Hello! from Australia

COMMUNITY LIVING OPTIONS
EVIDENCE BASED POSITIVE BEHAVIOUR SUPPORT: MENTAL-HEALTH, FORENSIC AND INTELLECTUAL DISABILITY IN A COMMUNITY SETTING

Melinda Kubisa and Sue Goodall
The National Disability Insurance Scheme (NDIS)

- The NDIS Act 2013
- Unprecedented social welfare reform in the history of disability/Mental Health services in Australia (similar to the introduction of Medicare)
- Targets to be fully operational by 2020
- This legislation ensured people with disability had funding for any ‘reasonable and necessary’ supports related to their disability.
The NDIS helps you:

- Maintain your informal support arrangements
- Receive reasonable and necessary funded supports
- Access community services and supports
- Access mainstream services and supports
The Quality and Safeguards Commission (QSC)

The Quality and Safeguards Commission is a national independent agency established to improve the quality and safety of NDIS supports and services.

The QSC rolled out in South Australia and New South Wales in July 2018.

Functions of the Commission

- Regulate NDIS Providers – the Practice Standards Audit and the Code of Conduct
- Review complaints
- Reportable Incidents
- **Behaviour Support and Restrictive Practices regulation**

**Compliance:** ‘National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018’

To practice, PBS practitioners need to be registered with the Commission and meet the core capabilities in the Behaviour Support Capability Framework.
Business Transformation

Not-for-Profits commenced a journey of business transformation to operate in both a market driven, but also mission driven environment.

This required CHANGE management at all levels of the organization:
- Governance
- Operations
- Business and Finance
- Human Resources
- And our new .......... CLINICAL TEAM. Providing supports under the NDIS billable hours scheme for:
  - Therapy
  - Support Coordination and Specialist Support Coordination
  - Positive Behaviour Support

- This shifted funding from block funded disability supports to a consumer market where individuals choose the provider to supply the funded goods.
- PBS is now a focused support under this scheme
In July 2018 psychosocial disability (Mental Health) rolled out under the NDIS. Never before in Australia have mental health supports been funded for PBS.

All people in this project are transitioning to community from James Nash House (forensic facility), Glenside Inpatient Rehabilitation Services (IRS) or Supported Residential Facilities (SRF): 27 community houses for consumers with high and complex needs.
## NDIS costing and pricing from the pricing guide and support catalogue

<table>
<thead>
<tr>
<th>Registration Group Number</th>
<th>Registration Group Name</th>
<th>Support Category Number</th>
<th>Support Category Name</th>
<th>Support Item Number</th>
<th>Support Item Name</th>
<th>Support Item Description</th>
<th>Unit</th>
<th>Price Controlled</th>
<th>Quote Required</th>
<th>NT - SA</th>
<th>ACT - NSW</th>
<th>National Remote</th>
<th>National Very Remote</th>
</tr>
</thead>
<tbody>
<tr>
<td>0110</td>
<td>Specialist Positive Behaviour Support</td>
<td>11</td>
<td>Improved relationships</td>
<td>11_022_0110_7_3</td>
<td>Specialist Behavioural Intervention Support</td>
<td>Highly specialised intensive support interventions to address significantly harmful or persistent behaviours of concern. Development of behaviour support plans that temporarily use restrictive practices, with intention to minimise use of these practices.</td>
<td>H</td>
<td>Y</td>
<td>N</td>
<td>$234.83</td>
<td>$214.41</td>
<td>$328.75</td>
<td>$362.25</td>
</tr>
</tbody>
</table>

1 US Dollar = 1.49 Australian Dollar

Within 1 year of operating our Clinical team has generated $224,000 YTD revenue, with full year contract funding projected to be $514,311. with:
- 7 Support Coordination Contracts
- 2 Specialist Support Coordination Contracts
- 1 therapy contract and
- 81 PBS contracts

We have a Clinical Services Manager with 6 registered PBS practitioners in our team.
NDIS – Supported Independent Living (SIL)

- SIL: is also a support category funded by the NDIS.
- Our model is an integration of two NDIS support categories SIL and PBS where both the implementing provider team and the Clinical team work from an integrated model to increase outcomes for consumers in a community setting.
- Levels of funding is dependent on support needs (including staff ratios).

- (x 7) x 24/7 houses open
- (x 13) 3 x 24/7 houses to open in February (x 2 in March and x 5 in April, 2 x May, 1 x June)
- (x 6) in current service development
- (x 13) Service agreements for transition supports
- (x 26) Service agreements for PBS
- 18 SIL quotes submitted:
  - (x 1) 3:1
  - (x 10) 2:1
  - (x 8) 1:1
  - (x 7) TBC
- Passive or active overnight.

<table>
<thead>
<tr>
<th>1:1 per week (AUS)</th>
<th>2:1 per week</th>
<th>3:1 per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,301.70</td>
<td>$23,705.40</td>
<td>$34,605.60</td>
</tr>
</tbody>
</table>
The Human Rights Therapeutic Model

- **Human rights** is at the core of the model (CRPD): building a life worth living and being valued as a contributing member of society.

- **Person centred planning and active support** - setting goals.

- **Recovery model** principles.

- Starts with **accommodation**; a home in the community is pivotal.

- **Capacity building**: developmental programming and functional skills development.

- **Restrictive practices**: Guardianship Act section 32 a, b, c special powers.
Primarily we used principles of:
- Dialectical Behaviour Therapy (Linehan)
- The Good Lives Model (Ward & Stewart)

Underpinning this:
- Anger management: emotional regulation
- Anxiety management
- Stress management
- CBT: Think feel do (A – event, B beliefs, C consequence)
Positive Behaviour Support

- PBS practitioner training to address ‘thin market response’ (building the multi-D team)
  - Development of PBS training manual
  - Business process systems: costing and invoicing
- Transforming PBS systems and processes to meet compliance

<table>
<thead>
<tr>
<th>Step</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify contextual info: BOC, supports and summarise goals, strengths and interests</td>
</tr>
<tr>
<td>2</td>
<td>Conduct Functional behaviour analysis: 3 month, 6 mth, 12 mth (as needed) from ABC recording (baseline recordings); measure changes at defined FBA intervals</td>
</tr>
<tr>
<td>3</td>
<td>Conduct file audit: reference documents, assessments</td>
</tr>
<tr>
<td>4</td>
<td>Collect observational data from team (DRS/ABC/frequency charts): hours of obs (staff)</td>
</tr>
<tr>
<td>5</td>
<td>RM/CSC team workshop: what is working/what is not - provide feedback = hours of review participation</td>
</tr>
<tr>
<td>6</td>
<td>Biopsychosocial assessment</td>
</tr>
<tr>
<td>7</td>
<td>Conduct functional assessment: WHODAS, AIBAS, Vineland or Life skills</td>
</tr>
</tbody>
</table>

- Interview with client or family or significant circle of support |
- Evaluate risk: Armitage or client risk assessment - risk and protective factors |
- Data analysis - formulate hypothesis for function of the behaviour |

- Utilise the PBSP template developed |
- Add in analysis information and define strategies |

- RM/team (CSC/clinical) to present to staff at meeting - ensure working knowledge of reviewed strategies and expectations for documentation |
- CSC/RM monitor implementation |

- FBA frequency decided based on risk - include quality of life factors |
- CSC reads daily the ABC documentation |
- CSC/RM/Clinical discuss at fortnightly meetings if increasing risk |
- Quarterly - seek feedback from team re plan effectiveness |
### Positive Behaviour Support

**Prescribed templates through the QSC portal**
1. Interim Behaviour Support
2. Comprehensive Behaviour Support
3. Monthly reporting

#### Behaviour Support Plan - Interim

**Participants:**

**Plan details:**

<table>
<thead>
<tr>
<th>Behavior Support Practitioner</th>
<th>Participant ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist Behaviour Support</td>
<td>Provider ID</td>
</tr>
</tbody>
</table>

**Important Information:**

This form is approved by the NDIS Quality and Safeguards Commissioner for the purposes of section 12 of the National Disability Insurance Scheme (NDA) and Behaviour Support Rules 2023. This form serves to collect information, including personal information, for the purpose of assessing and enforcing the National Disability Insurance Scheme and the National Disability Insurance Scheme (Tasmanian Area and Behaviour Support) Rules 2023. Please refer to the Privacy Collection Statement and the RISC Quality and Safeguards Commissioner’s Privacy Notice at [https://www.ndiscommission.gov.au/privacy](https://www.ndiscommission.gov.au/privacy). The NDIS Commission makes no representations about, and accepts no liability for, the accuracy of information in this document.

**Instructions for listing behaviour support plans:**

1. Complete the behaviour support plan on this document, or use your own template or this template.
2. Engage and support the implementing provider(s) as needed in obtaining, reviewing, and updating your approved plan.
3. Include details of all plans to support the NDIS Commission.
5. You will need an approved account. Click on the “My Account” button and select “My Account” to start. After successful login, you will receive an email with instructions for setting up your approved access.
6. Log in and select “Behaviour Support Plan.” Click on “Create plan” and select “Interim” or “Comprehensive.” Enter the plan details, key concepts, details of start and end dates of the plan, the problems, and the schedule of restrictive practices.
7. Go to “My Account” on the left hand side navigation menu and select “My Account.”
8. Go to the “My Account” and click on “Plan Editor.”
9. Further guidance material about how to lodge a plan is available on our website.

#### Behaviour Support Plan - Comprehensive

**Participants:**

**Plan details:**

<table>
<thead>
<tr>
<th>Behavior Support Practitioner</th>
<th>Participant ID</th>
<th>Specialist Behaviour Support Practitioner</th>
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Underpinning the PBS plan are:
• The “Reimagine My Life” Planning book.
• The CLO “My Life, My Way” person centred support planning and goal setting tool
• Goal setting framework (Quality of life domains)
• Capacity building: Developmental programming – task analysis
• Clear and robust plans:
  • Interagency risk plan
  • Support and Crisis plans
  • My Safety Plan
Demographics:
- Age: 21 to 64 years of age (average = 43 years)
- 20 males
- 9 females
- 27% forensic involvement.

Highest Presenting Behaviours include:
- Assault (2 x murder)
- Elicit drug use/alcohol and drug misuse
- Property damage

Other behaviours include:
- Self harm/self neglect
- Medication non-compliance
- Armed Robbery
- Trespass/theft
- Use of weapons (gun/knives)
- Fire lighting
Target group of participants

Diagnostic range: Schizophrenia, intellectual disability, acquired brain injury, schizoaffective disorder, personality disorder (Borderline, dependent, antisocial), anxiety disorder, autism, PTSD, multiaxial diagnosis (2+)

Health: diabetes, obesity, sleep apnoea, asthma, congenital deafness, substance abuse, frontal lobe dysfunction.
Positive Behaviour Support

• Aligning PBS with evidence based best practice.
  o Quality PBS increases quality of life, respects human rights and decreases harm and reduces behaviours of concern.

• Recording and monitoring use, reduction and elimination of restrictive practices.

Focus on:

• Functionally equivalent skill development.

• Functional skills development (capacity building)
  1. Environment
  2. Independent Living Skills
  3. Augmentative and alternative communication skills
  4. Social, emotional and behavioural skills
  5. Community skills: lifestyle factors such as meaningful social and recreational opportunities (education and employment)
  6. Reward programme(s) – Reinforcement schedule (Applied Behaviour Analysis)
  7. Reactive strategies – Stress Assault cycle and Crisis Plan
  8. Direct treatment – Therapeutic model + referral to external
The Rewards Program:

- Used to provide maintaining consequences for appropriate behaviours and to build or strengthen appropriate behavioural responses so the person can live their life happily and safely.
- Delivering a reinforcer after an alternative behaviour, or the absence of the behaviours of concern.
- It is then expected that the desired behaviour should increase and replace the behaviours of concern.
- **Note:** for many of the clients in the project highest probability reinforcer is money for purchasing preferred items – and accessing the ‘shops’. (immediate, intermittent and token economy)
**Assessing outcomes: Evidence based assessment**

- **Data:** Functional Behaviour Analysis
- **ABC recording**– Behaviour Incident data.
- **Daily Recording Charts** = monthly reporting = analysis of active support model.
- **FBA demonstrating:**
  - Reducing frequency and intensity of BOC
  - Reduced restrictive practices
  - Reduced level of support
  - Increased choice and quality of life

**Assessments (Pre and Post)**
1. **WHOQOL** (Quality of life measure).
2. **Life skills questionnaire.**
3. **Risk management:**
   - Assessment of Risk and Manageability of Intellectually Disabled Individuals who Offend (ARMIDIL), 1 month, 3 month, 6 month.
   - Dynamic Risk Assessment and Management System (DRAMs),
   - treatment focussed risk assessment for suicide and self harm,
   - household safety questionnaire. (day to day tool).
4. **Mental Health:** additional mental health tools – preliminary data only
   - Mental State Examination (MSE)
   - The Moss Psychiatric Assessment Schedule (MPAS-Check)
5. **Record of Goals and Outcomes/CANSAS** – Goal attainment Scale (GAS) within the outcomes framework
Assessing outcomes: BIP-QEII

Behavior Intervention Plan Quality Evaluation Tool II (BIP-QEII) (Wright, D. B California State University) to measure the quality of Behaviour intervention plans.

BSP plans reviewed by external consultant for effectiveness. (Flinders University Lecturer, PHD)
• Initial plans scored low overall
  • Great information on model and background
  • More information on function based strategies
  • Clearer behavioral goals

Implications for a business model:
• Plans coming through with limited hours (varies between 10 and 45) therefore, the balance between quality and business
• Clients transitioning from an institutional setting often have the lack of assessment and behaviour data (as they are not in behaviour support based settings) which does not support the development of a strong hypothesis or functional analysis for interim plan development. The baseline is essentially being established in the community setting from generalized interim plan.
Implementation is the key to success. Staff training and support is critical:

• Starts with values based, person centred recruitment.

Training provided:

• 4 day Induction includes:
  • Positive Behaviour Support and Restrictive Practices.
  • Person centred planning and active support (human rights approaches).
  • Incident (ABC) documentation and reportable incidents.
• Regular training on Personality Disorder
• Suicide risk assessment/self injury and crisis responding and reportable incidents.
• Mental health training.
• De-briefing processes.
• MAPA. (Management of Actual or Potential Aggression)
• Team building: monthly staff meetings.
Staff training and Support – PIVOTAL to success

Staff must have the following training:

- NDIS orientation module
- Zero Tolerance
- Freedom from abuse video
- Human Rights

Overall, Dedicated Manager and Coordinator for the team (that excel at PBS implementation):

Coaching and supervising Person centred active support and PBS implementation skills of front line staff is critical.
<table>
<thead>
<tr>
<th>Participant</th>
<th>Time period living in own home</th>
<th>TOTAL BoC data recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11 months</td>
<td>193</td>
</tr>
<tr>
<td>2</td>
<td>9 months</td>
<td>114</td>
</tr>
<tr>
<td>3</td>
<td>4 months</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>3 months</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>4 months</td>
<td>8</td>
</tr>
<tr>
<td>6</td>
<td>4 months</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>3 months</td>
<td>0</td>
</tr>
</tbody>
</table>

**Time periods = 7 x participants**
<table>
<thead>
<tr>
<th>Expected high risk BoC</th>
<th>Reality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire lighting behaviours</td>
<td>NO fire lighting reported</td>
</tr>
<tr>
<td>Potential for daily/weekly assaultive behaviour</td>
<td>2 x assaults across the reporting period (involving P1 and P2)</td>
</tr>
<tr>
<td></td>
<td>1 x recorded incorrectly</td>
</tr>
<tr>
<td></td>
<td>1 x anxiety over medical procedure and small push to staff shoulder.</td>
</tr>
<tr>
<td>Verbal threat to harm</td>
<td>1 x participant has displayed these behaviours</td>
</tr>
<tr>
<td>Self-harm</td>
<td>1 x participant has displayed these behaviours</td>
</tr>
<tr>
<td>Alcohol/ drug misuse</td>
<td>1 x participant has exhibited these behaviours</td>
</tr>
<tr>
<td>Property damage</td>
<td>1 x participant = 5 x property damage (minor)</td>
</tr>
</tbody>
</table>
TOTAL high risk behaviours of concern across participants

Summary:
- Participant 1 = green
- Participant 4 = yellow
- Participant 5 = purple
Highest frequency antecedents leading to BoC across participants

- Unable to have needs met: 57
- Anxiety: 27
- Instruction or prompt: 54
- Money: 31
Most frequently used positive programming strategies during a behavioural incident

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff withdrew</td>
<td>178</td>
</tr>
<tr>
<td>Validating/listening</td>
<td>77</td>
</tr>
<tr>
<td>Redirection/distraction</td>
<td>54</td>
</tr>
<tr>
<td>Positive reinforcement</td>
<td>43</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>8</td>
</tr>
<tr>
<td>Debriefing</td>
<td>18</td>
</tr>
<tr>
<td>Crisis communication</td>
<td>16</td>
</tr>
<tr>
<td>Anxiety support</td>
<td>49</td>
</tr>
<tr>
<td>Anger management strategy</td>
<td>26</td>
</tr>
</tbody>
</table>

Summary:
- Validating/listening and staff withdrawing to give space to calm were the highest positive programming strategies used.
- Redirection and providing anxiety support also highly effective.
- Across participants, mindfulness has not been a strategy that has proved successful.
Most frequently used reactive programming strategies during a BoC

Summary:
- NO MAPA holds used at all (trained physical restraint methods)
- SAPOL/SAAS – crisis plans were enacted (planned response)
- We were expecting high levels of PRN medication to be requested by participants but this did not occur
**Step down models – progress towards independent living and increasing choice and control**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Support model currently</th>
<th>Model currently</th>
<th>Steps to be completed/ progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 1</td>
<td>2:1 Active overnight</td>
<td>1:1 Passive overnight</td>
<td>Reached goal of least restrictive alternative support level</td>
</tr>
<tr>
<td>Participant 2</td>
<td>2:1 Active overnight</td>
<td>1:1 Passive overnight</td>
<td>Reached goal of least restrictive alternative support level</td>
</tr>
<tr>
<td>Participant 3</td>
<td>2:1 Active overnight</td>
<td>1:1 Passive overnight</td>
<td>Reached goal of least restrictive alternative support level</td>
</tr>
<tr>
<td>Participant 4</td>
<td>2:1 Active overnight</td>
<td>2:1 Active overnight</td>
<td>Only 3-4 months into own home</td>
</tr>
<tr>
<td>Participant 5</td>
<td>2:1 Active overnight</td>
<td>2:1 Active overnight</td>
<td>Only 3-4 months into own home</td>
</tr>
<tr>
<td>Participant 6</td>
<td>2:1 Active overnight</td>
<td>2:1 Active overnight</td>
<td>Only 3-4 months into own home</td>
</tr>
<tr>
<td>Participant 7</td>
<td>2:1 Active overnight</td>
<td>2:1 Active overnight</td>
<td>Only 3-4 months into own home</td>
</tr>
</tbody>
</table>

**Summary:**
- Goal is to have as many as possible clients 1:1 and PON
## Reducing and eliminating restrictive practices

<table>
<thead>
<tr>
<th>Participant</th>
<th>Restrictive practices in place pre transition</th>
<th>Restrictive Practices currently in place</th>
<th>Fade out stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 1</td>
<td>• Knives locked away 24:7/ no access</td>
<td>Knives locked away 24:7/ no access</td>
<td>Following up with Father to gain permission to step-down/ FBA completed</td>
</tr>
<tr>
<td>Participant 2</td>
<td>• Chemical restraint</td>
<td>Chemical restraint</td>
<td>Medications are prescribed by treating psychiatrist for the treatment of a mental health illness and will remain.</td>
</tr>
<tr>
<td>Participant 3</td>
<td>• MAPA holds/blocks</td>
<td>No</td>
<td>COMPLETED – RESTRICTIVE PRACTICE REMOVED</td>
</tr>
<tr>
<td>Participant 4</td>
<td>• NIL</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
| Participant 5 | • Approved visitors list  
• MAPA holds/blocks | • Approved visitors list  
• MAPA holds/blocks | |
| Participant 6 | • MAPA holds/blocks  
• Chemical restraint  
• Line of sight  
• Locked gates/roller door | • MAPA holds/blocks  
• Chemical restraint  
• Line of sight | LOCKED GATES/ROLLER DOOR COMPLETED – RESTRICTIVE PRACTICE REMOVED |
| Participant 7 | • Tobacco rationing  
• Caffeine consumption limits  
• Approved visitors list  
• MAPA holds/blocks | • Tobacco rationing  
• Caffeine consumption limits  
• Approved visitors list  
• MAPA holds/blocks | |
A CASE STUDY – INTRODUCING PARTICIPANT 1
Participant 1 = living in own home for 11 months

Diagnosis:
- Intellectual Disability
- Schizophrenia
- Acquired Brain Injury – motor vehicle accident
- Epilepsy; known triggers - cannabis

Age: 41 years

CLO Supports:
- 2:1 staffing ratio, 24:7; active overnight

Behaviours of concern:
- Reported since 7 years of age.
- Multiple offences including aggravated assault and property damage.
- Drug use.
- Fire lighting.

“I hear voices” and “I can’t concentrate on things”
What is important to me?
• My Christian beliefs
• Maintaining a good diet
• Family

How I want to be treated:
• With respect
• Have good manners
• Be responsible
• Honesty
• Acceptance
• Caring
• Listen to me

Participant 1 was clear about what he wants from support workers:
• Staff that show care, show positive reinforcement
• I want my support worker to be honest and reliable and caring
• I want support workers that can tell jokes and make me laugh
• Share interest in sport and games

“I don’t like feeling ill”
<table>
<thead>
<tr>
<th>Participant 1 - Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health</strong></td>
</tr>
<tr>
<td>• Thought disorder and self-harming behaviours.</td>
</tr>
<tr>
<td>• Emotionally reactive to difficult situations</td>
</tr>
<tr>
<td>• History of psychotic and reckless behaviours</td>
</tr>
<tr>
<td>• Low levels of motivation, concentration and restlessness</td>
</tr>
<tr>
<td>• Medications</td>
</tr>
<tr>
<td><strong>Guardianship</strong></td>
</tr>
<tr>
<td>• Administration orders</td>
</tr>
<tr>
<td>• SACAT Special Powers, Section 32</td>
</tr>
<tr>
<td><strong>Forensic history</strong></td>
</tr>
<tr>
<td>• Extensive offence history</td>
</tr>
</tbody>
</table>

“****’s thought disorders and very limited self-awareness of the offending-related behaviour do not allow the kind of self-management required to deliberately avoid repeats of past offending.”
### Participant 1 - Risk Factors

**Accommodation:** - Multiple supported residential facilities (SRF’s) and cluster accommodation.
- CLO previously provided support up until early 2018; = threatened to kill staff with a knife - leading to arrest.
- Placed in JNH, until he moved into his own home through this project.

**Supervision/treatment compliance issues**
- History of breaching bail conditions.
- Drug and Alcohol misuse; primarily Marijuana use.

**Relationships:**
- Lack of positive peer group and friendship circle; vulnerable to “falling in with the wrong crowd”.
- **vulnerable to be taken advantage** of in the community or to present with verbally or physically aggressive behaviours.
**Participant 1 - Goals**

<table>
<thead>
<tr>
<th>Goal 1 – Enrol in a short course</th>
<th>Who or what can help me?</th>
</tr>
</thead>
</table>
| 3 months – **Choose a course I like**  
To enrol in the course | My support workers can help me |
| 6 months – To become an actor in Hollywood after studying to become a martial artist | **Do an acting course**  
Improve computer skills  
Go to gym and exercise regularly |
| 12 months – Become a movie director and go for a holiday in Colorado.  
Ride horses on a horse farm. | Save money to pay for holiday in Colorado |

<table>
<thead>
<tr>
<th>Goal 2 – Be healthier and fitter</th>
<th>Who or what can help me?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 3 months my goal is to “<strong>get fitter and healthier</strong>”</td>
<td>Going to the gym regularly</td>
</tr>
<tr>
<td>Within 6 months I will “ride horses on a big farm”</td>
<td>Do a horse riding course</td>
</tr>
<tr>
<td>Within 1 year I will “<strong>Get an autograph signed on t-shirt from Arnold Schwarzenegger</strong>”</td>
<td>Visit America for a holiday</td>
</tr>
</tbody>
</table>

“I want to live independently”
24/7 Removal of sharp knives/kitchen knives

- Lacked the skills to self-monitor and self-regulate when becoming agitated or excited.
- Extreme **difficulty in making safe choices** and **highly likely to self-harm** at such times.
- The removal of knives was **preventative in nature**; designed to reduce the likelihood of harm to Participant or others.
- A fade out plan was developed; the goal being.....

“**** can store his sharp knives in the kitchen and have free access to them whenever he needs to use them”.
Participant 1 - Strategies:

1. Reward program; monetary system.
2. Drug and Alcohol Programme
3. 10 point scale
4. Menu planners/cooking program
5. Task Analysis; “How to do”
6. Mental health program; understanding schizophrenia
7. Transport and Pedestrian programme
8. Weekly planner and shopping list
9. Therapeutic worksheets
### Participant 1 - Total Behaviours of Concern March 2019 – January 2020

<table>
<thead>
<tr>
<th>MONTH</th>
<th>NUMBER OF BOC</th>
</tr>
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<tbody>
<tr>
<td>MAR-19</td>
<td>13</td>
</tr>
<tr>
<td>APR-19</td>
<td>23</td>
</tr>
<tr>
<td>MAY-19</td>
<td>16</td>
</tr>
<tr>
<td>JUN-19</td>
<td>7</td>
</tr>
<tr>
<td>JUL-19</td>
<td>7</td>
</tr>
<tr>
<td>AUG-19</td>
<td>6</td>
</tr>
<tr>
<td>SEP-19</td>
<td>5</td>
</tr>
<tr>
<td>OCT-19</td>
<td>11</td>
</tr>
<tr>
<td>NOV-19</td>
<td>8</td>
</tr>
<tr>
<td>DEC-19</td>
<td>4</td>
</tr>
<tr>
<td>JAN-20</td>
<td>5</td>
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</tbody>
</table>

**Summary:**
- Peaks in April – “honeymoon period”
- Peak in October – community access without staff increased (access to marijuana)
Participant 1 - High Frequency Behaviours March 2019 – January 2020

Primarily behaviours are related to:
- Money
- Drug related
- Relationship based; feeling controlled and lacking choice and control
- The drug or alcohol abuse increased in September - October due to participant increasingly going into the community independently.
The primary antecedents leading to behaviours include:
- Access to money
- Unable to have wants or needs met
- Anxiety
- Being prompted or given an instruction; primarily related to ADL’s.
Summary:
• Direct correlation between the reduction in anxiety (antecedent to BoC) with the level of support needed i.e. as the anxiety was decreasing, the level of support required also decreased.
• Highest is: validating/listening, redirection/distract and positive reinforcement.
Participant 1 - Consequences (Reactive Strategies)

Summary:
- Of the 9 x incidences where staff enacted the crisis plan; 8 were related to P1 leaving site without staff. 1 x ambulance called due to illness.
- 0 x related to assaultive or property damage behaviours.

Number of Incidences

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<tbody>
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<td>1</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

- PRN administered
- SAAS/SAPOL (crisis plan enacted)
- Staff withdrew from immediate environment
**The Australian WHOQOL-BREF:**

<table>
<thead>
<tr>
<th>Domain</th>
<th>PRE</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall perception of QOL</td>
<td>Poor</td>
<td>Neither poor nor good</td>
</tr>
<tr>
<td>Overall perception of health</td>
<td>Fairly Dissatisfied</td>
<td>Fairly Dissatisfied</td>
</tr>
</tbody>
</table>

**Summary:**
- Higher scores denote higher QOL.
- Participant has self-reported an increase in QOL across all domains, except for Social Relationships.
- He has noted that since he has moved from JNH he has had less people around him and he misses that – this may have influenced the reduction in his perception of his social relationships.
**Participant 1 - Quality of Life Outcomes:**

- Reduction in signs of anxiety.
- Increasing engagement with supports.
- Increased time on his own in the community.
- His goal was to *maintain his tenancy long term* and pass landlord inspections = passed all inspections.
- Has set bail conditions and has **not breached any** of them (has not been detained or arrested).
- 2:1 community supervision at all times at start of service = now has **independent community access without supports**.
- Has been consistently maintaining **hygiene standards**.

“He is extremely house proud and wanted to show me around when I arrived” (staff member)
Participant 1 - Increased Quality of Life Outcomes:

- Community engagement:
  - Indoor cricket
  - Acting classes
  - Club Cool social event
  - Beach visits/ walking on the jetty
  - Street markets
  - Registered with a job network provider

Q: What do you like about living in your new home?

A: “It is spacious, new and it’s awesome”

And I like…. “Living in the community”
Participant 1 - Choice and Control:

- Recognising that drug use impacts on his behaviour and reduction in use.
- **Requesting PRN medication has ceased** (since August 2019).
- **Engaging** well with tailor-made development programming; consistently engages in weekly budgeting, weekly planners/activity planning and weekly shopping lists, and menu planning.
- **Independently** selects his meals and activities for the week; regularly selecting healthy meal options, and saving up for things he wants.
Participant 1 - Behavioural and Functional Skill Development:

- **Self-regulating** when agitated.
- Only ONE incident of minor property damage in the 11 months.
- **Validating concerns** the biggest predictor of success, and space to voice what is going on, to feel safe and supported.
- Long standing medication non-compliance; from 13 x in first month - to 11 months later and only 2 x noncompliance (and attending 90% of medical appointments).

Was 2:1, active over night.

Now 1:1, passive over night
The Life Skills Assessment:

**Note:**
- Self report
- The higher the score, indicates the “greater degree of disability”.
- **A reduction in all subscale scores;** apart from self-care.
- This may be the result of discussions that staff have had with the participant related to health and diet and his increasing awareness of his reduced skills in this area.
- However, overall he has reported a **increase in his perception of his skill and abilities** since commencing with CLO.
Participant 1 - Elimination or Reduction of Restrictive Practices:

• Due to history of assault using a weapon; restrictive practice i.e. prohibited from accessing/using knives and all knives were locked away.
• Since then, a knife fade-out plan was implemented; participant allowed to use knives under staff supervision and when at baseline.
• The fade-out plan was highly successful as he is now able to use knives of all shapes and sizes.

Outcome:
• It is expected that the restrictive practice will have been eliminated by the end of March 2020.
• Alternative ways of expressing agitation (i.e. talking, asking for help, asking to be left alone) evidenced on a regular basis.
Project Findings - What are we learning?
What have we learnt?

- Navigating complex psychosocial pathways through a new national system (NDIA and QSC) while the whole system is in implementation phase.

- Interagency planning/ complexities of navigating different services and reporting requirements.

- Navigating all timelines converging: court dates and bail/licence changes, house readiness, recruitment and training of staff, SIL approvals and the Specialist Support Coordination assessments and timing.

- The complex steps involved in SDA assessment for individuals with the additional EHO steps and assessments to align the NDIS plan with the house allocated through the 100 homes project.
What have we learnt?

• PBSP’s being written; funding insufficient or wanting them written before participant has moved into home, limited data or information, often based on historical information and not current behaviour statistics = best practice?
• Changing RP’s and gaining authorisations. Writing of PBS plans, only to require amending a few months later to include new RP’s.
What have we learnt?

The new pricing guide: how to build a billable hours model while ensuring quality PBS plans while ensuring flexibility and responsiveness.

We invested in:
• a Regional Manager position dedicated to the project.
• A dedicated PBS practitioner 1.3FTE.
• Staff Development Coordinator (to assist with on boarding, assessment, training and support of a large workforce).

Staffing; workforce supply and demand. Difficulty finding appropriately qualified staff.

How to ensure the participant is involved in ALL aspects of their supports, including PBSP, RP’s, staffing, daily activities etc. while the system itself is complex and new.
What have we learnt?

• It CAN be done.
• Our staff are our greatest assets; working together has resulted in outcomes beyond what was expected.
• We can reduce and eliminate restrictive practices!
• Recidivism can be reduced; we can support positive community engagement, social relationships and participation in ADL’s.
• Slow and steady wins the race; clear and realistic goal setting and the ability to assess for areas of strength and areas requiring support = appropriate level of support being provided that builds on current capacity and focuses on building this further.

• Increased sense of agency and self-efficacy comes from feeling and being valued as a contributing community member – no matter past behaviours.
To wrap up:

We want to acknowledge the leadership and support provided by:
- Joumana El-Merhibi (Mental Health Project Regional Manager)
- Kerry Gardner (PBS Practitioner)
- Grace Wu (PBS Practitioner)

Also to the Client Services Coordinators:
- Muji Ahmed
- Janet Quintreel
- Katie Wilde
- Ashton Tobard
- Vikki Mather
- Molly Springhall

A big thank you to all our clients, we continue to enjoy supporting you on your journey, to our staff, we couldn’t do it without your dedication and to our stakeholders for supporting our programmes.
THANK YOU!
Questions?