



Evaluation of the Sector and Workforce Development Project to Promote the Use of Positive Behaviour Support in Disability Services

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Executive summary

Introduction

This is the report of the evaluation of an action research pilot project to determine **what is required to support the disability services sector and its workforce in WA to promote the use of Positive Behaviour Support**. The project is one of a suite of initiatives developed in response to the finding of the 'Western Australian Sector Health Check on Disability Services' (2007) (see footnote 1), that there was "limited capacity of the sector as a whole, with only a few providers having the knowledge and skills to manage challenging behaviour" and that this had significant social, service and economic consequences. The initiatives were collectively designed to progress sector learning about Positive Behaviour Support.

The purpose of this project was to identify the learning for the sector and for the development of the sector workforce, from the experience of implementing a Positive Behaviour Support approach in a consortium of three pilot project organisations: a supported accommodation service provider (Nulsen), a provider of Alternatives to Employment (ATE) services (Valued Independent People or VIP) and a provider of children's respite services (Red Cross Lady Lawley). The project's purpose was not to further test the strong evidence in support of Positive Behaviour Support as a model to guide practice in working with people whose behaviour is sometimes challenging, but **to learn about what conditions facilitated and what created barriers to implementing and embedding a Positive Behaviour Support model in an everyday working service environment**.

The target population for the project were 29 residents at seven of Nulsen's residential group homes, a VIP ATE site that services 25 people, and 28 children who accessed one or more of Lady Lawley's three respite services (home based-Intensive Family Support, planned centre-based respite and centre-based day respite). All project service sites were in metropolitan Perth.

Findings

Positive Behaviour Support is an approach that results in an improved quality of life for people whose behaviour is sometimes challenging and produces better outcomes for the services that support them. It is an important element of person-centred, outcomes-based practices. Supporting people with an intellectual disability to develop new and more adaptive behavioural skills is often the precursor to the opportunity to engage in valued social roles.

Footnote 1

Disability Services Commission, 2007, "Western Australian Sector Health Check on Disability Services"

This project highlights that it is possible to significantly reduce the use of restrictive practices through:

- gaining senior level organisational support for the introduction of Positive Behaviour Support
- providing appropriate staff training
- supporting emerging leadership at all levels within disability sector organisation, but particularly at the operational level through the introduction of leadership/mentor roles specific to the area of behavioural support
- implementing robust and consistently applied organisational systems and processes that support and embed good behaviour support practices
- fostering cross-sector and inter jurisdictional collaboration
- recognising and responding to the critical importance of timely, accessible support to organisations from professionals with experience in Positive Behaviour Support.

This report finds that the many of the restrictive practices in place are often not recognised as restrictive and have emerged over time in response to Occupational Health and Safety and issues of staff injury and welfare. There has been a need for a clear and evidence based decision making process that provides the justification supporting the use or non-use of a restrictive practice. The Voluntary Code of Practice for the Elimination of Restrictive Practices has arisen in response to this need and future training will be needed to reinforce defensible and transparent decision making process that recognises the rights of people with a disability and the welfare needs of all concerned

The outcomes set for the project reflect what the literature suggests would, ideally, be in place for a service system to reflect best practice in Positive Behaviour Support (See footnote 2) (see footnote 3 on next page).

Footnote 2

Allen D, "Positive Behavior Support as a Service System for People with Challenging Behavior", *Psychiatry* Volume 8.1, pp 408–412

Rotholz D and Ford M "Statewide system change in Positive Behaviour Support", *Mental Retardation*, Volume 41, 5 pp354–364

Reid D, Rotholz D, Parsons M, Morris L, Braswell B, Green C and Schell R, 2003, "Training Human Service Supervisors in aspects of PBS: Evaluation of a Statewide, Performance Based Program", *Journal of Positive Behavior Interventions*, Volume 5,35, pp 35–45

There was valuable learning from the project, in terms of what went well and what was achieved, but also what went less well. Success was not only about measuring the extent to which the outcomes were achieved, but also in the learning about the organisational arrangements on which the WA disability services sector should focus, in order to maximise capacity to achieve the outcomes over time.

The learning extended past that associated with the planned outcomes noted above. Additional strategies were implemented in response to the experience of the consortium partners as the project progressed and new and unanticipated challenges and opportunities arose. These provided further important learning to inform the next phase of the rollout of the Challenging Behaviours Framework across the sector, and particularly into regional areas.

Footnote 3

- 1) A comprehensive model of Positive Behaviour Support for rollout across the disability services sector
- 2) Positive Behaviour Support Products and Tools available and in use in pilot agencies
- 3) Collaborative partnerships to support best practice are in place in pilot agencies
- 4) Embedded PBS Practice Leadership in the Pilot agencies
- 5) Skilled support staff are attracted and retained
- 6) Constructive and sustained consumer routines
- 7) Reduction in use of restrictive practices
- 8) Reduction in number, occurrences and severity of adverse incidents related to challenging behaviours
- 9) Compliant, Consistent and Accountable Services

Recommendations

Recommendation 1

Rollout should be supported by an evidence based multi element Positive Behaviour Support framework that is supported by a comprehensive and integrated range of organisational policies, practices and tools, including capacity to provide objective feedback to staff on the impact of their changed practices on those with whom they work.

Recommendation 2

Organisations should be prepared to direct organisational effort towards comprehensive change management planning for the their rollout, including enlisting the support of their Boards, CEOs and Senior Managers, ensuring that policies and procedures support the planned directions, organisational systems are aligned with the new requirements and staff are informed and prepared for workplace changes.

Recommendation 3

Planning should be based on an expectation that it will likely take two years at a minimum to set up **and** embed a comprehensive multi element Positive Behaviour Support model.

Recommendation 4

Planning should be predicated on an understanding that implementation requires at least some changes to staffing arrangements (eg backfilling) so that staff can be trained during work time and resources are available to complete Positive Behaviour Support requirements such as behavioural assessments, development of individual plans, recording of behaviours etc.

Recommendation 5

Workplace “champions”, who show commitment to working within a Positive Behaviour Framework, have current direct care responsibilities and are respected by their peers, should be identified and trained as peer mentors for their colleagues.

Recommendation 6

The model of short term respite for families of children with behaviour that are sometimes challenging be reviewed to enhance the capacity of this type of family support to implement planned Positive Behaviour Support.

Recommendation 7

Rollout should be supported by an evidence based multi element model of Positive Behaviour Support which is supported by an integrated suite of validated products and tools that are aligned with supportive policies, procedures and organisational systems. Further work is required to develop training, products and tools that are freely available and accessible to the disability sector.

Recommendation 8

Organisations should be encouraged to implement Positive Behaviour Support in collaboration with a small group of peer organisations wherever possible.

Recommendation 9

Positive Behaviour Support Panels, as trialled in the project, should be incorporated into the rollout of Positive Behaviour Support in all organisations.

Recommendation 10

Strategies (including ongoing training in Positive Behaviour Support), should be designed not only to implement Practice Leadership, but to embed it by checks and reviews and by ensuring succession planning for identified future leaders.

Recommendation 11

Organisations should plan for the impact of staff turnover and ongoing known operational imperatives during their implementation of Positive Behaviour Support.

Recommendation 12

Organisations should use validated tools to audit and monitor the extent to which constructive routines are in place and followed and to motivate staff to comply.

Recommendation 13

Restrictive Practice Audits should be a required element at the commencement of the implementation of Positive Behaviour Support in all organisations.

Recommendation 14

Restrictive Practice Audits should be conducted so as to identify restrictive practices not only in relation to individuals, but also practices that are embedded into standard work site and organisational level culture and practice.

Recommendation 15

A reduction in the number, frequency and severity of adverse incidents related to challenging behaviours should continue to be a primary outcome sought from the implementation of Positive Behaviour Support arrangements.

Recommendation 16

Sustained attention must be given to training. Arrangements for the ongoing development of staff knowledge and skills past the “elementary” level should be included in planning rollout in each disability sector organisation.

Recommendation 17

The use of structured tools that assess the quality and application of behaviour support plans are effective reinforcers of both learning and its application in the workplace and should be incorporated into the further rollout of Positive Behaviour Support.

Recommendation 18

The findings of the evaluation should be widely distributed and formally discussed across the Disability Services sector, including families, carers and the services that support them, so the learning is embedded into all activities supporting the further rollout of the Positive Behaviour Framework in disability sector organisation across the State;

Recommendation 19

The next phase of rollout of the Positive Behaviour Framework should include pilot projects in regional and rural Accommodation and ATE settings and in disability sector organisations providing individual options in the community.

Recommendation 20

There is a role for specialist clinical consultancy to support the disability sector in responding to the needs of people with a disability who sometimes display challenging behaviours. This support will be integral to the project's successes and consideration of how the sector will access this type of support into the future will be integral to the future success of the Positive Behaviour Framework reform agenda.

Recommendation 21

The Disability Services Commission should continue across portfolio negotiations to achieve a consistent and respectful approach to working with people with disability whose behaviours are sometimes challenging, regardless of where and how they engage with Western Australia's community services, education, justice and health systems.

1. Introduction

This is the report of the evaluation of an action research pilot project to determine what is required to support the disability services sector and its workforce in WA to promote the use of Positive Behaviour Support. ‘Action research’ supports practitioners to identify and adopt ways to provide an enhanced quality of care and support. Koshy (2010) (see footnote 4) described it as follows:

“Action research is a method used for improving practice. It involves action, evaluation, and critical reflection and – based on the evidence gathered – changes in practice are then implemented.”

Koshy further noted that:

- it is situation-based and context specific
- it develops reflection based on interpretations made by the participants
- knowledge is created through action and at the point of application, and
- it can involve problem-solving, if the solution to the problem leads to the improvement of practice.

Consistent with Koshy’s definition, the report is presented in four sections: this introduction which addresses the background, purpose and inputs to the project, and then sections which correspond to Koshy’s description of action research. The second section describes the evaluation requirements, the range of activities and initiatives that preceded and contributed to the establishment of the pilot project, and describes the key features of the pilot project’s practice model. The third section describes the evaluation methodology and the results the pilot project achieved. The fourth and final section brings together the critical reflections of those involved in the project and the evaluator. It draws out the learning from the project and how it can constructively inform future practice as the WA disability services sector moves forward with its commitment to eliminating restrictive practices and creating a respectful, person-centred environment within organisations and across the service system.

Footnote 4

Koshy V, 2010, “Action Research for Improving Educational Practice. A step-by-step guide”, Sage, London, Second Edition

1.1 Background to the project

The Sector Workforce and Development Project was an outcome of a number of initiatives.

In 2007 one of the findings of the Commission's 2007 'Western Australian Sector Health Check on Disability Services (see footnote 5), was that there was "limited capacity of the sector as a whole, with only a few providers having the knowledge and skills to manage challenging behaviour" and that this had significant social, service and economic consequences.

In 2009 in response to the Sector Health Check finding, and following an extensive consultation process, the Disability Services Commission (the Commission) introduced the Positive Behaviour Framework (see footnote 6) with the support of disability sector organisations. The framework is a strategic plan that provides a staged approach to the implementation of strategies to develop Positive Behaviour Support at all levels of disability service delivery across WA.

In addition to the consultation process, the framework was informed by an extensive review of literature which addressed:

- definitions of challenging behaviour
- prevalence of challenging behaviour
- impacts of challenging behaviour, and
- evidence-based practice and service approaches relevant to challenging behaviour.

The literature review focused heavily, although not exclusively on the work of international experts in the field of intellectual disability, Applied Behaviour Analysis and challenging behaviour, including Eric Emerson, Gary La Vigna, T J Willis, E G Carr, Keith McVilly and Jim Mansell (see footnote 7).

A guiding committee was convened to guide the implementation of the Positive Behaviour Framework. The committee included representatives from the Commission, disability sector organisations and advocacy organisations, and was chaired by a parent of a young man whose behaviours are considered to be sometimes challenging. Disability sector organisation representatives on the committee included trained senior staff who have extensive experience and training in the management of behaviour, a number of whom have been part of a Positive Behaviour In Action (PBIA) Interest Group since 2005.

Footnote 5

Disability Services Commission, 2007, "Western Australian sector Health Check on Disability Services"

Footnote 6

Disability Services Commission, Western Australia, 2009, "Positive Behaviour Framework"

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In late 2009, the Towards Responsive Services for All Report (see footnote 8) was released. This was an initiative arising from the Positive Behaviour Framework, conducted by a project team led by National Disability Services (NDS) WA. The report focused on the current state of play in the West Australian disability services sector in relation to services provided to people with disability whose behaviour is sometimes challenging. One of its recommendations was for the development of specific infrastructure to support responsive service provision, including sector and workforce development.

In 2011, the Sector and Workforce Development Project was commissioned by the Commission, under the auspice of the guiding committee. The project was one of a suite of initiatives collectively designed to progress sector learning and a direct outcome of the Positive Behaviour Framework and the Towards Responsive Services for All Report.

In March 2011, the Commission formally sought expressions of interest from Disability sector organisations that were members of the guiding committee. Interested disability sector organisations were invited to form a consortium to undertake a 12-month project to trial an evidence-based approach to Positive Behaviour Support based on current best practice, to provide learning that would influence and inform broader sector rollout of positive behaviour strategies in disability sector organisations across the State.

Project partners were sought across Accommodation, Respite and Alternatives to Employment (ATE) services in order to test the approach in a range of service settings.

Footnote 7

It is not the intention of this report to revisit and redescribe the literature that informed the Workforce Training and Development project design. Readers are referred to the Disability Services Commission website www.disability.wa.gov.au for links to further information about the evidence base.

Footnote 8

National Disability Services, 2010, "Towards Responsive Services For All", a project commissioned by the Disability Services Commission, Western Australia

1.2 Project purpose

The purpose of the project was to identify the learning for the sector and for the development of the sector workforce, from the experience of implementing a Positive Behaviour Support approach in the three pilot project organisations. **The design of the project was guided by the recommendations of the Towards Responsive Services for All Report and the learning from the literature conducted to inform the Positive Behaviour Framework, about what is required to develop an organisational capacity and associated operational arrangements to introduce Positive Behaviour Support strategies and reduce restrictive practices.** The strong evidence base that supports the effectiveness of Positive Behaviour Support approaches and the benefits to service users, families, and organisations that provide services to them, was ‘a given’ in the project. The project was not implemented in a controlled trial environment. There were no controls over the staff who worked in each service site that was part of the evaluation, or of organisational management practices such as rostering, recruitment and selection, performance management and the movement of staff for reasons of organisational need.

The project’s purpose was therefore not to further test the strong evidence in support of Positive Behaviour Support as a model to guide practice in working with people whose behaviour is sometimes challenging, but to learn about **what conditions facilitated and what conditions created barriers to implementing and embedding a Positive Behaviour Support model in an everyday working service environment.**

1.3 The consortium

The successful consortium included: the lead agency, accommodation provider Nulsen; respite provider Lady Lawley Cottage (LLC), a Red Cross service; and alternatives to employment (ATE) provider Valued Independent People (VIP).

With a history of providing services to people with disability and their families since 1956, Nulsen is one of the oldest disability services organisations in WA. Its services focus on people with profound physical and intellectual disability, many of whom have complex support needs, including challenging behaviours. It provides a range of disability services, including supported accommodation services to more than 100 people in 24 homes.

Like Nulsen, LLC is one of the oldest providers of services to children with disability and their families in WA. It offers services to children who have physical and/or intellectual disability and/or chronic, complex medical conditions, from infancy to 16 years of age. Its services include: planned overnight on-site respite of varying durations to meet individual family needs, planned day respite on weekends and throughout school holidays, and home based respite for families who are in receipt of Intensive Family Support funding from the Commission.

VIP commenced operations in 1992. It provides ATE services to people who, because of a disability, are unable to participate in mainstream employment. ATE services include support for people to access community services, to develop and

maintain independent living skills, to participate in recreation and sporting activities, to engage in training or volunteer work, to build and maintain relationships and to be assisted with personal care.

1.4 Project leadership group

The participating organisations each identified a staff member to be part of the project leadership group. The duties of these positions included:

- liaison with senior management in their organisation
- coordination across the consortium
- engaging, training and supporting front line supervisors and direct care staff in their organisations, and
- monitoring progress within their organisation.

With Nulsen as the lead agency, the Nulsen project leader was also the overall project manager and team leader across the three agencies. Her professional background was occupational therapy with significant experience in working with people with intellectual disability at a practice and management level. From her experience as the manager of a previous major Positive Behaviour Support project at Nulsen, she brought to the project specialist training and experience in Positive Behaviour Support and ABA. Nulsen also appointed two project officers to the project, both of whom had significant experience in the direct care and support of people with disability and who were specifically trained in the requirements of the pilot model. These staff acted as specialist peer mentors to front-line managers and staff at Nulsen and VIP.

The VIP project representative was a disability support worker with considerable experience as a front-line service manager and a special interest in positive behaviour approaches. As will be discussed in Section 4, there were changes in the occupant of the VIP leadership role across the life of the project.

The LLC project representative was an experienced psychologist with a professional history in positive behaviour approaches and the use of applied behavioural analysis with people with disability whose behaviour can be sometimes challenging.

At Nulsen, project staff were formally released from other duties to work full-time on the project. VIP was able to allocate a dedicated resource to the project for only some periods due to major unrelated changes in the organisation. At LLC, the leadership group team member incorporated involvement with the project into an existing workload.

1.5 Organisational preparedness

All three partner organisations brought to the project a pre-existing commitment to reducing the use of restrictive practices in their organisations and to using the evidence base to change other organisational practices to create a respectful and supportive environment for all of their service users.

Nulsen had implemented a comprehensive internal project in 2010 to move the organisation towards practice based on Positive Behaviour Support approaches. Nulsen had previously appointed a specialist clinical consultant to support and advise on their 2010 project.

Learning from that project resulted in the use of the non-linear model of Positive Behaviour Support that was applied in this project.

At LLC a separate earlier project had been undertaken to reduce the number of restrictive practices used in its respite services.

1.6 The model

The person-centred non-linear model of Positive Behaviour Support trialled by the consortium organisations was, as noted above, derived from a strong evidence base and adapted from LaVigna and Willis 1995) (see footnote 9).

A short summary of the key features of the model is provided here, but readers seeking detailed discussion about the model, its associated tools and its evidence base should refer to the source document.

Participation in the pilot project required the informed consent of potential participants, or the informed consent of their representative if the person was not able to provide informed consent.

The Applied Behaviour Analysis approach used in this project was strongly outcomes-focused and included both personal and social outcomes for the individual. It used multi element behavioural assessment and support to promote the use of non-aversive strategies to help staff to more effectively and respectfully respond to challenging behaviours. Its underpinning philosophy was consistent with ‘social role valorisation’:

“The enablement, establishment, enhancement, maintenance and/or defence of social valued roles for people by using, as much as possible, culturally valued means.” (Wolfensberger, 1983)

Behaviour support plans included the person’s physical and mental health and wellbeing and the service system in which they were located – supervision, quality assurance and the prevalence and nature of restrictive practices. They were person-centred and highly customised to the individual’s circumstances. The effectiveness of a plan was directly related to the quality and comprehensiveness of the assessment which informs it. The assessment included analysis in eight critical areas.

Footnote 9

LaVigna G and Willis T, 1995, “Challenging Behavior: A Model for Breaking the Barriers to Social and Community Integration”, Positive Practices, Volume 1 Number 1

Behaviour support plans were predicated on an understanding that it is highly unlikely that any single strategy will achieve the desired outcomes in relation to an individual's challenging behaviours. They included four components, three proactive and one reactive, which in combination, are intended to achieve the desired outcomes.

These were:

1. Ecological changes – planned environmental changes that over time, produce a change in behaviour, for example, lifestyle and routines, background stimuli and environmental pollutants.
2. Focused support strategies – strategies that should result in more rapid effects including, for example, schedules of reinforcement, stimulus control or satiation and background stimulus change.
3. Positive programming – to change the person's behavioural repertoire to better deal with their environment through changes to communication systems, coping and tolerance strategies and functional related or equivalent skills development.
4. Situational management – reactive strategies to establish control and prevent harm when a situation occurs.

The proactive strategies were consistent with the model outlined in **the Effective Service Design Report** and designed to achieve reduction in the frequency of the challenging behaviour, therefore reducing the need for reactive strategies. The reactive strategies were those which manage the challenging behaviour when it occurs. Both sets of strategies play a role in reducing episodic severity, but it is the proactive strategies which maintain the reduction in the longer term.

The model includes a role for a specialist support person (a behaviour support consultant) in the settings in which a Positive Behaviour Support plan is being introduced, to model support strategies and provide immediate support and advice to those implementing the plan. As the service providers become competent in carrying out the plan, direct contact is progressively reduced and the specialist role becomes one of review. Formal reviews occur at regular intervals to monitor client progress and identify any barriers to progress, and make changes as necessary. The ultimate aim is the service provider has the necessary internal skills to manage the plan.

In summary, the model is grounded in Applied Behaviour Analysis and related fields, is evidence based, person centred, has multiple elements and is strongly outcomes focused.

The key elements in the model are:

- front-line leadership
- training/skills development; (e-learning and onsite client specific practice, mentoring)
- current state assessment through a comprehensive audit of restrictive practices that addresses both organisational and individual service practices

- behavioural assessments for Individuals
- person-centred planning that include multi -element behaviour support plans
- an online staff resource kit;
- transparent and accountable decision-making processes via restrictive practices panels
- monitoring and supervision, including structured auditing practices and processes to measure procedural reliability over time
- feedback and continuous improvement.

Of significance outside the primary reasons for selecting this model for the project was its broader relevance, in the context of the State Government policy Delivering Community Services in Partnership.

The model was not only consistent with the Effective Service Design Report, which was specifically focused on design that promotes positive approaches in responding to challenging behaviours, but is also an exemplar model that satisfies the requirements of the Commission's current initiatives in relation to procurement reform, including individually-funded outcomes-based services funding.

1.7 Service population in project scope

The target population for the project were the 29 residents of seven of Nulsen's residential group homes, one of VIP's ATE sites that services 25 people, and 28 children who accessed one of more of Lady Lawley's three respite services, home based Intensive Family Support, planned centre-based respite and centre- based day respite. All service sites included in the project were based in metropolitan Perth.

From the commencement of the project, Nulsen decided to introduce the model across all 24 of its residential group homes. Part way through the project, VIP extended the model into its other three service sites. Nulsen and VIP report that results at these other sites are broadly consistent with findings in relation to the project sites.

2. Evaluation methodology and project outcomes

2.1 Evaluation requirements

The evaluation brief was to provide an objective external assessment and review of the pilot project activities, related to outcomes that were agreed in consultation with key stakeholders and reflected in a Program Logic.

The outcomes were:

- a comprehensive model of Positive Behaviour Support for rollout across the disability services sector

- Positive Behaviour Support products and tools available and in use in pilot agencies
- collaborative partnerships to support best practice are in place in pilot agencies
- embedded Positive Behaviour Support Practice leadership in the pilot agencies
- skilled support staff are attracted and retained
- constructive and sustained consumer routines
- reduction in use of restrictive practices
- reduction in number, occurrences and severity of adverse incidents related to challenging behaviours
- compliant, consistent and accountable services.

The outcomes reflect what the literature suggests would ideally be in place for a service system to reflect best practice in Positive Behaviour Support (see footnote 10). The success of the pilot project was not necessarily being achieved in all of these outcomes but in the learning about the organisational arrangements the WA disability services sector should focus on to maximise its capacity to achieve those outcomes over time.

Footnote 10

Allen D, "Positive Behavior Support as a Service System for People with Challenging Behavior", *Psychiatry*, Volume 8.1, pp 408–412

Rotholz D and Ford M, "Statewide system change in Positive Behaviour Support", *Mental Retardation*, Volume 41,5, pp 354–364

Reid D, Rotholz D, Parsons M, Morris L, Braswell B, Green C and Schell R, 2003, "Training Human Service Supervisors in aspects of PBS: Evaluation of a Statewide, Performance Based Program", *Journal of Positive Behavior Interventions*, Volume 5:35, pp 35-45

The evaluation was required to address both formative and summative issues in an action research pilot project designed to:

- test the extent to which a pilot model, based on Applied Behaviour Analysis and related fields, contributed to Positive Behaviour Support practices that contributed to a reduction in restrictive practices in the consortium organisations, and
- use the experience of consortium partners in implementing the pilot project as learning about requirements at a sector and an organisational level, if a Positive Behaviour Support model was to be successfully rolled out beyond the pilot project consortium organisations.

Formative evaluations take place during a project's implementation and aim to improve the project's design and performance. They provide early information about whether or not a project is proceeding as planned, what is working and what isn't, and about what other influencing factors (internal and external) contribute to this. To this end, evaluation activity took place across the 12 months of the project. The evaluator and the project team worked together and progressively took into account the findings from early data collected for the project and the experiences of the consortium partners at different stages of the project's implementation.

Formative evaluations complement summative evaluations, and were conducted at the end of the project. They enabled consideration of the project across its life span from beginning to end. They informed decisions about the extent to which the project's outcomes were met, the project's strengths and weaknesses, if there were unintended positive or negative consequences, what contributed to its successes and failures and the feasibility and desirability of extending the project into other areas and under what conditions .

2.2 Evaluation design

A 'program logic' was designed in collaboration with key stakeholders, to map the project's inputs, activities, outputs and outcomes. This approach was selected because it clearly identifies the processes that are anticipated to ultimately lead to the project having its desired impact, from implementation, to delivery of services to the results of the delivery of the services – the spectrum required in this evaluation.

As described in the W K Kellogg Foundation Program Logic Model Development Guide (2004) (see footnote 11).

“A logic model is a systematic and visual way to present and share understanding of the relationships among the resources you have to operate the activities you plan, and the changes or results you hope to achieve.”

Footnote 11

W K Kellogg Foundation, 2004, “Program Logic Model Development Guide”, Michigan

The guide notes that many evaluation experts agree that using logic is an effective way to ensure a program's success, because it helps organise and systematise planning, management, and evaluation functions.

Using a program logic model during implementation and management ensures that the focus is on identifying requirements, achieving and documenting results.

In the planning phase, the program logic model serves as a planning tool to develop strategy and enhances ability to clearly explain and illustrate concepts and approach for the key stakeholders. It helps to ensure that all key stakeholders have a common understanding of the program's requirements before it is implemented. It brings together the learning that has led up to the program's commencement and helps to identify any gaps in knowledge and requirements.

In the management phase the program logic model helps to ensure that required data is identified and collected at the right time to monitor progress. It helps to keep the focus on the key aspects of the program that are most important for tracking and reporting so that adjustments can be made as necessary.

In the evaluation and reporting phase, a program logic model presents data, other information and results in terms of progress toward or success in achieving the planned outcomes in ways that inform, provide evidence for a particular approach, and teach stakeholders.

The full program logic, which was developed with the input of the Collaboration Partners and the Guiding Committee, addressed nine outcome areas as keys to success in reforming practice in ways that would contribute to the following impact:

People with disability who sometimes display challenging behaviours, their families and carers, will have access to support and services that maximize their decision making and free choice, their ability to contribute as valued community members and their human right to be free from abuse and exploitation.

The outcomes were agreed by key stakeholders and the guiding committee, based on the evidence base of 'what works' and their collective experiences as family members, advocates and service providers.

The program logic was supported by a collaboratively developed list of measures to determine success in relation to the achievement of each outcome. The measurement tools were an integral part of the model's design and therefore integrated into practice. The list of success measures and associated tools are summarised in Appendix 1.

In the concluding stages of the project, qualitative interviews were conducted with:

- the project manager
- the project leaders at VIP and LLC
- front-line managers of project sites in all three consortium organisations
- support workers/direct care staff at Nulsen (group meetings)

- the chief executives of each consortium agency
- the director of operations at Nulsen

The interviews were customised according to the person being interviewed, the organisation (service type) they represented and their role in the project. All were framed around the nine outcome areas in the program logic.

The evaluator observed at one Restrictive Practices Committee meeting.

2.3 Limitations

The project scope was ambitious. As noted in Section 1, the project used an iteration of a multi-element model of Positive Behaviour Support that had a strong evidence base and that previously had been trialled in a separate in-house project at Nulsen. The model was designed to effect positive life changes for individuals with challenging behaviours, their families and the staff who work with them. Its comprehensive range of tools is all designed to support those outcomes. **These outcomes were part of what the project was intended to demonstrate but it had a second and equally important strategic requirement, that of drawing conclusions about requirements at sector and workforce level to facilitate successful sector wide rollout.** The Positive Behaviour Support model was not designed for the purpose of determining sector and workforce requirements.

At times across the 12 month course of the project, it was difficult to balance the two levels of outcome – client and organisation on the one hand and whole of sector and workforce on the other – because there was a high level of activity around the former by virtue of the model design, and less around the latter.

The project succeeded in demonstrating some higher level activities, such as the value of restrictive practices panels, but retrospectively it was evident that the second set of outcomes would, ideally, have been built more robustly into the project design and the evaluation methodology. It would have been better for activities associated with those outcomes to have had separate arrangements for the management of the activities around the model itself. This was recognised as the project progressed. The qualitative processes at the end of the project were designed in part to address the imbalance in the focus of project effort and were a reasonably successful strategy.

It would be helpful for future projects to take this learning into account and more strongly embed processes associated with the evaluation of the more strategic sector and workforce development component into the project design. More program design and evaluation activity around the sequencing of the implementation of some elements of the model would also be helpful. For example, implementation of e-learning training was prioritised behind some other elements and was not consistently implemented in timing, coverage or follow up support across the consortium agencies. This resulted in limited objective evidence to support the value or otherwise of the training.

2.4 Relevance of Positive Behaviour Support to broader government and Disability Services Commission policy agendas

Over the time the project was running, disability sector organisations were concurrently preparing for new requirements associated with the State Government's Delivering Community Services in Partnership (DCSP) policy. The policy is designed to improve the lives of people with disability, their families and carers by enhancing choice, sustainability and flexibility in the services and supports that are purchased. A major part of the new arrangements is a strong focus on services that are actively person-centred and on outcomes for people who receive services rather than outputs from a service provider. Service providers are being expected to better articulate what they do, why they do it and what difference this makes in the lives of people using their services. This is being reflected not only in the policy but in the way the Commission (and other funders) set up service agreements with community services sector organisations.

Although outside of the project's scope, the evaluation identified that while the focus of the project was to develop more respectful ways to respond to behaviours that are sometimes described as challenging, there is a high degree of synergy between Positive Behaviour Support principles and practices and what is being required of organisations under the new policy arrangements. Key documents supporting Positive Behaviour Support, including the Positive Behaviour Framework, Towards Responsive Services for All (see footnote 12), and the Effective Service Design Report (see footnote 13) have direct relevance to the concurrent Delivering Services in Partnership policy and to the Commission's initiatives towards person-centred and outcomes-focused services. An organisation operating according to Positive Behaviour Support principles and practices should achieve compliance with these associated emerging requirements with minimal, if any, adjustments being required.

2.5 Constraints to achieving outcomes

It is not unusual for action learning projects to encounter constraints – indeed, as noted above, they should be anticipated and valued for the learning that arises from them. As an action research project, learning from the project included not only what went well, so that it could be replicated or built on, but equally as importantly, what did not work as well, so that remedial action could be taken and less successful elements revised. To provide context for the reporting in this Section of what was achieved, the constraints encountered are first identified below.

Footnote 12

National Disability Services, 2010, "Towards Responsive Services For All", a project commissioned by the Disability Services Commission, Western Australia

Footnote 13

Millier P, 2011, "Effective Service Design", a project commissioned by the Disability Services Commission, Western Australia

The project encountered constraints that, in some cases, limited capacity to introduce some planned initiatives and, in others, delayed the timing of planned initiatives or prevented the continuation of activities already commenced. When constraints occurred, the program logic was useful in keeping the focus on what could be done (much of what was planned) and in helping to avoid undue focus and energy being placed on what did not proceed as planned, and on trying to remediate those issues at a cost to the other elements in the project.

The constraints encountered are described in this Section, because they had an impact on some of the activities and outputs, and therefore on the outcomes set in the program logic. However, they provided valuable learning for the consortium organisations and the sector. The learning will be discussed in more detail in Section 4.

2.5.1. The 12-month timeframe for the project

The project was funded as a 12 month pilot project. Positive results and significant learning was achieved, but it was not possible to reach conclusions in relation to some outcome areas as planned in the time and with the resources available. Some planned outcomes were, arguably, too ambitious for a 12 month project that was introduced into active work places where controlled trial conditions could not be imposed. An example is the outcome related to skilled support staff being attracted and retained and the outcome of Positive Behaviour Support practice leadership being in place and embedded.

The complexity of the data collection system requirements and resource intensity to measure achievement of one outcome, (a reduction in number, occurrences and severity of adverse incidents related to challenging behaviours) was underestimated and beyond the capacity of the project, in terms of both time available and of resources (people and technical).

Other issues which became apparent only as the project was implemented and that delayed measurements and the achievement of results in some areas, included:

- the complexity and time intensity of some early activities, in particular setting up data collection arrangements in relation to people identified to have challenging behaviours and training staff in how to work with the data collection forms and to understand what was required of them
- the challenges of concurrently testing the model in multiple service settings including one, as discussed below, for which the model was not a good organisational fit
- the volume of initiatives to be implemented concurrently in three different service types in the timeframe available meant that there were issues with the sequencing of some activities related to sector and workforce development – in particular, training
- significant staff changes at VIP, including the appointment of a new chief executive, the departure of the VIP project leader on extended leave and the

departure of her planned and trained replacement caused a fall in activity that was challenging to overcome in a 12 month project

- the start-up resource requirements necessary to implement the model
- an under-estimation of the level expertise required to develop some behaviour support plans and to be actively involved in their implementation.

2.5.2. The fit of the model with Lady Lawley's respite service models

As noted in Section 1, one of the eight critical areas in conducting a Behaviour Assessment is a mediator analysis and assessment of contextual fit to determine the likelihood of success in carrying out a behaviour support plan in a particular setting.

This takes into account:

- the characteristics of the person for whom the plan is designed
- variables related to the people ("mediators") who will implement the plan, and
- features of the environment and systems within which the plan will be implemented.

'Contextual fit' is the compatibility between the features of the planned behaviour intervention and other features related to the individual and their environment. The closer the 'fit' the more likely the behavioural intervention will succeed.

'Mediators' are the categories of people who participate by supporting the person through relating to them in the ways set out in a behaviour support plan. Potter and Wieman (2011) note that mediators include:

- 'natural mediators', whose relationship with the individual is a personal one, such as that of a parent or family member
- professional staff, whose relationship with the individual is linked to their disability, for example, direct care workers, or
- specialist staff whose relationship with the individual is related specifically to their challenging behaviours.

Early in the project it became evident that significant elements of the model would be difficult to implement at LLC. The reasons were found in the mediator analysis. There was not a good contextual fit between the model and LLC's respite service delivery models.

The most important mediators of behavioural change are the people who have continuity in a child's life. This model has difficulties in application within a short term respite facility where there are limits on the influence staff or the service can have over the usual environmental conditions, physical health care or medications prescriptions are in place. This project highlighted the importance of staff in respite services to build their understanding of the functional reasons behind a child's behaviour, the limitations (and therefore the appropriate focus) of staff efforts to make changes. This is elaborated on in McConkey, Gent and Scowcroft (2011) (See footnote 14 on next page)

The specific respite service models in place (based on small group care arrangements) and the episodic nature of the respite services provided by LLC, also made it difficult to implement major elements of the project. Behaviour support plans are an example. As will be discussed later in the report, staff at all the consortium partner organisations expressed views about who should and should not write behaviour support plans, however some issues were specific to LLC. To develop behaviour support plans in a respite setting requires significantly more time to collect and interpret data than in other settings. Supervisors and staff at LLC reported that multiple occasions of respite were required, often over a period of many months, for the same staff to have had sufficient contact to know the child and family well enough to make informed observations about presenting behaviours, their antecedents and appropriate alternative Positive Behaviour Support practices.

The target group for the LLC service and its respite models means that all of the children in a group are likely to have complex support needs and some will have other characteristics, such as medical conditions, which also require specialist management. Managing the complexity of the group's needs in an intense and short term care environment, or in the family home produces a unique set of challenges. Staff only engage with the child for one weekend a month or less (residential respite) or for a limited number of hours per week (in home respite) and in the residential setting, the same staff did not necessarily support the child on consecutive respite stays.

Rostering arrangements in the context of the episodic nature of the residential respite service were a particular challenge. Respite needs are prioritised and planned around individual families' needs, and the needs of the group of which the child is a part when they come into respite. Rostering is based on the needs of the group on each respite occasion.

LLC could not ensure that staff who had been involved in commencing a behavioural assessment for a child would necessarily have contact with the child the next time they entered respite. Similarly, it was not possible to ensure that any of those involved in completing a behavioural support plan would have contact with the child in future respite stays.

There were challenges at LLC around mediation. Success in implementing behaviour support plans requires the engagement of all mediators. In the LLC respite service setting, this included not only supervisors and direct care staff, but families and in some cases, staff of the school the child attended.

Footnote14

McConkey R, Gent C and Scowcroft E, 2011, "Critical features of short break and community support services to families and disabled young people whose behaviour is severely challenging", *Journal of Intellectual Disabilities*, Volume 15, p 252

Staff working with families to provide home based respite services through the Intensive Family Support (IFS) had more direct contact with families than their colleagues in the centre-based service, but also encountered more difficulties around the use of behaviour support plans. All IFS staff except for the coordinators reported it was difficult to engage casual staff in the project. Many were students who were most comfortable in engaging with the children in activities that gave families a break and were enjoyed by the children. Coordinators reported that staff were not sufficiently 'on board' with the project and did not feel sufficiently skilled or ethically mandated to initiate major changes in practices in the family's home, when they were in the home for relatively short periods. Their observation was that practices 'worked' for families that were often experiencing very high levels of stress related to the care of children whose disabilities were profound. They questioned whether they should challenge these practices given that their contact with the child was limited and families were the primary caregivers.

In some cases, in both on site and IFS respite, family users were reported to have firm ideas about what was best for their child and family, and refused to consider change, even though staff encouraged them to try other, less restrictive options. The model has a capacity to engage with families and includes material directed specifically to families. However, the pilot project itself was neither designed nor resourced to provide the family, as natural mediators (or teachers as professional mediators) with the information, support and resources to motivate them to fully engage so that a new Positive Behaviour Support plan could be consistently followed. To achieve the necessary level of engagement and involvement with families and schools would have required a level of training and support to families in their homes and the child's teachers at school that was outside of the pilot project's scope.

Notwithstanding the difficulties of implementing the model, staff interviewed at the conclusion of the project consistently reported that the project had given them a different way to think about their roles and practices.

Although not systemically successful, the project was reported to have resulted in new/improved relationships with a small number of families and has helped them to move forward.

Staff noted the value of having access to LLC's specialist psychologist (the project team leader) to support the development of their skills and knowledge about Positive Behaviour Support – access to specialists was identified as a success factor across all three service types.

An alternative approach, based on the Commission's Behaviour Support Teams model as described in the Positive Behaviour Teams report (see footnote 15), might be a better contextual fit for a respite service than the model piloted in the project. One of the report's recommendations is directly relevant.

Rec 29: "That the model of service delivery (Behaviour Support Teams) continue with an emphasis on in-home provision of support, together with support provided in other settings where the person spends their time (eg, at respite, school, places of further education, day support and places of employment)."

The model includes provision for a 'family function', offering in-home Behaviour Support Team intervention focused on family outcomes, with the family at the centre as the primary mediator and the respite service as one of the other mediators. In this model, a Commission Positive Behaviour Support team would engage with the family and include LLC staff as occasional mediators – in contrast, the pilot project model placed the service provider in the role of the primary mediator.

Although the model proved not to be a good fit for LLC, staff reported some important positive qualitative outcomes. The organisation remains strongly committed to using Applied Behaviour Analysis and Positive Behaviour Support to underpin its service delivery. It has adapted some elements of the model for application in its respite services. These include continuing with a restrictive practices panel but using different operating arrangements and developing a customised assessment tool to ensure compliance and procedural reliability. A structure for dealing with eliminating restraint is now embedded in work processes, based on the recently implemented Voluntary Code of Practice for the Elimination of Restrictive Practices.

3. Outcomes

Outcome 1: A comprehensive model of Positive Behaviour Support for rollout across the disability services sector

The first measure for this outcome was that there is a document in place that describes the model and defines its key terms.

The project has piloted a comprehensive evidence-based, integrated multi-element model of Positive Behaviour Support.

Footnote 15

McVilly K, 2011 "Impact, effectiveness, & future application of Positive Behaviour Teams (PBTs) in the provision of disability support services in Western Australia", a research report commissioned by the Disability Services Commission, Western Australia

This approach has achieved positive results in reducing restrictive practices in residential group home and ATE settings in the metropolitan area, but not in respite settings.

The second measure for this outcome was that there are Commission policies in place to support the model.

Some Commission policies and related documents which support the development of good practice in Positive Behaviour Support and the reduction of restrictive practices had already been developed as components of the Positive Behaviour Framework and pre-dated the pilot project. These include outcomes associated with the Positive Behaviour Framework, Towards Responsive Services for All, (see footnote 16), the Commission's Positive Behaviour Teams Evaluation Report (see Footnote 17), a Restrictive Practices Issues Paper (see footnote 18) and the Effective Service Design Report (see footnote 19).

The progressive learning about policy requirements, practice issues, and supporting structures that were acquired in the course of the project was used to inform other initiatives under development as part of the implementation of the Positive Behaviour Framework and to engage with the disability services sector through meetings, sector forums and workshops. This project, funded by the Disability Services Commission, directly contributed to:

- The Voluntary Code of Practice for the Elimination of Restrictive Practices (2012) (see footnote 20 on next page)
- The Information Guide Positive Behaviour Support Information for disability sector organisations (2012) (see footnote 21 on next page)
- planning for the extension of the pilot project into regional WA (South West Project)
- the design of Positive Behaviour (Restrictive Practices) Support Panels

Footnote 16

National Disability Services, 2010, "Towards Responsive Services For All", a project commissioned by the Disability Services Commission, Western Australia

Footnote 17

McVilly K, 2011, "Impact, effectiveness & future application of Positive Behaviour Teams (PBTs) in the provision of disability support services in Western Australia", a research report commissioned by the Disability Services Commission, Western Australia

Footnote 18

Millier, P, 2011 "Restrictive Practices Issues", a project commissioned by the Disability Services Commission, Western Australia

Footnote 19

Millier P, 2011, "Effective Service Design", a project commissioned by the Disability Services Commission, Western Australia.

The extent of preparatory planning that had been conducted by each participating organisation before and independent of the commencement of the project contributed to extent to which the pilot rollout achieved results in a 12 month timeframe. Other organisations should factor in time for planning and setting up an organisational environment that is aligned with Positive Behaviour Support practice (information to staff, policies, procedures and systems reviewed) and recognise that the implementation is a major organisational change that will require leaders to have a sound understanding of change management theory and practice.

Even with the extent of pre planning that had taken place, the time taken to implement the model was longer than anticipated. Organisations should allow for at least a two year implementation period. Initially the participating organisations intended to conduct most training to support the rollout, including online training, in normal rostered shifts. This proved to be difficult and at some sites, the training provided to support the rollout was compromised as a result. Changes which enabled staff to access training outside of their regular shifts was introduced at some sites, which resulted in a higher uptake than was achieved at sites that did not provide this option. Similarly tasks such as completing behavioural charts and writing individual plans according to Positive Behaviour Support principles and practice in normal rostered hours was difficult for staff to achieve, both because of time and a lack of expertise and experience. This resulted in the appointment of two specially trained peer mentors to support staff at Nulsen and VIP. This successful strategy is further discussed later in the report.

Footnote 20

Disability Services Commission, Western Australia, 2012, Voluntary Code of Practice for the Elimination of Restrictive Practices

Footnote 21

Disability Services Commission, Western Australia, 2012, "Positive Behaviour Support Information for Disability Sector Organisations"

Outcome 1:

A comprehensive model of positive behaviour management for rollout across the disability services sector

This outcome was achieved.

The introduction of Positive Behaviour Support in the form of a Positive Behaviour Framework has resulted in the development of a broad range of resources being available to the WA disability sector. This framework has facilitated buy-in and collaboration in the sector and has provided the foundation for consensus about the need to develop consistent and evidence-based Positive Behaviour Support practice to reduce the routine use of restrictive practices.

The evaluation has confirmed that an approach based on Positive Behaviour Support/Applied Behaviour Analysis principles was more contextually relevant to the accommodation and ATE pilot sites than to the respite study site.

The model was well supported by a range of Positive Behaviour Support curriculum materials and by supportive Disability Services Policies and Guidelines.

The expectation that some training, completion of behavioural charts and writing individual plans based on Positive Behaviour Support principles and practice could be achieved by staff as part of a normal rostered shift was not fulfilled. At least during the implementation phase, until staff have developed and practiced the skills, they require additional support.

A critical success factor was that organisational policies, practices and systems were aligned with the new Positive Behaviour Support practice requirements. From a staff perspective, support was particularly necessary in relation to their understanding of duty of care and risk management requirements in a Positive Behaviour Support workplace.

Recommendation 1

Rollout should be supported by an evidence-based multi-element Positive Behaviour Support framework that is supported by a comprehensive and integrated range of organisational policies, practices and tools, including capacity to provide objective feedback to staff on the impact of their changed practices on those with whom they work.

Recommendation 2

Organisations should be prepared to direct organisational effort towards comprehensive change management planning for their rollout, including enlisting the support of their Boards, chief executives and senior managers, ensuring that policies and procedures support the planned directions, organisational systems are aligned with the new requirements and staff are informed and prepared for workplace changes.

Recommendation 3

Planning should be based on an expectation that it will likely take two years at a minimum to set up **and** embed a comprehensive multi element Positive Behaviour Support model.

Recommendation 4

Planning should be predicated on an understanding that implementation requires at least some changes to staffing arrangements (eg backfilling) so that staff can be trained in non-rostered during work time and resources are available to complete Positive Behaviour Support requirements such as behavioural assessments, development of individual plans, recording of behaviours etc.

Recommendation 5

Workplace ‘champions’, who show commitment to working within a positive behaviours framework, have current direct care responsibilities and are respected by their peers, should be identified and trained as peer mentors for their colleagues.

Recommendation 6

The model of short-term respite for families of children with behaviour that is sometimes challenging be reviewed to enhance the capacity of this type of family support to implement planned Positive Behaviour Support.

Outcome 2: Positive Behaviour Support products and tools available and used in pilot agencies

The evidence to support that this outcome was achieved included:

- restrictive practices audits
- agency policies that are consistent with and support Positive Behaviour Support
 - staff training in Positive Behaviour Support
- behavioural assessments and individual risk assessments
- mental health assessments
- Positive Behaviour Support plans and reviews
- formal approvals for use of restrictive practices
- procedural reliability procedures – percentage of completed trials
- management reports reporting Positive Behaviour Support data and Positive Behaviour Support related issues.

Restrictive practice audits

Restrictive practice audits are a central element to the model. The pilot model conceptualised three phases to the process of addressing restrictive practices, these being:

Audit of practices to identify the unauthorised restrictive practices being used in the organisation

A restrictive practice authorisation and review panel was formed to meet regularly to consider applications for the use of restrictive practice, the justifications offered, the evidence base of the practice considered and necessary consents required (including reference to the Office of the Public Guardian and the State Administrative Tribunal) for any consideration for the use of a restrictive practice. For organisations starting out, there are barriers to their ability to apply different approaches to working with people who sometimes exhibit challenging behaviours. A major early barrier is the absence of data around what restrictive practices are in place in their service settings, the prevalence of those practices and to whom they are applied.

Many practices, relating to both the support of individuals and to the organisational management of the service are historically and culturally normalised as 'the way we do it here'. They are accepted and explained in the context of defensible 'risk management' or 'duty of care'. They are not recognised as restrictive until a cultural paradigm shift is facilitated through information and education for staff on what constitutes a restrictive practice.

The restrictive practice audits had a key role in assisting staff to understand what restrictive practices were. This was confirmed by the number of practices identified and in qualitative discussion with staff. The audits identified the range of practices in place and the extent to which they were in use. They provided a baseline upon which progress in changing practices could be measured.

The restrictive practices audits covered 22 restrictive practices and were conducted at each service site that was part of the trial project. The practices were each accorded a rating of 1 (most serious that are unlawful and constitute abuse) to 4, the least serious.

The audits were conducted on a non-punitive basis. Staff were assured of anonymity in reporting. The 'no blame and no consequence' message was strongly and consistently delivered. In each organisation a Board led (for Nulsen and VIP) and chief executive /senior management led (for all three organisations) amnesty was declared. Staff in all three organisations were actively encouraged to be open in identifying restrictive practices without fear of any adverse personal or service level repercussions.

The audits were conducted via compulsory staff meetings that were facilitated by project staff who were trained in Positive Behaviour Support. The meetings began with a discussion about what constituted a restrictive practice and reiterated the message from Board and senior management, that the purpose of the audits was to improve service quality and there would be no repercussions for staff who disclosed restrictive practices. Each client was individually discussed with data in relation to each being entered into a Survey Monkey online form.

Practices were prioritised into one of four categories:

Priority 1: Unlawful practices – mechanical restraint, physical restraint, seclusion and punishment – to be approved/not approved or given interim approval within three months of the audit.

Priority 2: Chemical restraint – to be approved/not approved or given interim approval within 3–6 months of the audit.

Priority 3: Response cost (losing privileges) – to be approved/not approved or given interim approval within 9–12 months of the audit.

Priority 4: Restricted access – to be approved/not approved or given interim approval within 12–18 months of the audit.

Result of the initial restrictive practice audits are at Table 1 below.

Table 1: Restrictive Practice Identified at Audit

	VIP	LLC	Nulsen
	Identified	Identified	Identified
Mechanical restraint	7	2	9
Physical restraint	9	15	11
Chemical restraint	9	12	18
Seclusion/exclusionary time out	3	6	5
Restricted access	10	18	14
Response cost	3	2	6
Overcorrection	0	0	0
Punishment	0	1	0
Total	41	56*	63

* Because LLC provides services to children, practices that are restrictive for adults might be age appropriate and consistent with community norms in relation to acceptable practices to protect children.

Agency policies that are consistent with and support Positive Behaviour Support

All three organisations either had, or introduced as part of the pilot project, policies of a good standard that facilitated the implementation of Positive Behaviour Support strategies. This included policies and procedures on Positive Behaviour Support, identification of and accountability for Restrictive Practices, Incident Reporting and Managing Challenging Behaviours.

Section 4 will outline the learning about what constitutes good policy in this regard.

Staff training in Positive Behaviour Support

The model provides multiple strategies to develop staff awareness of Positive Behaviour Support and to develop understanding of the model itself, as well specific skills training in relation to the support of a particular individual. However, due to the number of initiatives requiring concurrent implementation across service types, project resourcing, prioritising decisions and the initial requirement for e-learning to be managed as part of a normal rostered shift, the implementation of e-learning was compromised. As discussed below, there was a high level of reliance in the project on the job training, primarily through project staff demonstrating and modelling required practices.

In qualitative discussions, staff stated that compared with the beginning of the project, they felt more competent to work with people using Positive Behaviour Support and following a Positive Behaviour Support plan.

Other positive outcomes staff identified about the increased use of Positive Behaviour Support plans included that they felt more involved and had a more structured role in contributing to the plans. However, they identified that there was still a significant gap at the end of the project between what they knew about Positive Behaviour Support – from the language to understanding the key elements, to interpreting behaviours and how to apply those elements in work practices in relation to individual clients – and what they believed was required for workplace competence.

They were comfortable about their ability to implement strategies set out in plans, but not to make assessments or develop Plans without the support of others with higher levels of training and expertise in Positive Behaviour Support. Staff at Nulsen and VIP expressed doubt that even if they had additional training and experience, there would be insufficient time in rostered shifts for supervisors to work with staff to do the work required to conduct complex assessments, analyse behaviours and develop the responses that would be required in a behaviour support plan. As will be discussed later in this Section, the roles of Nulsen's two dedicated project officers, the three project leaders and the project consultant were key success factors in providing the support necessary for staff to implement individual plans. LLC made arrangements for staff to have time 'off the floor' to support attending to project documentation requirements and the development of plans. Staff noted that this was a key to the success in their development.

As will be further discussed in Section 4, staff comments need to be understood in the context of the requirements to implement Positive Behaviour Support with a current population of people for whom there has previously been a different set of behaviour management arrangements. While necessary levels of expertise will not change, once arrangements are in place and embedded for existing clients, the workload impost will reduce to that required to assess and plan for new clients using an already embedded system.

Online e-learning

Online e-learning provides a system based approach to staff (and where appropriate, family) training. It is designed for use in association with individual staff development plans so that performance monitoring and staff performance expectation are coordinated.

Modules available in the project included:

- legal and ethical requirements
- planning
- teaching and instruction
- behaviour support
- intellectual disability and key support areas
- responsibilities related to positive programming
- front line management In Positive Behaviour Support.

Some modules included provision for staff to repeat them and pass the set standard every six months, to maintain their accreditation and to ensure that good practice was regularly reinforced.

Although referred to as 'e-learning' the training was available for multimedia delivery, via audio, video, multimedia slides, downloadable content and online group classes as well as individual. It could be made available for staff to access at any learning site and at any time that is convenient for them.

At the start of the project, it was intended that all staff who were to be involved in the project would, over time, complete all modules in the self-paced e learning package.

The package was designed to allow staff time in each fortnight's roster to complete the reading and exercises via online training during the initial period. For a range of legitimate operational reasons, this did not occur as planned.

Qualitatively, there was considerable support for the e-learning approach in the project but given its relatively low take-up rate, it was not possible to test its effectiveness. It should also be mentioned that the e-learning package was a private product that incurred site licence fees.

Supervisors at LLC identified a barrier to completing the training was the expectation that time could be allocated in their rostered working hours for them to progressively complete the modules. This was compounded by the fact that e-learning was undertaken later in the project than it ideally should have been and staff and coordinators reported it was difficult to consolidate the learning into on the job competencies.

The planned implementation of e-learning was interrupted at VIP when the project's team leader proceeded on planned long service leave, and her trained replacement left the organisation. At the same time, the organisation had a new chief executive.

Although VIP rebounded from the impact of such significant staff changes and achieved some positive results in the project, it was not possible to organise for the e-learning to be completed at a later stage.

At Nulsen, because the pilot project was, in many respects, a continuation of work already commenced through the organisations 2010 internal project, a lesser priority was placed on the completion of the e-learning modules. However, the residential service manager and staff at the one home where the e-learning was completed reported it to have been very useful in increasing their awareness and understanding. Due to the project's timeframe, no staff were required to complete re-accreditation.

Specific skills training

Specific skills training requires the supervisor to take each support worker through the procedures in place to support the person, as set out in their Positive Behaviour Support plan. There are three parts to the training. The support worker is first asked to explain the procedures, and then to role play the procedures or demonstrate completion of the procedures with the person. The manager then provides coaching and support to the staff member until they achieve full reliability with the procedures for each person.

The standard set for the acceptable level of compliance with specific skills training was 85 per cent. The standard was exceeded at Nulsen and VIP. Data was not available for LLC.

Behavioural assessments and risk assessments

Risk assessment was included in the behavioural assessment tool used in the project. It was a matrix based tool that addressed 18 risk domains by frequency of occurrence and consequence.

The behavioural assessment was structured and nonlinear and included analysis in eight critical areas adapted from the findings of earlier research including that of La Vigna and Willis (1995) (see footnote 22); Albin, Lucyshyn, Horner, and Flannery, (1996) (see footnote 23); and Carr, Reeve, and Magito-McLaughlin (1996) (see footnote 24 on next page).

Footnote 22

La Vigna, GW & Willis TJ, 1995, "Challenging behavior: A model for breaking the barriers to social and community integration", *Positive Practices*, Volume 1, pp. 9–15

Footnote 23

Albin RW, Lucyshyn JM, Horner RH & Flannery BK, 1996, "Contextual fit for behavioural support plans: A model for 'goodness of fit'. in L Koegel, R Koegel & G Dunlap (Eds.), "Positive behavioral support: Including people with difficult behaviour in the community", pp. 81–98, Baltimore: Paul H Brookes

The critical areas were:

- challenging behaviour – its characteristics, cycle, course, strength and episodic severity
- antecedent events – the person(s), places and times where the behaviour is more or less likely to occur
- consequent events – to determine things that possibly increase or decrease a behaviour, or have no effect on it
- physiological variables – physical health, mental health, medications, the presence or absence of brain injury or dysfunction
- motivational factors – to identify events in the person’s environment that might have motivational or rewarding functions or avoidance functions
- skills analysis – understanding the person’s behavioural and cognitive functioning levels through review of developmental, language and psychological assessments, interviews with support staff and family members, and direct observation in the settings in which the person functions.
- mediator analysis and contextual fit – to determine the likelihood of success in carrying out a behaviour support plan in a particular setting, taking into account:
 - the characteristics of the person for whom the plan is designed
 - variables related to the people who will implement the plan, and
 - features of the environment and systems within which the plan will be implemented
- mediation – (a) consideration of the categories of people who participate in support teams, including natural mediators whose relationship with the person is a natural one, such as a parent and staff such as support workers, whose relationship is a function of the person’s disability such as support workers, and specialist staff whose relationship with the person is a function of their challenging behaviour, and (b) training requirements as they relate to mediation, including the general skills needed to support the person, the specific skills required to implement the procedures in the behaviour support plan and quality assurance requirements to ensure compliance with the plan.

Footnote 24

Carr EG, Reeve CE& Magito-McLaughlin D, 1996, “Contextual influences on problem behaviour in people with developmental disabilities”, in L Koegel, R Koegel & G Dunlap (Eds.), “Positive behavioral support: Including people with difficult behaviour in the community”, pp. 403–423, Baltimore, MD: Brookes

Mental health assessments (PAS-ADD Tool)

Psychiatric Assessment Schedules for Adults with Developmental Disabilities (PAS-ADD) – is the general name for a set of mental health assessments originally developed for people with intellectual disability. These assessments have been in continuous development since the late 1980s. More recently, the system has adapted to incorporate children and adolescents, including those with and without intellectual disability.

Mental health assessments were conducted when concerns about an individual's mental health was identified during their initial assessments. Ten mental health assessments were conducted in relation to the pilot project's participants, two at VIP and eight at Nulsen. There was an identified need to conduct an assessment on a child at LLC, but the family declined to support it. The PAS-ADD assessment is conducted by someone with clinical expertise who has training in how to use the tool. During the project these were conducted by the project manager.

Positive Behaviour Support plans

Positive Behaviour Support plans were a key tool in the project. Staff completing the plans were required to have skills in both behavioural assessments and functional analysis. As will be discussed in Section 4, a common theme in discussions with staff was that they felt competent to contribute data to the assessment and analysis through identifying, tracking and recording occurrences of behaviours. They did not feel they had the expertise to conduct the assessments and functional analyses, or to write the plans. They advocated strongly for this to be recognised as a specialist role.

The project directly resulted in increasing the number of behaviour support plans in place for people identified to have challenging behaviours at Nulsen from nine to 21 and at VIP from one to 20. Data for the number of behaviour support plans in place at the end of the project was not available for LLC.

Management reports reporting Positive Behaviour Support data and Positive Behaviour Support related issues

The Positive Program Review Tool (PPR) was developed and applied for use with the model and is the primary tool for ensuring service consistency and quality and to foster continuous improvement.

The PPR tool was used effectively at both Nulsen and VIP. As well as providing important information for management, the tool motivates staff by providing regular, constructive feedback on their site's performance. Sites were audited quarterly against pre-determined objective measures including:

- ecological – individual client routines
- skills development
- community access
- relationships
- regular staff being on roster for the individual/group.

At Nulsen, each home in the pilot project received their site PPR and a summary PPR of the score each quarter across all the sites, so that they could not only see their own performance, but could see how that compared to the overall performance across the project sites. In qualitative interviews, staff reported positively on the PPR feedback arrangements, with comments focused on the recognition they received when they did well, feeling good that objective evidence confirmed that what they were doing was worthwhile and enjoying the friendly competition it created in trying to achieve results that were above the average for all the pilot sites. There was a consistent rate of improvement in PPRs at Nulsen from 40 per cent on the first PPR to 74 per cent at the fifth and final PPR at the conclusion of the project.

Individual site results demonstrated the usefulness of the PPR in providing important management information. For example, improvements or decreases in performance could be attributed to events such as changes in the residential services manager (on leave or by transfer to a different house), a new resident with challenging behaviours entering a house or a resident with challenging behaviours leaving a house. The information in the site PPRs directly contributed to management decision-making.

In contrast to the consistently improved results at Nulsen, VIP's PPRs showed more variation, with best results achieved mid-way through the project. The variation in scores at VIP demonstrated the impact of resourcing on results achieved.

In the first two quarters, in which PPR scores were 59 per cent and 58 per cent respectively, the VIP Project leader continued to fulfil managerial/supervisory responsibilities at the project site as well as her project leadership role. She was then allocated to the project full time, resulting in a 25 per cent increase in PPR score to 83 per cent. In the following quarter she began planned long service leave and her trained replacement resigned from the organisation. This resulted in a 36 per cent drop in the PPR score to 47 per cent. The score increased to 61 per cent as a new project leader settled in to the project. However for operational reasons, VIP was unable at that time to allocate the new project leader to the role full time, resulting in scores similar to those when the first project leader had responsibilities outside of the project.

Due to operational barriers as already described, only one PPR was completed at LLC, so improvements were not demonstrated. These figures highlight the challenges in adopting and maintaining a periodic service review type of approach to Quality Management, an approach that is unsustainable without significant ongoing focus and attention by all levels of an organisation and associated commitment to sustain that effort. There needs to be a good fit between the approach to process and procedure in monitoring the quality of behavioural supports being provided and the organisational capacity to sustain the effort required. This project highlighted this dilemma.

Reviews of restrictive practices

As noted earlier in this Section, restrictive practices panels are in place in all three consortium organisations, as a direct outcome of the project. All panels include an external member, in the case of Nulsen and LLC, this is a member of the project team. At VIP the external member is someone outside of the project who has significant experience at practice, teaching and policy levels in the area of Positive Behaviour Support. By invitation, the project manager has also attended the VIP restrictive practices panel meetings.

By the conclusion of the project all identified restrictive practices at all three project sites had been considered by a panel.

Outcome 2:

Positive Behaviour Support products and tools available for use in pilot agencies

This outcome was achieved.

The pilot project used a wide range of validated products and tools to support the integrated multi element Positive Behaviour Support model.

The benefits of system supports and procedural guidelines in implementing Positive Behaviour Support were demonstrated however future project developments will benefit from designing such supports in a manner that is a good environmental fit with the context of the host organisation.

Recommendation 7

Rollout should be supported by an evidence based multi element model of Positive Behaviour Support which is supported by an integrated suite of validated products and tools that are aligned with supportive policies, procedures and organisational systems. **Further work is required to develop training, products and tools that are freely available and accessible to the disability sector.**

Outcome 3: Collaborative partnerships to support best practice are in place in pilot agencies

The relationship between the consortium partners was trusting and highly collaborative, manifest primarily through the project leadership group members, but also at senior management level across the three organisations.

Evidence for this was:

- the feedback of project leaders, senior managers and chief executives that each partner organisation's understanding of Positive Behaviour Support and strategies to reduce restrictive practices had been enhanced by their involvement in the consortium
- the program of meetings between the consortium partners
- preparedness to share restrictive practices identified in audits between consortium partners and contribute to each other's solutions
- information about strategies to reduce restrictive practices in one partner organisation being shared with and adopted by one or both of the others
- procedures developed by one organisation being shared with and adopted by one or both of the others
- leadership group members being involved as the external representative on other members' Positive Behaviour Support panels
- peer mentoring and shared approaches to problem solving
- the project leader actively supporting VIP to extend the project into all of the organisation's service sites part way through the project, even though this was not a requirement of her role and was outside of the project's brief
- arrangements made between consortium partners for the relationships and collaboration established in the pilot project to be continued when the pilot concluded.

The level of collaboration extended beyond the partner organisations, to include collectively and as individual organisations, sharing the experience of the project and the knowledge being gained about what works with the broader sector and colleagues in individual disability sector organisations. This was evidenced in:

- chief executives, senior managers and project leaders sharing their experiences and information about their organisation's practices in the pilot project at guiding committee meetings, at sector forums and other disability sector organisation meetings, as well as one-on-one with colleagues in other organisations, and
- chief executives, senior managers and project leaders contributing their experience to the development of broader policy and practice to related positive behaviours initiatives such as the development of the South West project, the

development of the Voluntary Code of Practice for the Elimination of Restrictive Practices and the development of arrangements for Positive Behaviour Support Panels.

The project leader, with the support of her consortium partners and her own organisation, took a broad approach to her role in sharing project learning, promoting good practice in Positive Behaviour Support and in reducing restrictive practices in her interaction with colleagues in other organisations as the project progressed.

Through the course of the project she participated in many initiatives in this role which had a collective impact beyond the three consortium organisations.

Activities included:

- participation in the Positive Behaviours in Action Interest Group, an open professional development group that meets to provide mutual support and in-service training in Positive Behaviour Support
- participation in the guiding committee, a 37-member cross-sector representative group that is providing sector leadership in the implementation of the Positive Behaviour Framework
- participation in cross-sector forums and workshops with eminent persons (the late Professor Jim Mansell and Professor Eric Emerson)
- participation in the Living in the West (2010) Conference
- participation in a National Disability Services WA (NDS WA) sub-committee for accommodation services to speak about restrictive practices
- presenting at three Restrictive Practice Seminars auspiced by National Disability Services WA
- participation in the NDS WA Training and PD sub committee
- presenting at a Sector Country Forum meeting
- presenting on multiple occasions at meetings convened by individual disability sector organisations wanting information to support their own moves towards new Positive Behaviour Support practices and the reduction of restrictive practices
- presenting about Positive Behaviour Support and restrictive practices at an Interagency meeting of nurses who work in disability sector organisations and at another meeting with nursing staff of an organisation which is a major employer of nursing staff.

As will be discussed in the next Section, the collaborative arrangements for the project have provided valuable learning for individual disability sector organisations and the sector as a whole, in how implementation of Positive Behaviour Support is facilitated by working in partnership with others.

Outcome 3:

Collaborative partnerships to support best practice are in place in pilot agencies.

This outcome was achieved

The consortium partners established both informal and formal collaborative arrangements through which they supported each other. There was evidence of a high degree of mutual trust between the partners. They effectively used Positive Behaviour Support panels as a mechanism to build collaboration and consistent evidence based decision-making in the area of Positive Behaviour Support

Recommendation 8

Organisations should be encouraged to implement Positive Behaviour Support in collaboration with a small group of peer organisations wherever possible.

Recommendation 9

Positive Behaviour Support panels, as trialled in the project, should be incorporated into the rollout of Positive Behaviour Support in all organisations.

Outcome 4: Embedded Positive Behaviour Support practice leadership in the pilot agencies

The project demonstrated success in implementing Positive Behaviour Support leadership practice, but the 12 month timeframe for the pilot project was not sufficient to demonstrate that these practices were embedded.

As discussed earlier in this Section, procedural reliability checks and positive program reviews were key strategies through which compliance with the supervision, modelling and coaching provided to staff was demonstrated.

At the end of the project it was evident that good practice was still dependent on the continuing involvement of the staff (the project leaders, other project staff and front line supervisors) who worked at the pilot project sites. Each time one of this group left the project (for reasons of leave, resignation or the operational needs of the organisation) there was a period in which commitment to the project reduced and compliance with procedures (as measured by the PPR) declined. As will be discussed in Section 4, based on the experience in the project, **it is important for the sector to understand that planning for implementation of Positive Behaviour Support requires consideration of not only immediate requirements but also requirements to ensure practices are embedded into organisational culture and systems.** The experience of the pilot project suggests that an implementation period of at least two years is indicated to assure organisations of the sustainability of the practices that are introduced.

The project's findings also suggest that providing dedicated resources to practice leadership will achieve faster and better results, and that early attention to backing up key people with others trained in their role is important. As already discussed, VIP's PPR results confirmed the importance of this.

As will be discussed in Section 4, many small to medium sized disability sector organisations will not have the economies of scale to enable them to dedicate staff full time to their implementation. Alternatives such as sharing a resource – similar to the way that Nulsen's Project Officers were shared with VIP – is an option that would assist smaller Disability sector organisations.

Front-line leadership

A major strategy in beginning the process to embed practices was to involve front line supervisors as practice leaders. Supervisors are in the best position to observe work practices, influence staff attitudes and behaviours, model required behaviours in the work place and monitor staff compliance with required practices and behaviours.

An early task of the project leaders was to engage front line supervisors at the nominated trial service sites, to provide information to them about the project and its evidence base, to introduce them to the tools that would support the project and to begin to identify and address their initial training requirements. These staff members were also trained in specific skills coaching to enable them to observe and assess the skills of the staff under their supervision. The project leaders (and a small number of trained project support staff) modelled the desired practices to front line supervisors who were trained to model similar behaviours to the staff under their supervision.

Supervisors at Nulsen and VIP who were interviewed in the concluding stages of the project reported feeling supported by the project leaders in taking on this role and having more confidence in working within a Positive Behaviour Support framework as the project progressed. They valued the feedback provided by procedural reliability checks and positive program reviews, both for the information the tools provided about the results the sites under their responsibility were achieving and for the feedback it provided them about the effectiveness of their leadership and supervision of staff.

In response to difficulties for front-line staff in managing some of the key tasks associated with the implementation of Positive Behaviour Support arrangements as part of regular shift responsibilities, a decision was taken part way through the project to allocate two experienced and respected support workers to the project. These staff received intensive training and support and were then assigned to working with staff at the Nulsen and VIP project sites, and to develop behaviour support plans which staff were then responsible for implementing. Because this strategy was responsive to needs that arose, rather than being part of the model from the beginning, measures were not in place to evaluate its effectiveness. However, **staff at work sites consistently identified these 'peer mentors' to be**

strong leaders for them and a key to the success of Positive Behaviour Support in their workplace. They reported it was helpful to work with peers who were informed and enthusiastic about the potential of Positive Behaviour Support to change the lives of both people whose behaviours were sometimes identified to be challenging, and of staff. They were reassured because the peers had current workplace experience and could identify with some of the issues that staff faced in achieving implementation expectations. They reported a high degree of trust and faith in them as Positive Behaviour Support ‘converts’ who provided leadership and modelled the new practices.

The evaluation found that embedding practice leadership (and all elements of a Positive Behaviour Support model more broadly), requires an organisational environment that is congruent with the requirements of the model. It requires a supporting organisational vision and values in a strategic plan that embeds practice at both outcome and strategy level, an organisation structure and staffing arrangements that allow for specialist roles, (or less ideal, at least tasks within a broader job description in small disability sector organisations) and policies that facilitate the staff behaviours and organisational activities required.

The cultural change required to embed practice leadership takes time and needs to be supported by consistent structures and processes. These issues are discussed in more detail in Section 4.

Outcome 4:

Embedded Positive Behaviour Support practice leadership in the pilot agencies

This outcome was partially achieved.

Practice leadership was in place and effective but continued resourcing and attention will be required before leadership is confirmed to be embedded.

The use of peer mentors as workplace leaders was a response to a need that arose rather than a planned strategy, but was highly effective and well received by staff who worked with them.

Progress was made towards the achievement of this outcome.

Recommendation 10

Strategies (including ongoing training in Positive Behaviour Support), should be designed not only to implement practice leadership, but to embed it by checks and reviews and by ensuring succession planning for identified future leaders.

Outcome 5: Skilled support staff are attracted and retained

As noted earlier in the report, it became evident as the project proceeded that some outcomes established in the program logic would not be achieved in the project's 12 month timeframe. This outcome was one of those.

It has not been possible to draw any conclusions about the impact of the project on staff attraction and retention. Firstly, the project was restricted to some service sites in each organisation and did not involve all staff. For standard operational reasons, some staff moved into and out of project sites to meet broader organisational needs. Secondly, it is now better understood that 12 months is not sufficient time to establish all the systems and practices to complete implementation.

To implement and embed a Positive Behaviour Support culture is a process which requires sustained reinforcement over time. The project's activities made a positive contribution to this, particularly the processes around reinforcing learning and auditing staff practices 'on the floor'. Positive Behaviour Support needs not only to be implemented but demonstrated to be embedded and sustainable, before any correlation between the program and staffing data could be made. Finally, reliable data would need to be collected for a period longer than one year to overcome the impact of single events that could skew results in the shorter term.

For example in the project, the retirement of VIP's chief executive, the appointment of a new chief executive and the implementation of a new organisational structure resulted in significant movement of staff that coincided with the start of the project, but was not related to the project in any way.

Outcome 5:

Skilled support staff are attracted and retained in pilot agencies

This outcome was not achieved.

However, this should not be interpreted as a failure of the model. The project was located in only some of each organisation's service sites and staff were not consistently retained in the project sites. The 12 month timeframe for the project was too short to enable evidence-based conclusions to be drawn about staff attraction and retention.

Recommendation 11

Organisations should plan for the impact of staff turnover and ongoing known operational imperatives during their implementation of Positive Behaviour Support.

Outcome 6: Constructive and sustained consumer routines

One of the outcomes for the Workforce and Sector Development Project was to increase the number of clients who had constructive and sustained consumer routines written and followed. The literature provides evidence that robust routines full of meaningful activities will contribute to improved quality of life for people with intellectual disability. The description for constructive and sustained routines was that the routines were meaningful to the person, and that activities were age appropriate and listed hour by hour for the clients and the staff to follow.

Compliance with established routines was measured through the Positive Program Review (PPR) using two standards. Appendix 2 details these standards. One standard for VIP and LLC (residential respite) allowed for group routines due to the nature of their service delivery. The equivalent standard for Nulsen and LLC (IFS) did not, as the service delivery was individualised. The second standard was the same for all services.

At Nulsen, improvements attributable to project inputs were observed. At the commencement of the project, clients in only **one of seven (14 per cent) homes had routines** and were observed to be following them at the time of the PPR. Post project clients in **four of seven homes (57 per cent) had routines and were observed to be following them at the time of the PPR. This represented an improvement of 43 per cent of homes having routines in place for clients and evidence they were being followed.**

As with some other outcomes already discussed, a 12 month timeframe is insufficient to enable conclusions to be drawn about the sustainability of the outcomes achieved.

Outcome 6:

Constructive and sustained consumer routines in place and followed in Pilot agencies

This outcome was partially achieved.

More clients at Nulsen had constructive routines in place at the end of the pilot 57 per cent than at the commencement (14 per cent).

VIP demonstrated that constructive routines were in place on the first review, so it was not possible to demonstrate that the project contributed to improvements.

LLC completed only the first review so conclusions could not be drawn about the impact of the project on their consumer routines.

A 12 month period is too short to enable conclusions to be drawn about the sustainability of any changes.

Effective tools to audit and monitor the extent to which the routines were in place and sustained contributed to the achievements at Nulsen and VIP.

Recommendation 12

Organisations should use validated tools to audit and monitor the extent to which constructive routines are in place and followed and to motivate staff to comply.

Outcome 7: Reduction in use of restrictive practices

Current state assessment – restrictive practice Audits

As discussed in relation to Outcome 2, **a major barrier for disability sector organisations starting to apply different approaches to working with people who sometimes exhibit challenging behaviours, is the absence of data about the restrictive practices in place in their service settings, the prevalence of those practices and to whom they are applied.** Audits were conducted at each service site that was part of the project. The audits followed information sessions with staff which included a focus on enhancing their capacity to identify what constituted a restrictive practice and assuring them that they would not face any repercussions in relation to practices identified. A total of 160 restrictive practices were identified.

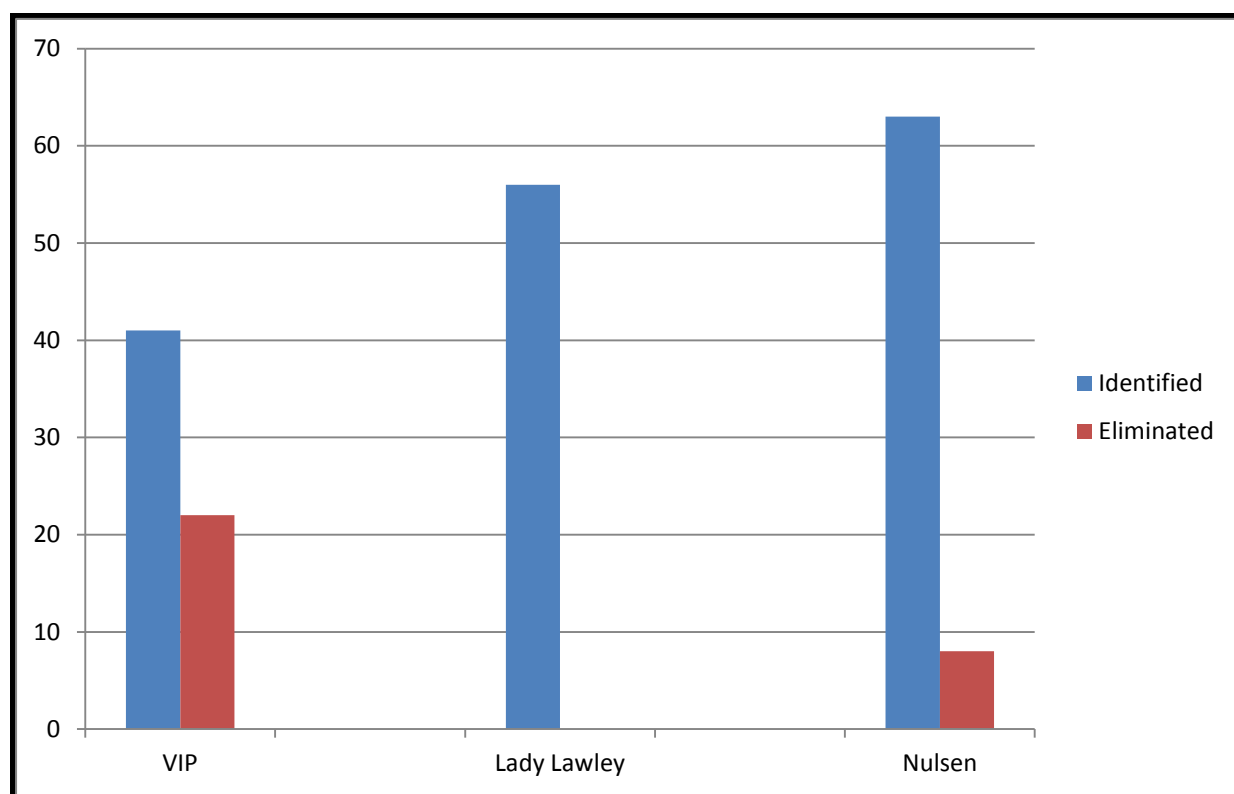
Table 2. shows the number and type of restrictive practices identified in restrictive practice audits and the number eliminated without the need for consideration by a restrictive practices panel. These results were achieved through raising staff awareness of what constitutes a restrictive practice and understanding of the purposes that they serve.

Table 2: Restrictive Practices Identified at Audit and Eliminated

	VIP		LLC		Nulsen	
	20 people with challenging behaviours 1 of whom had Behaviour Support Plans		28 people with challenging behaviours 1 of whom had Behaviour Support Plans		25 people with challenging behaviours 9 of whom had Behaviour Support Plans	
	Identified	Eliminated	Identified	Eliminated	Identified	Eliminated*
Mechanical restraint	7	3	2	0	9	1
Physical restraint	9	6	15	0	11	2
Chemical restraint	9	0	12	0	18	3
Seclusion/exclusionary time out	3	3	6	0	5	1
Restricted access	10	3	18	0	14	1
Response cost	7	3	2	0	6	0
Overcorrection	0	0	0	0	0	0
Punishment type 1	0	0	1	0	0	0
Total	41	22	56*	0	63	8

* LLC provides services to children. Some restrictive practices that are restrictive for adults might be age appropriate and consistent with community norms in relation to acceptable practices to protect children.

Figure 1: Restrictive practices identified at audit and eliminated



Consideration of restrictive practices for which Positive Behaviour Support panel authorisation was sought suggested that at this early stage of their operation, the panels were already having a positive impact in helping staff to reduce the use of restrictive practices.

The Nulsen Positive Behaviour Support panel had considered 63 practices in relation to 23 people. Of these, 6 practices were endorsed. A further 24 practices were given interim approval pending staff undertaking other activities such as consultation with medical practitioners and families, collecting more data or gradually introducing a less restrictive practice without taking undue risks by removing the original practice too quickly. Review dates have been set for practices with interim approval. Ten practices were approved, with the panel able to make suggestions about less restrictive alternatives to the practice they were requested to consider and eight were eliminated.

At VIP a total of 41 practices were identified as restrictive, with 22 such practices being eliminated. Of these, the VIP restrictive practices panel considered eight practices in relation to eight people. Interim approvals were initially granted in all eight cases and at a first or second review, two have been approved, three not approved and one eliminated, while two continue to have interim approvals.

Outcome 7:

Reduction in use of restrictive practices

This outcome was achieved.

A reduction in the use of restrictive practices that could be attributed to the project was demonstrated at Nulsen and VIP.

LLC had processes in place before beginning the project to reduce restrictive practices that were for organisational convenience and practices that involved exclusion and time out.

Recommendation 13

Restrictive practice audits should be a required element at the commencement of the implementation of Positive Behaviour Support in all organisations.

Recommendation 14

Restrictive practice Audits should be conducted to identify restrictive practices not only in relation to individuals but also practices that are embedded into standard work site and organisational level culture and practice.

Outcome 8: Reduction in number of occurrences and severity of adverse incidents related to challenging behaviours

As with outcomes discussed earlier, the 12 month project timeframe was too short to provide quantitative evidence to support that this outcome was achieved. As indicated in Table 13 below, individual data was collected quarterly for most but not all people who were identified to have challenging behaviours at Nulsen and VIP. However, due to the way that the data was recorded, the amount of data and its complexity for some individuals (to provide evidence of reduction in number and severity of behaviours) would require a manual collation exercise that was beyond the capacity of the project.

Qualitative information supports that there have been reductions in frequency and severity of behaviours.

As discussed in Section 1, behaviour support plans developed in the project include four components – three proactive and one reactive – which, in combination, are intended to achieve the desired outcomes of reducing the number, frequency and severity of incidents.

These are:

- Ecological changes — planned environmental changes that over time, produce a change in behaviour, for example, lifestyle and routines, background stimuli and environmental pollutants.

- Focused support strategies — strategies that should result in more rapid effects including, for example, schedules of reinforcement, stimulus control or satiation and background stimulus change.
- Positive programming – to change the person’s behavioural repertoire to better deal with their environment through changes to communication systems, coping and tolerance strategies and functional related or equivalent skills development.
- Situational management – reactive strategies to establish control and prevent harm when a situation occurs.

The proactive strategies are designed to achieve reduction in the frequency of the challenging behaviour, therefore reducing the need for reactive strategies.

Both sets of strategies play a role in reducing episodic severity, but it is the proactive strategies which maintain the reduction in the longer term.

It was possible to state that in two instances challenging behaviours were reduced. This could be attributed to the interventions described in their behaviour support plans, which provided for support arrangements that were significantly different to those in place before the project.

Qualitatively, project staff and supervisors and direct care staff at Nulsen and VIP consistently reported positive changes in the incidence and severity of challenging behaviours for most but, at this stage, not all people. They provided stories of positive behavioural changes which demonstrated the effectiveness of the Positive Behaviour Support plans they were asked follow and motivated them to stay engaged. They also reported increased levels of confidence in their own ability to intentionally apply reactive strategies, including counter intuitive strategies, to diffuse situations as soon as behaviours were exhibited, and before they escalated.

Staff also reported that restrictive practice audits had eliminated practices that in some cases, with the benefit of more knowledge, they could now see had escalated a behaviour because the practice added a further trigger to the one that had originally precipitated the behaviour.

All three organisations demonstrated that they have policies and procedures that directly support Positives Behaviour Support and have implemented supportive system changes including changed arrangements for staff recruitment and selection, staff induction, supervision and training. All of these were consistently qualitatively assessed to contribute to a reduction in frequency and severity of adverse incidents.

Outcome 8:

Reduction in number, occurrences and severity of adverse incidents related to challenging behaviours

This outcome was not demonstrated to have been achieved.

This outcome was not demonstrated due to the project's 12 month timeframe, and data collection and analysis limitations. Reductions were qualitatively observed via case reviews and case studies, and reports in staff interviews.

Recommendation 15

A reduction in the number, frequency and severity of adverse incidents related to challenging behaviours should continue to be a primary outcome sought from the implementation of Positive Behaviour Support arrangements.

Outcome 9: Compliant, consistent and accountable services

As has been discussed in relation to earlier outcomes a 12 month timeframe was not sufficient to enable confident conclusions that services are at this stage sustainably compliant, consistent and accountable. Staff interviewed at the conclusion of the evaluation identified a need for further training and consolidation of the new practices, including a need for procedures to help new staff to quickly access the e-learning package and to be provided with the information and on the job training that others have had. Most staff commented on the need to rapidly extend the pool of staff with higher level expertise to reduce the current reliance on the small group of project staff whose roles were consistently identified to be critical to the successes achieved in all areas of the project.

The future role of dedicated staff in the area of Positive Behaviour Support is seen as central to sustained change in culture and work practice and in building and mentoring staff skills in behaviour support. This is consistent with literature regarding system change using Positive Behaviour Support. There was positive evidence that progress has been made towards achieving this outcome at Nulsen and VIP. As discussed, the model was not a good contextual fit with the LLC respite services. This evidence for this outcome has in part already been addressed in discussion in relation to Outcome 2 (Positive Behaviour Support tools and products available and used) and Outcome 6 (constructive and sustained consumer routines in place).

The audit functions built into the model of Positive Behaviour Support applied in the project are one of its key features. As discussed in relation to Outcome 2, specific skills training, customised to the support requirements of each client, is provided to staff and is then subject to random procedural reliability checks to determine the extent to which staff continue to understand and apply the skills as they work with the client.

As discussed in relation to Outcome 6, compliance with established routines was measured through using the Positive Program Review (PPR) tool with measurement against two standards. **The PPRs for Nulsen and VIP showed that more clients at Nulsen had constructive routines in place at the end of the pilot 57 per cent than at the commencement (14 per cent).** At VIP the first PPR showed that constructive routines were already in place on the first review, so it was not possible to demonstrate that the project contributed to improvements.

The Positive Behaviour Support panels, as described in relation to Outcome 2, established in each organisation are a major strategy through which organisations demonstrate accountability because panel membership included a representative from outside of the organisation.

Outcome 9:

Compliant, consistent and accountable services in pilot agencies

This outcome was partially achieved.

The 12 month project timeframe was not sufficient to enable confident conclusions to be drawn that services were sustainably compliant, consistent and accountable by the project's conclusion.

Available evidence confirmed that progress had been towards the achievement of the outcome. The robust audit functions built into the model of Positive Behaviour Support used in the project. Specifically:

- the specific skills training for staff, customised to the support requirements of each client
- the subsequent random procedural reliability checks to determine the extent to which staff continued to understand and apply the skills as they work with the client, and
- the use of the Positive Program Review tool (PPR) were all important strategies to ensure that over time, compliant, consistent and accountable services would be embedded in organisation practice.

The effectiveness of the Positive Behaviour Support panels, as a mechanism through which the consortium partners demonstrated accountability through including a representative from outside of each organisation would be expected to contribute to the evidence of compliant, consistent and accountable services over a longer period of time.

Recommendation 16

Sustained attention must be given to training. Arrangements for the ongoing development of staff knowledge and skills past the 'elementary' level should be included in planning rollout in each disability sector organisation.

Recommendation 17

The use of structured tools that assess the quality and application of behaviour support plans (such as the procedural reliability checks and PPRs used in the pilot) are effective reinforcers of both learning and it's the application of that learning in the workplace and should be incorporated into the further rollout of Positive Behaviour Support.

Systemic learning from these outcomes

In the course of the evaluation, learning emerged, that had systemic relevance more broadly than in relation to any of the nine separate outcomes which were the project's primary focus:

- the importance of early and continuing engagement with families and carers as Positive Behaviour Support is rolled out across all service types
- the importance of the Commission and Disability sector organisations recognising that Positive Behaviour Support is more than an approach which results in better outcomes and a good life for people whose behaviour is sometimes challenging. It is an exemplar of the person-centred, individualised planning and outcomes-based practices which are now required in the procurement reforms that are integral to the State Government's community services sector reform agenda, as reflected in the Commission's recent outcomes-based contracts initiative
- recognising that as with the respite service in the project, the core values and key principles of Positive Behaviour Support as implemented in the project will be relevant in all settings, but practices will need to be customised according to the setting into which it is being introduced
- recognising that it is likely that there will be implementation issues for small organisations and those in regional rural and remote locations that have not been identified in this project
- recognising and responding to the critical importance of timely, accessible support to organisations from professionals with expertise in Positive Behaviour Support and Applied Behavioural Analysis
- recognising that elements of a Positive Behaviour Support approach are not consistent with current Certificate III and IV curriculum and this creates added challenges for staff training and engagement
- recognising that best outcomes for people with disability whose behaviour is sometimes challenging will only be achieved through sustained cross-portfolio collaboration at government and service sector levels.

Recommendation 18

The findings of the evaluation should be widely distributed and formally discussed across the disability services sector, including families, carers and the services that support them, so the learning is embedded into all activities supporting the further

rollout of the Positive Behaviour Framework in disability sector organisations across the State.

Recommendation 19

The next phase of rollout of the Positive Behaviour Framework should include pilot projects in regional and rural Accommodation and ATE settings and in disability sector organisations providing individual options in the community.

Recommendation 20

There is a role for specialist clinical consultancy to support the disability sector in responding to the needs of people with disability who sometimes display challenging behaviours. This support will be integral to the project's successes and consideration of how the sector will access this type of support into the future will be integral to the future success of the Positive Behaviour Framework reforms.

Recommendation 21

The Commission should continue with cross - portfolio negotiations to achieve a consistent and respectful approach to working with people with disability whose behaviours are sometimes challenging, regardless of where and how they engage with Western Australia's community services, education, justice and health systems.

4. What have we learnt?

The purpose of this section is to:

- reflect on what has been learned in the project through consideration of the outcomes collectively rather than each in isolation to constructively inform other disability sector organisations seeking to follow a similar path to those in the pilot
- provide further qualitative discussion from the collective outcomes perspective, to further support the recommendations
- inform the sector more broadly, not only at the level of operational service delivery, but also at the strategic and policy level.

Given the level of interest across the sector in moving forward with the rollout of positive behaviour approaches, the consortium partners, the Commission and the evaluator have shared observations and interim results throughout the course of the project rather than waiting for the final evaluation report. As noted in the previous Section, some of the early learning from the project has already informed the development of other initiatives such as the project to pilot a positive behaviours model in the South West, the development of the Voluntary Code of Practice for the Elimination of Restrictive Practices and the development of arrangements for Positive Behaviour Support panels.

4.1 Staff perspectives

This section is based on feedback received from supervisors and staff who participated in focus groups and one-on-one meetings in the latter stage of the project. According to Lucyshyn et al (2007) (see footnote 25), staff need to see the following to believe in and participate in Positive Behaviour Support:

1. Practicality: Do I understand what I need to do and do I have the resources, time, energy, material and support (professional, managerial) to carry out the strategy?
2. Practicality: Do I understand what I need to do and do I have the resources, time, energy, material and support (professional, managerial) to carry out the strategy?
3. Desirability: Is this approach actually worth implementing?
4. Goodness of fit: Am I comfortable with this approach?
5. Subjective effectiveness: Is the outcome in the person's best interests and worth the effort involved?
6. Subjective evaluation of quality of life: Is this leading to the person having a better life in terms of inclusion and participation?

Interviews with staff were conducted using a semi-structured format framed on Lucyshyn's observations. The responses of staff provide important learning for other disability sector organisations in terms of what is necessary for successful implementation, and in understanding the importance of pre-implementation preparation to acquaint staff with the new expectations and to provide them with information and early access to training before any changes are made. The views of staff are well summarised in the conclusions of one group that "work is more rewarding but it's not easier, sometimes it's harder".

Footnote 25

Lucyshyn JM, Albin RW, Horner RH, Mann JC, Mann JA & Wadsworth G, 2007, "Family implementation of Positive Behaviour Support with a child with autism: A longitudinal, single case experimental and descriptive replication and extension", *Journal of Positive Behaviour Interventions*, Volume 9, pp 131–150

Do staff understand what they need to do and do they have the resources, time, energy, material and support (professional, managerial) to carry out the strategy?

Supervisors and staff interviewed at Nulsen and VIP expressed a clear understanding of what they need to do for Positive Behaviour Support to guide their workplace practice.

They described themselves as having more skills than they had at the start of the project, but most also said they continued to struggle with the complexity of some aspects of the model and with the more complex theory and language that underpins Positive Behaviour Support practice in the work place. Most reported that they felt competent to identify restrictive practices, and when properly instructed and supported, to carry out the strategies in a behaviour support plan. Most felt competent to document occurrences of and responses to challenging behaviours.

Staff stressed the importance of being well-informed before the project started. Several felt that this was an area in which the project could have done better. Several said that they “didn’t get it” at the beginning and one described the process as “drip feeding us information as things came up, when we needed to know more about it before we got started”.

There was strong advice that implementation in other disability sector organisations should begin with a formal, structured approach to providing information about Positive Behaviour Support and helping staff to understand what it will mean in the workplace. This should be followed by a formal program such as e-learning. Some staff said they felt “thrown in at the deep end” when the project began and that it would have been helpful to have had more time to ask questions. They observed that what is expected of them now in some areas of their work is radically different to what was required before, and it doesn’t sit well with the teaching in Cert III and IV about risk management and duty of care. Most had not had exposure to the e-learning, but those who had suggested it should be followed up by practical workshops and work place training and practice around some of the key procedures and documents before the project “went live”.

Concerns about accommodating implementation requirements in a normal rostered shift were consistent. Several staff raised concerns about organisational expectations that e-learning could be completed during working shifts. Almost without exception staff reported they did not have the time on regular shifts to conduct assessments of behaviour and functional analyses, to complete documentation additional to that routinely required on a shift and to write, or contribute to the writing of behaviour support plans.

Some supervisory staff noted that the skill set required to collect and analyse data and develop a behaviour support plan was not necessarily the skill set required to be a good support worker – although some support workers could develop the skills over time, with training and work place support. Others do not have the levels of literacy (including for some, sufficient fluency in English), the writing skills, the

behavioural knowledge or the analytical skills to develop plans, but are competent to follow a plan, especially if the required staff behaviours are modelled by trained and experienced peers and supervisors.

Staff expressed reservations about the continuation of the gains made in the project after the project concluded. They are not confident they have the time or the expertise to continue the progress that has been made unless they continue to be supported by specialist staff. These issues highlight the need for behaviour support plans to be developed in a person centred and accessible format.

They saw the sustainability of Positive Behaviour Support to be contingent upon the continuing availability of specially trained and experienced staff acting in specialist roles at different levels across the organisation – supervisors and trained and experienced peers in the work place, as well as specialist professional staff. Some also noted the importance of the continuing support of senior management to “maintain the message”.

As noted above, some staff recounted early doubts about the new practices because they conflicted with what they had been taught in their Certificate III and IV training. Conflicts around duty of care and management of risk, as represented in relation to some clients, presented a radical departure from what had been previously expected of them by their employers and was sometimes not consistent with their training. Most said that as the project proceeded they were reassured that risks were managed appropriately and responsibly, but differently.

Their views on duty of care had changed from one that was only risk management based, to one that was based on a duty to ensure the people they supported were safe and able to lead the best life they could and have their rights respected.

Some staff noted that some of their Cert III and Cert IV training was counter-productive if Positive Behaviour Support was to be the ‘way of the future’ in providing disability services. They noted that newly-trained staff coming into a service would have to immediately ‘unlearn’ what they had just been taught, and learn something different on the job. Staff undertaking studies while they were employed would be required to act in their workplaces in ways that were not consistent with what they were being taught in their training. Negotiations with the Community Services, Health and Education Industry Training Council and providers of Certificate III and IV training will be necessary to ensure an alignment between training and organisational requirements as Positive Behaviour Support is rolled out.

There were many comments about the amount of paperwork associated with the model. While some tools were valued (especially those that provided feedback on progress, such as Specific Training Procedural Reliability and the Positive Program Reviews), staff had concerns about the extra workload associated with the project’s processes and documentation requirements.

Some staff suggested that those who developed the level of expertise to develop behaviour support plans, and support their peers in working according to what a plan

required, should have their additional skill set acknowledged and that this should be reflected in pay rates.

Desirability: Is this approach actually worth implementing?

Staff at both Nulsen and VIP consistently expressed support for the approach and considered it to be worth implementing. Not all were supportive in the early stages. Some acknowledged an early belief that the new arrangements would be “just the next flavour of the month”. As noted above, they believed their reservations could have been addressed or reduced, through a more structured approach to informing staff about what was involved before implementation commenced, by consistently providing staff with access to e-learning and following up with more explanation and discussion to address any remaining reservations.

Staff reported that over time, when feedback and their own observations confirmed that their efforts were making a difference, they became increasingly convinced that the time and effort involved was worthwhile.

As already discussed, staff at LLC were generally less supportive of the approach because it did not sit well with the models of respite service within which they worked.

Goodness of fit: Am I comfortable with this approach?

Staff at Nulsen and VIP were comfortable with the approach, with most adding a caveat that they were concerned about their capacity to fit in all the requirements while completing a shift on the floor. Most noted that some language and terms were “challenging”, “very technical” and “for the professionals” and advocated for the approach to be simplified. Some staff acknowledged they were still working out what practices should be considered restrictive and when and how they could use practices for reasons of immediate safety and reduction of harm. They said that they felt comfortable discussing these issues with supervisors and project staff.

Subjective effectiveness: Is the outcome in the person’s best interests and worth the effort involved?

Staff feedback consistently indicated that they observed Positive Behaviour Support to be in the person’s best interests and worth the effort. A consistent theme was a change in their perceptions over the course of the project, from ‘best interests’ being related only to safety and protection, to best interests including respect for and protection of human rights.

An issue of discussion with some was who should determine what is in the person’s best interests. At all three sites there were examples of differences of opinion with other mediators about what was in the individual’s best interests. Examples included a family that was reluctant to agree to an alternative to a restrictive practice that had had a calming effect on their adult son since childhood, even though their preferred practices was age-inappropriate; families that were reluctant to consider changes to physical restraint practices; doctors refusing to look at behavioural data and to consider alternatives to current psychotropic medications; and other disability sector

organisations that had a significant role in the individual's life resisting engagement with a consortium partner to discuss mutual opportunities to change practices.

Some staff expressed reservations about it being "worth the effort" when other key supporters and decision-makers in the person's life were not supportive. They observed that it was not in the person's best interests to be subjected to different support practices in different settings, creating confusion and uncertainty for them.

Subjective evaluation of quality of life: Is this leading to the person having a better life in terms of inclusion and participation?

Staff provided many examples of how quality of life was improved through the practices that were more respectful of their human rights, but reported that for most people at this stage, the change was more in the quality of their inclusion and participation rather than extending their inclusion and participation into new areas.

The significant reduction in use of time out, in punishment and in response cost practices were identified to have contributed to some people now being rarely excluded from programmed activities or no longer excluded at all.

Reduction in the use of physical restraints was reported to have made participation in activities a more pleasurable experience for other people and for staff.

4.2 Plan and conduct pre-implementation activities

As noted earlier in the report, disability sector organisations planning for the implementation of Positive Behaviour Support need to include not only planning for the implementation of changed workplace practices and the conduct of a restricted practice audit but also identifying and planning for activities that will enhance organisational readiness in the period preceding the implementation.

Pre implementation activities should include:

- initial awareness raising training for the Board and senior managers about Positive Behaviour Support, the importance of their leadership, expectations around cultural changes, the need to review systems, policies and procedures to ensure a good fit with the planned new practices, and the messages that staff need to hear to reduce their concerns and foster their engagement
 - identification of in house champions to form part of the implementation leadership group in each disability sector organisation; (discussed in more detail below)
- initial training for supervisors about Positive Behaviour Support, what the new practices will mean for their role as work site leaders and supervisors, and opportunities for staff at this level to meet and discuss the proposed changes with their own supervisors
- e-learning or similar competency based training for supervisors and managers, including training in the key terms and language of Positive Behaviour Support

- e-learning or similar competence based training for support workers in the start-up knowledge and skills that will support them, including training in the key terms and language of Positive Behaviour Support
- opportunities through workshops and group discussions for support workers to discuss the proposed changes with their supervisors
- an awareness raising strategy through which to engage clients, families, carers and other stakeholders in the reasons for and implications of moving to a Positive Behaviour Support approach.

Although each disability sector organisation will have some specific needs in the pre-implementation phase, based on size, location, service type, client group and so on, it should be anticipated that much of the material to support the pre-implementation activities will be generic. It would be more efficient in terms of time, resourcing and access to expertise for the sector to work together to develop a core set of pre-implementation support materials, rather than each disability sector organisation being required to develop its own. Each disability sector organisation DSO could then adapt the core materials according to their own organisational need.

4.3 Changing culture takes time

As noted above, all three consortium partners had already introduced initiatives to support movement towards Positive Behaviour Support and a reduction in the use of restrictive practices, and all had made progress in varying degrees, towards aligning wider organisational structures and processes with the requirements of the approach.

Notwithstanding this, consortium agencies found that to effect the changes requires a strategic, staged and well thought out plan that is broader than simply implementing a Positive Behaviour Support model. The changes in practice require a major cultural shift. As will be discussed later in this section, policies and procedures related to human resource management, risk management and duty of care will need to be reframed and re-explained to staff whose training and work experience has been about doing things in a different way.

The experience of the consortium partners was that especially in the early stages, some changes are likely to be seen to create more work, not less. Some of the restrictive practices to be eliminated will be embedded in the disability sector organisations culture. Staff will be familiar and comfortable with some of them because the practices work for them, even if they don't work for their clients.

Clearly understood and consistently applied auditing practices, as demonstrated in the project, are valuable reinforcers, as are requirements for skills and knowledge to be updated as part of continuing professional development and challenging behaviours practices accreditation for staff.

For many disability sector organisations, the changed practices and changed expectations of their staff will represent a major cultural change that could (and did in

some pilot project sites) result in some early staff resistance. By anticipating this, understanding change management theory and planning strategies to address any resistance as part of the implementation plan, the extent of resistance, and its impact, can be reduced. Strategies that were not necessarily or uniformly implemented in all three consortium organisations (because their importance has only retrospectively been recognised) are all strategies that will contribute to reducing cultural resistances to the changes over time. These include early structured engagement with staff at all levels of the organisation about the planned changes, structured and planned information dissemination, preparatory training for leadership staff in the management of change and their identification of changed organisational requirements, and early immersion of all staff in awareness raising training. These strategies are discussed in more detail later in this section.

Consideration will also need to be given to the disability sector organisations expressed organisational values and the extent to which they align or don't align with the planned new way of providing support.

4.4 Change can be effected, but not embedded, in a 12 month timeframe

Aside from the time taken to effect cultural change as already discussed, it is also important for disability sector organisations to understand that the experience of the project was that it takes more than 12 months to set up **and** embed a comprehensive multi-element Positive Behaviour Support model. Also important to note is that the range of supports available to the consortium members might not necessarily be available to other disability sector organisations – and this could further extend the implementation period.

The project achieved positive outcomes in most of the outcomes areas in which it was set up to achieve. However, it is likely to take another year at a minimum to embed the practices. Review data demonstrated that staff changes at VIP, and changes in residential service managers at Nulsen had a negative impact on performance at the next (and sometimes) subsequent Positive Program Review. A Positive Behaviour Support model will not be embedded in organisations until there is a critical mass of trained and motivated staff, not only in key management and front line positions but also in positions that back up positions when staff go on leave, get promotions or resign.

4.5 Identify, train and support champions

“If there aren't drivers, there aren't passengers to come on the ride” was the way one senior manager described the importance of having passionate qualified people to lead implementation in the organisation. The importance of disability sector organisations having a capacity to allocate motivated, skilled resources to lead the successful implementation of Positive Behaviour Support and to sustain progress – either in-house or in partnership with others – was a consistent theme in the project. The role described for the positions was consistent with the roles and expertise of the project team members.

Identified “champion” requirements included:

- strong leadership qualities
- excellent communication skills
- a personal value system that is respectful of the human rights of people with a disability
- a personal commitment to contributing to services that support and maximise the exercise of those rights
- good organisational and management skills
- workplace experience, knowledge of the jobs of support staff
- comprehensive understanding of what is involved in Positive Behaviour Support
- expertise or training in writing Positive Behaviour Support plans
- the knowledge, skills and training to model what is expected of staff and to provide training to supervisors and staff.

Few disability sector organisations are likely to have ‘role ready’ staff who will meet all the requirements at the beginning. Senior managers consistently identified that personal qualities were equally as important as formal qualifications and that based on their experience, disability sector organisations should identify people who meet the first six requirements and invest in them so that they can meet the other three.

This investment would be ideally made in the six to 12 months before formal implementation commences. The number of leaders will vary according to the size of the organisation and number of service sites from which it operates. The experience of the project strongly suggests an investment in a group of leaders, rather than a single position. This should be the preferred strategy to reduce the risks of implementation faltering through the loss of a single skilled leader before new practices are strongly embedded. For smaller disability sector organisations, this could include investment in champions to be shared across organisations, not only within.

4.6 Strong leadership as a key success factor

The project has highlighted the importance of integrated leadership across policy, practice level and disability sector organisation/service level as a major success factor.

Policy level

The Commission, with the support of the guiding committee and the Office of the Public Advocate both before and during the pilot project, has already provided significant leadership in producing policy level documents and guidelines that will support the further rollout of Positive Behaviour Support and the reduction in the use of restrictive practices. These have included the Positive Behaviour Framework, the Towards Responsive Services for All report, the Effective Service Design Guidelines,

the Behaviour Support Information document, the Voluntary Code of Practice for the Elimination of Restrictive Practices and Advance Health Directives.

However, as will be discussed later in this Section, for sustainable, systemic outcomes to be achieved, other government agencies that have a role in providing services to people with disability and their families will need to actively engage at the policy level, in particular and as a priority, the Department of Education, the Department for Child Protection, the Mental Health Commission and the Office of the Chief Psychiatrist.

Practice level

The Commission's Positive Behaviours Interest in Action Group, the guiding committee and the behaviour support consultancy teams all have a continuing sector leadership role in promoting good practice. The leadership expectations of people in these roles should be anticipated to increase as Positive Behaviour Support rollout proceeds and demands for practice support grow.

The consortium partners have expressed concern that the essential clinical practice leadership expertise which, as already discussed, has been a critical success factor, will not be available to disability sector organisations in rollout and that this will be a risk and a barrier to successful implementation. Stakeholders consider the availability of clinical practice expertise in the non-government sector to be a challenging issue because there are few practitioners with the credentials (academic and practice) available to step into these roles. They noted that the Commission's internal expertise is already stretched to meet current demands.

One strategy to address this issue could be to engage with tertiary institutions and with relevant professional bodies to help identify private practitioners with the expertise to fulfil this role, who could be engaged on a contract basis. Another could be for the Commission to offer scholarships to suitable doctoral students to encourage them to focus on this area and contribute their expertise.

In regard to practice level support for staff in the workplace, identified in the literature as central to the successful implementation of Positive Behaviour Support, the peer support practitioner role as fulfilled by the project's Nulsen-based project officers also needs to be replicated across disability sector organisations in rollout.

Disability sector organisation level

In the consortium, active and sustained leadership and support for the model was provided by the Boards at Nulsen and VIP (LLC does not have a Board), chief executives at Nulsen and VIP, the Director of Nursing at LLC, and Senior Managers at each organisation. Some staff commented that they knew the project was "for real" because of the extent of support at senior levels in the organisation. Senior level leadership was essential and successful in leading change in organisational values and culture, driving change in organisational policy, systems and practices and in actively engaging with staff.

Service/site level

At the site level, particularly at Nulsen, but also VIP, key success factors were the leadership of residential services managers (RSMs) and team leaders – they embraced the change, initiated training (including specific procedures training), modelled new practices, mentored staff under their supervision, focused supervision on the new practice requirements and assisted staff to prepare material for Restrictive Practice Panels. In some cases, positive program review results for a particular house at Nulsen dropped significantly when an engaged RSM moved from a project service site. Sector level investment in developing the leadership of front-line managers will assist disability sector organisations in successfully implementing Positive Behaviour Support in their organisation.

4.7 More is required than action to reduce/eliminate restrictive practices success requires alignment of Positive Behaviour Support with other organisational systems and policies

Significant policy development work leading to the development of the Voluntary Code of Practice for the Elimination of Restrictive Practices was occurring concurrently with the project. Possibly because of this timing, one issue consistently identified in consultation with managers and senior managers was the importance of disability sector organisations understanding that the model was a multi-element model. Reducing and eliminating restrictive practices was only one of multiple initiatives that together have resulted in the consortium partners' work places making progress towards operating within a Positive Behaviour Support framework.

The experience of all three consortium partners was that attention was required to other organisational systems and policies to achieve the necessary congruence and contextual fit with Positive Behaviour Support practice. Areas that disability sector organisations should note for review include:

- organisational values
- strategic and operational plans
- human resource policies and procedures including:
 - staff code of conduct
 - job roles and job description forms
 - recruitment and selection procedures
 - staff induction procedures
 - supervision practices
 - performance appraisal practices
 - training and development practices
- risk management policies and procedures
- partnership and collaboration policies and procedures
- quality assurance policies and procedures.

4.8 One size doesn't fit all

The design of the project was determined by sector experience (including Nulsen's considerable experience, as will be discussed below), funding and the time available. One objective was to test a Positive Behaviour Support model in three different settings. With the time and resources available, to do this concurrently was the only option.

As discussed in Section 1, the model was not a good contextual fit at LLC and their experience (and the literature) suggests it would be unlikely to be so for any respite service.

This is because, although families had information about the project and gave consent for the involvement of their family member, the focus of the project was on disability sector organisations and their staff, not families. With respite services, clients spend only small blocks of time in the service and their main mediators (those who spend time with the person and relate to them according to what is established in the behaviour support plan) are outside of the service.

A model which focuses primarily on the individual and their family in their home environment would be a better contextual fit. In the context of the disability services sector, it would be more appropriate to conceptualise disability sector organisations that are primarily respite, in-home support providers and providers of similar service types as sector 'responders' and not 'initiators' in the next stage of the Positive Behaviour Support rollout.

4.9 Awareness and theory/practice training for all staff should be undertaken outside of rostered shifts

The logistical challenges and potential costs of providing significant amounts of training to staff outside of rostered hours are recognised. However, the project experience and the subjective views of managers and staff strongly suggest that investing in that cost up front will result in smoother and more efficient implementation of the new arrangements.

Once existing staff have been trained, initial training in Positive Behaviour Support should be included as part of the induction of new staff into the organisation. As noted earlier in this Section, one off 'immersion' training was considered by staff at project sites and by managers to be insufficient. There was strong support for theoretical training away from the workplace to be immediately followed by supported on-the-job mentoring skills practice using peer and specialist clinical support. There was also support for ongoing training and development, off and on site, to assist staff to maintain their core skill practice levels and to move to higher levels of expertise.

Following up initial training with regular on-the-job reinforcement and ongoing skills and knowledge development is an important success factor, as was the understanding by staff that their application of the training to their day-to-day workplace practice would be checked.

The skills development approach used in the project recognises the need for reinforcement of skills training and there are procedures for the formal reinforcement and extension of skills and knowledge at regular intervals.

As noted earlier in the report, the completion of the e-learning modules was reasonably successful at LLC. However, staff identified the need for further practice to reinforce the knowledge and skills gained from the training. Some had previously completed in-house training with LLC's specialist psychologist that was described as "more hands on".

They felt they would have been better equipped to apply the knowledge and skills in the e-learning modules if they had access to the mentoring and support of someone such as the specialist psychologist until competency in practice could be achieved.

It would not be feasible for all disability sector organisations to provide this level of mentoring and support in-house. One strategy through which it could be achieved would be to develop a pool of clinical consultants to support implementation, as discussed elsewhere in this section.

The need for consultation with industry training representative and training providers in the Vocational Educational and Training sector to achieve an alignment between curriculum and work place requirements is discussed later in this Section.

4.10 Restrictive practice audits are essential

As discussed earlier in the report and reflected in the recommendations, restrictive practice audits are a non-negotiable early step in implementing Positive Behaviour Support practices.

For organisations starting out to apply different approaches to working with people who sometimes exhibit challenging behaviours, a major early barrier is the absence of data around what restrictive practices are in place in their service settings, the prevalence of those practices and to whom they are applied. Many practices, relating to both the support of individuals and to the broader management of the service, are historically and culturally ingrained as 'the way we do it here'. They are not recognised as restrictive until a cultural paradigm shift is facilitated through information and education on what constitutes a restrictive practice.

A theme in consultations with staff at management, supervisory and workplace level who had strong positive personal values that underpin their work, was that the audits were a very confronting process for them. Until the audits, they held genuine beliefs that their services were good services that met the requirements of Disability Services Standard 9.

They acknowledged that it was only with information and training to assist them to reframe their perceptions that they could see where practices fell short and were restrictive.

As discussed above, restrictive practice audits should be preceded in a pre-implementation phase by information to staff, skills training and workshop opportunities, and Board/chief executive/management reassurances that disclosure

is a safe and positive step towards better practice. These strategies will support staff to begin the cultural reframing that will enable them to change their practices.

The audits identify the extent to which restrictive practices are in use and therefore provide a baseline upon which progress in changing practices can be measured. Practices identified included many that were embedded into day-to-day service practices that were in place for all service users, as well as those in place in relation to particular individuals.

Audits were conducted at each service site that was part of the trial project, following information sessions with staff which included a focus on enhancing their capacity to identify what constituted a restrictive practice. In each organisation a Board (for Nulsen and VIP) and chief executive/senior management (for all three organisations) led amnesty declaration was made and staff were actively encouraged to be open in identifying restrictive practices without fear of any adverse personal or service level repercussions.

The number of restrictive practices in the project consortium organisations was significantly reduced by making staff aware of what constituted a restrictive practice, providing a safe, no-blame environment for them to identify and talk about such practices in their work environments and encouraging them to creatively identify safe and less restrictive options.

4.11 Clinical support is a key success factor

A consistent theme in the literature is the importance of skilling front-line staff in Positive Behaviour Support. This was an important element in the model and in the design of the pilot project and a contributing factor to its success.

However, the importance of complementing those roles with that of clinical advisors and mentors should not be underestimated.

Access to a clinician with Positive Behaviour Support experience, who is available to work intensively with front line staff around **complex** functional analyses and Positive Behaviour Support planning, and who advises, supports and reassures when challenging situations arise, was identified in the evaluation to be important to the project's success in several outcome areas. This experience added positive value to staff understanding and the development of plans for some of the people with the most complex challenging behaviours. It was also an important element in service accountability and a risk management strategy for each organisation.

At Nulsen and VIP, clinical support was provided by the project's external clinical consultant and at LLC by their in-house specialist psychologist, who was also the LLC representative on the project leadership group. The project manager also had a level of clinical experience through her experience working with the model and in the earlier Nulsen project. The availability of clinical advice was seen to be of critical importance in the development of high level Positive Behaviour Support responses to seven of the 44 people (16 per cent) identified at Nulsen and VIP to have challenging behaviours. The support included doing complex assessments, providing comprehensive advice, writing and/or reviewing complex behaviour support plans,

and mentoring and modelling required actions. In addition, both the clinical support and the project manager provided advice to Positive Behaviour Support panels (as either a member or external advisor) and other informal specialist advice on an as needs basis.

The people with whom clinicians were involved were among those with higher rating (unlawful or abusive) restrictive practices and those whose support needs consumed significant amounts of staff time and energy. **Although not measured in the project, the extent of the challenging behaviours and complexity of the needs of this group meant that although they constituted 16 per cent of people with challenging behaviours, the time and energy allocated to their support was qualitatively reported to be much higher than 16 per cent.** Success with those with the most challenging behaviours was identified by staff to be one of the reasons they embraced the project. They observed positive changes in some of the people whose behaviours were the most challenging, that made life better for them, for staff and for other residents or service participants.

Staff recognised that the skills that supported the planning for this group was beyond that which could be reasonably be expected of even a well-trained front-line staff member, especially (but not only) if the work was required to be done as part of a normal rostered shift.

The importance of the clinical role to the successful implementation and embedding of Positive Behaviour Support practice has implications for the wider role of Positive Behaviour Support practices across the sector. Until practices are embedded across the sector and the level of sector expertise has been raised, a consistent and accessible group of people who are skilled in Positive Behaviour Support, who understand service delivery across different service types and who have the trust of the organisations with which they are working, would ideally be available to support disability sector organisations.

The logistical difficulties of establishing a specialist clinical consultancy capacity to support implementation are recognised, but the role was integral to the project's successes and every effort should be made to overcoming those difficulties. disability sector organisational creativity, funding support from the Commission and collaboration with tertiary institutions as well as clinicians in private practice might all be required to achieve what is required.

4.12 Peer mentoring and collaborative partnerships are key success factors

As noted in the discussion about the outcome of embedded Positive Behaviour Support practice leadership, strength of the collaborative partnership between the consortium members was peer mentoring and the learning that came from it. The experience of the project suggests there are strong benefits in working in collaboration with a small group of peer disability sector organisations to implement and embed Positive Behaviour Support practices. While the guiding committee provides some collective support and a forum at which the implementation of Positive Behaviour Support practices can be discussed, this is not its primary role.

The group is too big (and getting bigger) to understand the specific organisational contexts within which its members are operating and the operational issues that can be associated with implementation.

Partnerships involving a common values and purpose and trust between disability sector organisations cannot be developed through external processes. No partnership will be exactly the same as any other, because each is a function of the members' shared values, services, previous relationships, experience and expertise. disability sector organisations planning to implement Positive Behaviour Support practices should be strongly encouraged to investigate opportunities do so with peer organisations that share common values and where trusting mutually supportive relationships could be developed.

Because of the location and size of the consortium organisations, it is not possible to make conclusions about collaborative peer mentoring implementation arrangements in relation to small disability sector organisations those in regional and rural areas, but this would be a useful area of consideration in the South West project.

The role of the two Nulsen-based project officers as peer worker mentors was consistently identified by staff in the consultations at the conclusion of the project to have been highly valued. Staff reported that:

- they could relate to the project officers because they understood work “on the floor”
- the project officers understood the difficulties staff encountered in trying to develop behaviour support plans and provided practical guidance, and in many cases, wrote the plans with a level of experience beyond that of the service site staff
- the project officers had expertise which they could easily translate to the staff
- the project officers were role models for staff in how, with more training and experience, staff could develop similar skills sets.

Nulsen staff in particular, expressed a view that had the project officers not been available, significantly fewer behaviour support plans would have been produced and some positive results could not have been achieved.

Staff were committed to Positive Behaviour Support and comfortable about recording and reporting but, as previously noted in the report, most felt that (1) they lacked the project officers' experience and understanding of the strategies which limited their ability to write plans, and (2) that an expectation that plans could be written by staff while on a rostered shift were unreasonable and unrealistic.

The project officers' role was highly valued by staff, demonstrably effective (in the number of behaviour support plans to which they contributed) and an important success factor at the workplace level. The sector should consider strategies to incorporate the more experienced peer support role into the broader role out of Positive Behaviour Support.

4.13 Stage the rollout

While the project outcome of having a comprehensive Positive Behaviour Support model in place for rollout across the sector was achieved, rollout has an associated requirement, identified by the consortium team, chief executives, senior managers and practitioners, that the sector must be ready to receive the model.

Disability sector organisations must have the capacity (leadership, organisational structures, the right model for the service type, staff motivation, knowledge and skills, support tools, access to clinical specialists) to work with the model both within their own organisation and across organisations – given that many people with disability are supported by more than one disability sector organisation. All three consortium partners identified barriers in implementing behaviour support plans in relation to some project participants, when implementation required engagement with disability sector organisations in other service areas – for example, ATE providers for Nulsen and accommodation providers for VIP. Other Disability sector organisations did not have the organisational readiness of the consortium partners. They did not share the consortium partner's growing knowledge of Positive Behaviour Support and enthusiasm to introduce new strategies to manage challenging behaviours, and/or did not have the knowledge and skills to understand what was being planned and how to engage in the process. Front line staff described their frustration at feeling unsupported by peer organisations when their own organisation was working hard to effect positive change in the life of someone for whom there were shared responsibilities.

Clearly this is a strategic, whole of sector issue, which will reduce over time as a critical mass of engaged disability sector organisations is achieved. However, Disability sector organisations that move to Positive Behaviour Support models over the next one to two years should understand that the absence of support Positive Behaviour Support practice arrangements in the other disability sector organisations who provide services to their client will have an impact on implementation and should be a consideration in their operational planning.

4.14 DSO and sector readiness

Factors external to the project itself were major contributors to its success.

As noted earlier in the report, all three consortium partners brought to the project a pre-existing commitment to reducing the use of restrictive practices in their organisations and to using the evidence base to change other organisational practices to create a respectful and supportive environment for all of their service users. Nulsen, in particular, had focused considerable energy and resources into moving towards Positive Behaviour Support and reducing the use of restrictive practices, starting from 2006.

Their experience value added to their project leadership as they shared it generously with their colleagues in the consortium and the broader sector.

Concurrent developments also contributed to the learning available to the pilot project agencies and, over time, will continue to be built upon – starting with the learning from the project. These developments to date have included:

- 2009 launch of the Positive Behaviour Framework
- 2010 release of the Towards Responsive Services For All report
- 2010 formation of the Guiding Committee
- 2011 release of Effective Service Design Paper
- 2011 release of the Restrictive Issues Discussion Paper
- 2011 release of the Deakin University report into Positive Behaviour Teams
- 2011 release of the Substantive Equality Report on PBT
- 2012 release of the Positive Behaviour Support information Paper
- 2012 The cross-sector collaboration and launch of the Voluntary Code of Practice for the Elimination of Restrictive Practices.

4.15 A new role in the sector – Positive Behaviour Support peer mentors?

As discussed already in the report, the role of the two Nulsen-based project officers was highly valued by staff and was a success factor for the project. The role evolved over the course of the project but is now retrospectively best described as peer mentoring. A consistent theme in the positive feedback about these roles was that the occupants were “grounded”, they had higher Positive Behaviour Support competencies than staff on the floor and they had a practical understanding of what was involved in providing direct support services to clients, so that staff were able to identify with them.

Should this role become part of a future disability services sector workplace landscape, attention will need to be given to working with the vocational education and training sector to develop a curriculum around the skill requirements for the position and to identify any background prerequisites. Attention would also need to be given to determining appropriate levels of remuneration and to how the positions will fit into existing sector workforce arrangements and the structures of individual disability sector organisations. Consideration should be given to not only locating peer mentors within organisations, but also to providing a pool of peer mentors that could be accessed by smaller disability sector organisations.

4.16 Regional and rural Disability sector organisations and other disability services settings

The pilot project demonstrated that the model was not a good fit for a respite service and assumptions should not be made about its appropriateness to other service settings or to disability sector organisations operating outside of the metropolitan area.

It would be prudent to undertake and evaluate trials in regional and rural disability sector organisations and in disability sector organisations providing support services to people in the community to identify if there are other factors that should be built into the broader rollout in those settings.

4.17 Cross-portfolio engagement

For maximum systemic impact, strategies are required to effectively engage the disability services sector with other sectors that have a role in supporting people with disability in the community. The project identified the critical importance of systemic engagement with the following agencies if the disability services sector workforce is to be well positioned to achieve best outcomes for clients:

- Education Department, in relation to developing consistent inter-sectoral Positive Behaviour Support practices with school aged children who sometimes exhibit challenging behaviours
- Department for Child Protection, in relation to the protection of the human rights of children and young people aged under 18 years, and in practices in relation to children with disabilities who are in foster care and/or in the care of the chief executive under the provisions of the Children and Community Services Act (2004)
- Office of the Commissioner for Children and Young People, in relation to the promotion and protection of the human rights of children and young people aged under 18 years who have a disability
- Mental Health Commission, in relation to developing consistent inter-sectoral Positive Behaviour Support practices for people with disability who also have a diagnosed mental illness, and in relation to providing community leadership about practices that result in the prescription of psychotropic medications for people with disability who do not have a diagnosed mental illness but who sometimes exhibit challenging behaviours.
- Royal Australian and New Zealand College of Psychiatrists (Western Australian Branch) and the Royal Australian College of General Practitioners, in relation to practices that result in the prescription of psychotropic medications for people with disability who do not have a diagnosed mental illness but who sometimes exhibit challenging behaviours.

Progress has already been made between the disability services sector and the Office of the Public Advocate which has its own supportive policies and has positively contributed to sector policy development.

The Positive Behaviour Strategy Sector and Workforce Development Project: Outcomes and Measures

<p>1. A comprehensive model of Positive Behaviour Support for rollout across the disability services sector</p>	<p>2. Positive Behaviour Support products and tools available and used in pilot agencies</p>	<p>3. Collaborative partnerships to support best practice are in place across pilot agencies</p>	<p>4. Embedded Positive Behaviour Support practice leadership in pilot Agencies</p>	<p>5. Skilled support staff are attracted and retained in pilot agencies</p>
<ul style="list-style-type: none"> • A document that describes the model and defines key terms. • Commission policies that support the model 	<ul style="list-style-type: none"> • Service and file audits that focus on evidence of: <ul style="list-style-type: none"> ○ Restrictive practices audits ○ Agency policies that support Positive Behaviour Support ○ Staff training in Positive Behaviour Support ○ Individual risk assessments ○ Behavioural assessments ○ Mental health assessments ○ Communication tools? ○ Support/treatment plans ○ Reviews ○ Formal approvals for use of restrictive practices ○ Procedural reliability procedures - % of completed trials ○ Management reports reporting Positive 	<ul style="list-style-type: none"> • Qualitative evidence of partnerships in place and outcomes achieved by the partnerships (For the pilot, this will be within each pilot agency, between the 3 pilot agencies and between the agencies and the Commission) • Qualitative evidence of positive engagement with the disability sector and movement towards broader take up of Positive Behaviour Support 	<ul style="list-style-type: none"> • Positive Behaviour Support practice leadership positions are in place in the pilot agencies • Evidence of coaching and supervision practices that include consideration of Positive Behaviour Support related issues • Evidence of workplace leadership * (via specific training procedure recording sheets) • Staff perceptions of supervision (pre and post) as measured by 12 	<ul style="list-style-type: none"> • % of staff who have completed awareness training • % of staff who have completed other Positive Behaviour Support related training (eg Active Support, positive programming, Communication) • Audit of job descriptions, recruitment and selection practices including use of psychometrics for new staff recruitment? (GP – literature supports that psychological suitability rather than change through training is best)

	<p>Behaviour Support data and Positive Behaviour Support related issues</p>		<p>month interval pre and post pilot survey tool (averages and trends at each location)</p> <ul style="list-style-type: none"> • (Data will pick up on 12 training sessions conducted in each quarter of the pilot – good data set) <p>* Via Specific Training Procedure recording sheets, specific training measures that are checked (Practice Leaders and Team) include role plays and on the job performance . Re-accreditation after training is based on set periods, some 6/12 and others 24/12.</p>	<p>recruitment practice – get the right person)</p> <ul style="list-style-type: none"> • Changes in staff MBI scores at 6 monthly intervals • Changes in attribution scales (CHABA) pre and post (12 month interval) (Interpret in the context of the literature, CHABA not designed as a tool to measure psychological change) • Changes in rates of retention of direct care staff pre and post (12 month interval)
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6. Constructive and sustained consumer routines in place and followed in pilot agencies	7. Reduction in use of restrictive practices in pilot agencies	8. Reductions in no of occurrences and severity of adverse incidents related to challenging behaviours in pilot agencies	9. Compliant, consistent and accountable services in pilot agencies
<p>Sample of files to audit Individual Support Plans in place, with focus on the number of plans that:</p> <ul style="list-style-type: none"> • are person-centred • contain behavioural assessments • show positive programming (need to define) and reviews • show reactive strategies • show evidence of review of s (pars are conducted 3/12 in the pilot) • qualitative feedback from a sample of staff. 	<ul style="list-style-type: none"> • Changes in levels of restrictive practices in pre and post restrictive practice audits (12 month interval) • Level/% of approved restrictive practice at 12 months • Changes in no of MH assessments completed (PAS-ADD) • Medication charts - changes in levels of psychotropic medication for clients who have not had a mental health assessment that confirms mental illness. (12 month interval) • Number of PRN protocols in place pre and post (12 month interval) • Qualitative feedback from a sample of staff. 	<p>Analysis of agency incidence reports pre and post (12 month interval)</p>	<p>% of Positive review standards achieved (85% average for each unit = positive result)</p> <p>Organisational structures that are consistent with and support Positive Behaviour Support</p> <p>Aggregation/analysis of measures of other outcomes</p>

Table: Data Summary for Routine Implementation

Service applied to	Standard
Nulsen and LLC (in home respite)	<p>Standard One Routine Operational definition:</p> <p>Choose one resident/service user at random. Review their daily routine. A 'Plus' is given if the daily routine has been posted (ie, located on a wall, in the recording book or similar) by the manager or support worker at the time of the review, lists activities by the hour throughout the day, and lists data-based skills training programs and community access activities, and lists the staff member assigned to facilitate the activity (if applicable).</p>
VIP and LLC (Residential Respite)	<p>Standard One Routine Operational definition:</p> <p>Choose one resident/service user at random. Review their daily routine. A 'Plus' is given if the daily routine has been posted (ie located on a wall, in the Recording book or similar) by the manager or support worker at the time of the review, lists activities by the hour throughout the day, and lists data-based skills training s and community access activities, and lists the staff member assigned to facilitate the activity (if applicable).</p> <p>The service user routine may consist of a group routine as long as evidence is provided that the service user had input into the activities selected for the group routine.</p>
All Services	<p>Standard Two Operational definition:</p> <p>Based on the resident/service user chosen above, a 'Plus' is scored if the staff member assigned to the resident/service user is directly observed carrying out the listed in the daily routine at the time of the observation.</p>

Table details the scores on the first PPR for VIP and Nulsen as compared to the final scores for both organisations. LLC data is excluded because data was collected through only one PPR at the commencement of the project, so changes in compliance with consumer routines cannot be measured.

Table: Positive review data first and final checks

Service site	Date	Standard 1	Standard 2	Date	Standard 1	Standard 2
✓VIP	22/07/11	✓	✓	13/06/12	✓	✓
Nulsen 1	23/02/11	x	x	31/07/12	✓	✓
Nulsen 2	26/10/10	x	x	30/07/12	x	x
Nulsen 3	10/02/11	✓	✓	24/07/12	✓	✓
Nulsen 4	1/03/11	x	x	1/08/12	x	x
Nulsen 5	28/10/10	x	x	14/05/12	✓	✓
Nulsen 6	6/05/11	x	x	23/04/12	✓	✓
Nulsen 7	18/04/11	x	x	28/06/12	x	x

✓ = Plus x = Opportunity

At the point of the first data collection, the VIP's commitment to individualised services and person-centred planning meant that clients at the service site had robust individual routines written in a way that could be followed when the first PPR was conducted. The routines were based on individual goals developed for each client, meaning there was no scope for improvement. Routines at VIP continued to be in place and adhered to at the final check 11 months later.