MLR consulting psychology

Building sector capacity to enhance behaviour support for individuals with traumatic brain injury living in the community

An initiative of icare lifetime care

The Stage 2 report

3 April 2017

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Project Building sector capacity to enhance behaviour support for individuals with traumatic brain injury living in the community

The Stage 2 report

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Definitions

Attendant care worker (ACW): An attendant care worker is a paid support worker with, or without, formal qualifications providing support to a person with a traumatic brain injury.

Care Coordinator: A person employed by the attendant care provider who is responsible for the day to day management of the attendant care program, including overseeing attendant care workers.

Carer: A carer is an individual who provides ongoing personal care, support and assistance to the person with a traumatic brain injury. Although not always, this person is often a partner or family member.

Challenging behaviour: Challenging behaviour is defined here as culturally abnormal behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, and is likely to seriously limit use of, or result in the person being denied access to ordinary community facilities (adapted from Emerson 1995).

Circles of support: People who provide formal or informal support to the person with a traumatic brain injury.

Functional analysis: An analysis of the possible purposes a behaviour serves in the environment. This is done via careful assessment and systematic evaluation of antecedents and consequences of the behaviour to identify those factors that influence the likelihood of the behaviour occurring.

Funder: Those bodies that approve the funding of services.

icare lifetime care: icare lifetime care administers the Lifetime Care and Support Scheme. This Scheme pays for treatment, rehabilitation and care for people who have been severely injured in motor accidents in New South Wales, regardless of who was at fault. Three quarters of the people in the Scheme have a traumatic brain injury.

Participant: An individual with a traumatic brain injury accepted into the Lifetime Care and Support scheme.

Person directed practice: A service provision that places the participant at the centre and, to the extent that they are able, in charge of the planning, design and implementation of the supports they need.

Positive behaviour support (PBS): A multicomponent framework for understanding challenging behaviour derived from applied behaviour analysis. PBS is based on

assessment of the broad social and physical context in which the behaviour occurs, and constructs socially valid interventions to enhance quality of life outcomes for both the participant and their carers.

Positive behaviour support plan: A document written by the PBS practitioner in close collaboration with key stakeholders. It sets out the case formulation for why challenging behaviour occurs, and details the PBS practices introduced to help the participant achieve as much as is possible their goals without exhibiting challenging behaviour.

Positive behaviour support practitioner: A professional person providing behaviour support services.

Traumatic brain injury (TBI): An induced disruption of brain function that is the result of an external force leading to impairment in cognitive, physical and/or psychosocial functions.

Validated psychological therapies: Time limited evidence base psychological therapies that follow particular protocols for defined clinical conditions.

Project Scope

As noted in the Stage 1 report several clarifications establish the scope of this project. The project does not aim to identify all areas in which practice may be improved. Rather, it seeks to help establish sustainable change in a small number of areas that the practice community identifies as relevant, needed and sustainable.

It is accepted that there will always be a small number of individuals with a traumatic brain injury who will not be able to be supported successfully in the community for particular periods of time because of very severe cognitive and behavioural difficulties.

A special note on terminology

The term ‘challenging behaviour’ continues to be used here in place of the more recent term ‘Behaviours of Concern’ adopted by some services and researchers. The consumer representative and person with lived experience of severe brain injury requested the term challenging behaviour be carried over from the Stage 1 report for specific reasons and these are set out in Appendix A. Working group members discussed terminology and agreed.

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BACKGROUND

The Stage 1 Appreciative Inquiry Report

In 2013 the New South Wales Lifetime Care and Support Authority identified a shortage of skilled clinicians and support workers throughout New South Wales (NSW) who were able to adequately support participants with challenging behaviours living in the community. The Authority subsequently approved funding for a project to produce a strategic action plan to build sector capacity to support its participants with brain injury who exhibit challenging behaviour. David Manchester was appointed as project manager.

A steering group of interested stakeholders was formed in early 2014 to advise the project leader and to feedback on the project's findings. After consultation with the steering group it was agreed the project would adopt an appreciative inquiry framework. Appreciative inquiry (AI) is a collaborative search to identify and understand a system's strengths, its greatest opportunities and also its people's aspirations and hopes for the future. It is an approach to complex behaviour change that has been found to be helpful in multiple organisations and service systems throughout the world (Cooperrider, Whitney, and Stavros 2008).

A literature search was undertaken by the project leader that informed the final recommendations, as did a wide consultation process with the practice community across NSW. The Stage 1 consultation process culminated in an AI Summit day on 26 August 2014. At this day steering group members, senior Lifetime Care and Support management and other invited stakeholders from brain injury services, advocacy groups, research bodies and the department of education attended a whole day meeting in Sydney. The purpose of the meeting was to discuss the findings to date and to outline future goals and designs that might guide capacity development in this area.

The summit day produced a refined set of key themes and five 'provocative propositions'. Provocative propositions are statements that bridge the best of 'what is' in a service with 'what might be.' They help to suggest desired possibilities for the service and its people. At the same time they are grounded in what has worked in the past. They provide a clear, shared vision for the service's destiny.

The final Stage 1 report, 'Building sector capacity to enhance behaviour support for individuals with traumatic brain injury living in the community – An appreciative inquiry approach' (Manchester, 2014) was provided to the Authority in December 2014. The report included a list of recommendations for further service development.

Stage 2

On 1 September 2015, the Lifetime Care and Support Authority became part of a new organisation **Insurance and Care NSW (icare).** In October 2015 **icare lifetime care** provided a subset of the Stage 1 report's recommendations to David Manchester requesting a proposed action plan to produce recommendations for progressing the following six deliverables.

The six deliverables:

1. The development of an assessment measure for **icare lifetime care** to use when identifying individuals with traumatic brain injury most in need of behaviour support in the community.

2. An approved minimum behaviour support checklist advising **icare lifetime care** what to look for in good practice.

3. Course headings and course outlines for a series of brief core standards training modules for practitioners and attendant carers/significant others.

4. A training framework for these core standards.

5. A framework to recruit practitioners to join an **icare lifetime care** list of 'preferred providers' for behaviour support.

6. A framework to recruit expert practitioners to provide coaching and mentoring as required to practitioners on the preferred provider list.

The Stage 2 working groups

Six working groups were formed in early 2016 to advise on each of these deliverables.

Each working group met on up to four occasions approximately once per month beginning in February 2016. Each meeting lasted between 60 and 120 minutes and was chaired by the project manager. Attendance was a mix of in person and by phone. Group membership varied between 5 and 22 participants. For a list of all members who participated at least once see Appendix B.

The final meeting was held on 18 July 2016.

This report presents the groups' final recommendations for each of the six deliverables. To maintain continuity between Stages 1 and 2 the five provocative propositions produced by the stakeholder groups at the Appreciative Inquiry Summit Day in 2014 are set out again in this report at the beginning of the deliverables to which they apply.

THE SIX DELIVERABLES

Deliverable 1

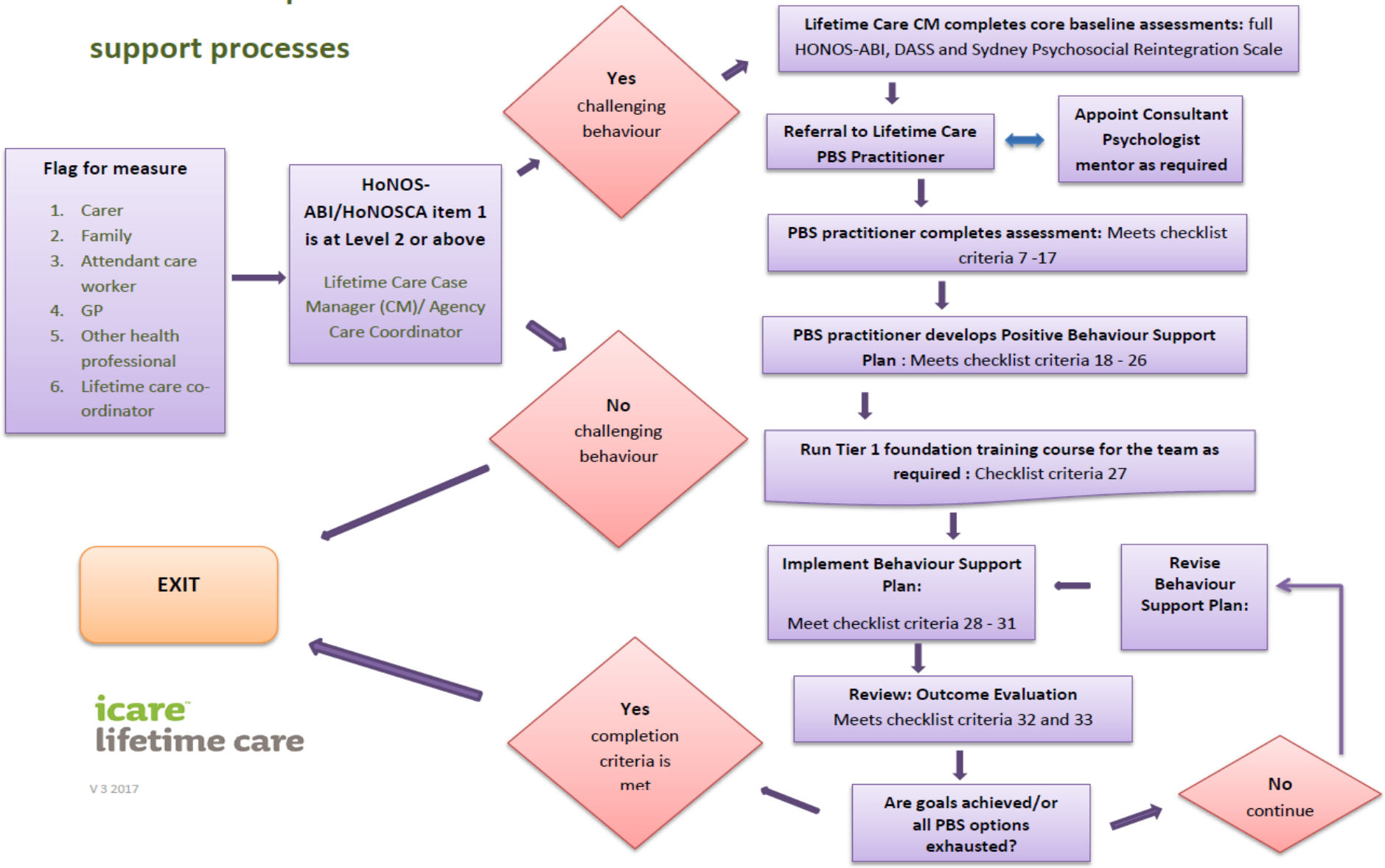
The development of an assessment measure for icare lifetime care to use when identifying individuals with traumatic brain injury most in need of behaviour support in the community

The working groups further refined the criteria for eligibility to receive behaviour support. It was agreed that the focus of the initiative would be on participants already demonstrating challenging behaviour at a level requiring coordinated support. The decision was made to exclude participants considered at risk of developing challenging behaviour, but who were not yet doing so, as it was felt this would lead to over inclusion in the initiative.

The focus was therefore on developing a guideline for behaviour support including a minimum single inclusion criteria followed by other key processes to sustain the approach. These further processes cover assessment, formulation, implementation and outcome evaluation.

The final '**Guideline for Positive Behaviour Support Processes''** is set out on the next page. It is underpinned by the good practices checklist on pages 13 – 24, and ought to be read in association with that checklist.

Guideline for positive behaviour support processes



icare lifetime care

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Deliverable 2

An approved minimum behaviour support checklist advising icare lifetime care what to look for in good practice

Relevant provocative propositions from the Stage 1 Appreciative Inquiry Summit Day

Philosophy and values: *"Our service adopts an integrated person directed approach to maximizing the person's everyday lived experience. The work is person directed, and culturally competent. Built on the principles of positive behaviour support, our work promotes human rights and social justice principles and it is strengths based. Our practitioners value the contribution of all involved, and promote a team approach that is responsive to the views of clients, their families and support staff. We advocate for evidence based practice promoting inclusion and participation and we collect data that informs our progress towards these goals."*

Well supported families and significant others: *"Our service views brain injury as a family affair. The natural support network is an important resource and has a right to be heard. Families we support feel included and listened to. Their experience is respected and validated. We recognise the primary role played by carers and we support their rights as enshrined in the NSW Carers (Recognition) Act 2010. We seek to be flexible and innovative in reaching out to support families. We regularly measure family satisfaction to check how well we are doing and we use this feedback to improve our service."*

Rationale

The primary intervention recommended in this report is positive behaviour support (PBS). PBS was recommended in the AI summit day as an evidence based method for supporting individuals with challenging behaviour and cognitive impairment in both intellectual disability services and brain injury rehabilitation (e.g. Carr et al 2002, LaVigna and Willis, 2005, Heyvaert et al 2010, 2012, Ylvisaker, Turkstra, Coehlo et al 2007).

PBS is defined as a multicomponent framework for developing and understanding challenging behaviour rather than a single therapeutic approach, treatment or philosophy. It is based on assessment of the broad social and physical context in which behaviour occurs, and used to construct socially valid interventions that enhance quality of life outcomes for both the person themselves and their carers that makes the occurrence of challenging behaviour less likely. A PBS approach is usually a team effort and involves families, carers, professionals and service providers all working together to support a person (Positive Behaviour Support Coalition 2015).

Many of the principles and procedures of PBS are based on applied behavioural analysis. PBS is also an inclusive approach that can include additional evidence based approaches that are supportive of its core values for example other validated psychological therapies might be included such as cognitive behaviour therapy for mood management. Genuine implementation of PBS requires among other things

quality training, consistency in practice and also continuous service evaluation.

Here we provide a detailed checklist to guide PBS assessment, implementation and evaluation. The checklist begins with foundation principles to underpin all of these stages.

The processes recommended by the working groups in the minimum positive behaviour support checklist also align closely with the core elements of positive behaviour support recommended by Gore et al (2013) for defining good practice in PBS. See Appendix C.

The icare lifetime care minimum positive behaviour support checklist

Foundation principles

1. All behaviour support is grounded in a positive treatment philosophy that is evidence based and person directed.

Positive behaviour support (PBS) is widely accepted as the evidence based approach for supporting individuals with challenging behaviour. It is therefore the approach supported by the working groups and recommended by **icare lifetime care**. It is consistent with modern disability services and legislation emphasizing community participation and inclusion, a focus on developing prosocial skills in the pursuit of personally meaningful goals, and the use of least restrictive practices.

The focus of support is on improving a participant's quality of life, strengthening relationships with family, friends and the wider community.

2. PBS is provided by icare lifetime care PBS preferred practitioners with demonstrated expertise in this area.

PBS is a complex technology based on applied behaviour analysis and is often misunderstood. Participants and their support networks expect and deserve support from practitioners with appropriate training and expertise in this approach.

icare lifetime care PBS preferred practitioners are practitioners who have demonstrated their competence in PBS planning and implementation. They have also undergone further training as required in PBS. In addition they have access to expert mentors under this **icare lifetime care** PBS initiative as well as to further training on how to adapt validated psychological therapies for supporting individuals with traumatic brain injury and their families/care givers.

3. The participant is included in all aspects of PBS commensurate with his or her level of insight or level of concern.

As the consumer advocate in the Stage 2 working groups said, "Nothing done for us, without us." The PBS practitioner meets with the participant, explains their role and obtains informed consent to work with the participant.

On occasions, participants may be less able to participate fully in goal setting and PBS planning because of impaired self-awareness due to cognitive impairment or they may simply not be interested in doing so. In such

instances PBS continues with the best interest of the participant still central to the process and with the support of their family and carers.

4. PBS is a collaborative, team oriented endeavour.

A team is formed of key stakeholders to assist the PBS provider in assessment, implementation and continuous review of the PBS approach. This team, its meetings and actions are coordinated by the **icare lifetime care** case manager.

Historically, all too often PBS recommendations are delivered in disability services in a written report with little collaboration or attempts to ensure consistent implementation and evaluation. When this happens the report is often quickly forgotten. To avoid this occurring the PBS practitioner works continuously with a team involving those professional, family members and attendant care workers who provide services to the participant. It includes an **icare lifetime care** case manager and the attendant care coordinator. The PBS practitioner liaises with the team during all phases of the PBS process including assessment, implementation and evaluation.

5. The PBS practitioner places a special emphasis on the therapeutic alliance with the both the participant and team members.

It is well established in general psychotherapy that a good therapeutic alliance predicts positive outcomes in treatment. A therapeutic alliance includes a warm therapeutic relationship and also agreement on the goals and task of support. The PBS practitioner regularly checks in and seeks the support of others that the goals and tasks of PBS are agreed.

6. Support is guided by relevant legislation including the NSW Carers (Recognition) Act 2010.

The PBS plan is written in close collaboration with concerned family members and carers. Their views and needs are included in decision-making, and their health and wellbeing is considered. This is consistent with the NSW Carers (Recognition) Act 2010. The purpose of the Act is to increase recognition and awareness of carers and to acknowledge the valuable contribution they make to society. It highlights their critical role and expertise in providing daily care and support to people with disability.

Assessment

7. A participant is referred for icare lifetime care positive behaviour support if an icare lifetime care case manager is concerned about their behaviour and they score 2 or above on item 1 of the The Health of the Nation Outcome Scales –Acquired Brain injury (HoNOS-ABI).

The HoNOS was initially developed for use with adult psychiatric patients to measure their health and social functioning, then later adapted for use with individuals who had sustained an ABI. The HoNOS-ABI contains the same items as the HoNOS, but the glossary is more targeted to the typical manifestation characteristics of ABI as opposed to those of psychiatric disorders.

The HoNOS-ABI was intended to be easy to use so that it could be used routinely by mental health practitioners in everyday practice and to specifically target sequelae of brain injury.

It consists of 12 items covering functions and outcomes in four domains:

1. Behavioural: aggression and overactivity; self-harm, substance abuse
2. Impairment: cognition, physical health
3. Symptoms: hallucinations and delusions, depression, other symptoms
4. Social: social relations, general functioning, housing, activities

icare lifetime care screening for the need for PBS is concerned only with the first item 1. Active Disturbance of Social Behaviour e.g. overactive, aggressive, disruptive or agitated behaviour, uncooperative, resistive, or disinhibited behaviour.

If a participant scores at least at level 2 they are eligible for referral to a PBS practitioner. Level 2 'Includes aggressive gestures, e.g. pushing or pestering others and/or verbal threats or aggression; lesser damage to objects/property (e.g. broken cup, window); significant overactivity or agitation; intermittent restlessness and/or wandering (day or night); uncooperative at times, requiring encouragement and persuasion.'

In children and adolescents the same score of 2 or above on item 1 of the Health of the Nation Outcome Scales for Child and Adolescents Mental Health (HoNOSCA) may be used.

8. Once a participant is identified as eligible the icare lifetime care case manager completes core baseline assessments and refers on to a PBS practitioner.

At a minimum, baseline assessment in adults includes completing full HoNOS-ABI, the Sydney Psychosocial Reintegration Scale version 2 (SPRS-2) and the Depression Anxiety and Stress Scales 21 (DASS 21). For reviews of both the HoNOS-ABI and the SPRS-2 see Tate (2010). The DASS 21 is a short form of Lovibond and Lovibond's (1995) 42-item self-report measure of depression, anxiety, and stress. These are validated measures that assess

behaviour, community integration and participation, and also emotional functioning. They are sensitive to change and are recommended here as core outcome measures. These are then forwarded with the referral to the PBS practitioner.

In children the HoNOSCA is completed along with the Sydney Psychosocial Reintegration Scale for Children (SPRS-C). The DASS 21 can also be administered to adolescents. It may be best to use a total score of general negativity as the DASS may not adequately differentiate between the experiences of negative affectivity, anxiety, and stress in younger people (Moore, Dowdy and Furlong 2016).

9. The PBS practitioner meets with the participant, explains their role and seeks informed consent to provide a service.

PBS is a person directed practice. After reviewing the referral and discussing this with the case manager the PBS practitioner meets with the participant. Close collaboration between the PBS practitioner and the participant is the bedrock of a good therapeutic alliance. Informed consent includes explaining the treatment approach, alternatives available, the risks and benefits of the service and the participant's right to choose or decline a service.

There will be occasions where a participant may lack capacity to make a decision regarding behaviour support because of their cognitive impairment. In such instances consent is sought from the participant's substitute decision maker.

If consent to work collaboratively with the PBS practitioner is declined then the practitioner may still work with the team to provide support via general mentoring and coaching.

10. The PBS practitioner identifies the participant's personal short and long-term goals.

PBS is directed by what the participant wants. Obtaining the participant's short and long term goals allows the subsequent PBS plan to be constructed in the service of achieving these goals as much as is possible within available resources.

11. There is a behavioural assessment and a functional analysis.

PBS is based on the evidence that *challenging behaviour very often serves a clear function* for the person. This function might be helping to remove an unpleasant event (negative reinforcement) or helping to acquire a desired event (positive reinforcement). Behavioural assessment looks at what is happening before a challenging behaviour occurs (antecedents) and what

happens afterwards (consequences) to better understand what relationships (contingencies) are maintaining the behaviour.

The PBS practitioner obtains further behavioural assessment data as required to allow an informed functional analysis of the challenging behaviour. This may include asking support staff to complete behaviour monitoring sheets that describe antecedents for challenging behaviour, as well as the type, frequency and intensity of challenging behaviour and also its consequences. Further information to assist behavioural assessment and functional analysis is also obtained from client interview, interview with significant others, behavioural observation, and file review.

Scales reviewed by the working groups and recommended for this purpose include the Overt Behaviour Scale (Kelly, Todd, Simpson et al 2006). This focuses specifically on the challenging behaviour itself and has nine subscales with differing levels of severity. It is sensitive to change, takes five minutes to complete and is used by services in other jurisdictions for example The Accident Compensation Corporation in New Zealand.

Another validated measure is the Motivation Assessment Scale (Durand and Crimmins 1988). The Motivation Assessment Scale consists of 16 items presented in a checklist/questionnaire format. The items describe specific situations, and the respondent rates how likely the target behavior is to occur. Items assist in identifying the function of a behavior based on four categories: sensory, escape, attention, and tangible.

12. It is acceptable to consider beginning a PBS plan without the collection of data from ongoing behavioural observations.

When collection of reliable data is not possible or the risk of delaying a service precludes initial data collection, then hypotheses for the maintenance of challenging behaviour are still formulated to allow for the rapid introduction of a PBS plan. These hypotheses are still to be based on the available evidence for example, participant and significant other interviews, and file review.

13. The participant's neuropsychological profile is determined via formal neuropsychological assessment when possible and also behavioural observation and functional assessment.

Knowing a participant's cognitive profile helps to make sure that PBS plans are sensitive to their learning ability. On occasions it may not be possible to complete formal neuropsychological assessment because a client is unable to complete assessment, or declines to do so. In such instances it is expected the PBS practitioner will consider other sources of information to reach a formulation about cognitive functioning. This can be done via functional assessment of what the participant is able to do in their day-to-day life, what they have been able to learn since their injury and how they adapt to new

problems as they occur.

14. There is an assessment of family and primary carer's psychological strengths and needs, and appropriate supports are identified to address these as they impact on the PBS plan.

Family burden can be a significant contributing factor to challenging behaviour. Families carry out a large proportion of support for participants. Inevitably the stress this may induce can build up over time.

Research indicates that helping to decrease carer stress can decrease challenging behaviour. The working groups considered the DASS 21 as a recommended measure for carer stress. Just the stress scale could be used if desired. As previously noted the DASS 21 is a self-report measure that takes only a few minutes to complete and is sensitive to intervention.

15. There is consideration of the attitudes of families, carers and attendant care workers (ACW) to the participant and attributions that they can make for challenging behaviour.

The explanations for challenging behaviour that families, carers and ACWs make (their attributions) can have a significant impact on their emotional responses and behavioural reactions, including the desire to help a participant. In particular, attributions about controllability (e.g. he can control his aggression if he wants to) can lead to less desire to help and more punitive responses. Identifying attributions means that the PBS practitioner can be sure to provide relevant mitigating information that reduces beliefs about the extent to which a participant can control their behavior e.g. information about impulsivity due to brain injury, impairments in problem solving and also the effects of impaired emotional functioning on behaviour.

Understanding the potential reasons for a participant's behavior can improve the emotional reactions of those providing support and can increase their willingness to assist. Structured assessments that can help in disability are available for example The Controllability Beliefs Scale (Dagnan, Hull and McDonnell 2013). However, sometimes just asking "Why do you think (participant's name) behaves this way?" or "How much do you think s/he can control this behaviour?" can be helpful.

16. The contribution of the participant's living environment to challenging behaviour is considered including opportunities to participate in favoured meaningful activities.

Individuals who exhibit challenging behaviour can find that their living environments become ever more restrictive as those working to support them seek to reduce the opportunities for challenging behaviour to occur.

Reactive strategies are especially likely to be introduced when a service is unfamiliar with PBS approaches. In this way challenging behaviour exhibited in the community can lead to restrictions placed on community access. Destruction of property can lead to property not being replaced or being replaced with unbreakable substitutes for example crockery or cutlery, windows or furniture that you would not find in any regular home. Over time environments can become sparse, unattractive and demoralizing places in which to live. In time the environment itself can have a negative impact on the participant, as it is a constant reminder of how they are seen as different from the 'norm'.

Providing risk averse and unusual home environments can increase the likelihood of risk and unusual behaviour as the participant reacts against the punitive and atypical living arrangements. The positive behavioural approach looks to provide as normal a home as is possible. The therapeutic intervention in PBS is focusing on how to increase pro social behaviour; it is not on how to ensure challenging behaviour can never occur by introducing increasingly austere and overly secure environments.

17. Where indicated, there is a medical review to consider possible physiological/organic causes of challenging behaviour including pain, mood disturbance and/or mental illness.

It is important to also consider other contributors to challenging behaviour that may not be due to external events, for example pain, poor sleep, or mental illness. Medical and/or psychiatric review is indicated whenever (psycho)physiological factors may be contributing to behavioural difficulties.

Case formulation and the Positive Behaviour Support Plan

18. Once assessment is complete, possible reasons (hypotheses) for the causes and maintenance of challenging behaviour are developed by the PBS practitioner in close collaboration with other relevant stakeholders including attendant care workers, family members and other involved practitioners. In the case of children with traumatic brain injury, this will often also be with the relevant school supports. The PBS practitioner then develops a case formulation.

After the assessment has been conducted the PBS practitioner looks at the information gathered and begins to discuss with team members possible reasons for the challenging behaviour based on this assessment and in particular the functional analysis. This discussion leads to a case formulation that integrates findings about the participant, their environment and behaviour into a coherent whole to explain the challenging behaviour. The case formulation then informs the next stage, which is designing the PBS plan.

19. A PBS plan is written by the behaviour support practitioner in close collaboration with the participant and team members.

The PBS plan is a document written by the PBS practitioner that will guide all PBS support. It includes the participant's long and short-term goals, and case formulation about what is maintaining the challenging behaviour. It then sets out positive strategies to help the participant and also reactive strategies for staff to follow in the event of challenging behaviour occurring. The plan also states what data is to be collected and by whom for evaluating the effectiveness of the program. It is recommended PBS practitioners use a standardized template for consistency to promote inclusion of core components of PBS plans. See Appendix D. The template is a guide only. It can always have elements added as required but the basic information it requires ought to be included when possible.

20. The start of the plan details the participant's personal short and long-term goals, as well as activities the participant enjoys, including conversational topics.

PBS is focused on supporting participants to achieve their personal goals. By stating these at the very beginning of the plan they are given precedence. Having upfront information about preferred activities and conversations also helps direct and encourage those using the PBS plan to provide positive interactions and activities.

21. The PBS plan includes criteria agreed by the team for ceasing or postponing PBS.

PBS is focused on helping a participant to achieve their goals. Therefore it continues for as long as there is evidence it is helping to do this. Agreeing outcome goals early on allows the team to review whether the approach is leading to improvements in the direction of these goals, to see if the goals have been achieved, or conversely to know that the approach is not working and needs to be changed or stopped.

22. Warning signs, and triggers for challenging behaviours are included as are least restrictive reactive strategies.

Antecedent control is a large part of PBS. Identifying triggers for challenging behaviours allows families, carers and other team members to avoid triggers when this is possible. Identifying early warning signs and least restrictive strategies also allows the team to use agreed responses that may avoid escalations in challenging behaviour.

23. The PBS plan has a major focus on proactive or preventative strategies to reduce the likelihood of challenging behaviour occurring and to strengthen alternative pro-social behaviours. These strategies are clearly defined.

The PBS plan includes proactive strategies. These may include ensuring that regular pleasant activities and community access are built into a participant's weekly program regardless of the incidence of challenging behaviour that week (non-contingent reinforcement), or the participant is helped to learn alternative functionally equivalent behaviours that achieve the same goal as the challenging behaviour did (functional equivalence training), for example asking the neighbours to turn their music down instead of swearing and threatening them. Behaviours that are incompatible with challenging behaviour, for example making a request in a normal vocal pitch instead of screaming is praised or otherwise rewarded (differential reinforcement of incompatible behaviour), or periods of time the participant goes without exhibiting challenging behaviours are recognized and rewarded (differential reinforcement of other behaviour). These proactive approaches are important to support the ongoing relationship between the PBS practitioner/carer and the participant and increase the likelihood of overall improved behaviour.

24. Information about relevant psychopharmacology is included in the positive PBS plan.

There are medical and psychiatric conditions that occur after TBI that can have a direct effect on the likelihood of challenging behaviour. In each condition there is likely to be an important role for medication. A PBS plan is not a medical document but the type of medication the participant has and the reason for this is important to know and include within the PBS plan, as adherence to medication can affect the outcomes of the PBS plan.

25. The PBS plan is a working document written in plain English.

PBS can come with a lot of technical jargon. The PBS practitioner needs to see that the PBS plan is written in plain English and that technical concepts are conveyed in everyday language. To be able to use the PBS plan people need to be able to understand it. The PBS plan is written in collaboration with those who will be using it and the PBS practitioner asks these stakeholders does it make sense? Keeping the document as short as possible increases its usefulness. Information about a participant's medical history, treatment and recovery in hospital can be obtained from other sources and do not need to be included in the PBS plan. Detailed explanations as to how the assessment was conducted can similarly be omitted.

26. Where indicated, validated psychological therapies are considered for altered mood states in particular depression and/or anger.

Other multi level supports may be incorporated into a PBS plan for example certain self-control strategies derived from cognitive and behaviour therapy. When this occurs it can be noted in the PBS plan.

Implementation

27. Tier 1 training is provided to the team.

Family**,** attendant care workers and other team members have already undergone, or undergo Tier 1 Foundation Information training (see page 28). This is crucial to enhance team understanding of the positive treatment philosophy and approach, to ensure the team is aware of the cognitive strengths and limitations of the participant, and appreciate the need for data monitoring and continuous quality review.

28. The PBS plan is introduced to, and discussed with the team.

As previously noted, all too often PBS plans are written up and then quickly forgotten. The PBS practitioner introduces the PBS plan to the team and allows for immediate discussion and feedback including advice about any changes that need to be made to make it work. Changes are then made as required.

29. The PBS practitioner begins implementation of the PBS plan with the assistance of the case manager and the care coordinator.

The PBS practitioner provides ongoing instruction, modeling of intervention recommendations in the context they are to be used, monitors their application by others, gives feedback to, and receives feedback from the participant as well as those carrying out the recommendations. By identifying and fixing problems as they arise early on everyone has the chance to be practicing the right approach from the very beginning.

30. The team meets regularly and reviews the implementation of the PBS plan.

Regular team meetings are vital to aid communication and support consistency in implementation. Regular meetings ensure continuous communication and collaborative support, ongoing review of data collected and timely changes as required. PBS plans are especially vulnerable in the beginning as they are unfamiliar to people. If a PBS plan is implemented

incorrectly and does not work the team can lose confidence in the process very quickly. Team meetings are a particularly effective method for maintaining motivation and correcting practice over time. If team meetings only occur monthly then these are supported by smaller, more regular case conferences for decision making and feedback that include at least the case manager, the care coordinator, the ACW, and the PBS practitioner.

31. Validated psychological therapies for emotional functioning are integrated into the positive behaviour support with appropriate advice and guidance. Whenever possible this is provided by the PBS practitioner as well.

There are several 1:1 validated psychological therapies that may assist a participant exhibiting challenging behaviour. These include cognitive and behavioural approaches for mood management in particular anger and depression, and also motivational interviewing to enhance motivation to participate in support approaches. When validated psychological therapies are also being used, they are acknowledged in the PBS plan.

Outcome Evaluation

32. Team meetings are central to the evaluation process. Data collection is reviewed by the PBS practitioner, analyzed and discussed in the case conferences and team meetings. Evaluation is continuous.

The PBS practitioner uses pre-agreed measures at pre-specified time points to monitor progress and outcomes. These will include repeat administration of the HoNOS-ABI, Sydney Psychosocial Reintegration Scale, and also the Depression Anxiety and Stress Scales 21. Evaluation may also include analysis of data collected continuously for example measures of the frequency of challenging behaviour collected via measures such antecedent, behaviour, consequences (ABC) monitoring forms. This data is discussed in team meetings and decisions about changing the PBS plan are made by the team based on this data. If the team is unable to meet in time for a decision to be made their input is still sought by the PBS practitioner or case manager via email.

33. Decisions to continue, cease or postpone PBS are made by the team based on data analysis as well as feedback from the participant.

There are three main reasons for pausing or ceasing a service based on information derived from the data collection and analysis:

1. Program objectives have been achieved.
2. All avenues have been exhausted and no PBS support is helping. This

means that every possible PBS approach and validated psychological therapy has been considered or attempted and the treating team agrees these are ineffective.

3. It is too dangerous to continue to provide the support. In this instance the attendant care provider may consider discontinuing supports where;
    - Attendant care workers are exposed to significant Work Health and Safety (WHS) risks and risk management strategies have not been successful in reducing or eliminating these risks
    - A participant refuses provision of supports from the attendant care provider and refuses to be referred to an alternative provider, or
    - Where a participant has a pattern of behaviour that places attendant care workers at risk.

Where an attendant care provider is unable to provide supports they will inform **icare lifetime care** as soon as possible.

Deliverables 3 and 4

Course headings and course outlines for a series of brief core standards training modules for practitioners and attendant carers/ significant others

And

A training framework for these core standards

Relevant provocative proposition from the Stage 1 Appreciative Inquiry Summit Day

Training: *"Our service believes in a robust training program that covers agreed core standards in behaviour support for both behaviour support practitioners and attendant care workers. We understand that effective training requires work practice with ongoing coaching, mentoring and support from those with expert knowledge. We expect this to produce skilled practitioners able to engage consumers, build rapport and provide evidence based approaches that help consumers to achieve their goals."*

The Stage 2 working groups recommended three tiers of training. These tiers reflect the different levels of knowledge required by each of the target attendee groups when implementing PBS plans.

Tier 1 training – Foundation Information

Tier 1 training is for a participant's wider circle of support including, family, attendant care workers and in the case of children, teachers and other school supports. It has three courses. The first two are, "An Introduction to Positive Behaviour Support"' and "Understanding Brain Behaviour Relationships After Brain Injury". These two courses explain the underpinning philosophy and values of PBS, they outline how PBS works including the **icare lifetime care** PBS plan, and they explain the nature of common neuropsychological changes after traumatic brain injury.

The third course is titled, 'Screening and outcome measures in the **icare lifetime care** positive behaviour support initiative'. It is for case managers who will screen and refer participants for PBS. The course provides a brief overview of the **icare lifetime care** PBS initiative and introduces the core screening and baseline measures recommended by the Stage 2 working groups.

Tier 2 training – Core Skills

Tier 2 training is for **icare lifetime care** PBS providers, and for case managers and care coordinators. It has two courses. The first, "Applying Positive Behaviour Support in Brain Injury Rehabilitation" provides an overview of the **icare lifetime care** initiative and a refresher of the principles, practices and processes of PBS. The second, "Motivational Interviewing in Brain Injury Rehabilitation" teaches practitioners core

skills for enhancing the therapeutic alliance, and for working alongside participants and significant others who may be ambivalent about PBS.

Tier 3 training – Validated Psychological Therapies

Tier 3 training is for PBS practitioners with a good working knowledge of evidence based psychological therapies, in particular cognitive and behaviour therapy (CBT) and acceptance and commitment therapy (ACT). It considers how CBT and ACT practices can be adapted in brain injury rehabilitation to maximize their chances of success.

Tier 3 training also includes training in a standardised positive behaviour support approach that has been validated with a brain injury population. It is produced, by the Parenting Research Centre in Victoria.

The Three Training Tiers at a Glance

Training	Tier 1 **Foundation information**	Tier 2 **Core skills**	Tier 3 **Validated Psychological Therapies**
Courses	**Course 1** An introduction to positive behaviour support **Course 2** Understanding brain behaviour relationships after brain injury **Course 3** Screening and outcome measures in the **icare lifetime care** positive behaviour support initiative	**Course 1** Applying positive behaviour support in brain injury rehabilitation **Course 2** Motivational interviewing in brain injury rehabilitation	**Course 1** Cognitive and behavior therapy for mood management after brain injury **Course 2** Acceptance and Commitment Therapy for mood management after brain injury **Course 3** Family interventions: Signposts for Better Behaviour
Attendees	**Courses 1+2** Participants, family members, attendant carers and other direct supports **Course 3** Case managers	**Courses 1+2** **icare lifetime care** PBS preferred practitioners, case managers and care coordinators	**Courses 1,2 and 3** **icare lifetime care** PBS preferred practitioners

Foundation Information

Tier 1 training

Course 1: An introduction to positive behaviour support (PBS)

Aim: To familiarize people in the PBS approach and to enhance motivation to engage in a PBS plan.
Target: Family, attendant care workers, case managers, care coordinators and teachers.
Duration: 1/2 day face to face.
When to deliver: The Stage 2 working groups decided that the best time to offer this training is when the need for a PBS plan has been identified. This allows the training to be individualized to a participant, the family and the attendant care team, and for the whole team to be introduced to the PBS approach just prior to the introduction of the PBS plan.

Rationale

The working groups in Stage 2 continued to emphasise that a core principle of PBS in brain injury rehabilitation is teamwork. They highlighted the vital contribution of family members and other carers including, attendant care workers, to ensuring excellence in PBS.

The Stage 2 working groups considered key information that team members require when implementing PBS plans. In addition, they looked at how this information is best conveyed and also how best to support new learning. The working groups were clear that the Tier 1 courses had to be highly practical and immediately relevant to attendees.

The Tier 1 courses for families and attendant care workers provide brief, easy to follow and highly relevant education on the foundation principles and practices of PBS. This information is critical for those who support the participant day to day and who will be asked to implement any PBS plan. The courses' goals are modest. They are not academic courses, but rather practical interactive information sessions with an applied focus.

The Stage 2 working groups recommended the first two Tier 1 training courses be provided to teams supporting a participant who has already been accepted into the PBS initiative. In this way, the focus is on those already working with a participant exhibiting challenging behaviour and who will be asked to work collaboratively on developing and implementing a PBS plan. This means training will be provided just prior to a PBS plan being implemented. In this way, retention of information is more likely, and can be more readily strengthened via subsequent team meetings and 1:1 support from the PBS practitioner.

Questions and concerns that may impede implementation of a PBS plan can also be answered in these two half day courses. It is recommended the courses are designed in such a way that they can be delivered by both a case manager familiar with PBS as well as the PBS practitioner.

Course outline

1. **Values**

- The values and philosophy of PBS
- Disability legislation relevant to PBS
- Positive approaches to PBS planning and also least restrictive practices
- Medications used in challenging behaviour

2. **Theory and Practice**

- The functions of challenging behaviour
- Why focus on positive behaviour?
- The **icare lifetime care** PBS checklist for good practice
- The support team in PBS decision-making; who's who, and what do they do?
- The PBS plan: Interventions to change behaviour proactively and manage behaviour reactively

3. **Implementing and evaluating PBS plans**

- Teamwork, supervision, and evaluation of PBS plans over the longer term
- A data driven approach to decision making at every stage

4. **Real life**

- Using PBS principles and processes to assess and support behaviour change: Case studies

Handouts

The working groups also recommended that icare lifetime care seek permission from Synapse to re-produce and possibly update two handbooks they produced when they were previously called Brain Injury Association of Queensland. These were considered to be particularly well written and helpful. They are:

- Understanding Challenging Behaviour Following An Acquired Brain Injury, and
- Responding to Challenging Behaviour Following An Acquired Brain Injury

Tier 1 training

Course 2: Understanding brain behaviour relationships after brain injury

Aim: To familiarize people with attribution theory and good practice when working with someone with common cognitive difficulties after brain injury.
Target: Family, carers, case managers, care coordinators and teachers and other educational support workers.
Duration: 1/2 day face to face.
When to deliver: The Stage 2 working groups decided that the best time to offer training is when the need for a PBS plan has been identified. This allows the training to be individualized to the participant, the family and the attendant care team.

Rationale

The Stage 1 report found that the attributions or reasons that others make about a participant's challenging behaviour can have an important effect on their willingness to help, in particular attributions that infer the participant is responsible for their behaviour and can control it if they want to. Importantly, changing attributions for challenging behaviour by increasing awareness of the multiple possible causes for challenging behaviour after traumatic brain injury can increase a carer's empathy for the individual exhibiting the behaviour and also increase a carer's helping behaviour.

The Stage 2 working groups considered good practice in changing attributions. It was agreed a particular focus on explaining brain behaviour relationships after brain injury can assist family members and attendant care workers to better understand the role of cognitive impairments and emotional recovery in challenging behaviour after brain injury. In this way, others can be supported to see that the participant often has less control over a behaviour than was at first assumed.

This course starts with an explanation of attribution theory. It then goes on to explain the major cognitive impairments that contribute to challenging behaviour so that attendees are able to make more accurate attributions for difficult behaviours they encounter in participants. It then informs attendees about how best to work with common cognitive impairments as well as commonly preserved cognitive strengths.

Finally, it considers the importance of psychological adjustment to trauma and good practice when working with different stages of adjustment.

Course outline

1. Common attributions or reasons people give for challenging behaviours, what are they and why do they matter?

2. Understanding and working with common cognitive difficulties after moderate and severe brain injury

3. Understanding and working with cognitive strengths that are often preserved after brain injury

4. Capacity and decision-making

5. Emotional recovery; the roles of anger, anxiety and depression after traumatic brain injury

Tier 1 training

Course 3: Screening and outcome measures in the icare lifetime care positive behaviour support (PBS) initiative

Aim: To familiarize case managers with the **icare lifetime care** PBS initiative, and core screening and baseline measures recommended by the stage 2 working groups.
Target: Case managers.
Duration: 2 to 3 hours face to face.
When to deliver: Twice per year on fixed dates and further courses run as required.

Rationale

The stage 2 working groups recommended a small set of measures to be used at baseline for screening of participants, and for baseline assessment. These measures are critical parts of the PBS process. They are also used to inform decisions regarding effectiveness of support and whether or not to continue, cease or postpone a PBS service.

The course is for case managers who may have responsibility for assessing whether a participant needs PBS and for measuring whether or not a PBS plan is helping a participant to achieve person directed goals. It introduces attendees to the **icare lifetime care's** guideline for PBS, the minimum PBS checklist, and to the screening and baseline measures.

Course outline

1. **Overview**

- What is PBS?
- A brief introduction to the **icare lifetime care** PBS initiative
- Why collect data?

2. **Core measures**

- The **icare lifetime care** screening measure, The HoNOS-ABI
- The Sydney Psychosocial Reintegration Scale version 2
- The Depression Anxiety and Stress Scale 21

3. **Supplementary measures**

- ABC monitoring forms

Core Skills

Tier 2 training

Course 1: Applying positive behaviour support (PBS) in brain injury rehabilitation

Aims: To familiarise attendees with the **icare lifetime care** guideline and checklist for good practice. To enhance practitioners' understanding and application of core practices and processes in PBS and also effective approaches in neuropsychological rehabilitation.
Target: icare lifetime care preferred PBS providers, case managers and care coordinators.
Duration: 1 days face to face.
When to deliver: Twice per year with follow up peer consultation and work practice support as required.

Rationale

The Stage 2 working groups emphasized the need for providers of PBS to be skilled in this area and to be properly supported over time via work practice support from an **icare lifetime care** preferred PBS Senior Consultant (see Deliverable 6).

The **icare lifetime care** PBS initiative aims to recruit practitioners who already have demonstrated skills in providing PBS support. The purpose of this course is not to teach a person how to do PBS. Rather, its focus is on introducing the **icare lifetime care** checklist for good practice and providing a refresher course on key principles and processes of PBS.

The Stage 2 working groups also recognised that many PBS practitioners will have gained their experience in intellectual disability. To help these practitioners gain confidence in working with a TBI population there is also a focus in this training on the relationship between common changes in the brain after brain injury and a participant's subsequent behaviour and emotional responses. Effective principles of neuropsychological rehabilitation that can enhance the success of PBS plans are also reviewed.

Course outline

1. **Foundation principles**

   - The philosophy and values of PBS
   - Introduction to the **icare lifetime care** PBS initiative and the checklist for PBS
   - Key stakeholders and their roles in PBS

2. **Assessment**

   Core measures for assessment and outcome evaluation
   - The participant's goals
   - The HoNOS-ABI
   - The Sydney Psychosocial Reintegration Scale version 2
   - The Depression Anxiety and Stress Scale 21
   - ABC monitoring

   Supplementary measures
   - The Overt Behaviour Scale
   - The Motivation Assessment Scale

3. **Formulation and the PBS plan**

   - Functional analysis and case formulation in PBS
   - Identifying and modifying antecedents
   - Identifying and modifying consequences
   - Effective approaches for eliciting and strengthening alternative behaviours
   - Writing up behaviour support plans using the **icare lifetime care** template

4. **Implementation**

   - Introducing and maintaining PBS plans – a team approach
   - Contextual rehabilitation; providing instruction in the environment skills are to be used
   - Troubleshooting common problems
   - When to postpone or cease a service

5. **Putting it all together**

   Case examples from real life

Tier 2 training

Course 2

Motivational interviewing in brain injury rehabilitation

Aims: To familiarise attendees with the principles and key practices of motivational interviewing in brain injury rehabilitation.
Target: LCS approved PBS providers, case managers and care coordinators.
Duration: 2 days face to face.
When to deliver: Twice per year with follow up internet or phone group coaching available 45-60 minutes once a month over three months.

Rationale

The stage 1 report noted that consumer engagement in treatment and support is an important issue. In general psychotherapy services up to 50% of clients terminate treatment prematurely. In parent training for challenging behaviour similar difficulties with poor retention have also been noted. Motivational interviewing (Mi) is an evidence based approach that has been shown to enhance engagement in consumers in other clinical areas for example behaviour support (Nock and Kazdin 2005) and also in substance abuse (Miller and Rose 2009). It is also advocated to help with engagement in parent management training (Scott and Dadds 2009). Its use has been demonstrated in brain injury rehabilitation to improve quality of life after traumatic brain injury, to reduce depression after stroke and its use has been recommended as a part of a positive approach to challenging behaviour in the brain injury population (Giles and Manchester 2006).

Mi was recommended as a core skill for practitioners in the Stage 1 Appreciative Inquiry report and also the Challenging Behavior Project of the NSW Agency for Clinical Innovation (Sabaz 2012). Mi is a deceptively difficult skill to learn. It is therefore not assumed that PBS practitioners will have a functional knowledge of the key skills and practices of Mi. The Stage 2 working group therefore recommended that introductory training in Mi be provided with follow up via group coaching by phone or internet once per month over three months to help consolidate the acquisition of MI skills.

Course outline

1. Principles

- An introduction to the principles of Mi
- Key factors in effective collaborative behaviour change conversations
- The therapeutic alliance in TBI rehabilitation: what is it, why does it matter and how do you strengthen it?
- A review of the evidence for Mi with a focus on TBI populations
- The SPIRIT of Mi – the relational component of Mi

  Partnership
  Acceptance
  Compassion
  Evocation

2. Processes

- The four processes of Mi

  Engaging
  Focusing
  Evoking
  Planning

3. Adapting Mi for common cognitive difficulties after traumatic brain injury

- Adapting Mi sessions to account for fatigue, attention and memory problems
- Behavioural experiments and collaborative empiricism
- Verbal mediation approaches and self-instruction training
- Recruiting significant others to help with practice sessions
- Using implementation intentions
- Comparing predicted performance with actual performance to enhance self awareness over time

4. Follow up and phone coaching

Validated Psychological Therapies

Tier 3 training

Course 1

Cognitive behaviour therapy (CBT) for mood management after brain injury

Aim: To enhance practitioners' ability to work individually with a participant when mood disturbance is contributing to their challenging behaviour.
Target: icare lifetime care preferred PBS providers.
Duration: 1/2 day face to face
When to deliver: Twice per year face to face – and follow up group Internet coaching once per month for three months, and or/individual coaching and mentoring

Rationale

The Stage 1 report made clear the high prevalence of depression after brain injury and its strong association with challenging behaviour. In fact, depression was more predictive of challenging behaviour than was severity of brain injury. Depression appears to be reactive in nature and increases over time as self awareness increases and losses mount up such as failure to return to work, breakdown in relationships and also personality change. The risk of suicide increases after severe brain injury not only because of the greater incidence of depression but possibly because of poor impulse control contributing to a greater likelihood of acting on suicidal ideation.

The Stage 2 working groups recommended brief training in how to adapt cognitive behaviour therapy (CBT) for traumatic brain injury. CBT is the most studied psychotherapy approach to mood management and it has been researched in the TBI population. In CBT a participant is helped to identify and moderate particular thoughts that exacerbate emotional dysfunction e.g. excessive negative rumination (in depression management), how to better control physical stress responses using relaxation training (in anxiety and anger management) and to learn alternative adaptive behaviours for achieving personal goals and for coping with difficult situations (depression, anxiety and anger management).

This course is for those already familiar with the core principles and practices of CBT. It provides an overview of key practices and considers critical adaptations recommended for common CBT protocols after traumatic brain injury (e.g. Khan-Bourne and Brown 2003, Mateer and Sira 2006, Anson and Ponsford 2006, Manchester and Wood 2001).

The Stage 2 working groups considered the earlier recommendations from the Stage 1 Appreciative Inquiry report highlighting the need for CBT approaches to focus more on the behavioural aspect of treatment. As one psychologist said in one of the early Stage 1 interviews, "It's the B in CBT that makes the difference." This is because there is often a disconnect between saying and doing after brain injury due to changes in a participant's ability to plan and initiate new behaviours. Therefore in the Tier 3

CBT course there is an emphasis placed on supporting the participant to exhibit new behaviours, sometimes before their thinking or feelings have changed. This is done through a variety of strategies including behavioural activation, contracting, guided practice, over-rehearsal, the use of verbal mediation, implementation intentions, and activity scheduling. Changing behaviour can often lead on to desired changes in thinking and feeling as the participant comes to see that their new behaviour is helpful and adaptive. This in turn reinforces the likelihood that alternative more adaptive behaviour will be repeated in the future.

Course outline

1. **Introduction**
   - An overview of the philosophy and processes of CBT
   - Who is suitable for CBT?
   - The Therapeutic Alliance in CBT after TBI
   - Biopsychosocial assessment and case formulation in CBT after TBI

2. **Depression**
   - Identifying triggers for depressed mood
   - Cognitive restructuring and reinterpreting events
   - Changing locus of control
   - Modifying performance expectations
   - Distraction techniques
   - Re-interpreting events
   - Behavioural activation
   - Behavioural contracting
   - Pleasant events and activity scheduling

3. **Anxiety**
   - Identifying triggers for mood
   - The role of avoidance in anxiety
   - Cognitive restructuring and reinterpreting events in anxiety
   - Modifying performance expectations
   - Relaxation training
   - Graduated exposure
   - Scheduling relaxing activities

4. **Anger**
   - Identifying triggers for mood
   - Cognitive restructuring and reinterpreting events
   - Problem solving and goal setting
   - Stress inoculation training
   - Learning and rehearsing alternative responses

5. **Adapting CBT for traumatic brain injury**

   - Adapting structured CBT sessions to account for fatigue, attention and memory problems
   - Behavioural experiments and collaborative empiricism
   - Verbal mediation approaches and self-instruction training
   - Recruiting significant others to help with practice sessions
   - Using implementation intentions
   - Comparing predicted performance with actual performance to enhance self awareness over time

Tier 3

Course 2: Acceptance and commitment therapy (ACT) for mood management after traumatic brain injury

Aim: To enhance practitioners' ability to work individually with a participant when mood disturbance is contributing to their challenging behaviour.
Target: icare lifetime care preferred PBS providers.
Duration: 1/2 day face to face.
When to deliver: Twice per year face to face – and follow up group Internet coaching once per month for three months, and or/individual coaching.

Rationale

Some aspects of CBT such as cognitive restructuring are inherently demanding on cognitive abilities that are often impaired after brain injury e.g. abstract reasoning, working memory and speed of information processing (Kangas and McDonald (2011). Therefore, a psychotherapy approach that places less emphasis on changing thoughts and more on increasing adaptive behaviours like Acceptance and Commitment Therapy (ACT) is thought to hold promise amongst the brain injury research community (e.g. Soo, Tate and Lane-Brown 2011, Kangas and McDonald 2011).

In ACT a person is supported to accept what an individual can and cannot change, to choose valued life directions and take action towards these. Core skills such as mindfulness training assist the person to experience thoughts and emotions without avoidance. Behavioural approaches including exposure, shaping and goal setting help the person to progress and complete agreed tasks.

ACT is an increasingly popular psychotherapy with a wide evidence base in other populations. It is included here as there is growing interest among the research community in its use with at least one randomized controlled study underway (Whiting, Simpson, et al 2012). Also, it has been used successfully as an adjunct to a PBS approach with parents of children with brain injury and behavioural difficulties in a randomized controlled study in Australia (Brown, Whittingham, Boyd et al 2014).

Course outline

1. **Introduction**

- The philosophy and principles of ACT
- Why ACT and traumatic brain injury?

2. **Processes**

- Acceptance strategies
- Cognitive defusion techniques
- Mindfulness and being present in the here and now
- Self as context – differentiating between physical and psychological experiences
- Values and purposive action
- Commitment and taking directive action

3. **Adapting ACT sessions for brain injury**

- Adapting ACT sessions to account for fatigue, attention and memory problems
- Behavioural experiments and collaborative empiricism
- Verbal mediation approaches and self-instruction training
- Recruiting significant others to help with practice sessions
- Using implementation intentions
- Comparing predicted performance with actual performance to enhance self awareness over time

Tier 3 training

Course 3: Family interventions

Signposts for Better Behaviour

Aim: To enhance practitioners' ability to work with parents of children with a disability who exhibit challenging behaviour.
Target: icare lifetime care preferred PBS providers.
Duration: 2 day face to face.
When to deliver: As required – with four hours of follow up coaching via teleconferencing during first delivery of the program.

Rationale

The Stage 1 report highlighted evidence based family supports provided via the internet in the brain injury population. Signposts is an evidence base approach for helping parents to manage or prevent challenging behaviour in their children with a disability aged 3-16 years. Practitioners trained in this model are able to offer behaviour support either face-to-face, by telephone or online via telephone and Skype delivery. Thus, it is able to support better access for participants in rural and remote areas.

Initially developed by the Parenting Research Centre in association with the Victoria State Government, Signposts was further developed by Professor Vicki Anderson's research group in Melbourne to include a module on children with traumatic brain injury.

As this course is already standardised it is recommended that **icare lifetime care** purchase the training from the Parenting Research Centre as required.

Deliverable 5

A framework to recruit practitioners to join an icare lifetime care list of preferred providers for positive behaviour support

Relevant provocative propositions from the Appreciative Inquiry Summit Day.

Recruitment: *"Our service believes in a focused approach to recruiting people who can demonstrate a passionate understanding of people with disability and cognitive impairment, who are team players and who are optimistic. We demonstrate our commitment by supporting financial incentives for doing this work, standardised induction, placements with service providers, professional development and access to continued mentoring."*

Skilled practitioners: *"Our service supports practitioners to have the skills and confidence required to provide effective behaviour support in the community. We demonstrate this by a commitment to standardised training in core skills. We use implementation science to support practitioner skills development in particular helping to provide coaching and mentorship. We acknowledge too the importance of supporting placements in brain injury rehabilitation teams to help develop experience and establish relationships with peers from the same and other disciplines. We seek feedback from our behaviour practitioners on what will further enhance their practice and we use this to further develop our training approach."*

Rationale

The Stage 1 report highlighted that single exposure training models, or the simple provision of information in manual or guideline form is ineffective for producing practitioner behaviour change. Effective approaches to training practitioners in work practice include expert instruction, ongoing supervision, coaching, and feedback on work practice.

In the stage 1 report both inpatient and outpatient psychologists talked about being unprepared to provide support following their initial training in psychology. A factor they identified as helping to increase their confidence was supervision from more expert practitioners.

Recruitment

It is recommended

A first phase of recruitment target endorsed clinical psychologists or neuropsychologists with experience providing positive behaviour support to individuals with cognitive impairment.

Marketing

A marketing brochure is produced including the information contained on the next two pages.

icare lifetime care writes to practitioners known to offer services PBS services enclosing the information pack and inviting applications.

A one page advert is placed in the Australian Psychological Society (APS) InPsych magazine inside front cover for two consecutive editions at a current cost of $3,550.00 inc GST per advert with key points about the recruitment initiative and a contact email for people to request the full information pack.

InPsych is a 60-page full-colour magazine published every two months and is distributed nationally to the APS 22,400 members.

If this first phase of marketing does not produce enough successful applicants within six months of it being launched then the entry criteria may be expanded in a second recruitment phase to include registered psychologists with an interest in working in this area and a willingness to commit to all three tiers of training.

Selection

Selection is via application and/or interview, and review of an example of PBS work practice.

Entry on to the preferred provider list is dependent upon the applicant agreeing to accessing mentoring and coaching for their first 2 cases and completing at least Tier 2 training as early as possible.

Exemption clause: Some applicants will have experience at such a level that it is determined that they do not require work practice support or Tier 2 training. This determination will be made by the **icare lifetime care** after application review, and/or interview and checks with referees. In such instances it can be recommended to **icare lifetime care** that the person become a preferred provider without further training or work practice support.

Marketing brochure for PBS preferred providers

Become a preferred provider of positive behaviour support with icare lifetime care

The role

Are you a clinical psychologist or neuropsychologist with at least two years' experience supporting individuals with cognitive impairment who sometimes present with challenging behaviour? Do you have a passion for helping people to achieve their goals and to participate in their communities?

Would you like to be an independent provider with a major government agency and receive industry-leading reimbursement for your work, as well as free training and work practice support?

If so, we would like to hear from you with a view to your joining our supportive practice community. We are the largest purchaser of brain injury support services in New South Wales. To help us to continue to provide great services to our participants and their families we are looking for practitioners who are available to do occasional work with us as a preferred provider of positive behaviour support (PBS). Whilst a key focus of the work is on providing PBS other psychological therapies and skills are often used too.

The person

In addition to your experience providing PBS you will have many of the other key skills that make this work so rewarding. These include being empathetic and reflective, a great communicator and listener, being able to work as part of a team, appreciating the importance of person directed practice and knowing how to establish and maintain a great therapeutic alliance. You can be using all these skills when assisting our participants with brain injury and also when working alongside a participant's family members and attendant care workers.

We also recognise how helpful it is for practitioners to receive specialised training and regular ongoing support from other experienced colleagues. That is why we like to see our preferred providers have access to induction training in core PBS skills and also motivational interviewing. In addition we offer our preferred providers work practice support from Senior PBS Consultants.

As a preferred provider we can offer you:

Approval to promote your status as a preferred provider with us through your practice
Free work practice support with an experienced Senior PBS Consultant
Reimbursement at full rates of pay recommended by your professional body
Pre-approved work hours when you accept referrals

Free training in core skills that are transferable to work areas, for example psychiatry and other disability services e.g. autism
Membership of the **icare lifetime care** peer consultation group

To apply we ask that you have:

Endorsement as a clinical psychologist or neuropsychologist with the Psychology Board of Australia
At least two years' experience in providing positive behaviour support services to individuals with cognitive impairment *in brain injury, or psychiatry or disability services*
Enthusiasm to enhance your expertise in positive behaviour support
A willingness to attend free training by in core skills and to access work practice support
Capacity to accept at least two referrals a year and potentially provide up to 30 hours support in each instance

The next step:

If you are interested in learning more about becoming a preferred provider with **icare lifetime care** apply today by emailing Jacqueline Scott and asking for an application form.

Alternatively you can ring (_____) on (number) for a discussion with any questions you may have. We look forward to hearing from you.

Deliverable 6

A framework to recruit expert practitioners to provide coaching and mentoring as required to practitioners on the preferred provider list

Rationale

As noted in the Stage 1 report effective approaches to training require expert instruction and work practice feedback. Coaching skills demonstrated to improve practice include working towards agreement on learning goals, strategies that support autonomy, giving feedback and remaining on task. The Stage 2 working groups considered how best to recruit senior psychologists able to offer work practice support to **icare lifetime care** preferred providers of PBS. They also considered the minimum experience and expertise that might be expected of a consultant psychologist able to provide practice support to other less experienced practitioners.

Recruitment

It is recommended

A first round of recruitment target endorsed clinical psychologists and neuropsychologists with demonstrated extensive experience in positive behavior support working with individuals with cognitive impairment. They will also need to have experience providing coaching, mentoring or supervision to other practitioners.

Marketing

A marketing brochure is produced including the information contained on the next two pages.

Icare lifetime care writes to clinical psychologists and neuropsychologists known to have extensive experience in PBS services inviting applications to be preferred Senior PBS Consultants.

The invitation includes an information session/forum telling people about the PBS initiative and the pathway to preferred PBS provider status.

A one page advert is placed in the APS InPsych magazine inside front cover for two consecutive editions at a current cost of $3,550.00 inc GST per advert.

Marketing brochure for Senior PBS Consultants

Become a preferred Senior Positive Behaviour Support Consultant with icare lifetime care

Are you a clinical psychologist or neuropsychologist with at least five years' experience in brain injury rehabilitation providing positive behaviour support (PBS) to individuals who can sometimes present with challenging behaviour? Do you have a passion for helping to develop the next generation of practitioners in this area? Are you enthusiastic about working with individuals with a brain injury, families and attendant care workers to help our participants achieve their goals?

If so, we would like to hear from you.

The role

An **icare lifetime care** Senior PBS Consultant provides work practice support on a private basis to **icare lifetime care** approved PBS practitioners. The Senior PBS Consultant facilitates case reviews and shares knowledge, advice, and supportive feedback with a focus on assisting our PBS practitioners to enhance participants' community inclusion and psychological wellbeing. This may be via the provision of technical assistance, in order to model, simulate, practice and review practical core skills. The aim is to enhance transfer of learning, support service quality and promote practitioner confidence in providing PBS services.

As a preferred Senior PBS Consultant with icare lifetime care we can offer you:

Approval to promote your status as a preferred Senior PBS Consultant with us through your practice
Reimbursement at full APS recommended rates
Pre-approved hours for cases you agree to take
Free training in core skills including:

- Positive behaviour support
- Motivational interviewing in brain injury, *and other*
- Focused psychological therapies
- Membership of the **icare lifetime care** peer Senior Consultants group

To apply you will need to have:

Endorsement with the Psychology Board of Australia as a clinical psychologist or neuropsychologist
Demonstrated expertise in positive behaviour support
At least five years' experience supporting individuals with brain injury
At least two years' experience providing coaching, mentoring and/or supervision
Experience working in community or educational settings with families, support workers and/or teachers and other educationalists

Availability to provide at least two hours formal work practice each week if required

The next step:

If you are interested in learning more about becoming an **icare lifetime care** approved Senior PBS Consultant come and join us at a two hour information session in Sydney on (date)

Alternatively, you can email Jacqueline Scott for an application form or ring Jacqueline on (____) with any questions you may have.

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APPENDICES

Appendix A

Using the term Challenging Behaviour instead of Behaviours of Concern

"First and foremost, and in contrast to "behaviours of concern", "challenging behaviours" is more "person (with a disability)-centred", places the person with the brain injury in an *active*, albeit potentially negative, role. Secondly, what constitutes such "norms" and what makes a particular behaviour challenging to them is clearly subjective, circumstantial, contingent (one person's "challenging behaviour" might be another's rightful self-expression) and mutable (public breast-feeding, for example). Lifetime Care's use of "challenging behaviours" would also, I believe, be more in keeping with, if not true to, the social model of disability (the paradigm shift away from the medical model of disability) encapsulated in *The United Nations Convention on the Rights of Persons with Disabilities*: that disability is the result of the interaction between people living with impairments and barriers in the physical, attitudinal, communication and social environment. For example, it is not the inability to walk that keeps a person from entering a building by themselves but the stairs that are inaccessible that keeps a wheelchair-user from entering that building. Surely, *one* of the objectives of the work that Lifetime Care is undertaking here is to enhance its understanding, and that of professionals who work with Lifetime Care clients with "challenging behaviours", of the (frequent) neurological basis of such behaviours and, thus, enhance its "care" of clients.

Conversely, "behaviours of concern" sounds like it was coined at the "barriers", above, by those normalising, norm-ing influences that exist to keep such behaviours in check. "Concern" carries the odour of a finger-wagging impulse to respond, perhaps punitively, to such behaviours where –surely – the way the world's moving is towards "*positive* behaviour supports" – non-aversive controls, such as making changes in the client's environment to reduce or remove triggers to such behaviours."

Mr Nick Rushworth
Executive Officer
Brain Injury Australia
Consumer representative on the Stage 2 working groups

Appendix B

Stage 2 Working Group Members

Working Group Member	Organisation
Dr Adeline Hodgkinson	Director Brain Injury Rehabilitation Unit Liverpool Hospital
Ailyn Libo-On	Chief Executive Officer, Attendant Care Industry Association
Amanda Holohan	Clinical Psychologist Westmead Brain Injury Unit/ AHW Psychology
Anne Marie Sarandrea	Clinical Psychologist, Kids Rehab The Children's Hospital, Westmead
Barbara Merran	Public Affairs Director, Southern Cross
Barbara Strettles	Network Manager, Brain Injury Rehabilitation Directorate, Agency for Innovation
Belinda Carr	Occupational Therapist, Carr Rehab
Corinne Roberts	Senior Clinical Neuropsychologist, Mid North Coast Brain Injury Rehabilitation Service
Damien Pegrem	Service Coordination Manager, Acquired Brain Injury Services
Dr David Manchester	Clinical Psychologist, MLR Consulting Psychology
Deb Toffolo	Case Manager/Speech Pathologist Access Brain Injury Services
Dianne Croker	Senior Project Officer, **icare lifetime care**
Dragan Vlaski	Manager Quality & Safeguards, Attendant Care Industry Association
Garry Kent	Senior Project Officer, **icare lifetime care**
Dr Gaston Nguyen	Staff Specialist, Liverpool Brain Injury Rehabilitation Service
A/Prof Grahame Simpson	Research Group Leader Brain Injury Rehabilitation Research Group, Ingham Institute of Applied Medical Research
Helen Badge	Agency for Clinical Innovation
Ian Catalano	Support Services Coordinator Synapse
Inbal Luft	Principal Occupational Therapist Encompass Occupational Therapy
Jacqueline Scott	Senior Project Officer, **icare lifetime care**
Jason Cusack	Clinical Psychologist Illawarra Brain Injury Service
Joe Hanna	Clinical Neuropsychologist, Brain Injury Unit Royal Rehab
Julia Church	NSW Team Leader, ARBIAS

Working Group Member	Organisation
Katherine Stone	Executive Manager Policy, Education and Research, Carers NSW
Kerry Stafford	Chief Executive Officer, Acquired Brain Injury Services NSW
Leanne Togher	Professor of Communication Disorders Following Brain Injury Speech Pathologist, The University of Sydney
Marion Fisher	Policy and Planning, Consumers and Paediatrics, Brain Injury Rehabilitation Directorate, Agency for Clinical Innovation
Matthew Conroy	Clinical Neuropsychologist/Case Manager Kaleidoscope: The Children's Health Network Paediatric Brain Injury Team
Naomi Brookes	Senior Clinical Psychologist Brain Injury Rehabilitation Program, Rehab2Kids Sydney Children's Hospital
Naomi Walker	Service Coordination Manager, Acquired Brain Injury Services
Neale Waddy	Leader, Support and Development, Learning and Wellbeing Department of Education
Nick Rushworth	Executive Officer, Brain Injury Australia
Nikki Aquiatan	Support Services Coordinator, Synapse
Paul Gertler	Clinical Psychologist, Gertler Psychology
Paul Rodriguez	Clinical Psychologist, Brain injury Rehabilitation Unit Westmead Hospital
Paula Olymbios	Clinical Psychologist, PolyPsychology
Rebekah Loukas	Statewide Manager – Corrective Services and ABI Assessment and Intervention, ARBIAS
Robert Scherf	Psychologist/ Rehabilitation Case Manager, New England Brain Injury Rehabilitation Service
Prof Robyn Tate	Professorial Research Fellow, John Walsh Centre for Rehabilitation Research, The University of Sydney
Samantha Grant	Director, Senior Clinical Psychologist, Inspire Rehab & Psychology
Suzanne Lulham	General Manager Service Delivery **icare lifetime care**

Appendix C

The Core Elements of Positive Behaviour Support

Values

The core aim of PBS is the prevention and reduction of challenging behaviour by improving the quality of life of the person and those around them.

It works by developing and building skills of the person and those who support them rather than using aversive (i.e. unpleasant) or restrictive (i.e. limits the persons movements or activities) interventions.

Practitioners work in partnership with the person and all those who are important to them including their family and friends, carers, and other professionals and actively include them in assessments, defining targets, implementing interventions and reviews.

Theory and Evidence Base

All behaviour, including challenging behaviour happens for a reason – understanding what this is (practitioners call it the function of the behaviour) can suggest how to make sure the person has access to the things they need in other ways, (e.g. by changing the environment, teaching them new skills etc.)

PBS uses the principles and procedures from behaviour analysis to assess and support skills teaching and behaviour change.

Other complementary evidence based approaches may be included in PBS plans (e.g. cognitive behaviour therapy, parent training for children with challenging behaviour).

Processes

PBS bases decisions on data gathered about a person's skills, behaviour and needs.

A functional assessment (a range of procedures) helps to identify the reasons (function) for a person's behaviour and is used to create a clear and structured plan of action.

A PBS plan will include proactive strategies to prevent challenging behaviour from happening, strategies to teach new skills to make the challenging behaviour less likely and reactive strategies that minimize restriction if it does occur.

PBS is not a quick fix: the aim is to actively support people over the long-term and to monitor and maintain their quality of life.

Gore et al (2013)

Appendix D

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POSITIVE BEHAVIOUR SUPPORT PLAN

Participant:	
Lifetime Care No:	
Plan current as at:	
Date for review:	
Summary of behaviour in need of support	
1.	
2.	
3.	
General information	
X's short term and long term goals	
X's understanding of why the above behaviours occur	
Activities that X enjoys include:	
Conversational topics that X enjoys include:	
Behaviour 1	
Functions of the behaviours and/or possible causes. The case formulation	
Warning signs, triggers and rates of behaviour	
Proactive strategies (To reduce intensity/frequency/duration of behaviours of concern, such as environmental strategies, routine & activity planning, opportunities for choices/control, reinforce alternative behaviours, skill development, communication training)	
Reactive strategies (immediate response to the behaviour to minimise risk, provide feedback, remove triggers, de-escalate behaviour)	

Behaviour 2	
Functions of the behaviours and/or possible causes. The case formulation	
Warning signs, triggers and rates of behaviour	
Proactive strategies (To reduce intensity/frequency/duration of behaviours of concern, such as environmental strategies, routine & activity planning, opportunities for choices/control, reinforce alternative behaviours, skill development, communication training)	
Reactive strategies (immediate response to the behaviour to minimise risk, provide feedback, remove triggers, de-escalate behaviour)	
Behaviour 3	
Functions of the behaviours and/or possible causes. The case formulation	
Warning signs, triggers and rates of behaviour	
Proactive strategies (To reduce intensity/frequency/duration of behaviours of concern, such as environmental strategies, routine & activity planning, opportunities for choices/control, reinforce alternative behaviours, skill development, communication training)	
Reactive strategies (immediate response to the behaviour to minimise risk, provide feedback, remove triggers, de-escalate behaviour)	

Additional information	
Plan for monitoring	• Any acts of aggression must be recorded on the abc data collection sheet • Staff to review behavioural issues and PBS plan regularly at team Meetings (STATE FREQUENCY) • Staff to contact PBS practitioner if plan needs immediate review • Core outcome measures HoNOS-ABI, DASS and SPRS-v2 will be re-administered (state when)
Criteria for postponing or ceasing PBS	• • • •
Medications (include medication and reason for use)	

Team members involved			
PBS practitioner writing and supporting this plan		**Case manager**	
Care co-ordinator		**Attendant Care Worker**	
Occupational Therapy		**Social Work**	
Specialist physician		**General practitioner**	
Other persons consulted in formulating this Behaviour Support Plan		**Other persons consulted in formulating this Behaviour Support Plan**	