participation after controlling for demographic and injury-related factors.

**Method:** Patients with ABI (n=100) were assessed within approximately two weeks of enrolment in inpatient rehabilitation. Predictor variables included demographic and injury-related characteristics and the following neuropsychological factors: active and passive coping, attention, executive functioning, verbal memory, learning potential, depressive symptoms, motivation, extraversion, neuroticism and self-awareness.

**Results:** Bivariate analyses revealed that passive coping, executive functioning, depressive symptoms, extraversion and neuroticism were significantly associated with HRQoL and/or participation. Hierarchical regression analyses showed that neuropsychological factors significantly explained additional variance in HRQoL (18.1%-21.6%) and participation (6.9%-20.3%) after controlling for demographic and injury-related factors. A higher tendency towards passive coping was the only significant neuropsychological predictor (beta=-.305 to -.464) of lower HRQoL and participation.

**Conclusion:** This study shows that neuropsychological functioning and in particular passive coping, plays a role in predicting HRQoL and participation after inpatient ABI rehabilitation and emphasizes the importance of addressing patients’ coping styles in an early phase of ABI rehabilitation.

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**Session 12 – Measuring outcomes**

The Minimal Clinically Important Difference for the Mayo-Portland Adaptability Inventory (MPAI-4)

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**Background/Aims:** The Minimal Clinically Important Difference (MCID) of a measure is critical to identify responders to intervention. Because each holds advantages, distribution- and anchor-based methods are commonly used together to triangulate on the MCID. We used such a multi-modal method to identify the MCID for the MPAI-4 and a moderate, i.e., more robust, level of change (RCID).

**Method:** Data were for individuals with acquired brain injury in rehabilitation programs throughout the U.S. in the OutcomeInfo Database (n=3087) with two MPAI-4 ratings. Anchored estimates were referenced to a subsample with the Supervision Rating Scale (SRS; n=2726). Finally, hypothesized MCID and RCID values were evaluated through clinical provider ratings of case protocols.

**Results:** T-scores (standard deviation=10) were used in all analyses; consequently, .5 standard deviation = 5 on the T-score metric (ST). Other distribution-based analyses found the standard error of measurement (SEM)=4.07 (small difference); 1.96XSEM=7.98 (moderate difference); and 2.77XSEM=11.27 (large difference = Reliable Change Index; RCID). Receiver operating characteristic (ROC) analyses anchored to the SRS suggested significant change on the MPAI-4 occurred between 7.5T and 8.5T. Among those who received intensive rehabilitation, 72% changed ≥5T and 54% changed ≥9T compared to 12% and 4%, respectively, among those receiving only supported living services. Virtually all clinical raters (99%) considered a 9T change to indicate improvement;