

# The Role of Occupational Therapy in Behaviour Support Work

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With the introduction of the National Disability Insurance Scheme (NDIS), the disability service sector is changing. There is much energy being invested in describing how best to meet the needs of children and young people with Intellectual Disability and Mental Health (IDMH) and complex behavioural difficulties and this article seeks to explore one aspect of this.

Behaviour Support (BS) is a clinical sub-specialty in intellectual disability. This type of input is required when behaviour is of such an intensity, frequency, or duration as to threaten the quality of life and/or the physical safety of the person or others and is likely to lead to responses that are restrictive, aversive or result in exclusion (Banks et al, 2007).

As behaviour is complex and may present across different environments and activities there is a need for multiple professionals to be involved in BS. Positive Behaviour Support (PBS) is an evidence-based approach that aims to increase a person's quality of life, and decrease the frequency and severity of behavioural difficulties (Disability Services Commission, 2012). The holistic and strengths based perspective of Occupational Therapy (OT) and its specific skill set will strengthen this work.

There are currently few OTs working solely in PBS in Australia. Some have specialised in PBS, whilst most provide consultative input to other disciplines. OTs however, are in a position to lead this work and provide positive BS with additional training and specialist supervision.

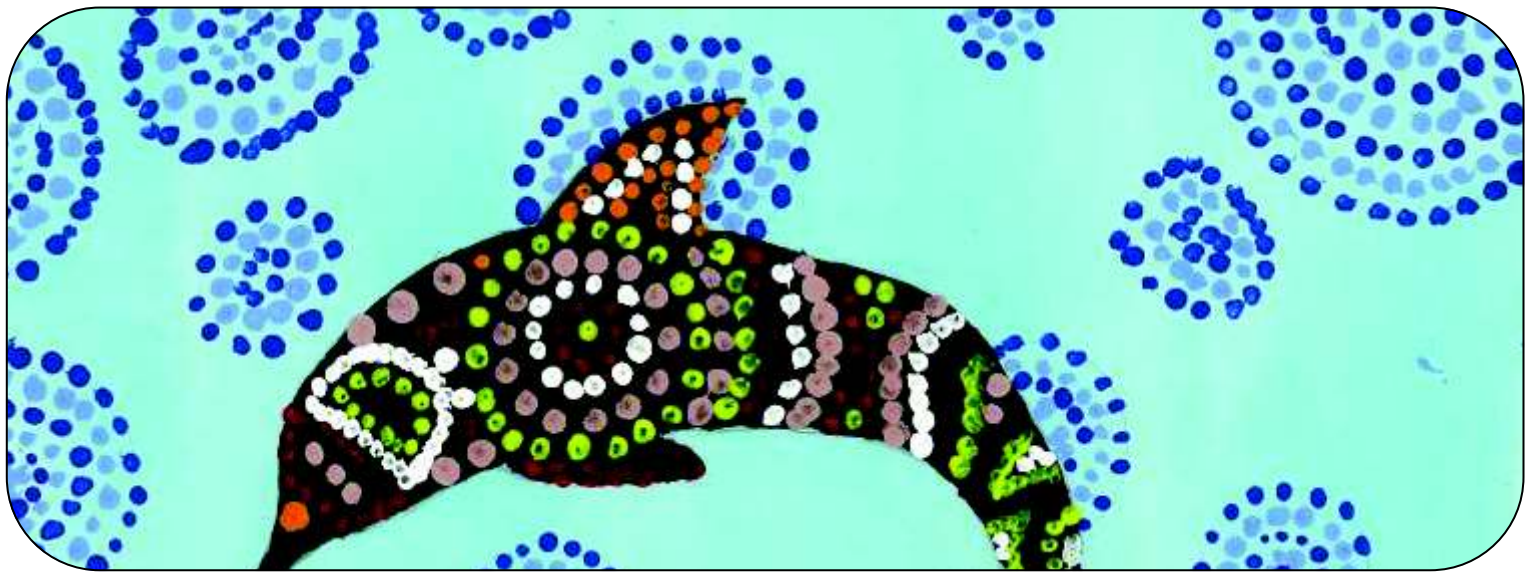
## **What is occupational therapy (OT)?**

Occupational therapy is a client-centred health profession concerned with promoting health and well-being through occupation (Occupational Therapy Australia, 2016). Occupation is everything people do to occupy themselves, including looking after themselves (self care), enjoying life (leisure), and contributing to the social and economic fabric of their communities (productivity, including play) (Law, Polatajko, Baptiste, & Townsend, 1997, p 34), as well as the things people do to rest, the purposeful pursuit of non-activity (Chapparo & Ranka, 1997, p6). As Iwama (2010) states the magnificent promise of occupational therapy is to enable people from all streams of life to engage and participate in activities and processes that they value.

A key component of OT work in PBS is assessing an individual's sensory processing style and developing strategies for self-regulation. The scope of OT practice, however, goes beyond this domain. OTs are trained to look at multiple factors influencing a person's performance of tasks, activities, routines and roles across multiple environments. They examine how biomechanics, cognition, sensory-motor; intrapersonal and interpersonal factors facilitate or limit a child's occupational performance. They have the capacity to prescribe specialized equipment and promote meaningful engagement which may contribute to the reduction of behavioural difficulties (Perez, Carlson, Ziviani & Cuskelly, 2012).

There are many similarities between OT and PBS. Both draw upon social, behavioural, psychological, educational and biomedical theory, and use a combination of evidence based practices, formal strategies and clinical reasoning to determine the best outcomes for a person with ID. The language and key concepts in





PBS, that is, ecological strategies, positive skill development; focused support, situational management (reactive strategies) and systems change (La Vigna & Willis, 2003) are comparable to OT constructs relating to person, occupation and environment congruence. A case study has been developed to illustrate the role of OT in PBS.

#### **Case study:**

Emma was a 14-year-old adolescent with a moderate/severe ID and an undiagnosed mood disorder. She would scream, scratch herself, bang her head against walls, car doors, hard objects and people and no one understood what this was about. Emma also grabbed, pinched, scratched and hit others. As Emma was volatile, her family, respite carers and school did not feel safe taking her out into the community and her respite options became limited. She presented with physiological arousal dysregulation which heightened during her menstrual cycle.

Emma was referred to the team for assistance with managing her self-injurious behaviours and restricted lifestyle. Initially the psychologist completed a behaviour assessment. The psychologist observed behaviours they thought were of a sensory and communicative nature and referred to Speech Pathology and OT for assessment. The speech pathologist and OT discovered that Emma had a long history of undiagnosed ear infections. It became clear that during periods of high levels of self-injury, Emma had an ear infection. This meant that staff could take her to the doctor for the treatment of the infections.

The OT also asked staff to collect data on the arousal levels and mood state of Emma over a 4-week period. This data was supplied to Emma's psychiatrist who diagnosed Emma with a mood disorder and prescribed appropriate medication.

When combined with observations and interview, the OT discovered there was much damage to Emma's hearing and that she sought intense movement (vestibular) and joint (proprioceptive) input to regulate herself. As a result Emma couldn't participate in stationery activities without having some movement or joint input. She also disliked having haircuts, being dressed; standing in lines and having other people too close to her. When Emma engaged in these activities, her arousal state escalated, and she felt a 'pain-like' response to these activities. Observations of Emma's physical and emotional developmental milestones equated to that of a 3-year-old, which meant the interventions, had to accommodate this. A safety plan (see table on page 14) was developed which reflected the arousal information obtained.

The team provided interaction guidelines (see page 15) that outlined how to respond to the communication, sensory and BS needs of Emma.

The OT, in collaboration with Emma and her support system, identified ways for Emma to engage in meaningful occupation. This included going out to eat at local cafes, taking her dog for a walk, going to the local trampoline facility, going for bushwalks and beach walks. All the BS strategies were used during these activities. Emma's behaviour was not eliminated; however, there was a reduction of frequency and intensity in her crisis behaviours. Her quality of life improved as her support network became familiar with her needs and provided appropriate support.

#### **Conclusion**

In conclusion, OT can offer a unique and valuable perspective to PBS, with its emphasis on promotion of health and well-being through occupation, and its specialist tools in facilitating occupational engagement. The changing landscape that is disability service provision enables a perfect opportunity for OT's to develop their role in this area.

Safety Plan for Emma	Early Warning Signs	Escalation	Crisis	De-escalation	Recovery
Behavioural Indicators	Paces, flaps objects, grabs all at once	Pacing more furiously, moaning, crying, banging objects, grabbing and pinching people	Screams, scratches herself, bangs her head against walls, car doors, hard objects and people Grabs, pinches, scratches and hit others	Removes herself Mouths objects	Paces
	Offer a drink/bottle of water  Offer a movement activity, e.g. walk or swing on porch chair  Direct her to the backyard where she could get leaves  Give her space  Offer ice to crunch	Offer walking Offer TV or tablet  Lead Emma to the outdoors guiding her physically with one hand on her back and on arm  Reassure Emma - "its ok"  Give her lots of space and maintain in line of sight  Give Emma a choice of something to chew, e.g. chewing gum, ice Provide leafy twig which was visual input that calmed Emma	Remain in outdoor area when possible When raining, use designated inside quiet area  Provide Emma something to chew, e.g. chewing gum, ice	Offer or redirect to a preferred activity  Go inside/or remain in quiet area  Direct to cushions to lie down and relax  Provide her something to chew  Provide ipad to look at favourite videos	Re-commence with typical daily routine activities using visual supports and key word signs
<b>Response Strategies</b> Apply in situations where Emma appears agitated or stressed	<b>Client Focussed</b>  Use a slow voice with a low pitch  Use three word sentences  Point and verbally prompt Emma outside to the leaves "Outside now Emma"  Use gentle physical prompt if Emma needs more direction	<b>Carer Focussed</b>  Remain calm  Inform other staff what is happening  Maintain personal safety, be at least 3 metres away, in line of sight  Use one word sentences 'gentle' with the key word sign  Use actions/ gestures/ pointing to direct him Avoid offering choices  Administer emergency psychotropic medicine as protocol	Keep something between Emma and yourself, e.g. table  Maintain personal safety e.g. - monitor from 5 metre distance in line of sight - limit interaction	Stay alert and continue to monitor  Provide first aid/ medical attention if Emma had hurt herself	Monitor for signs of re-escalation  Use single words with key word signs and physical guidance as appropriate

Things I need & like	Things I don't like	How can you support me
To be kept calm and at a just right level	When I become upset and agitated	Be familiar with my behavioural indicators and ways to keep me calm
A quiet open place to pace and calm down	Visually and auditory busy places	Read my signals try not to let me get too upset as it is hard for me to calm down
Activities that provide body awareness information e.g.: swimming, banging objects, crashing onto crashmat, rocking in a chair	Activities requiring balance Being told to stop banging	Try to incorporate the physical activities throughout the day
People using firm / deep pressure when touching me	People using light touch	When interacting with me always use firm touch. I also need deep pressure input regularly throughout the day
Crunchy foods and things that I can chew on Regular snacks and drinks	Being hungry / thirsty	Use the foods I like at mealtimes and provide regular crunch and chewy snacks throughout the day. Provide me with water in a clear plastic pop-top bottle that I can access freely.
People using simple language, key word signs and gestures	When people use lots of words When I get too many instructions at once	Use simple language with key word signs and gestures. Only give me one instruction/piece of information at a time. Show me how to do things so I know what you expect of me.
I like to fidget with and look at lots of different things but they usually only hold my attention for short time	Always having to do what others want me to do	Rather than hand me an object to play with stand near me and use it yourself e.g. model how to use it, then put it down I can pick it up and use it if I choose to Ensure I have access to items around the house that I can safely fidget with
To have a routine and knowing what I can do next	Waiting for the routine to happen	Use a visual routine and 'Now and Then' board to help me understand what happens next. When it is time to transition to the next activity, tell me the current activity is finished, use the finished key word sign and tell/show me what is happening next.

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