stimulus change or removal.
- Provide swift diversion techniques.
- Reduce or increase arousal.
- Teach staff to ethically manage risk.

In summary, the Australian Psychological Society indicates that, following development of a behaviour support plan, the BSS practitioner should be able to answer the following questions (Horner et al., 2000):

- Is there a good understanding of the problem?
- What needs to be done differently?
- Are you organised for success?
- How will the plan be monitored and reviewed?

15.4 Occupational health and safety

The Department of Human Services is committed to ensuring the health and safety of its employees and to, wherever possible, improving the health and safety of its workplaces, and expects its funded agencies to do the same. A number of occupational health and safety resources (Appendix 49) have been developed to assist staff in ensuring their practices are consistent with the requirements of relevant legislation.
In Victoria the *Occupational Health and Safety Act 2004* (OHS Act) is the cornerstone of legislative and administrative measures to improve occupational health and safety. The OHS Act outlines employers’ responsibilities in ensuring a safe and healthy workplace. Section 21(1) of the OHS Act states, ‘An employer must, so far as is reasonably practicable, provide and maintain for employees of the employer a working environment that is safe and without risks to health’. This includes providing information, instruction training and supervision that enables employees to perform their role in a way that is safe and without risk to health. These are examples and this is in no way an exhaustive list.

The obligations of employees are outlined in section 25(1) of the OHS Act. These include:

- taking reasonable care of his or her health and safety
- taking reasonable care for the health and safety of those who may be affected by the employee’s act or omissions at a workplace
- cooperating with his or her employer with respect to any action taken by the employer to comply with a requirement imposed by or under the OHS Act or the regulations.

When undertaking assessments and identifying intervention strategies for a client’s behaviour support plan, practitioners must be mindful of obligations under health and safety legislation. This includes ensuring health and safety risks for carers, support staff or to others are considered.

For a person residing in a department-managed accommodation service, practitioners must also be aware of the consultation processes outlined in section 35 of the OHS Act that prescribe the circumstance in which the employer (Department of Human Services management) must consult in relation to a range of health and safety related activities. Consultation should occur, in conjunction with the appropriate manager, with departmental employees (Disability Accommodation Services staff) and their health and safety representative prior to finalisation of any strategies in a behaviour support plan. Further information relating to departmental responsibilities for clients residing in Disability Accommodation Services regarding occupational health and safety issues can be found in section 3.1 and 3.4 of the *Residential services practices manual* (see Appendix 49). CSOs may have consultative processes that differ from those used by the department; it is the responsibility of the CSO to discuss these with the BSS practitioner.
16 Inclusive support

Practice principles

No. 3 Ecological validity
Apply science in real-life community settings utilising typical stakeholders (parents, teachers) supporting individuals in typical settings (home, school, workplace) for long periods of time.

No. 5 Stakeholder participation
Collaborate with stakeholders as active participants in defining quality of life and in planning assessment and intervention strategies.

No. 7 Systems change
Focus on problem contexts, not problem behaviours, through system change that enables change to occur and be sustained; adopt a common vision, clear direction, adequate resources and training and incentives to change.

No. 11 Multiple theoretical perspectives
Recognise that individuals in community settings are interdependent and multicultural and so change is an individual–system balance; change requires reallocation of time, money and political power and behaviour is a continuous process of individual–environment adaptation.

Practice strategy

<table>
<thead>
<tr>
<th>Task</th>
<th>Deliver support that is inclusive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner:</td>
<td>Works in partnership to create an innovative, flexible system, whether intervention with the person or via carers or staff.</td>
</tr>
<tr>
<td></td>
<td>Provides capacity-building to individuals, organisations and the community.</td>
</tr>
<tr>
<td></td>
<td>Maintains skills and capacity to respond to the diverse behaviour support needs of people with a disability.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Support strategies provided:</td>
</tr>
<tr>
<td></td>
<td>1. Address the unique needs of the person.</td>
</tr>
<tr>
<td></td>
<td>2. Provide consultation and skills building to staff and carers.</td>
</tr>
<tr>
<td>Industry standards</td>
<td>Refer to practice matrix (Appendix 7)</td>
</tr>
</tbody>
</table>
Inclusive support determines how services are provided. Support should be comprehensive and consistent with international best practice standards and determined on the basis of the person’s presenting circumstances.

The behaviour support plan must be actively implemented by carers and staff. The importance of carers and staff in carrying out behaviour support plans cannot be underestimated and difficulties in implementation should not reflect negatively on them. As behaviour support plans are not always carried out in accordance with a scientist-practitioner approach, what are the system constraints to implementation (Appendix 50)?

Support provides capacity building, whether direct intervention or consultancy is provided. Capacity building enhances the ability of people, organisations, institutions and communities to effectively respond to and manage their changing circumstances.

A person-centred approach cannot substitute for quality leadership, effective and efficient resources, skilled and motivated staff, service development or system changes requiring cultural and organisational change. The primary goal of maximised quality of life is realised if the environment supports person-centred goals, is well organised and interventions are delivered by well-trained staff. In positive behaviour support, inclusive support enhances skills and constructive systems change (Appendix 51) procedures to create competencies to promote quality of life.

Inclusive support addresses the individual and unique needs of the person and capacity building assists staff and carers to understand and respond to behaviours of concern. The Australian Psychological Society notes that behaviours of concern can be complex, so working in a multidisciplinary team is considered most effective to provide a richer understanding, ensure no duplication, minimise unnecessary intrusion and ensure all treatment approaches are complementary and add value. Therefore, positive behaviour support requires a multiagency approach because: behaviours of concern have detrimental effects on the person and individuals who interact with him or her; there are varied and multiple social, physical and staffing responsibilities that must be fulfilled; and intervention and support is not the responsibility of one person or a small group of people (Reid and Parsons, 2002).

The clearest common factor regarding successful outcomes is a positive working relationship (Appendix 52) between key players through mutual respect and trust.

16.1 The person: beyond diagnoses

BSS practitioners must demonstrate competence in considering unique needs when designing and implementing interventions for the person.

Behavioural assessment and contemporary intervention needs to take into consideration the unique needs of the person, carers and staff. The 2010–2020 National disability strategy (Appendix 53) supports a person-centred approach – policies, programs and services for people with disability responding to the needs and wishes of each individual. The strategy recognises that not all people with a disability are alike. People with a disability have specific needs, priorities and perspectives based on their personal circumstances, including the type and level of support required, education, sex, race, age, sexuality, ethnic or cultural background and multiple disadvantages. The strategy takes an approach that is comprehensive while recognising the different needs, perspectives and interests of people with a disability. Recognition of the diversity of experiences of people with disability underpins the outcome areas of the strategy.
While there are clear state government policy directions regarding inclusive support, the available literature regarding behavioural assessment and contemporary intervention with the person with diverse needs (other than children and adolescents) is sparse. The following are ‘tips’ for BSS practitioners not based on ‘diagnosis’ or ‘disability’. Research and evaluation in these areas is strongly encouraged.

16.2 Children and adolescents

- Children with a disability are first and foremost children.
- Improving health and development outcomes for children and young people is a joint responsibility of parents, carers and government on behalf of the community.
- Guidelines derived from managing behaviours of concern in adults need to be carefully implemented.
- The education system is a crucial setting and application of positive behaviour support varies across schools.
  - Behaviour management, including the manual handling/ Touching of students and the use of restrictive practices/use of restraint and punishment, varies across schools.
  - School systems in Australia are starting to utilise this training since it is considered to be safer, more respectful of the person and fits well with a human rights focus.
- Emphasise the normal rhythms of the child’s life.
- Explore parenting models that the family may use and ensure that interventions support them (such as the Sleepwise program for children with an intellectual disability or autism spectrum disorder, which explores parenting style and their values base and then develops an intervention within the family’s framework).
- BSS practitioners must apply appropriate policies and practices to children and adolescents (Appendix 54).

16.3 Aboriginal and Torres Strait Islanders

- Aboriginal and Torres Strait Islander peoples are the most disadvantaged members of the Australian community, with disability at approximately twice the rate of the general population.
- Disability results from multiple barriers in the Aboriginal community, as well as the wider community, which results in double disadvantage. The National Indigenous reform agreement has resolved to address the needs of Aboriginal people with a disability.
- A significantly larger number of Aboriginal and Torres Strait Islander people have a disability but are not accessing disability services, particularly if services are not culturally responsive. Services can be inclusive by employing Aboriginal staff, providing staff training and ensuring the availability of Aboriginal advocates.
- Be mindful of the worldview of Aboriginal and Torres Strait Islander people in which individuals with a disability are seen to still have roles and responsibilities within the kinship system. Aboriginal families consider themselves to be supportive and accepting of family members with a disability.
BSS practitioners must apply appropriate policies and practices to Aboriginal and Torres Strait Islander people (Appendix 55) in:

- addressing social inclusion
- improving outcomes for Aboriginal and Torres Strait Islander people
- recognising Aboriginal and Torres Strait Islander people as vulnerable
- increasing access through appropriate service delivery arrangements.

### 16.4 Culturally and linguistically diverse backgrounds

- Positive behaviour support emphasises cultural diversity in conceptualising behaviours of concern relative to the cultural context (cultural relativism).
- Barriers to access include: lack of accessible information; communication difficulties; cultural sensitivities; reluctance to acknowledge a disability; need for counselling and referral to appropriate disability support agencies; need for translated information; need for plans to include long-term issues; importance of carer support groups; lack of professional interpreters; and scarcity of services in regional centres.
- ‘Disability’ is socially constructed and so may differ between cultures and religious and cultural beliefs may view disability positively or negatively.
- Language problems can be a barrier when working with carers with some languages not having terms for ‘disability’.
- Culture and ethnicity can strongly influence the expression of behaviours (and symptoms) and the way that the behaviours are interpreted by staff.
- Culturally appropriate services designed and implemented in consultation with people with culturally and linguistically diverse backgrounds and disabilities are essential to accessible service delivery and basic human rights.
- Structured assessment processes may be invalid in terms of cultural bias and normative data.
- Children and adolescents from culturally and linguistically diverse backgrounds may be over-represented as having a disability in schools.
- The socially determined position of men and women in a particular society may have an impact on differences in gender.
- Competent bilingual professional are to be present to facilitate the process, interpretation should be planned and the interpreters be ‘matched’ to their clients.
- Train staff in issues relating to cultural sensitivity and effectiveness.
- Consider the family’s history as some families may have experienced significant transitions in relation to emigration and/or experiences of war.

BSS practitioners must apply appropriate policies and practices to people from Culturally and linguistically diverse backgrounds (Appendix 56) in:

- Understanding people and their needs
- Encouraging participation in decision-making
- Providing culturally relevant and accessible information
- Ensuring a culturally diverse workforce
- Using language services to be effective
- Meeting the specific needs of different communities
- Promoting the benefits of a culturally diverse Victoria.
16.5 Carers and staff: values and skills

The Positive practice framework requires that carers and staff are engaged to develop values and skills supportive of positive behaviour support. There are two primary reasons why implementation of behaviour support plans fail: (1) carers and staff do not know how to implement the strategies or (2) carers and staff do not wish to implement the strategies (Reid and Parsons, 2002).

BSS practitioners need to support ‘the will and the way’ in carers and staff to implement behaviour support plans (Birgden, 2004). Attitude change is considered a precursor of behaviour change; emerging theory of organisational change argues that cognitive or attitude change is required for cultural change. The problem with organisational change management has been the focus on behavioural change (how to do things differently) as opposed to cognitive change (how to think differently about how to do things). It is expected that carers and staff constantly examine their core beliefs and assumptions to make sense of organisational change and to resolve conflict inherent in accepting change (that is, cognitive dissonance). This process is described by Porporino (2001) as ‘sensemaking’ or an ongoing process of adjustment and receptivity to change that is both emotional and cognitive, and so attitudinal. The cognitive schemata about change that carers and staff develop will lead them to either accept or reject change for very personalised reasons. Therefore, relying upon a skills-based approach assumes that carers and staff are motivated to change.

Effective strategies for attitude change (Appendix 57) include persuasive communication strategies and active participation techniques.

BSS practitioners engage in collaboration (Appendix 58). Collaboration with ‘inter-professional’ teams should occur with carers as equal partners, highlighting the focus on stakeholder participation, mutual education and capacity building that supports systems change (Carr et al., 2002). BSS practitioners understand the importance of collaborative relationships (Appendix 58) and collaborative teams (Appendix 58) with the person, carers and staff. Partnership models include family partnership approaches and collaborating with carers in natural settings.

BSS practitioners provide consultation and skills building to carers and staff. Staff and carers require both emotional support (through good teamwork, supervision, debriefing and counselling) and technical support (through skills building in care and treatment).

16.6 Support through consultation

Consultation occurs with carers and staff who support individuals with behaviours of concern. Consultation provides advice and assistance in the planning and development of support services to prevent, reduce or minimise the likelihood of the development of the behaviours of concern (Jenkins, 2006). The consultation is specific to the particular environment and may include a service review, supporting a non-government organisation, or regional planning. Consultation may be assisted by referring to specialist services available in other agencies.

Behaviour support plans are rarely effective if carer or staff implementation and the person’s response to the strategies are not systematically monitored. Effective monitoring requires ensuring that carers and staff know they will be observed, are informed of the purpose, are treated respectfully in the process and receive feedback as soon as possible (Reid and Parsons, 2002).
Based on positive behaviour support, consultation needs to focus on the quality of the environment and what supports it offers to:

- work alongside carers and staff to model and implement interventions
- highlight incremental successes
- facilitate problem-solving approaches to unforeseen circumstances
- facilitate supportive social networks
- be available to assist
- encourage positive behaviour support.

Behaviours of concern may require numerous intervention approaches that can cause significant stress to the person, carers and staff. Carers and staff may therefore experience a range of strong and negative emotional reactions that may lead to restrictive practices and reduced wellbeing. Positive behaviour support endeavours to ensure contextual fit between the behaviour support plan and the resources and wellbeing of those who put it in place. Self-care (Appendix 59) is also important because the work involves an intense focus on the needs of others; self-care leads to less fatigue, greater ability to enjoy life, less emotional overload and burnout and less ‘compassion fatigue’ (Allen, 2009). Mindfulness-based interventions allow carers to develop mechanisms to cope with stress.

### 16.7 Support through skills building

The PPF recognises that carers and staff are critical mediating factors in effective and ethical support (NDTi, 2007) (Appendix 60). The attitudes and motivations are crucial; carers and staff need to view the person in a positive light and this will have a direct effect on the quality of their interaction with them. The most successful services are those where staff are willing to learn and take advice from others and look to wider community resources for opportunities and relationships. In other words, the staff are committed to the person and do not give up on the person when ‘the going gets tough’. BSS practitioners need to provide ongoing support to staff who are directly engaged with the person and nurture such organisational strengths. In particular, carers and staff need to be actively assisted in implementing behaviour support plans (Reid and Parsons, 2002).

It is considered that there is a difference between learning and training. Whichever term is used, learning and/or training requires the development of knowledge and skills that are supported by experientially based application that reinforces the competency of the learner. *Learning* can be considered to be the acquisition of knowledge through observation, discussion and testing of knowledge. *Training* (Appendix 61) takes the learning through to the on-the-job application of the learning. Optimum learning takes place when the person is able to apply the theory to practice and observe change in the workplace. The development of skills requires that the person providing the learning has significant and substantial practice experience in the area of behaviours of concern and familiarity with communication with people with a disability in order to ensure a strong knowledge base and credibility. The approach to skill development should de-emphasise formats relying on the use of ‘lectures’ and instead favour real-life settings such as schools, community residences and worksites, to produce staff competence. Carers and staff should develop an understanding of how a given intervention is contextualised within the broader infrastructure (knowledge of administrative issues, mechanisms for funding, mission statements and interagency collaboration) and provided with the opportunity to rehearse and practice the strategies.
Skills building can utilise a collective leadership model (Appendix 62) that involves a group of staff harnessing the available skills, experience and resources to work together in their communities. The group is led by a team leader (depending upon the setting) and includes an embedded BSS practitioner who ensures service delivery based upon the PPF. Activities such as communities of practice and active learning can further enhance learning.

Staff and carers are to receive managing behaviours training (Appendix 63).

### 17 Review and exit

<table>
<thead>
<tr>
<th>Practice strategy</th>
<th>Review and exit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task</td>
<td>Undertake review and exit planning</td>
</tr>
<tr>
<td>Process</td>
<td>BSS practitioners:</td>
</tr>
<tr>
<td></td>
<td>- Summarise interventions and measure the effectiveness of BSS within the context of achievement towards Goal 1 and Goal 2, ongoing system support and in consultation with the person (and/or their guardian).</td>
</tr>
<tr>
<td></td>
<td>- Determine when review and exit planning should occur.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Timely and effective review and exit planning for people occurs.</td>
</tr>
<tr>
<td>Industry standard</td>
<td>Refer to practice matrix (Appendix 7)</td>
</tr>
</tbody>
</table>

#### 17.1 Review

BSS practitioners are ethically obliged to determine the outcome success of Goal 1 and Goal 2. The functional assessment and behaviour support plan ensures this.

Review (Appendix 64) is the measurement of change to determine the impact or effectiveness of interventions. Outcome success should be determined by: reduced barriers to participation; realisation of the person’s rights, dignity and quality of life; and improved health and safety of the person and others. Review of the referral occurs when Goal 1 (maximise quality of life) and Goal 2 (minimise behaviours of concern) are met.

Very little guidance regarding structured consumer feedback appears to be available. The Victorian Advocacy League for Individuals with Disability Inc. (VALID) (Appendix 65) strongly supports advocacy and have developed the *Having a say* resource manual for people with an intellectual disability.
Feedback (Appendix 66) communicates the information about the process and the effectiveness of the intervention. Hudson et al. (1995) conducted a three-year outcome study on eight BSS teams established in Victoria between 1991 and 1993. The authors found that of 134 completed interventions, there was a good rate of success in reducing or eliminating behaviours of concern, improved skills acquisition and satisfaction expressed by carers.

17.2 Exit planning

The exit criteria depend upon the agreed definition of behaviours of concern and goals of intervention. A re-evaluation of dynamic risk factors may be required.

Once agreed goals have been achieved, the focus shifts to maintenance of change. Planning for the end of the intervention commences as part of the initial engagement and assessment process and should be reflected in the behaviour support plan. Throughout the practice pathway the BSS practitioner should be preparing the person, their family, carers and significant others for the eventual cessation of service.

After the review process (Appendix 64) is completed and it is agreed that the exit criteria as reflected in the behaviour support plan has been met, the referral is closed and the service ends. This does not preclude re-referral at a later stage should the person’s circumstances change.
Part I: Effective governance

Governance is a system through which organisations ensure they are accountable for continuously improving the quality of their services and safeguarding high standards. It includes corporate functions, strategic direction, managing risk, improving performance and ensuring compliance with standards and statutory requirements.

Clinical governance occurs within a broader context of broader governance role of organisations.

For the purpose of BSS ‘clinical governance’ is the system by which managers, practitioners and staff share responsibility and accountability for quality, continuously improving, minimising risks and fostering an environment of excellence…

18 Policy and standards


18.1 One DHS standards

The department is transitioning to the One DHS standards (Appendix 67). These standards replace the Industry Standards for Disability Services, the Outcome Standards for Disability Services, the Registration Standards for Community Service Organisations and the Homelessness Assistance Service Standards. Full implementation of the One DHS standards will occur by July 2012.

An interim Behaviour Support Services practice framework standards matrix (Appendix 7) has been developed that matches each key practice task with the Standards for Disability Services in Victoria and the One DHS standards.

18.2 Behaviour support services performance framework: individual and organisational outcomes measures

Positive behaviour support is an applied science and BSS practitioners function as scientist-practitioners:
- as practitioners to supervise organisational outcome measures to ensure process standards
- as scientists to supervise individual outcome measures to ensure outcome standards.

1 Adapted from Department of Human Services 2005
A performance framework identifying individual and organisational outcomes measures will be considered to assist practitioners to monitor performance within the context of the practice model.

1. **Individual outcome measures** – the influence and impact upon the political, social, cultural, economic and physical wellbeing of people with a disability and areas of life important to them (Goal 1 and Goal 2) of the PPF = outcome measures (Appendix 68)

2. **Organisational outcome measures** – the organisational systems and processes that are good practice and are required to ensure better outcomes for people with a disability (the PPF) = process measures (Appendix 68).

### Practice principles

**No. 6 Social validity**
Define success by its objective effectiveness, practicality, desirability, contextual fit and subjective effectiveness (quality of life and behaviours of concern) as viewed by stakeholders.

**No. 8 Multicomponent intervention**
Recognise that multiple functional and structural variables influence behaviours of concern and require multidimensional strategies.

**No. 10. Flexibility in scientific practice**
Employ a systematic data source to evaluate and guide intervention utilising qualitative data, ratings, interviews, questionnaires, logs, self-reports, correlational analyses, naturalistic observations and case studies for data collection in uncontrolled settings.

### Practice strategy

<table>
<thead>
<tr>
<th>Task</th>
<th>Ensure effective governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Governance is supported through:</td>
</tr>
<tr>
<td></td>
<td>– professional development – competency-based orientation and training (to address training needs)</td>
</tr>
<tr>
<td></td>
<td>– clinical supervision – at least fortnightly supervision to ensure practice outcomes (to reinforce training)</td>
</tr>
<tr>
<td></td>
<td>– peer support meetings – regular multidisciplinary meetings (to provide group supervision and reinforce training).</td>
</tr>
<tr>
<td></td>
<td>2. Monitoring and evaluation is undertaken against:</td>
</tr>
<tr>
<td></td>
<td>– the PPF</td>
</tr>
<tr>
<td></td>
<td>– process and outcome standards.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>1. Adherence to process standards (delivery of practice in line with the PPF)</td>
</tr>
<tr>
<td></td>
<td>2. Adherence to outcome standards (meeting Goals 1 and 2 of the PPF)</td>
</tr>
<tr>
<td>Standards</td>
<td>Refer to interim practice matrix (Appendix 7) and BSS individual and organisational outcome measures (outcome measures and process measures) (Appendix 68)</td>
</tr>
</tbody>
</table>
Figure 7 presents a diagrammatic representation of BSS process and outcome measures to achieve the goals of maximise quality of life (Goal 1) and minimise behaviours of concern (Goal 2).

**Figure 7: BSS process and outcome measures**

19 **Clinical leadership**

Successful clinical leaders act as change agents who support carers and staff to effectively implement programs by ensuring a contextual fit between the person and their environment. Change agents have: professional credibility; intimate knowledge of the agency and its staff; support of the senior agency officials and direct care staff; professional orientation and values compatible with the agency’s mandate and goals; and a history of successful program implementation in the agency’s program area. They continue until there are clear performance indices that management and staff are able to maintain the delivery of the program with a reasonable degree of competence (Gendreau et al., 2002).

Effective change agents employ:
- persuasion
- motivational interviewing techniques (such as empathy, discrepancy, non-confrontational, self-efficacy support)
- authority (but do not use threats)
- reinforcement (such as praise)
- modelling
- systemic problem solving
- advocacy/brokerage.
Strong clinical leadership requires ongoing professional development (Appendix 69) regarding positive behaviour support.

The Australian Health Practitioner Regulation Agency (AHPRA) (Appendix 70) was established in July 2010 and is responsible for the registration and accreditation of 10 health professions across Australia, including psychology, occupational therapy and nursing (but not speech therapy). Psychologists are required to engage in a program of continuing professional development to develop the required personal qualities (values and attitudes) and maintain, improve and broaden their knowledge, expertise and competence (skills). A minimum standard for psychologists per year is 30 hours of professional development and 10 hours of individual or group peer supervision. The nursing code of ethics does not include professional development or clinical supervision and the occupational therapy guidelines have not yet been established at December 2010.

20 Promoting good practice

Professional practice can be enhanced by a community of practice (Appendix 71).

The Australasian Society for the Study of Intellectual Disability (ASSID), following a five-year consultation across Australia and New Zealand, published the Australasian code of ethics for direct support professionals (McVilly and Newell, 2007). This document outlines a range of principles to consider in the design and delivery of contemporary disability services. These principles include:

- professional competence
- evidence-based practice
- professional conduct
- self-care and the care of colleagues
- collaboration
- accountability
- consent
- confidentiality
- relationships
- person rights
- advocacy
- skills development and lifelong learning.

In addition to professional codes, this document can be used to frame standards for clinical supervision.
Practitioners should function as scientists and adhere to basic assumptions about behaviour (Appendix 72).

Practitioners should gather data regarding efficacy. Positive behaviour support applies a problem-solving approach using systematic data collection to evaluate and guide intervention and support, in determining efficacy in maximising quality of life (Goal 1) and minimising behaviours of concern (Goal 2). These data include qualitative measures, quantitative measures and econometric measures (Appendix 73).

BSS practitioners determine whether outcome success (Appendix 74) is achieved.
Part J: Appendices

Appendix 1: Behaviour support services policy

BSS policy
(in development at time of publication)

Appendix 2: Disability Services policy and legislation

Disability Services access policy 2009
The Disability Services access policy describes to people with a disability and their support networks how they may access disability services, provides disability support providers with clear guidance about their roles and responsibilities in relation to considering a person’s access to disability services and describes the process for determining, in a fair manner, the priority for access to disability services.


Disability Act 2006 (Vic)
The Disability Act establishes the compliance framework for quality assurance. It identifies the standards and performance measures and mandates compliance and the authority for the Department of Human Services to monitor and take action in cases of noncompliance.


Appendix 3: Social model of disability

A social model definition of disability
There are various current definitions. In the UK, disability tends to be seen as a social construct, created by the environment rather than individual attributes and requiring social change; society disables individuals with impairments, which results in unnecessary isolation and exclusion from full participation. In the US, disability tends to be seen as the experience of discrimination and segregation through sensory, attitudinal, cognitive, physical and economic barriers, similar to other oppressed minority groups. Either way, society needs to include all peoples regardless of their individual differences.


Return to Section 2 | Return to Section 3.4
Return to Section 3.1
Return to Section 3.1
Return to Section 3.3
Appendix 4: International Classification of Functioning, Disability and Health

**International Classification of Functioning, Disability and Health**

In 2001 WHO endorsed the International Classification of Functioning, Disability and Health (ICF). The ICF classifies health and health-related domains in terms of body functioning, activity and participation and environmental factors. The emphasis is on function rather than the aetiology of condition or disease and the definition is relevant across cultures, age groups and genders. The ICF therefore ‘mainstreams’ the experience of disability as a universal human experience and so integrates the medical and social model of disability. [www.who.int/classifications/icf/en](http://www.who.int/classifications/icf/en)


Appendix 5: Human rights

**Convention on the Rights of Persons with Disability**

The UN Convention on the Rights of Persons with Disability adopts a social model of disability in defining it as interactive – impairments interacting with various social barriers may hinder a person’s full and effective participation in society on an equal basis with others.

Human rights goals of habilitation and rehabilitation (s. 26) incorporate three goals:

- attain and maintain full inclusion and participation in all aspects of life
- attain and maintain maximum independence
- attain and maintain full physical, mental, social and vocational ability.


**The Victorian Charter of Human Rights and Responsibilities**

The *Victorian Charter of Human Rights and Responsibilities* is a law that protects the human rights of all people in Victoria. The *Charter* complements other laws – such as equal opportunity legislation – by setting out a familiar list of 20 rights that assist all people to live with freedom, respect, equality and dignity.

The Charter places obligations on public authorities such as the department to act in a way that is compatible with the human rights contained in the Charter and to give relevant human rights proper consideration when making decisions.


Appendix 6: Policy and funding

**Department of Human Services policy and funding plan 2010–2012**


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### Appendix 7: Standards matrix

#### Standards matrix

<table>
<thead>
<tr>
<th>One DHS standards</th>
<th>1. Empowerment: People’s rights are promoted and upheld</th>
<th>2. Access and engagement: People’s rights to access transparent, equitable and integrated services is promoted and upheld</th>
<th>3. Wellbeing: People’s right to wellbeing and safety is promoted and upheld</th>
<th>4. Participation: People’s rights to choice, decision making and to actively participate as a valued member of their chosen community is promoted and upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Service access – fair and equitable practices that are consistent with funding obligations, applicable legislation and the purpose of the service are applied when managing and allocating resources</td>
<td>13.2. Manage referrals (allocate referrals)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Individual needs – planning and support is tailored, flexible, responsive and appropriate to the individual</td>
<td>13.3. Referral: assess risk (undertake a risk assessment)</td>
<td>14. Behavioural assessment (provide a BSS assessment report)</td>
<td>15. Contemporary interventions (deliver contemporary intervention strategies)</td>
<td></td>
</tr>
<tr>
<td>3. Decision making and choice – support options are planned, developed, implemented and reviewed in a manner that is responsive to the decisions, choices and aspirations of individuals</td>
<td>17. Review and exit (undertake review and exit planning)</td>
<td></td>
<td>13.1 Engage the person</td>
<td></td>
</tr>
<tr>
<td>4. Privacy, dignity and confidentiality – are respected and maintained</td>
<td></td>
<td>15. Contemporary interventions (deliver contemporary intervention strategies)</td>
<td>16. Inclusive support (deliver support that is inclusive)</td>
<td></td>
</tr>
<tr>
<td>5. Participation and integration – support options are planned, developed, implemented and reviewed in a manner that builds opportunities for individuals to participate in the life of the community</td>
<td></td>
<td>17. Review and exit (undertake review and exit planning)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Positive practice framework: A guide for behaviour support services practitioners
### One DHS standards

| 1. Empowerment: People’s rights are promoted and upheld |
| 2. Access and engagement: People’s rights to access transparent, equitable and integrated services is promoted and upheld |
| 3. Wellbeing: People’s right to wellbeing and safety is promoted and upheld |
| 4. Participation: People’s rights to choice, decision making and to actively participate as a valued member of their chosen community is promoted and upheld |

| 6. Valued status – support options are planned, developed, implemented and reviewed in a manner that recognises the skills, abilities and potential of individuals and enables the achievement of valued roles in the community |
| 7. Complaints and disputes – are addressed promptly, fairly and respectfully without compromising services to the individual |
| 8. Service management – management and governance practice is sound, accountable and consistent with current disability policy and practice |
| 9. Freedom from abuse and neglect – supports are provided in safe and healthy environments that support individuals to exercise their legal and human rights. |

| 17. Review and exit (undertake review and exit planning) |
| 13.2 Manage referrals (allocate referrals) |
| 18.2 Victorian standards for disability services (ensure effective governance) |

Information on the One DHS project can be found at:

### Appendix 8: Engagement

**Engagement**


In reviewing 114 behaviour support plans in which restrictive practices were being applied, the OSP found only 52 per cent (2008–09) and 53 per cent (2007–08) of people with a disability and 65 per cent (2008–09) of guardians had been consulted in their development and approval.
Appendix 9: Advocacy

Advocacy resources
The Disability Action Resource Centre (DARU)
The Disability Action Resource Centre (DARU) is a statewide service established to resource the disability advocacy sector in Victoria. The DARU website contains an advocacy resource map where you can search for advocacy services and organisations via region.
http://advocacyagencies.daru.org.au

Office for Disability, Disability Advocacy Program
The Office for Disability Advocacy Program also provides further information on advocacy service in Victoria and a list of funded organisations.

Appendix 10: MacArthur Treatment Competence Study

MacArthur Treatment Competence Study
The MacArthur Competence Assessment Tool – Treatment (MacCAT-T) is a clinical tool. The MacCAT-T assesses understanding, appreciation and reasoning. Understanding determines the patient’s ability to paraphrase what has been disclosed about the disorder, the recommended treatment and the treatment’s risks and benefits. Appreciation explores whether the patient fails to appreciate the disorder and that treatment may have some benefit, based on delusional or otherwise distorted perceptions. Reasoning rechecks the patient’s first choice and reasoning including a no-treatment option, generating consequences, final choice and logical consistency of choice.


Appendix 11: Referral information

Preliminary referral information

- file search
- residential, day/community services and respite arrangements
- weekly structure of the person including their residential, day/community, respite and social/leisure arrangements
- intellectual functioning
- adaptive behaviour
- existing diagnoses
- involvement of other professionals
- previous and current assessments and interventions
- recent changes in circumstances
- stakeholder’s perception of the person’s needs and behaviours of concern
- ensure that fundamental human rights are in place – a safe living environment, adequate social and community access, regular activities and respect from staff and other providers.

Special Projects Team: Directorate of Learning Disability Services, Bro Morgannwg NHS Trust 2010, A hitchhiker’s guide for the specialist behaviour team (operational guidance), GIG CYRMU, Wales.

<table>
<thead>
<tr>
<th>Intensity of behaviour</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency of behaviour</strong></td>
<td><strong>Low</strong></td>
<td><strong>High</strong></td>
</tr>
<tr>
<td>Low</td>
<td>Most commonly overlooked yet have potential over time to adversely effect the health, wellbeing and quality of life of person and those supporting them</td>
<td>Can cause fear and apprehension among family and support staff and give rise to unnecessarily restrictive practices ‘just in case’ the behaviour occurs</td>
</tr>
<tr>
<td>High</td>
<td>Commonly regarded as ‘nuisance’ behaviours that are often tolerated and subsequently rarely addressed effectively, potentially resulting in/contributing towards more serious behaviours</td>
<td>Most commonly recognised as behaviours of concern</td>
</tr>
</tbody>
</table>

Appendix 12: Risk assessment

Risk assessment screen

Clinical indicators for risk of aggression in people with a disability includes:

- males aged 15–34 years
- aggression as the single most form of behaviour of concern
- aggression is persistent over time (past behaviour is a predictor)
• mental health problems
• co-occurrence of self-injury and other behaviours of concern
• life events – losses and changes, physical and sexual abuse, bereavement, service transitions
• impaired receptive and expressive communication skills
• poor impulse or anger control
• failure to recognise emotional cues.

Environmental risk factors can be further divided between immediate situational and system-level factors (although the following information is based on institutions with general population individuals)

1. Situational risk factors:
   – crowded and hot environment
   – few structured activities in place
   – inconsistent approaches by carers
   – violent cues present – accessible weapons and aggressive behaviour modelled by carers
   – purposeful aggressive behaviour
   – pressure from peers to be violent
   – authoritarian, rejecting carers
   – aversive demands presented by carers.

2. System-level risk factors:
   – inexperienced staff
   – high usage of temporary staff
   – expectations of violence.

Risk assessment should include strategies to prevent escalation:
• describe precisely the frequency, duration and intensity of the behaviour
• indicate who and what is at risk
• identify any behavioural precursors that may escalate the risk
• identify any aspects of the environment associated with increased likelihood of risk
• determine risk to self and others
• consider existing risk management strategies.


Appendix 13: Health screening resources

**Health screening resources**

*IASSID health guidelines for adults with an intellectual disability* at
<www.iassid.org/pdf/healthguidelines.pdf>

Management guidelines: Developmental disability by the Therapeutic Guidelines Group in Melbourne <www.tg.org.au/?sectionid=93>
Comprehensive Health Assessment Program (CHAP)

The Comprehensive Health Assessment Program is a system for providing comprehensive medical histories for patients with disabilities. The information is stored in one central location, completed by the patient with their carers and practitioners. Further information on the CHAP in the context of client residential health plans can be found in part 5 of the Residential services practice manual at: http://intranet.dhs.vic.gov.au/resources-and-tools/guides-and-manuals/residential-services-practice-manual

Appendix 14: Mental health screening tools

Mental health screening tools

Psychiatric Assessment Schedules for Adults with Developmental Disabilities checklist (PAS-ADD) (revised)

Purpose: A 25-item questionnaire designed to collect data on an individual’s mental health. The PAS-ADD may be used by families and care staff and aims to assist them to decide whether further assessment of an individual’s mental health may be warranted (in other words, identifying individuals at risk). The checklist produces three scores relating to: affective or neurotic disorder; possible organic condition (including dementia); and psychotic disorder. It is also suitable for exploring conditions in autism spectrum disorder.


Reiss Screen for Maladaptive Behaviour

Purpose: A psychiatric screening interview to be used with individuals with an intellectual disability that may be administered by carers or family. The test consists of 36 items identifying symptoms of psychiatric disorder screened in three ways (severity of challenging behaviour, diagnosis and rare but significant symptoms such as suicidal behaviour). A ‘positive’ result may indicate that the person needs to referred for further professional evaluation.

www.reiss-screen.com/shortform.htm

Psychopathology Instrument for Mentally Retarded Adults (PIMRA)

Purpose: Contains 56 items that are distributed across eight clinical scales including schizophrenia, affective disorder, psychosexual disorder, adjustment disorder, anxiety disorder, somatoform disorder, personality disorder and inappropriate adjustment. The instrument consists of two structured interview schedules: ‘self’ (an interview with the person) and ‘other’ (interview with the carer/staff).


Developmental Behaviour Checklist (Adult version) (DBC-A)

Purpose: An instrument for assessing behavioural and emotional problems of adults with developmental and intellectual disabilities. The assessment provides an overall measure of
behavioural/emotional disturbance and categories of disturbance across six dimensions (disruptive, self-absorbed, communication disturbance, anxiety/antisocial, social relating and depressive).


**Glasgow Depression Scale for People with a Learning Disability (GDS-LD)**

Purpose: A 20-item scale used for screening, monitoring progress and appraising outcomes for people with an intellectual disability who may have a depressive illness.


**Glasgow Anxiety Scale for People with Intellectual Disability (GAS-ID)**

Purpose: A self-rating scale to measure anxiety symptoms in people with a mild intellectual disability. The scale includes cognitive, behavioural and somatic symptoms associated with anxiety disorders. It is not intended as a diagnostic tool but may be used to indicate that further assessment is required by a mental health professional.


**Centre for Developmental Disability Health Victoria, Depression in Adults with Intellectual Disability, Checklist for carers**

Purpose: The depression checklist is for use by carers, in particular paid support staff. It is intended to be completed on behalf of adults who are unable to report their own feelings or symptoms because of severe communication impairment.

The checklist is not a diagnostic tool; it provides information for use by a medical or mental health practitioner in screening for possible depression or related disorders in adults who are unable to self-report. The checklist is not a substitute for a clinical assessment. Health professionals are responsible for conducting individual clinical assessments. The information obtained by a carer who knows an individual well completing the checklist may assist the health professional in this clinical assessment.

There is a short registration process to access the checklist, which can be accessed here: www.cddh.monash.org/research/depression

**Further resources:**


More specific tools regarding dementia in Down syndrome, anxiety, depression and other conditions are described by the Australian Psychological Society in Appendix A (see source below) and indicate areas that may require further specialist assessment.


NADD – National Association for Persons with Developmental Disabilities and Mental Health Needs

NADD is the leading North American body for providing professionals, educators, policymakers and families with education, training and information on mental health issues relating to people with intellectual or developmental disabilities.

www.thenadd.org

Acquired brain injury

Acquired brain injury requires an assessment as part of a comprehensive protocol that includes:

- cause of brain injury – historical accounts, neuropsychological assessments and discharge summaries
- cognitive strengths and deficits
- time post-injury
- pre-morbid personality profile
- current comorbidities
- current accommodation setting
- existing psychosocial supports
- risk factors.


Overt Aggression Scale Modified for Neurorehabilitation (OAS-MNR)

Purpose: derived from use with psychiatric populations. It allows for: (1) objective recordings of aggressive behaviour; (2) frequency of aggressive behaviour; (3) severity of aggressive behaviour on a four-point Likert scale; (4) clear verbal descriptions of aggression weighting to enhance reliability and validity; and (5) observer recordings of efforts to manage aggressive behaviour.

Appendix 15: Risk assessment tools

Risk assessment tools

Note: While this area is still under development, the tools are nevertheless useful to guide clinical judgement.

Assessment of Risk and Manageability of Intellectually Disabled Individuals who Offend (General version): ARMADILLO-G

For forensic populations, the ARMADILLO-G assesses the risk and risk manageability for offending behaviour including violent, challenging and sexual behaviour in offenders with intellectual disability. It is primarily based on a review of the client file and interviews with significant others; the person need not necessarily be interviewed. The manual provides key questions and a scoring key for 24 domains such as goal setting, compliance with supervision and treatment, pro-criminal attitudes, self-efficacy, relationships, mental health, employment, communication, attitude towards the client, and changes in access to various risk and supports. At 2010 the tool is still under development and is currently available from Dr Doug Boer: <drdoug@waikato.ac.nz>.


Assessment of Risk and Manageability of Intellectually Disabled Individuals who Offend – Sexually: ARMADILLO-S

The ARMADILLO-S is a similar tool combining the SVR-20 and the Static-99. It determines: stable client items (such as supervision and treatment compliance, sexual preoccupation, impulsivity, mental health and unique lifestyle considerations); stable environment items (such as attitudes towards the client, communication among support people, consistency of supervision, unique considerations such as staff modelling); acute client items (such as changes in supervision, treatment, sexual drive and coping strategies); and acute environmental items (changes in social relationships, victim access, social relationships, situational changes and unique considerations). At 2010 the tool is still under development and is currently available from Dr Doug Boer: <drdoug@waikato.ac.nz>.

Boer, D and Haaven, J 2010, Assessment of Risk and Manageability of Intellectually Disabled Individuals who Offend – Sexually (The Armadillo-S).

Dynamic Risk Assessment and Management System (DRAMS)

The tool anticipates the likelihood of a person being involved in a serious incident so that additional supports can be put in place or a program temporarily suspended.

Administration: 31 items administered collaboratively with the person in an understandable format using traffic-light pictorial cues as the rating scale. The Victorian Office of the Senior Practitioner was trialling the tool at 2009.

Steptoe, LR, Lindsay, WR, Murphy, L and Young, SJ 2008, ‘Construct validity, reliability and predictive validity of the dynamic risk assessment and management system (DRAMS) in offenders with intellectual disability’, *Legal and Criminological Psychology*, 13, 309–321.

For a detailed plan for conducting risk assessments see:


A range of risk assessment tools and offence-related behaviour/attitude scales are provided at:


**References**


<www.dhs.vic.gov.au/__data/assets/word_doc/0010/607654/osp_clinicalriskassessriskmanageinpeoplewithintellectdis_word_0510.doc>

The Kinsella approach considers and seeks to balance the dimensions of ‘personal safety’ and ‘personal happiness’: <www.paradigm-uk.org>.


Appendix 16: Communication assessment tools

**Communication assessment tools**

**Functional Assessment of Comprehension Skills (FACS)**

Purpose: Assesses communication interactions in everyday contexts and the role of communication in the management of behaviours of concern.


**Checklist of Communication Competencies (Triple C)**

Purpose: Designed to sensitise communication partners to potentially communicative behaviours and identify communication strategies to support the person with behaviours of concern. The Triple C assesses both pre-intentional (reflexive, reactive and proactive) and intentional (informal, formal and referential) speech.


**Reynell Developmental Language Scales: Comprehension and Expressive Language Scales III**

Purpose: A 62-item test that was constructed to reflect knowledge of language impairment and structural and lexical development in children's language. The RDLS III assesses the comprehension of spoken language (comprehension scale) and the use of spoken language (expressive scale).


**FCP-R Functional Communication Profile – Revised (FCP-R)**

Purpose: The Functional Communication Profile assesses the communication skills in individuals across age ranges with developmental and acquired delays across 11 areas: sensory, attentiveness, receptive language, expressive language, pragmatic/social, speech, voice, oral, fluency and non-oral communication. The FCP-R evaluates the person’s ability, severity of impairment, mode of communication, degree of independence versus assistance or prompting and overall skills.

Administration: Approximately 45–90 minutes.


Appendix 17: Sensory processing problem resources

**Sensory processing problem resources**

Appendix 18: Phenotype information

Phenotype information
Currently recommended assessment, intervention and support practices are provided by the Society for the Study of Behavioural Phenotypes: [www.ssbp.org.uk](http://www.ssbp.org.uk)

Appendix 19: Context tools

Context tools

**Contextual Assessment Inventory (CAI)**

Purpose: The CAI filters contextual variables to guide the direction of subsequent assessment. A detailed interview schedule is designed to provide a systematic appraisal of a number of contextual variables (setting events) that may contribute to behaviours of concern. The inventory contains 93 statements describing possible contextual variables and the statements are spread over four categories: social/cultural (subcategories of negative interactions and disappointments); nature of task or activity (subcategories factors related to tasks or activities and daily routines); physical (subcategories uncomfortable environment and changes in the environment); and biological (subcategories medication, illness and physiological stress).

Respondents rate on a five-point Likert scale how likely it is that the person would display behaviours of concern in response to the situation described in each item. Items rated as 4 or 5 are identified as potentially significant and requiring further analysis (such as via direct observation methods).

Administration: The CAI takes approximately 25 minutes to complete and reliability is improved when the interviewer completes a separate inventory for each behaviour identified.


**The Stress Survey Schedule for individuals with autism and pervasive developmental disabilities (PDD)**

Purpose: A tool used to increase awareness if environmental stressors that impact on people with autism spectrum disorder. The schedule may be used to determine a person’s needs and develop interventions that aim to modify stress reactions as well as a communication tool for staff and parents to increase their awareness of stressful situations.


**Emotional Reactions to Challenging Behaviours Scale (ERCBS)**

Purpose: Designed to assess carer stress (in the form of typical emotional reactions experienced by carers as part of their work) in response to behaviours of concern. The ERCBS consists of 23 emotional reactions that carers have said they experience when they work with people with behaviours of concern. Respondents are asked to rate how they typically feel in a given situation,
by considering each emotion separately and rating on a five-point Likert scale that assesses both negative and positive emotional responses.

Administration: The scale is to be completed within the first six weeks of involvement and at discharge/closure for pre- and post-evaluation.


**Emotional Reactions to Behaviours of Concern Scale**

Instructions:
Below is a list of emotions that caregivers have said they experience when they have to work with people who display behaviours of concern. We want to know how you typically feel in this situation when working with [INSERT NAME]. Think of your own recent experiences of behaviours of concern displayed by [INSERT NAME]. Consider each of the emotional reactions and select the responses next to each item that best describes how you feel when working with [INSERT NAME].

For each time, tick the box that is most relevant for you. For example, if there have only been a few occasions when you have felt ‘shocked’ by [INSERT NAME] behaviour then tick the ‘yes, but infrequently’ box.

<table>
<thead>
<tr>
<th></th>
<th>No, never</th>
<th>Yes, but infrequently</th>
<th>Yes, frequently</th>
<th>Yes, very frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Shocked</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Confident</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Guilty</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Comfortable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Afraid</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Angry</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Invigorated</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Incompetent</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Happy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Frustrated</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Helpless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Self-assured</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Disgusted</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Relaxed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Resigned</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Frightened</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Cheerful</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. Humiliated</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. Betrayed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. Sad</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22. Excited</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23. Nervous</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Appendix 20: Adaptive behaviour scales


Purpose: Designed to provide an assessment of a person’s strengths and needs in relation to adaptive skills. The assessment consists of two parts, although Part One is used most frequently due to Part Two being deemed unreliable (Special Projects Team, 2010). Part One consists of 10 categories: independent functioning; physical development; economic activity; language development; numbers and time; domestic activity; prevocational/vocational activity; self-direction; responsibility; and socialisation.


Vineland Adaptive Behaviour Scales II (Vineland-II)

Purpose: A measure of adaptive behaviour from birth to adulthood. Vineland-II is used to diagnose developmental disabilities, for assessing the personal and social skills needed for everyday living and for developing educational and treatment plans. Broad domains include: communication, daily living skills, socialisation, motor skills and a maladaptive behaviour index.


Adaptive Behaviour Assessment System Second Edition (ABAS-II)

Purpose: The ABAS-II assesses three general areas of adaptive behaviour (conceptual, social and practical). It also assesses 10 specific adaptive skills areas (communication, community use, functional academics, home living, health and safety, leisure, self-care, self-direction, social, work). The ABAS-II also evaluates how individuals respond to the daily demands from the environment.

Harrison, PL and Oakland, T 2003, Adaptive Behaviour Assessment System (2nd edn), Pearson Assessment Minneapolis, MN.

Scales of Independence Behaviour – Revised (SIB-R)

Purpose: A comprehensive measure of adaptive and problem behaviours that assesses functional independence and adaptive functioning across school, home, employment and the community. The instrument has been designed to provide for individual evaluation, program planning, selection, placement and to assess service needs. The SIB-R yields two scale scores: adaptive behaviour full scale score and the problem behaviour scale score. Different rating systems are used for the two scales: the adaptive behaviour items (the extent to which the individual performs a task completely and independently) and the problem behaviour scale (the frequency and severity of
each behaviour). A support scale score is based on information obtained from the other two scales and indicates an approximate level of support that the person may need in order to be independent in a number of areas.


**Comprehensive Test of Adaptive Behaviour – Revised (CTAB-R)**

Purpose: Developed to assess self-help skills, home living skills, independent living skills, social skills, sensory and motor skills, academic and language concepts. The CTAB-R also yields a composite total score.


**Autism Spectrum Screening Questionnaire (ASSQ)**

Purpose: A 27-item checklist for assessing symptoms characteristic of Asperger's syndrome and other high-functioning autism spectrum disorders in children and adolescents with normal intelligence or mild mental retardation. It is scored on a three-point scale and covers areas such as social interaction, communication problems, restricted and repetitive behaviour and motor clumsiness. The ASSQ is not intended for diagnostic use but as a screen for a comprehensive assessment.


**The Inventory for Client and Agency Planning (ICAP)**

Purpose: Measures adaptive (motor, social and communication, personal living and community living skills) and maladaptive behaviour (internalised, externalised, asocial and general). The ICAP also enables the gathering of additional information (such as demographic characteristics, diagnoses, residential placement and social/leisure activities). This information, in addition to a generated total service score made up of a combined measure of adaptive and maladaptive behaviour, is used to indicate the overall need for care, supervision or training required.


Appendix 21: Quality of life scales

**Classification and Assessment of Support Needs (I-CAN)**

Purpose: Assesses and describes the supports needed to achieve person-centred dreams and goals. The I-CAN is a web-based assessment tool that is scored automatically and generates a report online, with cost estimation and needs comparison functionality. The assessment utilises a semi-structured group interview format, with domains across *health and wellbeing* (including physical health, mental and emotional health, and behaviour of concern) and *activities and...*
participation (including communication, self care and domestic life, interpersonal interactions and relationships, community, and social and civic life).

Arnold, SRC, Riches, VC, Parmenter, TR, Llewellyn, G, Chan, J and Hindmarsh, G 2009, I-CAN: Instrument for the classification and assessment of support needs, instruction manual V4.2. Centre for Disability Studies, Faculty of Medicine, University of Sydney, Australia.

www.i-can.org.au

Reiss Profile for Human Needs (Intellectual Disabilities version) (RMP-ID)
Purpose: The Reiss Profile of Human Needs assesses 12 human needs and holistically focuses on the individual. It is recommended for all individuals with an intellectual disability from the ages of 12 years onwards.

Administration: 10 minutes.


Guernsey Community Participation and Leisure Assessment (GCPLA)
Purpose: Gathers information about the quantity and quality of community-based activities, contacts and leisure activities. The GCPLA identifies 53 potential activities or contacts that the person may access, divided into six categories: services; public transport; indoor leisure; sport and recreation; social; and facilities/amenities. Each activity is operationally defined to indicate frequency of contact or participation and level of support required by the person to participate.


The Life Experiences Checklist (LEC)
Purpose: Used to explore the person’s quality of life. The LEC consists of five categories each (home, leisure, relationships, freedom and opportunities) containing 10 items. The score for each category is then totalled and an overall score is obtained. The scores for each of the categories can then be compared with percentages of the general population participating in the specific life experiences.


The Mood, Interest and Pleasure Questionnaire (MIPQ)
Purpose: A 25-item questionnaire draws on proxies to evaluate the subjective wellbeing of persons with profound and multiple disabilities over a two-week period. The MIPQ is considered a valid and reliable instrument. An adapted version (Petry et al., 2010) assesses ‘positive mood’ (nine items), ‘interest’ (seven items) and ‘negative mood’ (seven items).

Appendix 22: Is functional assessment an effective and ethical approach?

Is functional assessment an effective and ethical approach?

Three meta-analyses have found that functional assessment explains behaviours of concern and contribute to more powerful interventions for children and adults with intellectual disability and will improve the likelihood of success for people with autism spectrum disorder.

References


Appendix 23: Measures of behaviour

Measures of behaviour

Form of behaviour

Internalised behaviours

- Withdrawn or inattentive behaviours (such as appearing shy, easily distracted, fearful, lacking motivation, constantly tired, psychiatric diagnoses)
- Repetitive and unusual behaviours that impede daily activities (such as pacing, sucking fingers or objects, rocking, twirling)
- Self-injurious behaviours that have the potential to cause the person harm (such as head banging, pulling/pulling out own hair, picking at skin, hitting self)
- Disruptive behaviour that interfere with the activities of other people (such as teasing, yelling, interrupting, clinging)
- Being destructive to property and objects (such as hitting, throwing, burning)
Positive practice framework: A guide for behaviour support services practitioners

- Being hurtful to others in causing physical or psychological harm (such as hitting, kicking, verbally abusing, punching)

**Externalised behaviours**

- Being uncooperative and includes behaviours that involve refusal to comply with reasonable requests (such as performing chores, take it in turns in a group situation, adhering to the law)
- Offensive behaviours that offend, embarrass or upset others who observe/hear them (such as swearing, public masturbation, inappropriate social touching, spitting, child sex offences)

**Frequency of behaviour**

- Never or rarely
- Less than once a month
- 1–3 times per month
- 1–6 times per week
- 1–10 times per day
- 1 or more times per hour

**Intensity of behaviour**

- Not serious/not a problem
- Slightly serious/a mild problem
- Moderately serious/a moderate problem
- Very serious/a severe problem
- Extremely serious/a critical problem


Return to Section 14.1.3

**Appendix 24: Functional assessment tools**

**Functional assessment tools**

**Functional Assessment Interview (FAI)**

**Purpose:** Comprehensive schedule designed to identify key variables that affect a person’s behaviour. The FAI has 11 major sections: descriptions and topographies of behaviours; ecological/setting events; antecedent events (setting events and discriminative stimuli); maintaining consequences; efficiency of behaviours; functional alternatives to challenging behaviours; the person’s primary communication skills; approaches that should and should not be used when supporting the person; possible positive reinforcers; the history of behaviours; and previous intervention strategies. Section 12 provides an opportunity for a formulation to be constructed.

**Administration time:** Approximately 45–90 minutes, although may take longer depending on the number and complexity of the behaviours identified.


### The Setting > Triggers > Actions > Results (STAR) method

**Purpose:** Represents a further development of the ABC method while incorporating ecological assessment (setting events) to understand the context to the behaviour of concern. The six components of the STAR method are:

- **date**
- **time**
- **setting** – What happened immediately before the incident? Where? Who was there? What was happening?
- **triggers** – What occurred immediately prior to the incident
- **actions** – What did the person do? What was the incident?
- **response** – What happened as a consequence of the incident?


<table>
<thead>
<tr>
<th>Setting</th>
<th>Triggers</th>
<th>Actions</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe where the incident took place or where the person had been.</td>
<td>Describe who was there and what they were or were not doing at the time that the incident occurred.</td>
<td>Describe precisely what happened. What did the behaviour look like? Sound like? Feel like? Write it out like stage direction for a play so someone who has never seen it could act it out accurately.</td>
<td>Describe the outcome. What did the person do? What did others do? How did the situation or expectations change from how it was before the incident?</td>
</tr>
<tr>
<td>What were the expectations/plans at the time?</td>
<td>What happened in the lead up (physically, socially and so on)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Motivation Assessment Scale (MAS)

**Purpose:** Develops an understanding of the variables that maintain behaviours of concern. Respondents (family member or staff) rate the likelihood of a specific behaviour occurring in 16 antecedent conditions, by completing a seven-point Likert-type scale. The antecedent conditions are organised into four motivational categories that suggest the possible motivation underlying the person’s behaviour: sensory stimulation, social contact, access to tangible items, and avoidance of demands.

**Administration:** Quick assessment to administer. Reliability is improved when a separate MAS is completed for each specific behaviour identified and when behaviours are high frequency.
Aberrant Behaviour Checklist (ABC)

Purpose: A 58 item checklist which examines a person's behaviour over the preceding four weeks and takes into account the frequency and severity of the behaviours of concern and the severity of the challenge on both the individual and their carers. There are five domains of concern including: irritability; lethargy; stereotypy; hyperactivity; and inappropriate speech.

Administration time: Approximately 10 minutes.


Functional Assessment Samples

Samples of a functional assessment can be found at:


Reference:


Appendix 25: Formulation

Features of a formulation are based on the functional assessment:

- Identified behaviour ► systematic observation, interviews and questionnaires.
- Vulnerabilities factors that predispose behaviours of concern ► person assessment.
- Maintaining factors that serve to reinforce the behaviour ► assessment of consequences.
- Setting events that are temporally distant and idiosyncratic antecedent events that relate to the problem behaviour ► assessment of setting events.
- Triggers/precipitants to the behaviour ► assessment of antecedent factors.
- Protective factors may be internal (specific abilities, likes/interests, strengths, motivations) or external (supportive relationships with carers or staff) that may act as buffers between the existing vulnerabilities of the person and behaviours of behaviour ► ecological analysis.
- Ensure the formulation is adequately documented for future reference and revision.


An example of a detailed formulation for offending behaviour can be found at:

Appendix 26: Systematic observation tools

Systematic observation tools

Scatterplots
Purpose: Record the patterns of incidents of target behaviours that may occur around specific times and can be of use when verifying hypotheses around time-based patterns. Scatterplots are used to record the timeslots in the day during which the specific behaviours either occur or do not occur. Continuous observation is required, which are then recorded onto a grid with columns (split into hour or half-hour cells) for up to seven days; when the target behaviour occurs during a particular time-slot, the cell is ticked/shaded. Separate codes may be assigned for each behaviour, although it should be noted that scatterplots do not record the frequency of the behaviour only that it has occurred within a given time period.

For an example:

For a template:

Behaviour Monitoring Form (BMF)
Purpose: These forms are completed by carers or family following a behavioural incident in order to provide comprehensive information about the circumstances surrounding specific incidents; they may be continuously administered. The BMF gathers information surrounding the date, location, day, time and duration of the incident, individuals present, setting events, antecedents, behaviours, consequences, reactive strategy used and its effectiveness, medication, severity of the behaviour and the confidence of the carer to manage the situation.

Special Projects Team: Directorate of Learning Disability Services, Bro Morgannwg NHS Trust 2010, A hitchhiker’s guide for the specialist behaviour team (operational guidance), GIG CYRMU, Wales.
## Behaviour monitoring form

1. **Service user name:**

2. **Date of incident:**

3. **Time of incident:**
   - Start:
   - Stop:
   - Day of the week (please circle): Sun Mon Tue Wed Thu Fri Sat

4. **Location:**

5. **Persons present:**

6. **Setting events**
   - Please describe any general factors you think may have contributed to the behaviour (such as the person was ill, tired or hungry; the environment was hot, noisy or crowded)

   
   
   

7. **Specific triggers**
   - Specific triggers – What happened just before the incident occurred? (such as was the person left alone, asked to do something, asking to do or have something)

   
   
   

8. **Behaviour**
   - Behaviour – Describe clearly what the person did:

   
   
   

9. Results
What happened as a result of the incident? (such as did you attend to the person, leave them alone, get them a drink, break off from an activity, suggest that they take some time to cool off)

---

10. Reactive procedures
Which reactive strategies did you use? (Please tick)
- [ ] Defusion/distraction
- [ ] Minimal restraint
- [ ] Breakaways
- [ ] As required medication
- [ ] Other (please specify):

11. Medication effectiveness
If you used emergency medications, please specify:
Medication given: ____________________________ Time given: ____________________________
Dosage: ____________________________

Please record half-hourly observations from administration of ‘as required’ medication until calm.

Please circle the appropriate number to indicate if the behaviour has improved or become worse since administering medication. Describe briefly the agitated behaviour/symptoms at time of recording.

All additional doses must be recorded on another chart.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>Much improved</td>
<td>No change</td>
<td>Much worse</td>
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Comments: ___________________________________________

Signature: ___________________________________________
## 2. Second recording

**Time:**

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<tbody>
<tr>
<td>Much improved</td>
<td>No change</td>
<td>Much worse</td>
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**Comments:**

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**Signature:**

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**Side effects:**

(List common side effects of ‘as required’ medication administration)

________________________
________________________
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## 3. Third recording

**Time:**

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<tbody>
<tr>
<td>Much improved</td>
<td>No change</td>
<td>Much worse</td>
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**Comments:**

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**Signature:**

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**Other observations noted:**

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## 4. Fourth recording

**Time:**

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</thead>
<tbody>
<tr>
<td>Much improved</td>
<td>No change</td>
<td>Much worse</td>
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</tr>
</tbody>
</table>

**Comments:**

________________________
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**Signature:**

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**Other observations noted:**

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12. **Behavioural severity**

How severe was the incident? Please circle the number on the scale that best reflects your views:

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<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Not at all</td>
<td>Moderately severe</td>
<td>Very severe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

13. **Ease of management**

How easy or difficult was it to manage the incident? Please circle the number on the scale that best reflects your views:

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<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Quite easy</td>
<td>Moderately easy</td>
<td>Very difficult</td>
<td></td>
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</tbody>
</table>

Completed by:  
Date:  

(please print name)

Adapted from:
Special Projects Team: Directorate of Learning Disability Services, Bro Morgannwg NHS Trust  
**Momentary time sampling (MTS)**

Purpose: May be used for behaviour that occurs at high rates and involves continuous observation over a specified length of time (such as 20 minutes). MTS requires that target behaviours are decided prior to commencement of observation and assigned codes. The target behaviours are then entered into an observation grid and observations are made at regular intervals (such as every 20 seconds) throughout the observation period. With MTS, observation should continue regardless of whether or not the behaviour actually occurs. If the behaviour occurs at the precise point that the designated interval (such as 20, 40 or 60 seconds) occurs, the code is entered in the appropriate grid; no code is entered if the behaviour occurs outside of the time-designated interval.


Return to Section 14.3

**Appendix 27: Mediator analysis**

**Mediator analysis**

Behavioural interventions will usually be carried out by a person’s usual carers (‘mediators’) rather than by external ‘experts’ and are likely to be more effective when implemented in this way. A critical part of behavioural assessment involves assessing the strengths and needs of mediators, as this will, in turn, impact upon intervention success. Designing complex intervention plans that are beyond the skills or resources of mediators will fail.

The following questions are helpful starting points in conducting a mediator analysis:

- Who will be implementing the plan?
- How many people will be involved?
- What are their characteristic strengths?
- How are they managed/organised/supervised?
- Have they been involved in the functional analysis?
- What previous training in behavioural approaches (proactive and reactive) have they had?
- What are their current beliefs about why the person engages in the behaviour of concern?
- What are their general attitudes towards the person?
- How motivated are they in relation to the intervention?
- Are there any particular people who will be crucial to the intervention’s success?
- Do they have experience of behavioural recording?
- What emotional supports are available to them?
- What key constraints (such as time, environment or sickness) may impact upon the intervention?
- What critical routines exist in the setting and must be maintained throughout the intervention process (set routines and activities around which the intervention must be able to accommodate)?

It is useful to try to summarise the results of a mediator analysis into strengths and needs. System strengths can be capitalised on in terms of introducing a behavioural intervention, whereas any identified needs should be highlighted in an action plan that would need to be implemented prior
to introducing the intervention if its impact is to be maximised. The key objective here is to achieve the best possible contextual fit between the behaviour support plan and the environment in which it is designed to operate. This can be done using a goodness of fit assessment (see Appendix D in the resource listed below: Goodness of Fit Survey).

Adapted from:
Special Projects Team: Directorate of Learning Disability Services, Bro Morgannwg NHS Trust 2010, A hitchhiker’s guide for the specialist behaviour team (operational guidance), GIG CYRMU, Wales.

Goodness of fit

It is important to achieve a goodness of fit between the contents of an intervention plan and the characteristics of the settings and the mediators. The Goodness of Fit Survey has been adapted for use in staffed settings. The survey tool should first be completed by individual staff members when the behaviour support plan is first finalised; it should then be completed at regular intervals or at any point that major revisions are made. Any areas where there is poor goodness of fit need to be considered and addressed. If there is a general consensus that the fit is poor, then it is likely that the behaviour support plan will need to be adjusted or aspects of the environment changed. However, if only one or two people report a poor goodness of fit, then it is possible that additional training or workplace support may be required for those individuals.
Goodness of fit survey

Name of service user: 

Name of person completing checklist: 

Date: 

Introduction: This survey is for use by staff supporting the above person and designed to help improve the effectiveness of the behaviour support plan. Your responses will help improve the quality of the plan and make sure the plan is as helpful as it can be. Below are 20 questions about the plan and its prospects for success. Once you have thoroughly familiarised yourself with the plan, please answer each question by circling the number under the rating that most closely matches your current view.

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>Not much</th>
<th>Can't tell</th>
<th>Well</th>
<th>Very well</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you believe the BSP takes into account your understanding of this person and their behaviour of concern?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Does the plan address what you feel are the highest priorities for this service user?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Do you understand what you are expected to do as part of this plan?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Are you comfortable with what you’ve been asked to do?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Are you comfortable with what others are expected to do (such as your manager and clinicians)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Does the plan recognise the needs of the service user and staff?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Does the plan recognise the needs of any other service users who live with this service user?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Do you feel you have the skills to implement this plan?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Do you feel that colleagues have the skills to implement this plan?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</tr>
<tr>
<td>10. Overall, how well does the plan fit in with the daily routines in this service?</td>
<td>1</td>
<td>2</td>
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<td>5</td>
</tr>
<tr>
<td>11. How well does the plan fit with your values and beliefs about how people with intellectual disabilities and behaviours of concern should be supported?</td>
<td>1</td>
<td>2</td>
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<td>5</td>
</tr>
<tr>
<td>12. Does the plan include successful strategies that you have used previously with this person?</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Question</td>
<td>Not at all</td>
<td>Not much</td>
<td>Can’t tell</td>
<td>Well</td>
<td>Very well</td>
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<tr>
<td>13. Will the plan significantly disrupt aspects of this service so that stress and hardship will be created?</td>
<td>1</td>
<td>2</td>
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</tr>
<tr>
<td>14. Does the plan recognise and build on strengths of this team?</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
</tr>
<tr>
<td>15. Does the plan recognise and build on strengths of this service user?</td>
<td>1</td>
<td>2</td>
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<td>5</td>
</tr>
<tr>
<td>16. Does the plan include any needs you may have for supervision and support?</td>
<td>1</td>
<td>2</td>
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<tr>
<td>17. All things considered, how difficult will it be for you to work to this plan?</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</tr>
<tr>
<td>18. Do you believe the plan will be effective?</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
</tr>
<tr>
<td>19. Does the plan cover any needs for emotional support that you might have?</td>
<td>1</td>
<td>2</td>
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</tr>
<tr>
<td>20. If the plan is effective, will you be able to keep implementing it in the long term (such as for the next year)?</td>
<td>1</td>
<td>2</td>
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</table>

Adapted from:
Appendix 28: Standards for a BSS behaviour support plan

Minimum standards

Minimum standards for a behaviour support plan (Budiselik, 2010, Appendix B, p. 43):

- Plans should be formulated in plain language and any technical terms should be explained in lay terms.
- The identified behaviour(s) should be operationally defined and the topography should be detailed (form, intensity, frequency and duration).
- The hypothesised function(s) of each behaviour, based on a documented functional assessment, should be outlined.
- Predictors and setting events should be described in detail (for example, places, activities, people and personal circumstances such as health status or social incidents), together with strategies to minimise their occurrence or diffuse their impact.
- The person’s preferred circumstances and needs should be outlined (provide details of the circumstances under which the behaviour is known not to occur because the person’s needs are met and they are happy).
- Environmental (social, physical, organisational and procedural) strategies should be detailed. These should include strategies to explicitly enhance the person’s quality of life and wellbeing.
- Educational strategies should be described, together with details of associated reward and reinforcement programs designed to enhance the development of alternative, more adaptive behaviours.
- The goals of the BSP should be outlined, as should the review/evaluation timeline and procedures (including data collection processes and time lines). Details of the circumstances under which the review process might be brought forward should also be included.
- Communication strategies should be detailed, providing a clear explanation of the person’s receptive and expressive communication skills and the strategies (including any augmentative or alternative communication techniques, aids or devices) that those who provide support should be using.
- Crisis management procedures (Carr et al., 1994) should be specified.
- The educational and other support needs of those expected to implement the plan should be outlined.
- Team coordination, communication and responsibility protocols should be detailed and include contact options for short-term consultations and clarification of the plan.
- Any legal requirements, such as details of the consent process and the necessity for guardianship, or others’ approvals for particular procedures should be documented.

References


Appendix 29: Contextual fit

Contextual fit
Contextual fit attends to:
- the values and goals of the team
- the current and desired routines within various settings
- the skills and buy-in of the people delivering the plan
- administrative support.


Appendix 30: Goal setting

Goal setting
Behaviour change occurs through building self-efficacy and mastery of new skills, which requires the following.
- Goals are clear plans of action – expressed as behaviours the person/carer/staff intend to do, not wishful thinking or good intentions or desirable outcomes.
- Goals are realistically challenging – not too hard and not too easy.
- Goals incorporate the person’s interests – the goal is genuinely interesting.
- Goals conform to the person’s values – consider diverse cultures and beliefs.
- Goals have verifiable outcomes – the person can see the goals that are being achieved.
- Goals depend on the person’s own efforts – only set what is under the person’s control.
- Goals should be achieved reasonably soon – closer goals (or sub-goals) are stronger motivators than distant goals.
- Goals are set with the person – goal setting is the beginning of successful behaviour change and must respect the autonomy of the person.


Appendix 31: Positive behaviour support: Getting it right from the start

Positive behaviour support: Getting it right from the start
Appendix 32: Quality of life

Quality of life
Improving quality of life requires attention to:
- achieve the person’s dreams
- meet health and physiological needs
- promote all aspects of self-determination
- improve active, successful participation in inclusive school, work, home and community settings
- promote social interactions, relationships and enhanced social networks
- increase fun and success in life
- improve leisure, relaxation and recreational activities throughout the day.


Appendix 33: Is relying on environmental strategies alone adequate?

Is relying on environmental strategies alone adequate?
A meta-analysis of 142 articles regarding 316 individuals under the age of 21 years, published between 1988 and 2006, found that no studies used systems change as the sole intervention, most likely reflecting clinical perspectives that systems change is a context for intervention rather than an intervention itself.


Appendix 34: Sensory environments

Sensory environments
Sensory environments are described by the Victorian Office of the Senior Practitioner at:

Autism-friendly environment

Tips for an autism-friendly environment have been published by the UK National Autistic Society, at: <www.autism.org.uk>

Hayward, B and Saunders, K 2010, Designing environments for autism spectrum disorders: an introduction to the available evidence, poster presented at the 45th ASSID Australasian Conference, Brisbane, Queensland, 29 September – 1 October 2010 (a copy can be provided upon request).


Appendix 35: Active support

Active support

Active support applies systematic techniques to provide support for engagement in meaningful daily activity utilising structured staff education, staff coaching and organisational policy and procedure. This approach results in new skills, improved mental health and positive changes in behaviour. Active support is effective for behaviour that is self-injurious, stereotypical, or severely withdrawn.


Appendix 36: Is skills building effective and ethical?

Is skills building effective and ethical?

A meta-analysis of 142 articles regarding 316 individuals under the age of 21 years, published between 1988 and 2006, found that skills building resulted in consistently higher effect sizes and may be more effective when combined with antecedent and system change approaches.
Appendix 37: Are cognitive-behavioural strategies an effective and ethical approach?

Are cognitive-behavioural strategies an effective and ethical approach?

The Royal College of Psychiatrists indicated in 2004 that cognitive-behavioural interventions had promising, albeit limited, effectiveness. The Australian Psychological Society suggests adapted cognitive-behavioural strategies in their Appendix C.


In managing behaviours of concern, cognitive-behavioural treatment may broaden the choice of available therapies, but does little to improve the overall outcome. However, cognitive-behavioural interventions may be more appropriate for deterring offending such as sex offending and addressing emotional problems and have been shown to be effective for depression.


As a cautionary note, a review of 80 articles published between 1980 and 2005 about children and some adults with intellectual disability found that behavioural interventions were more effective than cognitive-behavioural interventions such as anger management.


Appendix 38: Teach skills resources

Teach skills resources

Teaching functional skills to people with severe disabilities involves identifying activities that:

- someone else would otherwise have to do for the person
- the person is more likely to perform
- a person can perform as paid employment
- provides a person something wanted or allows a person to avoid something unwanted without behaviours of concern.


Appendix 39: Social skills resources

**Social skills resources**

**Intensive interaction**

Intensive interaction is effective for people with severe to profound intellectual disability and physical and sensory disability and may be effective for people with autism spectrum disorder. It teaches fundamental skills for social interaction and communication through: (1) the creation of mutual pleasure and interactive games; (2) staff adjustment of their personal behaviours in order to become more engaging and meaningful for the person; (3) interactions flowing in time with pauses, repetitions and blended rhythms; (4) the use of intentionality – responding to the person’s behaviours as if they were initiations with communicative significance; and (5) the use of contingent responding: following the person’s lead and sharing control of the activity.

Appendix 40: Speech and communication resources

Speech and communication resources

Functional communication training
A positive behaviour support intervention designed to reduce behaviours of concern by replacing them with meaningful or functional communication using words, gestures or alternative communication systems (such as Picture Exchange Communication System).


Functional communication training for children with autism spectrum disorder – Centre on the Social and Emotional Foundations for Early Learning:
www.vanderbilt.edu/csefel/briefs/wwb11.html

Functional communication training for children with autism spectrum disorder
www.asatonline.org/intervention/procedures/functional2.htm


SCOPE Communication Resource Centre
This is part of the Communication Access Network in Victoria for people with complex communication needs (such as Children's Aided Language Tools, COMPIC pictographs).
www.scopevic.org.au/index.php/site/resources#Communication

Appendix 41: Attachment and trauma resources

Attachment and trauma resources


References


Appendix 42: Behavioural and family systems interventions

**Behavioural and family systems interventions**

Four stages of intervention are presented to integrate contemporary behavioural and systemic orientations to facilitate action in families to address behaviours of concern:

1. standard behavioural assessment
2. mediator analysis (family assessment)
3. family therapy (if required)
4. behavioural intervention.


For preschoolers, the Stepping Stones Triple P is an adapted version of the Triple P Positive Parenting Program, combining behavioural family intervention and parent management training. Stepping Stones Triple 3 has been found in a randomised clinical trial to have fewer child behaviour problems reported by mothers and independent observers, improved maternal and paternal parenting style and decreased maternal stress at six-months follow-up.


Appendix 43: Social stories resources

Social stories resources


Appendix 44: Mindfulness techniques resources

Mindfulness techniques resources


Appendix 45: Punishment

Punishment

Punishment-based strategies such as response cost (such as removal of possessions or limiting rights as a consequence to specific behaviours), exclusory time-out/seclusion and overcorrection are ineffective, inconsistent with contemporary clinical practice and may be inconsistent with what is legally permitted. Therefore punishment-based strategies are not recommended practices by the Australian Psychological Society.


Appendix 46: Reinforcement schedule resources

Reinforcement schedule resources

Reinforcement inventory for adults

Willis, TJ, LaVigna, GW and Donnellan, AM 1993, Behaviour assessment guide, Institute of Applied Behaviour Analysis, Los Angeles, CA.


Appendix 47: Counterintuitive strategies

Counterintuitive strategies

Apply strategies that are counter to control and dominance of behaviour to avoid situations that would otherwise lead to restrictive practices.

- Provide high-density non-contingent reinforcement – maintain routine and enjoyable activities as long as they are not contingent on the behaviour of concern (that is, it does not give rise to an event) and there is a short time delay between the behaviour and the preferred event.

- Avoid using natural consequences if the person is less likely to learn because the consequence in itself can become the setting or trigger for further behaviours of concern.

- Do not ignore behaviours of concern unless it is certain that the only function is to gain attention; behaviours generally have numerous functions.

- Remove punishments because aversive situations act as setting events to further escalate behaviours of concern; diversion to a more compelling activity or even ‘strategic capitulation’ in providing the person with what they want until a more appropriate time can be found to teach skills.

Appendix 48: Planned immediate responses resources

**Planned immediate responses resources**


Appendix 49: Occupational health and safety resources

**Occupational health and safety resources**

*Occupational Health and Safety Act 2004*

To view a copy of the OHS Act go to <www.legislation.vic.gov.au>

**Occupational Violence Risk Assessment and Management Tool (OVRAMT)**

The OVRAMPT is a tool designed to prevent occupational violence caused by residents. It identifies, triggers and causes of occupational violence and solutions to eliminate or control risks. Further information on OVRAMT can be located at:


**Residential services practice manual**

To view a copy of the Residential services practice manual go to:


Appendix 50: System constraints to implementation

**System constraints to implementation**

Numerous explanations can be offered:

- Settings do not have the necessary resources.
- Plans are not implemented as designed by carers and staff.
- Preparation is insufficient for carers and staff.
- Supervision and clinical support for carers and staff is lacking.
Appendix 51: Constructive systems change

Constructive systems change

Constructive system change to sustain evidence-based procedures among staff and carers includes:

- vision – a common set of goals that consider cultural and personal values
- skills – knowledge and expertise by all supports to solve real-life problems
- incentives – responsive to social and emotional needs and motivation in staff and carers
- resources – time, money and material necessities are feasible
- action plans – defined roles and responsibilities.


Additional references:


Appendix 52: Positive working relationships

Positive working relationship

The NDTi developed a how-to guide for disability commissioners to turn evidence-based expectations into practical commissioning actions. The NDTi did so by analysing locations that have made good progress in supporting people with behaviours of concern. The NDTi found that the clearest common factor across all sites making progress was the strength of positive relationships between key players. These relationships helped to encourage, build and then sustain the capacity and capability needed to deliver services. People from different organisations and from different parts of the same organisation demonstrated: respect to one another; trust in particular areas of expertise and responsibility; and a ‘no blame’ culture. Consequently, agreement on how to move forward was achieved.


www.ndti.org.uk
Appendix 53: National disability strategy


Return to Section 16.1

Appendix 54: Children and adolescents

Children and adolescents

Australian disability standards for education 2005

Helping children with autism 2010

National plan to reduce violence against women and their children 2009

Return to Section 16.2

Appendix 55: Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people


Return to Section 16.3
Appendix 56: Culturally and linguistically diverse backgrounds

Culturally and linguistically diverse backgrounds
Further Information on working with people from culturally and linguistically diverse backgrounds can be found here:


Appendix 57: Strategies for attitude change

Strategies for attitude change
Active participation strategies include personal contact and role-playing to so that a situation can be viewed from another’s perspective and increase the likelihood that carers and staff will perceive the new information as relevant.

Persuasive communication strategies are designed to provide new information for the person to assimilate. Important characteristics are the source or change agent (trustworthy, expert, high status, attractive and credible), the message (such as a two-sided argument, argument presented towards the end of the presentation, ‘unusualness’ in type of communication) and the audience (such as persuasibility and open-mindedness). Failure to provide a message that is attended to, comprehended and accepted will inhibit attitude change.


Appendix 58: Collaboration

Collaboration
BSS practitioners:
• understand and respect the importance of collaboration in providing effective positive behaviour support
• use skills needed for successful collaboration, including the ability to
  – communicate clearly
  – establish rapport
  – be flexible and open
  – support the viewpoints of others
  – learn from others
  – incorporate new ideas within a personal framework
  – manage conflict.
Collaborative relationships

BSS practitioners establish a collaborative relationship to:

- ensure a ‘no blame’ culture
- develop a decision-making partnership
- utilise a structured approach
  - practical hands-on activities and models direct work with the person
  - plain language
  - simple reports and written documentation
  - ready access to direction and debriefing, particularly if threatening behaviour occurs.
- demonstrate skill in
  - communication
  - rapport
  - flexibility and openness
  - support of alternative viewpoints
  - learning from others
  - incorporating new ideas
  - managing conflict.

Collaborative teams

BSS practitioners establish collaborative teams based on:

- facilitation
- coaching
- mediation
- consensus building
- meeting management
- team roles and responsibilities
- advocate for resources to carry out team decisions.


References


Appendix 59: Self-care

Self-care

The Australian Psychological Society website and some psychology registration board websites provide self-care resources for clinicians:

www.psychology.org.au/practitioner/resources/self-care

Allen, D 2009, Ethical approaches to physical interventions: Vol. 2. Kidderminster, BILD, UK.

Appendix 60: Supervision

Supervision


www.ndti.org.uk

Supervision of staff implementing behaviour support plans requires:

- specifying expected staff duties
- training staff in performance skills constituting duties
- observing staff performing the duties at work
- providing positive support for adequate staff performance
- implementing corrective action for inadequate staff performance.

Reid, DH and Parsons, MB 2002, Working with staff to overcome challenging behaviour among people who have severe disabilities: A guide for getting support plans carried out: Volume I: Behaviour analysis applications in developmental disabilities series, Habilitative Management Consultants, Inc., Morganton, NC.
Appendix 61: Training

Training
Competency-based training requires:
1. describing the rationale and skills to be taught
2. providing a succinct written description of the skills to be taught
3. demonstrating how to perform the skill
4. observing carer/staff performing each skill
5. providing feedback regarding proficiency
6. repeating 3–5 until proficiency is demonstrated for each skill.

Reid, DH and Parsons, MB 2002, Working with staff to overcome challenging behaviour among people who have severe disabilities: A guide for getting support plans carried out: Volume I: Behaviour analysis applications in developmental disabilities series, Habilitative Management Consultants, Inc., Morganton, NC.

References


Appendix 62: Collective leadership model

Collective leadership model
Create a participatory process that:
• defines roles and responsibilities
• defines expectations for all staff
• formalises collaborative decision-making and planning processes
• fosters a feedback culture
• maintains transparent distribution of resources
• facilitates communication across all stakeholders.

Appendix 63: Managing behaviours training

Managing behaviours training

- Use a calm voice and speak slowly.
- Use open questions.
- Do not sound accusatory or threatening.
- Genuinely acknowledge the feelings of the person in a way that they understand.
- Provide positive feedback.
- Be patient and honest.
- Negotiate (rather than adopting a ‘win at all cost’ approach).
- Moderate eye contact to maintain visual communication but without causing anxiety.
- Keep facial expression serious but calm and avoid the expression of anger or fear.
- Adopt an open physical posture (such as avoid crossing arms and adopting an accusatory or domineering stance).
- Avoid physical contact with the person unless this is absolutely necessary or know to provide comfort and reassurance.
- Manage personal space – keep distant, stand off to the side, be on the same level as the person, ensure there is a clear exit path and remain calm and safe.


Blackburn, R 2006, Physical interventions and autism: A service users' perspective, in S. Paley and J. Brooke (Eds), Good practice in physical interventions. Kidderminster: BILD.


Using a cognitive-behavioural framework for carer and staff training in low-arousal approaches includes the following:

- Reduce potential points of conflict by decreasing staff demands and requests.
- Adopt verbal and non-verbal strategies that avoid potentially rousing triggers (direct eye contact, touch, aggressive posture and stances).
- Explore staff beliefs about management of behaviour.
- Provide emotional support to staff.


Additional information

Some states have adopted non-violent intervention training to address the need for careful and safe management of specific types of behaviours of concern.

www.crisisprevention.com/Specialties/Nonviolent-Crisis-Intervention/International-Training/Australia-New-Zealand
Appendix 64: Review

Review

According to the British Psychological Society, good practice guidelines regarding review include:

- routinely evaluating interventions for effectiveness
- repeating baseline measures to evaluate change
- evaluating the specific impact of the intervention (such as reduction in anger)
- evaluating generalisability to other settings
- follow-up evaluation over time.

Appendix 66: Feedback

Feedback
According to the British Psychological Society, good practice guidelines regarding feedback include:

- doing so at post-assessment, if there is a major revision of the behaviour support plan, at post-intervention and at exit
- providing it to the person, individuals involved in the assessment and treatment, the referral source and significant others
- meeting requirements of ethical codes regarding confidentiality
- elicited feedback regarding own BSS practitioner performance.


Appendix 67: One DHS standards

One DHS standards
The One DHS standards set out the expectations of better practice for delivering services and supports to people with a disability.

Information on the One DHS project can be found at:

Appendix 68: Outcome and process measures

Outcome measures
Outcome standards are the measure of an agency’s success in meeting goals and objectives. For example, the standard for participation could be that the person has attended 20 per cent more community-based activities than at baseline.

Process measures
Process standards hold an agency accountable for completing the necessary tasks to reach its goals and objectives. For example, BSS practitioners attend fortnightly supervision meetings.

Together, outcome and process measures can be the basis for:
- performance monitoring
- supervisory and managerial actions to improve and maintain performance
- staff training.
Appendix 69: Professional development

Professional development

• Pursue continuing education and in-service training.
• Consult peer-reviewed journals and current publications to stay abreast of emerging research, trends and national models of support.
• Attend national, regional, state and local conferences.
• Seek out collaboration, support and/or assistance when faced with challenges outside of one’s expertise.
• Seek out collaboration, support and/or assistance when intended outcomes are not achieved in a timely manner.
• Seek out knowledge from a variety of empirically based fields – education, behavioural and social sciences and biomedical sciences.


Additional references


Appendix 71: Community of practice

Community of practice
Communities of practice include people who engage in a process of collective learning through:

- a domain – shared interest
- a community – joint activities and discussions, helping each other and sharing information
- a practice – practitioners with shared resources – experiences, stories, tools, solving recurring problems.

www.ewenger.com/theory

Appendix 72: Assumptions about behaviour

Assumptions about behaviour
Assumptions about behaviour include the following.

- Problem behaviour serves a function.
- Positive strategies are effective in addressing behaviours of concern.
- When positive behaviour intervention strategies fail, additional functional assessment is required to develop more effective positive behaviour support strategies.
- Features of the environmental context affect behaviour.
- Reduction of problem behaviour is an important, but not the sole, outcome of successful intervention; effective positive behaviour support results in improvements in quality of life, acquisition of valued skills and access to valued activities.


Appendix 73: Qualitative, quantitative and econometric measures

Qualitative measures are used to generate hypotheses to answer ‘the why and how’ questions regarding the person. Conclusions are therefore informative guesses. Single-case research design is a method supported by positive behaviour support.

Quantitative measures are used to test hypotheses systematically and empirically. Quantitative measures can be used as both intermediate measures of change and outcome measures. Quantitative measures can be selected from the range of assessment tools provided in the Positive practice framework.

Econometric measures include quantitative and qualitative measures of cost-benefit and cost-effectiveness.

Appendix 74: Outcome measures

Outcome success

As described in the Standards for Disability Services in Victoria:

- individuality – each individual has goals, wants, aspirations and support needs and makes decisions and choices about their life
- capacity – each individual’s abilities and potential are identified and encouraged
- participation – each individual is able to be part of his or her community
- citizenship – each individual has rights and responsibilities as a member of the community
- leadership – each individual has the opportunity to inform the way that supports are provided.

Return to Section 21
Part K: References


National Development Team for inclusion (NDTi) 2007, How to guide for commissioners of service for people with learning disabilities who challenge services, NDTi, Bath.

NSW Department of Ageing 2009, Disability and Home Care. <www.adhc.nsw.gov.au>


Reid, DH and Parsons, MB 2002, Working with staff to overcome challenging behaviour among people who have severe disabilities: A guide for getting support plans carried out: Volume I: Behaviour analysis applications in developmental disabilities series, Habilitative Management Consultants, Inc., Morganton, NC.

Special Projects Team: Directorate of Learning Disability Services, Bro Morgannwg NHS Trust 2010, A hitchhiker’s guide for the specialist behaviour team (operational guidance), GIG CYRMU, Wales.

Weiss, NR and Knoster, T 2008, ‘It may be nonaversive, but is it a positive approach? Relevant questions to ask throughout the process of behavioural assessment and intervention’, Journal of Positive Behaviour Interventions, 10(1), 72–78.