Behaviour Support: Policy and Practice Manual

Guidelines for the provision of behaviour support services for people with an intellectual disability

Part 1: Policy and Practice

January 2009

NSW GOVERNMENT
Family & Community Services
Ageing, Disability & Home Care

Foreword

The Office of the Senior Practitioner (OSP) was established within the NSW Department of Ageing, Disability and Home Care (DADHC) to provide leadership, guidance and innovation in the provision of behaviour support and intervention services for people with an intellectual disability. The development of this *Behaviour Support: Policy and Practice Manual* is a practical extension of this mission.

The delivery of effective support and assistance to people with a disability is a complex combination of activities; it requires an integrated approach where all those involved work together to enhance an individual's quality of life. The manual has been designed to provide a contemporary, practical resource for the development of high quality and consistent support and intervention practices which adhere to relevant departmental policy and procedures and legislative standards.

The Department's positive approach to behaviour support draws on principles and practice methods from areas such as education, habilitation, psychology and social justice frameworks. This manual is targeted to assist Behaviour Support Practitioners drawn from a range of professional backgrounds and who undertake their work in diverse contexts. It will assist them to interact in inclusive, consultative and collaborative ways through the use of accessible, evidence-based support formats and practice approaches. It is not, however, a recipe book which prescribes the ingredients for behaviour support. It is reflective of best practice orientations and the scope and diversity of highly valued contributors.

Importantly, the manual provides guidelines to safeguard the rights of the individual Service User and promotes the use of person-centred positive behaviour support practices. It recognises that all behaviour occurs within a context and that meaningful, longitudinal behaviour change relies not only on maintenance of appropriate supports for the Service User, but also on refinement of the wider support system built around the individual.

In recent years, the promotion of changes to Occupational Health and Safety legislation has increased awareness in staff of their responsibilities in relation to management of risk in the workplace. This manual reinforces for us that the management of risks and incidents in the absence of person-centred positive practices is not an acceptable or appropriate level of behaviour support.

This manual forms part of a series of works undertaken by the Office of the Senior Practitioner designed to inform ethical and resilient practice in supporting Service Users. Further guides to support specific areas of practice will be developed over time with your support and valuable contributions.

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How to use this manual

This manual is presented in two parts.

Part 1, the blue booklet **Policy and Practice**, is applicable to all disability services delivered or funded by the NSW Department of Ageing, Disability and Home Care (DADHC). Part 2, the orange booklet **DADHC Procedures and Templates**, is specifically for services delivered by DADHC but it is also provided to DADHC-funded services to support their own work practices.

Part 1 Policy and Practice

Part 1 is applicable to both DADHC-funded and DADHC services.

Part 1 (A) **Behaviour Support Policy**

(Incorporates Policy for Children, Young People and Adults)

Part 1 (B) **Work Practice**

Appendix 1.1 Glossary of Terms

Appendix 1.2 Work Practice Quality Feedback Tool (QFT)

This is provided as a work practice evaluation tool for Behaviour Support Practitioners and their supervisors.

Part 2 DADHC Procedures and Templates

Part 2 is a separate document and is applicable to DADHC services only, although it may also inform the practices of DADHC-funded services.

Part 2 (A) **DADHC Procedures**

Part 2 (B) **DADHC Templates**

Appendix 2.1 Policy Framework: Providing behaviour support services for people with an intellectual disability.

This is not a new document but is included with the manual so as to complete the set of resources.

Which parts apply to your service?

The following table indicates which services the components of this manual apply to.

Table 1

		Applicable to DADHC services?	Applicable to DADHC-**funded** services?
Part 1 (A)	**Behaviour Support Policy**	✓	✓
Part 1 (B)	**Work Practice**	✓	✓
Appendix 1.1	Glossary of Terms	✓	✓
Appendix 1.2	Work Practice Quality Feedback Tool (QFT)	✓	Not directly, but may inform practice
Part 2 (A)	**DADHC Procedures**	✓	Not directly, but may inform practice
Part 2 (B)	**DADHC Templates**	✓	Not directly, but may inform practice
Appendix 2.1	Policy Framework	✓	Not directly,but may inform practice

Part 1 (A)
Behaviour Support Policy

1 Policy position and principles

1.1 Purpose of policy

This policy document outlines minimum requirements for DADHC-direct and DADHC-funded services in providing a behaviour support service to adults, children or young people with an intellectual disability. The recipients of a behaviour support service are referred to within this Policy as ***Service Users.***

DADHC recognises that quality support should be informed by good practice and sound research.[1] Consistent with a contemporary disability services approach, legislative requirements, and evidence-based practice, the Department promotes a positive approach to behaviour support.

1.2 Target group for policy

This Policy applies to all services for adults, children and young people with an intellectual disability provided directly, or funded, by DADHC.

1.3 Position statement

DADHC recognises that ***Service Providers*** have a responsibility to ensure that people who receive a behaviour support service are protected from exploitation, abuse, neglect, and unlawful and degrading treatment.

All activities related to behaviour support will be supportive and respectful of the individual needs and goals of the Service User, as identified through an Individual Plan, and based on a current and comprehensive assessment.

Behaviour support services will be provided with consideration of the needs of Service Users and their families from Aboriginal and Torres Strait Islander backgrounds, and from culturally and linguistically diverse (CALD) communities.

1.4 Governmental context

The NSW Government has launched ***Stronger Together: A new direction for disability services in NSW 2006 – 2016*** *(Stronger Together)* to deliver better services for people with a disability and their families.

In addition, in February 2007 the NSW Government launched ***Better Together: A new direction to make NSW Government services work better for people with a disability and their families: 2007 – 2011*** *(Better Together)*. This whole-of-government plan will support the work of the *Stronger Together* plan in delivering better services for people with a disability, their families and carers.

While *Stronger Together* delivers increases in specialist disability services, *Better Together* will ensure vital public services such as transport, health, education and housing are better able to meet the needs of people with a disability and their families.

1 *Stronger Together 2006-2016.*

1.5 Policy context

This policy supersedes the *DADHC Behaviour Intervention Policy* (February 2003).

This policy sits within, and should be read in conjunction with the DADHC *Policy Framework: Providing behaviour support services for people with an intellectual disability (June 2006, Reviewed March 2008).* It further interlinks with other Departmental policies, procedures, guidelines and with legislation. A shortlist of such documents relevant to behaviour support is given at the end of this policy document.

In addition, all services provided to children and young people must be in accordance with the standards and guidelines outlined in the following documents:

- *NSW Out-of-Home Care Standards (NSW Office of the Children's Guardian);*
- *Living in the Community: Putting Children First (July 2002);*
- *The Children's Standards in Action (2004);*
- *Individual Planning for Children and Young People Living in Out-of-Home Placements: Policy and Procedures (May 2007);*
- *Memorandum of Understanding between the Department of Community Services and the NSW Department of Ageing, Disability and Home Care on Children and Young Persons with a Disability, and;*
- *NSW Interagency Guidelines for Child Protection Intervention (DoCS 2006).*

1.6 Legislative context

The ***NSW Disability Services Act (1993)*** provides the legislative basis for the provision of services to people with a disability in New South Wales.

The ***Children and Young Persons (Care and Protection) Act (1998)*** governs the care and protection of children and young people in NSW. This legislation provides the framework for the development of any behaviour management policy pertaining to children and young persons in out-of-home care placement.

Children and Young Persons (Care and Protection) Regulation (2000).

The ***Guardianship Act (1987)*** plus ***Guardianship Regulations (2005)*** specify the conditions governing the appointment of Guardians who may be authorised to consent to treatment and restrictive management strategies for the management of challenging behaviour for people over the age of 16 years.

Other relevant legislation includes:

- *Anti-Discrimination Act (1977)*;
- *Mental Health Act (2007)*;
- *Occupational Health and Safety Act (2000)*, and;
- *Occupational Health and Safety Regulation (2001).*

1.7 Principles and their application[2]

1.7.1 Principles

In accordance with the *NSW Disability Services Act (1993)*, people with a disability have the same basic human rights as other members of Australian society, irrespective of the nature, origin, type or degree of disability. These rights include:

Table 2: Principles

■ The right to respect and dignity;
■ The right to live in and be part of the community;
■ The right to realise their individual capacities for physical, social, emotional and intellectual development;
■ The same right to access services to support a reasonable quality of life;
■ The right to choose their own lifestyle and to have access to information,
■ The right to participate in decisions which affect their lives;
■ The right to receive services in a manner which results in the least restriction of their rights and opportunities;
■ The right to pursue any grievance without fear of recrimination from service providers or discontinuation of services, and;
■ The right to protection from neglect, abuse and exploitation.

2 Refer the *NSW Disability Services Act 1993, Schedule 1, Principles and applications of principles.*

1.7.2 Application of principles

Table 3: Application of principles

Service Providers must apply the principles set out in Table 2 above in the design and administration of services in order to:

✓	Promote positive outcomes for the ***Service User***;
✓	Promote the norms and patterns of everyday life which are valued in the general community as far as is practicable;
✓	Meet the individual needs and goals of the *Service User*;
✓	Meet the needs of *Service Users* who experience an additional disadvantage as a result of their gender, ethnic origin or Aboriginality;
✓	Promote community acceptance and inclusion of persons with disabilities;
✓	Maximise participation of the *Service User* in community life;
✓	Ensure that no single organisation providing services exercises control over all or most aspects of the *Services User's* life;
✓	Ensure accountability to stakeholders;
✓	Provide age-appropriate and valued lifestyles through goal-directed service provision;
✓	Promote participation of the *Service User* in the process of making decisions that affect their lives;
✓	Ensure that persons with disabilities have access to advocacy support where necessary to ensure adequate participation in decision-making about the services they receive;
✓	Preserve the family relationships of the *Service User*;
✓	Be sensitive to the cultural and linguistic background of the *Service User*;
✓	Facilitate the lodging of grievances by or on behalf of the *Service User* without fear of reprisal, and the resolution of these grievances;
✓	Facilitate participation of the *Service User* in the planning and operation of services and programs which they receive, and consultation on the development of major policy and program changes, and;
✓	Respect the rights of the *Service User* to privacy and confidentiality.

2 Provision of behaviour support

2.1 Challenging behaviour

Challenging behaviour may be defined as:

> *"Behaviour…of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion."*[3]

Any behaviour displayed by a person which is considered challenging or inappropriate by others, or which gives rise to reasonable concern, may be considered as challenging. However, the use of the term challenging should be understood in terms of the social context in which behaviour occurs, rather than a symptom of individual pathology[4].

Often the Service User who presents with challenging behaviour is considered to be challenging as a result of their behaviour. However, challenging behaviour is a ***social construct*** which is a product of an interaction between an individual and others in their environment.[5] Challenging behaviour should not be interpreted automatically as an expression of deviance or abnormality inherent in the individual, but viewed rather with reference to much wider contextual factors.[6]

Responses to the behaviour may present barriers to community participation by the person, undermine their (or others') rights, dignity or quality of life, or pose a risk to the safety of the person (or others).[7] It can have a significant negative impact on the Service User, on their health or lifestyle, on their relationships with parents, siblings, relatives, carers, friends and wider social networks, on community perception and acceptance.

Care must be taken to assess the characteristics of significant environments in order to inform analysis of the impact of each on the Service User, bearing in mind what is known about the person and how they experience different situations around them.

2.2 Access to services

Quality of life issues including the maintenance of support structures are addressed through the Individual Planning process. Requests for a behaviour support service may be made where a need is identified within the framework of an ***Individual Plan***.[8]

3 Banks *et al,* 2007, p14.
4 Emerson, 1995, p5.
5 Banks *et al* (June 2007), p 24; Emerson (1995), p 9.
6 Emerson (1995), pp 12, 37.
7 McVilly (2002), p 7.
8 See *Individual Planning for Adults in Accommodation Support Services (Sept 2005); Individual Planning for Children and Young People Living in Out-of-home Placements: Policy and Procedures (May 2007).*

2.3 Conditions for provision of service

A behaviour support service is a service delivered by a Service Provider, funded by DADHC, and which specifically addresses the behaviour support needs of a Service User or service system in accordance with this Policy. A behaviour support service may be appropriate where:

- There are reasonable concerns over risk of harm or serious injury to the Service User or to others;
- Existing strategies have not been effective in managing the behaviour;
- There are concerns over the use of existing strategies for other reasons;
- The challenging behaviour appears to prevent other significant needs being met;
- Existing strategies appear to prevent significant needs being met;
- The Service User is in jeopardy of being excluded from other services, employment or from school; or
- The capacity of the support system is under significant stress.

2.4 The behaviour support practitioner

Ideally, behaviour support services should be provided by ***Behaviour Support Practitioners*** with tertiary qualifications in Psychology, Special Education, Speech Pathology, Social Work or other relevant discipline, and/ or training and experience in the provision of behaviour support. Specific skills related to behaviour support are to be developed through professional development training, mentoring and work practice supervision.

2.5 Work practice requirements

Work practice requirements for Behaviour Support Practitioners are articulated in ***Part 1 (B)*** of the ***DADHC Behaviour Support: Policy and Practice Manual*** *(January 2009).*

2.6 Consent

Implementation of behaviour support strategies requires the informed consent of the Service User, their guardian, their person responsible, parent or the person with parental responsibility as appropriate to individual circumstances. Where the Department of Community Services (DoCS) has case management responsibility, consent should be obtained from the Supervising Manager, Casework. See also ***Section 4*** of this ***Policy: Restrictive, Restricted and Prohibited Practices.***

2.7 Service agreement

Provision of a behaviour support service should be driven by the scope of work as defined in a written ***Service Agreement*** and endorsed by relevant stakeholders. The Service Agreement should be goal-specific, time-limited and regularly reviewed.

2.8 Collaboration

All steps in the provision of behaviour support require collaboration with a range of parties including (but not limited to):

- the Service User himself/ herself;
- the person with parental responsibility;
- the guardian, where one has been appointed;
- the Service User's parents or carers;
- the Service User's advocate;
- significant others who are important to the Service User (e.g. case worker, siblings, extended family members, friends);
- other professionals who are involved with provision of care and/or support to the Service User (e.g. therapist, teacher, neurologist, paediatrician, psychiatrist); and
- practitioners from other disciplines who are involved in providing a service to the Service User, or to others within their support system (e.g. mental health worker, probation and parole officer).

2.9 The positive approach

Service Providers have a responsibility to ensure that people who receive a behaviour support service are protected from exploitation, abuse, neglect, and unlawful and degrading treatment. The Department promotes a positive approach to behaviour support, based on comprehensive assessment and analysis of the meaning and function of behaviour in a whole-of-life context. The aim of positive approaches to behaviour support is to provide a respectful and sensitive environment in which the Service User is empowered to achieve and maintain their individual lifestyle goals.

2.10 Person-centred planning

The Department promotes the development of services which are person-centred and outcome-focussed. This places the Service User at the centre of service delivery, incorporating what can be learned about their lifestyle, skills, relationships, preferences, aspirations, and other significant characteristics, in order to provide appropriate, respectful, and meaningful behaviour support in a holistic framework.

A focus on outcomes ensures that this support adequately addresses the changing needs of the Service User.

2.11 Prevention

An important element in the provision of behaviour support services should be a focus on strategies which aim to prevent the occurrence of behaviours which challenge the support system.

2.12 Management of risk

It should be clearly understood by service providers that there is a fundamental distinction between:

(a) assessment and management of risk, and;

(b) assessment of behaviour and provision of behaviour support.

Service Providers have a ***Duty of Care*** towards the people who receive their service. Risk management strategies should be in place to minimise or remove the risk of harm arising from activities or events across multiple domains in the Service User's life, e.g. health, nutrition, swallowing, mobility, transitioning, etc.[9] Assessment and management of risk of harm to a child or young person may include a report to *DoCS*. Employers also must show reasonable care for the safety of workers. Risk management strategies are required in all designated workplaces under *NSW Occupational Health and Safety legislation and regulations*.[10] Additional DADHC Policies are relevant to the management of these risks.[11]

Risk evaluation and assessment should also be pivotal components of a comprehensive behaviour assessment, and risk management strategies associated with an identified behaviour should be included in behaviour support plans.

> Strategies developed only to manage an identified risk are not sufficient in themselves to fulfil all the requirements of behaviour support in the context of this Policy.

Rather, behaviour support must address multiple elements of the *Service User's* life, promote positive approaches, and deliver positive person-centred outcomes.

In certain circumstances, however, an interim risk management strategy may be appropriate, for example in response to a new challenging behaviour, a crisis, or where a complete ***Behaviour Support Plan (BSP)*** has not yet been developed. Any strategy used for the purposes of risk management should be no more restrictive or intrusive than is necessary to prevent foreseeable harm to the Service User and/or others, and applied no longer than is necessary to manage an identified risk. This is known as the ***least restrictive alternative***. The presenting issues should be referred as soon as practicable to a Behaviour Support Practitioner for appropriate action.[12]

2.13 Communication screening

In recognition of the growing evidence supporting a significant link between communication difficulties and challenging behaviour,[13] comprehensive assessment of behaviour should be informed by a recent and detailed communication assessment (ideally undertaken by a qualified Speech Pathologist). Where ***Augmentative and Alternative Communication (AAC) Systems*** have been developed in support of an individual, careful analysis should be made not only on the Service User's ability to use the AAC System, but also on the competency or capacity of carers to use the same AAC System effectively.[14]

Where no recent communication assessment has been completed, the behaviour support service should proceed on the basis that any support plans or strategies developed are subject to review when the communication assessment report has been completed.

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9 See *Health Care Policy and Procedures (March 2007).*
10 *Occupational Health and Safety Act, 2000; Occupational Health and Safety Regulation, 2001.*
11 *Client Risk Policy and Procedures (March2008); Incident Management Policy (June 2006, amended January 2007).*
12 Refer *Behaviour Support: Policy and Practice Manual, Part 2-Work Practice.*
13 Balandin (2002); Bloomberg & West (1999); Bradshaw (2002, 1998); Desrochers *et al* (1997).
14 CDDS (2002).

2.14 Progress notes

All Behaviour Support Practitioners should maintain ***Progress Notes*** which accurately and professionally record all communications relating to work being undertaken in accordance with a *Service Agreement.*

Progress Notes should be updated after each occasion of service or contact, and be accessible to line management. Service Providers should maintain the confidentiality of *Progress Notes* in accordance with organisational policy.[15] For DADHC staff, Progress Notes also constitute records under the *NSW State Records Act (1998)*.

2.15 Endorsement by practitioner

All work practices must be clearly documented and endorsed by the Behaviour Support Practitioner responsible for provision of the service. As a minimum, this endorsement must include:

- The date;
- The author's name, position, agency, location and contact details, and;
- The schedule for regular review.

2.16 Outcomes

Service Providers should have a consistent and defined approach to the provision of behaviour support services. This approach seeks to deliver positive, measurable and sustainable positive outcomes for Service Users and their families. These outcomes include not only the reduction in targeted behaviour but also improvement in the Service User's quality of life, and improvements in the capacity and confidence of the support system in providing appropriate support.

2.17 Training

Service Providers should provide training in the implementation of any recommended support strategies in order to ensure that positive outcomes are achieved and may be maintained over time.

2.18 Key performance indicators

For DADHC-funded Service Providers service outcomes will be monitored and reported against Key Performance Indicators (KPIs) as set down in the ***Integrated Monitoring Framework (IMF)***.[16]

For direct accommodation and respite services, relevant outcomes will be monitored and reported against KPIs as set down in the ***Quality and Safety Framework (QSF)***.[17]

From 2009 the DADHC ***Quality Framework*** will replace the quality component of the current IMF and be applied to all DADHC-funded and DADHC-direct services.

15 For DADHC staff, this includes *Records Management Policy Document (May 2002); Privacy, Dignity and Confidentiality (October 1996).*
16 Further information on the IMF is available by visiting the DADHC Internet site. Go to www.dadhc.nsw.gov.au/dadhc
17 Further information on the QSF is available to DADHC staff via the intranet. www.dadhc.nsw.gov.au/dadhc

3 Restrictive, Restricted and Prohibited Practices

3.1 Restrictive Practices

People with an intellectual disability have the same rights and responsibilities as anyone else in the community.[18] Support services delivered to people with an intellectual disability must promote the quality of life, uphold the dignity and safeguard the rights of the Service User.

Where support strategies are used with the intention of influencing or changing behaviour they must be sanctioned by means of a documented ***Behaviour Support Plan (BSP)*** or ***Incident Prevention and Response Plan (IPRP)*** which has been developed in accordance with DADHC work practice requirements for behaviour support services.[19] Where a documented BSP recommends the use of certain strategies or practices which impose restrictions on the Service User's rights or freedom, these must be justifiable in the context of DADHC work practice requirements and may be considered for implementation only with legal consent. Such strategies may be wide-ranging and are referred to by DADHC as ***Restrictive Practices.***

3.2 Restricted Practices

A distinct number of Restrictive Practices also have significant ***additional safeguards*** placed upon their use by DADHC. They are known as ***Restricted Practices*** and are outlined in ***Table 4*** following.

18 Barry, (2007).
19 *Behaviour Support: Policy and Practice Manual, Part 2 - Work Practice.*

Table 4: Restricted Practices – children, young people and adults.

1 Exclusionary Time Out

Recommendation to deny access to reinforcement by forcibly moving a Service User from one setting to another (e.g. room, corridor), where they are unable to leave for a period of time.

Time Out must be:

1. Part of an overall **planned** strategy;
2. Time-limited;
3. Contingent on behaviour change; and
4. Recorded.

If any aspect of Time Out is aversive, intended to humiliate the Service User, or has the effect of so doing, then it is prohibited.

2 Physical restraint *

The recommendation to intentionally restrict a Service User's voluntary movement or behaviour by the use of:

- devices such as lap belts, table tops, posy restraints, bedrails, water chairs, deep chairs or beanbags;
- physical force; or
- arm splints

***beyond that which is reasonably required to ensure safety*,** prevent harm or to comply with legal requirements, e.g. the requirement to wear a seat belt in a moving vehicle. However, recommendation of additional devices such as seat belt covers which prevent a person's access to the release mechanism of a seat belt is a Restricted Practice.

Physical restraint does not include ***physical assistance*** or support related to involuntary movement, daily living routines, eating, function support, aids or other safety devices used to prevent injury, which are commonly used for specific medical, dental and surgical treatment and where the person does not resist. However, all such strategies must be consented to, clearly documented, linked to distinct outcomes and endorsed by a Practitioner from a relevant discipline (e.g. Occupational Therapist, Physiotherapist).

Where any concerns arise in relation to:

a) the appropriateness or degree of physical assistance recommended in support of an individual;
b) whether or not a Service User has the capacity to demonstrate their objection to physical contact; or
c) whether or not a carer can identify a distinct behaviour or set of behaviours as an attempt by the Service User to demonstrate their objection to physical contact, these concerns should be directed immediately to line management for review.

*See also ***Crisis Response to a Critical Incident*** below.

Notes

1. Section 158 of the *Children and Young Persons (Care and Protection) Act 1998* includes circumstances where physical restraint may be used and the extent and limitations which apply under these circumstances.
2. In addition, Section 35 (2) (d) (ii) of the *Children and Young Persons (Care and Protection) Regulation 2000* requires that any child or young person who is subjected to physical restraint receives support and counselling.

3 Psychotropic Medication on a prn basis

The use of Psychotropic Medication is considered a Restricted Practice where it is prescribed for administration on a prn basis.[20]

In the context of DADHC Policy, the term Psychotropic Medication refers to any medication which affects:

- cognition (i.e. perception and thinking);
- mood;
- level of arousal; or
- behaviour.

It includes psychoactive medication and androgen-reducing medication used to influence behaviour.

Psychotropic Medication may be prescribed by a Psychiatrist or Paediatrician as part of a treatment plan for a ***diagnosed mental illness***, psychiatric disorder, aetiological or contributory psychiatric symptoms. Under these conditions, and where such medication is administered on a ***routine*** basis, it is ***not*** a Restricted Practice.

However, where routine psychotropic medication is in place, the support of the Service User is to be managed as a Complex Case within the meaning of the DADHC IP Policy.[21]

Psychotropic Medication must not be the primary behaviour support strategy used for a person with intellectual disability. Where used at all, it must form part of a documented support plan which has been developed in collaboration with the consultant Psychiatrist/ Paediatrician.

Notes

1. **Consent is always required for the administration of Psychotropic Medication.**
2. **Consent is of no effect if the treatment is for a purpose other than promoting the health and well-being of the Service User.**

4 Response cost

The recommendation to withhold positively valued items or activities from a Service User in response to a particular behaviour or set of behaviours (e.g. access to a computer game or TV program).

Withheld items must not include:

- money;
- personal possessions;
- attendance at school or day placement;
- access to employment;
- access to family or a support person; or
- denial of food, shelter, comfort or ready access to toilet facilities.

Response Cost strategies that are excessive or interfere with identified support needs, health or well-being are prohibited by DADHC.

20 "Pro re nata" is a Latin term meaning *"as required"*. It is abbreviated as *"PRN"* or *"prn"*.

21 *Individual Planning for Adults in Accommodation Support Services (Sept 2005); Individual Planning for Children and Young People Living in Out-of-home Placements: Policy and Procedures (May 2007).*

5 Restricted access

The recommendation to use physical barriers such as locks or padlocks or impose enforceable limits or boundaries in an environment ***beyond normally accepted community practices*** (e.g. keeping hazardous chemicals or cleaning products securely stored, keeping a wardrobe door or front door locked) in order to limit a person's access to items, activities or experiences, with the intention of manipulating a particular behaviour or managing risk associated with it.

6 Seclusion

The recommendation to isolate an adult Service User (18 years and over) on their own in a setting from which they are unable to leave. **This should only be a short-term response to a particular crisis or critical incident** in order to manage risk of harm.

A person placed in seclusion must be kept under continuous observation.

This differs from Exclusionary Time Out in two ways:

i. it may be an emergency response (as distinct from a planned response); and
ii. the duration of time spent in seclusion is dependent on the duration of the crisis and therefore cannot be specified beforehand.

Adults in seclusion must be provided with:

a. Bedding and clothing appropriate to the circumstances/ conditions;
b. Food and drink appropriate to the circumstances/ conditions and at the appropriate times;
c. Ready access to appropriate toilet facilities; and
d. Environmental/ climatic comfort.

The use of this practice as punishment, for reasons of convenience or in response to resource limitations is prohibited.

Note
Seclusion of children or young people (less than 18 years of age) is a PROHIBITED Practice and is not permissible under ANY circumstances.

3.2.1 Consent and authorisation requirements for a restricted practice

The use of a Restricted Practice must be informed by strict guidelines which provide clear conditions and limitations on their use. These conditions and limitations should be detailed in a documented *Behaviour Support Plan (BSP)* or *Incident Prevention and Response Plan (IPRP)* which requires:

a) appropriate informed consent[22]; and
b) authorisation by an internal ***Restricted Practice Authorisation*** mechanism***.***

3.2.1(a) Consent requirements

In the context of Restricted Practices consent is the permission given by the Service User (where they have the capacity to consent) or person(s) with appropriate legal authority for the use of a specific practice as a component of an overall behaviour support strategy. Consent requirements for Restricted Practices are summarised in ***Table 5: RPA Consent Requirements.***

Consent for Children *(under the age of 18 years)*

For children who are not the subject of a court order reallocating parental responsibility, consent for the use of a Restricted Practice as a component of behaviour support should be obtained from the parent or guardian.

For children who are under the parental responsibility of the Minister for Community Services, consent for the use of a Restricted Practice as a component of behaviour support must be obtained from the person with ***parental responsibility***. This consent must be documented in the child or young person's case plan. The Behaviour Support Plan must be approved by the ***Director, Child and Family,*** DoCS. This approval must be recorded on the DoCS form *"Authorisation for Designated Agency for use of a restricted practice in a Behaviour Management Plan".*

Psychotropic Medication in Behaviour Support of Children

For children who are under the parental responsibility of the Minister for Community Services, consent for the use of ***psychotropic medication*** as a component of behaviour support must be sought from DoCS.

Where a carer has been given written consent from DoCS for the use of psychotropic medication as a component of behaviour support, this consent must be documented in the child or young person's case plan. The Behaviour Support Plan must be approved by the ***Director, Child and Family***, DoCS. This approval must be recorded on the DoCS form *"Authorisation for Designated Agency for use of a restricted practice in a Behaviour Management Plan"*.

It is important to note that psychotropic medication prescribed to manage challenging behaviours on a prn basis is considered a Restricted Practice by DADHC.

It is also important to note that while parents are allowed to reasonably chastise their children (unless under the parental responsibility of the Minister for Community services or subject to a Court Order), they cannot consent to another person doing this or agree to the use of any behaviour management technique that constitutes an assault or wrongful imprisonment.

22 Refer to the *NSW Children and Young Persons (Care and Protection) Act (1998); the NSW Guardianship Tribunal's Position Statement: Behaviour Intervention and Support in Applications Relating to a Person with a Disability;* and *Behaviour Management and Guardianship* as appropriate.

Consent for Young People[23] and Adults[24]

Where the Service User does not have the capacity to consent to the use of a Restricted Practice as a component of an overall behaviour support strategy, and where there is no person(s) with appropriate legal authority to consent on their behalf, a legally appointed Guardian may be required. In such cases specific authority to consent to the use of Restrictive Practices may be granted to a Guardian by the ***Guardianship Tribunal.***

Only a legally appointed guardian with a ***Restrictive Practices function*** can give consent to the use of a Restricted Practice as a component of behaviour support of an adult or young person (aged 16 years or over). In the event that there is no legal guardian with that function, information should be sought immediately from:

The Guardianship Tribunal

2a Rowntree Street, Balmain NSW 2041
Telephone: (02) 9556 7600
Fax: (02) 9555 9049
Tollfree: (02) 1800 463 928
email: gt@gt.nsw.gov.au
Website: www.gt.nsw.gov.au

Consent of the guardian to the use of a Restricted Practice is legal only for the time specified by the guardian.

If the legality of a practice or strategy is unclear, a guardian should have power to consent. In the event that there is no legal guardian with that function, information should be sought immediately from the Guardianship Tribunal.

There is no need to appoint a guardian:

- For restraint as part of risk management or safety, unless the Service User or someone else is objecting to the practice or strategy; or
- Where minimum force or confinement is used in a crisis to prevent harm.

Psychotropic Medication in Behaviour Support of Young People and Adults

Written consent is required for **ALL** medical & dental treatment. This may be provided either by:

- the ***patient*** (i.e. the Service User) where they have the capacity; or
- the ***Person Responsible*** under the Guardianship Act.

Although medication prescribed to manage challenging behaviours does not constitute a ***restrictive*** practice as defined by the Guardianship Tribunal, consent to such use of medication must be ***conditional*** on its use in the context of a Behaviour Support Plan.[25] It is important to note that medication prescribed to manage challenging behaviours on a prn basis is considered a ***Restricted Practice*** by DADHC.

Psychotropic medication requires consent as for ***Major Medical*** (or Dental) ***Treatment***.

– The ***Person Responsible*** can consent if the patient does not object
– If there is no Person Responsible, or if the patient (Service User) objects then only the ***Guardianship Tribunal*** can consent.

23 Aged 16 – 18 years and over and not under the care of the Minister for Community Services.
24 Aged 18 years and over.
25 *Guardianship Tribunal Position Statement (March 2006).*

Note: Androgen-reducing medications prescribed to control behaviour, while not psychotropic, fall under ***Special Medical*** (or Dental) ***Treatment***. Only the ***Guardianship Tribunal*** can consent to this.

Questions in relation to the *Guardianship Act 1987* or the process of guardianship should be directed to the Guardianship Tribunal on (02) 9556 7600 or on the website of the Guardianship Tribunal www.gt.nsw.gov.au

The consent of the person(s) with appropriate legal authority does not release the Service Provider from the ethical imperative to establish and maintain a ***Restricted Practice Authorisation*** mechanism which evaluates, authorises and monitors all instances of the use of a restricted practice by its staff.

Table 5: RPA Consent requirements

Service User	Practice		
	Exclusionary Time Out (ETO), Physical Restraint, Response Cost, Restricted Access	**Seclusion**	**PRN Psychotropic medication**
Children (under 18 years) ***not*** subject to court order reallocating parental responsibility	Parent or guardian	**PROHIBITED**	Parent or guardian
Children (under 18 years) subject to court order reallocating parental responsibility	Person with parental responsibility	**PROHIBITED**	Person with parental responsibility
Young people (16-18 years)	Guardian with a Restrictive Practices function	**PROHIBITED**	Either: (a) The Service User where they have the capacity; (b) The Person Responsible; or (c) The Guardianship Tribunal where the Service User objects.
Adults (18 years and over)	Guardian with a Restrictive Practices function	Guardian with a Restrictive Practices function	Either: (a) The Service User where they have the capacity; (b) The Person Responsible; or (c) The Guardianship Tribunal where the Service User objects.

3.2.1(b) Authorisation requirements

A Restricted Practice may be recommended for use as a component of a behaviour support strategy only within the context of a documented ***Behaviour Support Plan (BSP)*** or ***Incident Prevention and Response Plan (IPRP)*** which has been developed in accordance with DADHC work practice requirements for behaviour support services.[26]

In addition to consent, any recommendation for the use of a *Restricted Practice* requires formal **authorisation** via a mechanism which considers the appropriateness of a documented support plan or strategy. This mechanism should operate at arm's length from the contributors to the documented support plans or strategies. Its role is to evaluate the recommendation within the context of work practice requirements.

The purpose of the mechanism is not to create obstacles in the face of "*common sense*", but rather to ensure that documented support plans or strategies which contain the use of a *Restricted Practice*:

1. Can be clinically justified;
2. Are authorised within the context of DADHC work practice requirements;
3. Include provision for appropriate consent; and
4. Can be safely implemented and monitored.

All Service Providers are expected to develop and maintain an ***RPA*** mechanism that addresses the above purpose in order to manage the use of *Restricted Practices* and maintain rigorous standards within their own service. Each RPA mechanism should be governed internally by the Service Provider and be responsible for:

- Transparent evaluation of formal ***RPA Submissions*** for all support plans and strategies which include a *Restricted Practice*;
- Issuing of formal decisions to either grant or decline ***Restricted Practice Authorisation (RPA)*** in relation to *RPA Submissions*; and
- Monitoring the use of *RPAs*.

Within DADHC this mechanism is known as the ***Restricted Practice Authorisation Panel (RPAP)***. Further details of the DADHC RPAP and associated processes are provided in the DADHC *Behaviour Support: Policy and Practice Manual, Part 2*.

A *Restricted Practice Authorisation (RPA)* must be strictly time-limited and may not exceed a validity period of twelve (12) months. Documented plans which contain the use of a *Restricted Practice* may not be implemented without a current *RPA* and appropriate consent. The Behaviour Support Practitioner who develops the documented support plan or strategy is responsible for preparing the ***RPA Submission***.[27]

The use of a *Restricted Practice* must be closely monitored to safeguard against potential abuse, and should be **replaced with a less restrictive strategy** as soon as possible.

26 *Behaviour Support: Policy and Practice Manual (January 2009), Part 1(B) – Work Practice.*
27 This may also be done by the manager responsible for delivery of behaviour support to the Service User.

Where an *RPA* is granted it must be **time-limited**. The use of a Restricted Practice must be closely monitored to safeguard against potential abuse, and should be **replaced with a less restrictive strategy** as soon as possible.

Restricted Practice Authorisation (RPA):

1. Does **NOT** constitute consent;
2. Does **NOT** replace the requirement for consent; and
3. Is **NOT** sufficient in itself to sanction the use of a Restricted Practice.

3.2.2 Minimum guidelines for limiting and monitoring the use of Restricted Practices

Note: In the event where there is no *Behaviour Support Plan (BSP)* or *Incident Prevention and Response Plan (IPRP)* but where the situation demands an ***Interim Incident Prevention and Response Plan (Interim IPRP)***, the development of a comprehensive BSP should be undertaken as promptly as is practicable.

Where a Restricted Practice has been recommended within a ***documented*** support plan or strategy, Service Providers must ensure that:

1. It forms part of a documented ***Behaviour Support Plan (BSP)*** or ***Incident Prevention and Response Plan (IPRP)*** which incorporates positive approaches and educational strategies.

2. A *BSP* or *IPRP* is developed and endorsed by a Behaviour Support Practitioner in accordance with Section 2.15 of this policy.

3. As a component of a *BSP* or *IPRP* strategy, a proposed Restricted Practice includes:
   - Description of the proposed practice/ strategy;
   - Expected outcomes related to the proposed practice/ strategy;
   - Rationale for the use of the proposed practice/ strategy, i.e. an explanation as to why positive practices alone are unable to achieve the desired outcomes;
   - Roles and responsibilities, contextual variables, proposed frequency of use, event monitoring requirements, reporting protocols associated with the proposed practice/ strategy;
   - Formal data collection procedures for the proposed strategy;
   - Schedule of review of the proposed practice/ strategy; and
   - Fade-out strategies where appropriate.

4. Carers are familiar with operational aspects of the proposed practice as a component of the behaviour support strategy, are competent to implement it, can demonstrate an understanding of its specific purpose, and have access to relevant supports within the overall support system.

5. A Restricted Practice may be considered only after a range of less restrictive options have been trialled and evaluated by a Behaviour Support Practitioner.

6. Where ***Physical Restraint*** or ***Response Cost*** is recommended within the context of a *BSP* or *IPRP*, a ***Physical Restraint/ Response Cost Register*** is maintained which records:
   - Date, time and location of each episode of implementation;
   - Brief description of environment and events prior to implementation of strategy;
   - Description of presenting behaviour;
   - Detail of other less restrictive strategies attempted (if any);
   - Consequences/ outcomes of less restrictive strategies attempted;
   - Reason for use of strategy;
   - Duration;
   - The people involved in implementation of the strategy;
   - Name and position of staff directing use of strategy; and
   - Consequences/ outcomes.

7. Where a child or young person is physically restrained the Service Provider must provide support and counselling to that child or young person.[28] Evidence of the provision of support and counselling in each instance should be included with the Physical Restraint Register.

   The *Physical Restraint Register* is to be maintained *in addition* to any other data recording/ reporting requirements of the Behaviour Support Plan or Incident Prevention and Response Plan.

8. Where ***Exclusionary Time Out (ETO)*** or ***Seclusion*** is recommended within the context of a BSP or IPRP, an ***ETO/ Seclusion Register*** is maintained which records:
   - Date, time and location of each episode of implementation;
   - Brief description of environment and events prior to implementation of strategy;
   - Description of presenting behaviour;
   - Detail of other less restrictive strategies attempted (if any);
   - Consequences/ outcomes of less restrictive strategies attempted;
   - Reason for use of *ETO/ Seclusion*;
   - Duration of *ETO/ Seclusion;*
   - Periodic observational notes of the presentation of Service User;
   - Name and position of staff directing use of strategy; and
   - Name and position of staff responsible for conducting and recording observations of Service User.

   The *ETO/ Seclusion Register* is to be maintained in addition to any other data recording/ reporting requirements of the *Behaviour Support Plan* or *Incident Prevention and Response Plan.*

9. Where *ETO* or *Seclusion* is used within the context of a *BSP* or *IPRP*, the environment used for the strategy is one which presents the minimal potential for risk of harm and has:
   - means of easy observation;
   - adequate light and ventilation;
   - comfortable temperature; and
   - easy Service User access to toilet facilities.

10. Where *ETO* or *Seclusion* is used within the context of a *BSP* or *IPRP*, each implementation of the strategy is formally reviewed within 24 hours. If implementation occurs during a weekend, then it should be formally reviewed by close of business on the next working day. The review should include the following parties:
    - The Service User and their advocate;
    - The Behaviour Support Practitioner familiar with the strategy;
    - Representative of staff on duty;
    - Unit Manager/ Supervisor;
    - The line manager of the Unit Manager/ Supervisor; and
    - Other stakeholders as appropriate.

    Due to the short timeframe required to hold this review, it is reasonable for it to be conducted via phone or other electronic media.

28 *Children and Young Persons (Care and Protection) Regulation (2000),* Clause 35 (2)(d)(ii).

11. The *ETO/Seclusion Review Meeting* confirms that:
    - The *ETO/Seclusion Register* is complete and up to date;
    - The Service User was observed at all times during implementation of the strategy;
    - The implementation of the strategy was directed by the delegated officer;
    - The duration of the use of *ETO/Seclusion* was less than fifteen (15) minutes;
    - Implementation was within the time limit specified; and
    - All required internal and external notifications were made.
12. Where ***Psychotropic Medication*** has been prescribed and consented to for administration on a "***prn***" basis, a written ***PRN Protocol*** is developed in collaboration with the prescribing psychiatrist/ paediatrician as an integral component of the *BSP* or *IPRP* and made readily accessible to all carers. This document should clearly indicate:
    - The name and contact details of the prescribing psychiatrist/ paediatrician;
    - The chemical and brand names of the medication;
    - Name and contact details of the person giving informed consent for medication;
    - The circumstances/ conditions under which the medication may be administered;
    - Any physical examination or investigation required prior to administration;
    - Instructions regarding the permissible dose, how to administer it, and how often;
    - Purpose of the prescribed medication and the desired outcome;
    - The likely time frame between administration of the drug and the onset of the beneficial effect;
    - The maximum dosage permissible in a 24 hour period;
    - Possible side effects/ adverse effects (e.g. on quality of life);
    - Symptoms of overdose;
    - Complications/ interactions with other medications; and
    - Monitoring, recording, response and reporting instructions.

    In such circumstances the contribution or benefit derived from the medication should be regularly reviewed by the treating psychiatrist/ paediatrician in consultation with a Behaviour Support Practitioner and documented accordingly.
13. The use of a *Restricted Practice* is closely monitored to safeguard against abuse, and replaced with less restrictive strategies as soon as possible.

3.3 Prohibited Practices

Prohibited Practices include those that are abusive, those that constitute assault and those that constitute wrongful imprisonment. Such practices are prohibited and not permissible. All are criminal offences and civil wrongs and may lead to legal action. Prohibited Practices also include those that may not be unlawful, but are unethical. Prohibited Practices include those that:

- Cause physical pain or serious discomfort;
- Restrict access to basic needs or supports;
- Are degrading or demeaning to the Service User;
- May reasonably be perceived by the Service User as harassment or vilification;
- Are aversive;
- Are unethical; and
- Constitute an unauthorised *Restricted Practice.*

In addition, it should be noted that the *Children and Young Persons (Care and Protection) Regulation (2000)* requires that an organisation's behaviour management policy includes a ban on:

- Any form of corporal punishment;
- Any punishment that takes the form of immobilisation, force-feeding or depriving of food; and
- Any punishment that is intended to humiliate or frighten a Service User.[29]

Some examples of Prohibited Practices are given in the following Table:

Table 6: Some examples of Prohibited Practices

Practice	Example
Aversion	Any practice which might be experienced by a Service User as noxious or unpleasant. Examples include an unwanted cold or hot bath, unwanted applications of chilli powder on food, unwanted squirting of liquid on a person's face or body parts.
Over-correction	Where a Service User is required to respond disproportionately to an event, beyond that which may be necessary to restore a disrupted situation to its original condition before the event occurred. This might include requiring them to clean an entire dining room in consequence of having deliberately tipped a meal on the floor, or insisting that they practise arm exercises after having bitten their fingers inappropriately.
Chemical restraint	The abuse of medication to control or influence behaviour, mood or level of arousal. This includes the administration of psychotropic medication contrary to the instructions of the prescribing psychiatrist or paediatrician, contrary to a documented PRN Protocol.
Seclusion of children or young people	Isolation of a child or young person (under 18 years of age) in a setting from which they are unable to leave for the duration of a particular crisis or incident.

29 *The NSW Children and Young Persons (Care and Protection) Regulation (2000),* Clause 35 (2) (e).

4 Crisis response to a critical incident

A crisis response may be required in situations where there is a clear and immediate risk of harm linked to behaviour(s) and there is no ***Behaviour Support Plan (BSP)*** or ***Incident Prevention and Response Plan (IPRP)*** in place. The risk may impact on the Service User or on others. In such circumstances immediate intervention may be considered necessary under the Service Provider's ***Duty of Care*** in order to manage the risk. This is referred to as a ***Crisis Response***.

The incident must be recorded as a ***Critical Incident***. As such, it must be fully documented, the levels of injury reported and dealt with appropriately in accordance with *Occupational Health and Safety* requirements.[30] DADHC direct services must also comply with local procedural guidelines and the ***Incident Management Policy***.[31]

A *Crisis Response* may require the use of a *Restricted Practice* in order to prevent serious self-injury or harm to another person. The *Crisis Response* should involve the minimum amount of restriction or force necessary, the least intrusion, and be applied only for as long as is necessary to manage the risk. A *Crisis Response* should never be used as a de facto routine behaviour support strategy.

As soon as practicable after the *Critical Incident* has been managed, steps should be taken to have a *Behaviour Support Plan (BSP)* or *Incident Prevention and Response Plan (IPRP)* developed in accordance with DADHC work practice requirements.[32]

Children and young people

If force or restraint is necessary to prevent harm to a child or young person or other persons, the ***NSW Children and Young Persons (Care and Protection) Act (1998)*** permits the use of reasonable force to achieve this. It should be applied for ***no longer than is necessary*** to prevent or contain the danger. The use of more than reasonable force or restraint may be considered unlawful and not covered by the legal defences of self-defence or necessity.

While the legislation provides for the use of physical restraint, it is necessary to clearly define the boundaries of when it can be used. Section 158 of the Act[33] permits persons having parental responsibility and authorised carers to physically restrain a child or young person, involving the use of 'reasonable' force. However, it can only be employed on a temporary basis if the child or young person presents a serious danger of injury to themselves or others. In this context, the person may also remove from the child or young person any weapon, alcohol, illegal substance or other thing to prevent them from injuring themselves or another person. The occurrence of such incidents would be classified as ***unforeseen*** and response to them would constitute an ***unplanned response to atypical behaviour***.

Where physical restraint is used the Service Provider must provide support and counselling to the child or young person.[34]

In exercising duty of care, persons having parental responsibility and authorised carers must take ***reasonable care*** to avoid ***reasonably foreseeable*** incidents with children and young persons for whom they provide support.

30 See the *NSW Occupational Health and Safety Act (2000).*
31 *Incident Management Policy (June 2006, amended January 2007).*
32 See *Behaviour Support: Policy and Practice Manual, Part 2-Work Practice.*
33 *NSW Children and Young Persons (Care and Protection) Act (1998).*
34 *Children and Young Persons (Care and Protection) Regulation (2000),* Clause 35 (2)(d)(ii).

5 The support system

The support system refers to the range of services and interactions which serve in combination to support the Service User. This includes families, paid and unpaid carers or implementers, Behaviour Support Practitioners, staff supervisors, case coordinators, key workers, managers, and other professionals such as therapists, medical practitioners and educators. Behaviour support services should aim at promoting, establishing and maintaining environments and interactions which promote resilience of the support system and deliver positive and sustainable outcomes for the Service User.

Those within the support system should be responsible for identifying any additional training and support needs relevant to their role within the support system.

5.1 Roles and responsibilities

Families and implementers

Implementers is a term given to those carers whose role it is to implement particular behaviour strategies. They will require training and support in order to implement strategies effectively and consistently.

In family settings, there is often a greater need for support of implementers (parents, siblings, extended family members) in order to maintain the capacity of the family to manage behaviour and monitor outcomes under complex and/or difficult circumstances. Every care must be taken in the provision of behaviour support services to identify any aspects of the support system which might lead to breakdown of support for the Service User and to address these constructively.

In supported accommodation placements, implementers have a duty to follow documented behaviour support strategies endorsed by management and developed in accordance with this Policy and related practice guidelines, and an obligation to demonstrate competence in the implementation of those strategies and in monitoring and reporting related outcomes.

Behaviour Support Practitioners

The role of the Behaviour Support Practitioner is to develop behaviour support strategies in accordance with the *Behaviour Support: Policy and Practice Manual (January 2009)*, and provide training to those who will implement them and/ or to their supervisors.

Training provided to implementers and/ or their supervisors should seek not only to establish procedural reliability in following the written strategies, but also to ensure a broad understanding of the individual characteristics of the Service User, the function served by the challenging behaviour, and the outcomes proposed in the support plan. Moreover, it should seek to instil an understanding of principles such as consistency between implementers across environments and over time, the importance of adherence to the written strategies, and the role of information recording (data recording) and monitoring.

Engagement with families in order to establish good contextual fit of the support plan and to maximise and sustain outcomes is of pivotal importance.

Behaviour Support Plans should be developed in collaboration with as broad a range of stakeholders as practicable and in accordance with Part 1 (B) of this manual.

Ideally, staff conducting assessments, planning and consulting on behaviour support should be Behaviour Support Practitioners, and be receiving regular practice supervision from an appropriately qualified and skilled supervisor. A supervision log should be maintained by the supervisor.

Supervisors

In supported accommodation settings it is the role of the supervisor to monitor implementation of behaviour support strategies, promote consistency in their implementation and address performance issues.

Case coordinators/key workers

Where multiple services are involved in the support of the Service User, the case coordinator or key worker plays a pivotal role in coordinating effective lines of communication between services. This ensures the wellbeing of the Service User and provides a central contact point for other services.

Management

It is the role of service management to promote environments in which positive behaviour support outcomes for the Service User and their families can realistically be achieved. There is a greater risk of the use of aversive and abusive practices amongst carers who are untrained, inadequately trained and inadequately supported.[35] Provision of training alone is an inadequate response. Sustained behavioural change is linked to good contextual fit of the support plan[36], which has implications for resource management and regular supervision.

35 McLean and Walsh (1995); Emerson (1995), pp167-168.
36 Pokrzywinski and Powell (2003); Albin *et al* (1996).

6 Supporting policies, procedures, guidelines and legislation

- *Aboriginal Policy Framework (July 2005);*
- *Abuse and Neglect Policy and Procedures (May 2007);*
- *Anti-Discrimination Act (1977);*
- *Behaviour Support: Policy and Practice Manual (January 2009);*
- *Child protection: Responding to Allegations Against Employees (June 2008);*
- *Children and Young Persons (Care and Protection) Act (1998);*
- *Children and Young Persons (Care and Protection) Regulation (2000);*
- *Children's Standards in Action (2004);*
- *Client Risk Policy and Procedures (March 2008);*
- *Code of Conduct and Ethics (2004);*
- *Consulting Effectively with Aboriginal People and Communities (July 2005);*
- *Decision Making and Consent (July 2008);*
- *Dignity of Risk and Duty of Care (1996);*
- *Disability Services Act (1993);*
- *Feedback and Complaint Handling: Principles and Guidelines (May 2005);*
- *Guardianship Act (1987);*
- *Guardianship Regulations (2005);*
- *Guidelines for the development, implementation and review of communication support systems for persons with an intellectual disability and complex communication needs (October 2002);*
- *Health Care Policy and Procedures (March 2007);*
- *Incident Management Policy (June 2006, amended January 2007);*
- *Individual Planning for Adults in Accommodation Support Services (Sept 2005);*
- *Individual Planning for Children and Young People Living in Out-of-home Placements: Policy and Procedures (May 2007);*
- *Intake Policy (December 2001);*
- *Interagency Guidelines for Child Protection Intervention (DoCS 2006)*
- *Living in the Community: Putting Children First (July 2002);*
- *Maintaining Family Relationships Policy (1996);*
- *Managing Risks and Incidents in the Workplace (January 2003);*
- *Medication Policy and Procedures (March 2008);*
- *Memorandum of Understanding between the Department of Community Services and the NSW Department of Ageing, Disability and Home Care on Children and Young Persons with a Disability (November 2003);*
- *Mental Health Act (2007);*
- *NSW Interagency Guidelines for Child Protection Intervention (DoCS 2006)*
- *NSW Out-of-Home Care Standards (NSW Office of the Children's Guardian);*
- *Occupational Health and Safety Act (2000);*
- *Occupational Health and Safety Policy (September 2004);*
- *Occupational Health and Safety Regulation (2001);*
- *Occupational Health and Safety Risk Management Policy (September 2004);*

- *Orientation to DADHC Disability Services Respite Services (August 2002);*
- *Out-of-Home Care Standards (NSW Office of the Children's Guardian);*
- *Policy Framework: Providing behaviour support services for people with an intellectual disability (June 2006, Reviewed March 2008);*
- *Prioritisation and Allocation Policy (August 2002);*
- *Privacy, Dignity and Confidentiality (October 1996);*
- *Responding to Risk of Harm to Children and Young People (March 2007);*
- *Standards in Action Manual (1998);*
- *Strategy to improve services for people from culturally diverse communities: DADHC CALD Strategy 2005-08 (December 2005).*

Note: This list is not exhaustive and entries may not apply across all service settings.

7 References

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8 Useful resources

Specifically for families with children with an intellectual disability

Some useful general resource materials based on positive approaches to behaviour support for families caring for children or young people with an intellectual disability include:

Name	Source
Triple P *(PPP)*	Sanders, M.R., Turner, K.M. and Markie-Dadds, C. (2002). The development and dissemination of the Triple P-Positive Parenting program: a multi-level, evidence-based system of parenting and family support. *Prevention Science, 3* (3), 173-189.
Stepping Stones	Sanders, M.R., Turner, K.M. and Markie-Dadds, C. (2003). *Stepping Stones Triple P-Family Workbook.* University of Queensland and Disability Commission of Western Australia, Brisbane.
Signposts	Department of Human Services, Victoria (undated). *Signposts for Building Better Behaviour (Signposts).*

For people with a intellectual disability in general

Some useful resource materials based on positive approaches to behaviour support which are developed generally for people with an intellectual disability include:

Name	Source
Inclusive Communication and Behaviour Support *(ICABS)*	Department of Human Services, Victoria (2004). *Inclusive Communication and Behaviour Support (ICABS)*.
Active support	Felce, D.,Jones, E. and Lowe, K. (2002). Active Support: Planning daily activities and support for people with severe mental retardation. In S. Holburn and P.M. Vietze (Eds.) *Person-Centred Planning: Research, Practice and Future Directions.* Paul H. Brookes Publishing Co., Baltimore. Mansell, J., Beadle-Brown, J., Ashman, B. and Ockenden, J. (2006) *Person-Centred Active Support: A multi-media training resource for staff to enable participation, inclusion and choice for people with learning disabilities.* Tizard Centre, University of Kent.

IMPORTANT

Where a behaviour support service is being provided either by DADHC directly or by a Service Provider funded by DADHC, the requirements of DADHC Policy take precedence over the content or recommendations of any other resource materials or program.

Part 1 (B)
Work practice

1 Introduction

1.1 Background

The NSW Department of Ageing, Disability and Home Care (DADHC) has a responsibility to provide and fund services to people with an intellectual disability, as outlined in the *NSW Disability Service Standards* and the *NSW Disability Service Act, 1993*. These include behaviour support services which are provided within the context of current policies and procedures.

Behaviour support services are delivered ideally by ***Behaviour Support Practitioners*** who are trained in the principles of applied behaviour analysis and are experienced in working within the field of intellectual disability and related support systems. In addition, it is likely that they hold tertiary qualifications in psychology, nursing, special education, speech pathology, social work, education or other relevant discipline.

This manual sets out the key elements expected by the Department in the provision of service by these Practitioners.

It is supported by the interactive resource, ***Understanding the Function of Behaviour: a Practice Guide,*** a computer-based tool designed to assist in the understanding of challenging behaviour.[37] To access this interactive resource, go to:
www.dadhc.nsw.gov.au/dadhc/People+with+a+disability/Behaviour+Intervention+Service.htm
and click on the link: Understanding the Function of Behaviour: A Practice Guide.

This manual encourages the use of positive approaches to behaviour support practices as outlined in DADHC Policy. The work practices outlined in this manual form a guide to enable service providers to apply the principles set out in the Act[38] and in DADHC policy.[39]

1.2 Target group

DADHC-funded Service Providers and DADHC staff who provide behaviour support services to adults, children and young people with an intellectual disability.

1.3 Context

A comprehensive list of relevant Departmental policies, procedures, guidelines and government legislation related to behaviour support work practice requirements is provided in Section 14 of this document.

37 Doyle & Owens, (2006).
38 *NSW Disability Service Act, 1993*
39 *Behaviour Support: Policy and Practice Manual, Part 1 (A) - Behaviour Support Policy.*

1.4 Categories of practice

Service Providers have a responsibility to ensure that clients who receive a behaviour support service are protected from exploitation, abuse, neglect, and unlawful and degrading treatment. Consistent with DADHC Policy, the aim of positive approaches to behaviour support is to provide a respectful and sensitive environment in which the ***Service User*** is empowered to achieve and maintain their individual lifestyle goals and enhance their quality of life. Behaviour support strategies developed simply to prevent challenging behaviours from occurring, or simply to ensure automatic compliance with the periodic wishes of the carer, do not meet Policy requirements.

All behaviour support activities and interventions will be respectful of the individual needs and goals of the Service User, as identified through an ***Individual Plan***[40], and based on a current and comprehensive assessment.

Behaviour support strategies fall into three distinct categories:

1. **Positive Practices;**
2. **Restrictive Practices; and**
3. **Restricted Practices.**

1.4.1 Positive Practices

All behaviour support strategies and work practices must emphasise positive practices above all others. Positive practices are aimed at preserving the dignity of the Service User and achieving positive and lasting behaviour change. Positive practices are founded on the principles of a ***positive approach*** to behaviour support. This is a distinct evidence-based clinical approach with established procedures and replicated positive outcomes.[41]

Consistent with this approach, legislative requirements, and current Departmental policies and guidelines, the broad principles upon which behaviour support services are delivered must be:

- Holistic;
- Person-centred;
- Skill-based;
- Solution/outcome focussed;
- Non-aversive;
- Socially, culturally and age-appropriate;
- Reflective of current methods of good practice;
- Consented to or approved by the person with legal authority to do so as appropriate; and
- Subject to regular monitoring and review.

All activities and interventions will be supportive and respectful of the person's individual needs and goals, as identified through an ***Individual Plan***, and based on a current and comprehensive assessment.

40 *Individual Planning for Adults in Supported Accommodation Services* (September 2005); *Individual Planning for Children and Young People Living in Out-of-home Placements: Policy and Procedures* (May 2007).
41 McVilly (2004), p 18.

1.4.2 Restrictive Practices

Some support strategies, although considered beneficial by the Behaviour Support Practitioner in order to enhance quality of life or achieve lasting positive behavioural outcomes, may nevertheless involve restriction of a person's freedom, or intrusion on their rights or dignity. These are known as Restrictive Practices, and cannot be implemented without informed consent.

▶ Refer **DADHC *Behaviour Support Policy*** for further details on ***Restrictive Practices.***

1.4.3 Restricted Practices

A number of Restrictive Practices are also identified by the Department as ***Restricted Practices***. Restricted Practices are defined and explained in the DADHC Behaviour Support Policy.

Restricted Practices must be documented in a written support plan or strategy. They must be legally consented to and the plan or strategy must have ***Restricted Practice Authorisation (RPA)*** by a ***Restricted Practice Authorisation*** mechanism.

The Department is seeking a consistent approach across the sector in relation to the use of practices which are restrictive. Service Providers across the wider sector are encouraged to develop and maintain an ***RPA*** mechanism to manage the use of *Restricted Practices* and maintain rigorous standards within their own service.

▶ Refer **DADHC *Behaviour Support Policy*** for further details on ***Restricted Practices.***

1.4.4 Prohibited Practices

A range of practices are prohibited by DADHC under any circumstances. Services using any such practices will be in breach of Policy and may be acting illegally.

▶ Refer **DADHC *Behaviour Support Policy*** for further details on ***Prohibited Practices.***

1.4.5 Key Performance Indicators

For DADHC-funded Service Providers service outcomes will be monitored and reported against Key Performance Indicators (KPIs) as set down in the ***Integrated Monitoring Framework (IMF)***.[42]

For direct accommodation and respite services, relevant outcomes will be monitored and reported against KPIs as set down in the ***Quality and Safety Framework (QSF)***.[43]

From 2009 the DADHC Quality Framework will replace the quality component of the current IMF and be applied to all DADHC-funded and DADHC-direct services.

In addition, a ***Quality Feedback Tool (QFT)*** has been developed which focuses on individual behaviour support ***Service Requests***, and measures work practice compliance in relation to that specific Service Request. Although optional, this Tool is included as a useful guide to inform ongoing service development. It is included as ***Appendix 1.2*** in this manual.

42 Further information on the IMF is available by visiting the DADHC Internet site. Go to www.dadhc.nsw.gov.au/dadhc

43 Further information on the QSF is available to DADHC staff via the intranet. www.dadhc.nsw.gov.au/dadhc

2 Preliminary work

2.1 Scoping of service provision

Before embarking on the provision of a behaviour support service, it is essential to:

- Establish whether or not consent for the *Service Request* has been obtained;
- Identify who is giving consent and in what capacity;
- Establish stakeholder expectations;
- Clarify the specific issues which prompted the *Service Request* to be made;
- Confirm the currency and scope of existing behaviour support;
- Identify any gaps in the information provided in the *Service Request*;
- Verify that the *Service Request* is appropriately placed with the unit that has received it; and
- Provide an opportunity for consideration of interim strategies where risk of harm is clearly identified;

This should be done ***prior to any assessment work taking place***, and the information recorded so as to inform a preliminary scoping of service delivery.

2.1.1 Before allocation for service

Within DADHC-direct services, the scoping process begins with the completion of a ***Review of Service Request Report (RSR Report)*** by a Behaviour Support Practitioner prior to allocation of a *Service Request* for action.[44] Similar to a ***triage*** process, completion of an ***RSR Report*** allows a Behaviour Support Practitioner to establish a snapshot of the Service User within the context of the existing support system, confirm the presenting issues, clarify the nature of the request, and consider the likely scope of service. This in turn allows a *Service Request* to be effectively prioritised relative to other *Service Requests* awaiting response from the Service Provider. It further provides additional clinical information to assist in the allocation process.

It also provides an opportunity to evaluate whether or not the request is appropriately placed and whether or not referral to other services might be appropriate. In addition, it provides an opportunity for flagging any known issues in relation to resource limitations, and consideration of interim strategies where risk of harm is clearly identified.

44 See *Behaviour Support: Policy and Practice Manual, Part 2 (A) – DADHC Procedures.*

2.1.2 After allocation for service

Following allocation of the *Service Request* to a Behaviour Support Practitioner for action, the scoping process should continue by means of negotiation of a written *Service Agreement* which is then endorsed by all parties. This endorsement constitutes agreement between the parties in regard to the scope of service provision, including any conditions or limitations associated with it. The *Service Agreement* also requires informed consent from the Service User or relevant substitute decision maker.

For DADHC-direct services, the scoping process and Departmental requirements are explained in greater detail in Part 2 (A) of this manual.

Once a *Service Agreement* has been established, work practices should follow a sequential and systematic process of:

1. Assessment and analysis;
2. Design of support plan;
3. Consent, authorisation and endorsement;
4. Implementation;
5. Monitoring;
6. Review; and
7. Closure.

Each step in the above process is addressed in the following Sections.

3 Assessment & analysis

3.1 Definition and purpose

Behaviour assessment is the process of systematically gathering information which clearly defines the behaviours/ issues identified in the *Service Agreement* and within the context of the whole-of-life of the Service User. Analysis is the process of using this information to develop informed hypotheses which seek to explain the function of each behaviour.

Behaviour assessment and analysis seeks therefore to understand the:

- conditions under which an identified behaviour does or does not occur;
- complexities of the support needs of the Service User across environmental contexts; and
- function of the behaviour for the Service User across environmental contexts;

Assessment and analysis should lead to the development of actions/ recommendations aimed at improving the quality of life of the Service User, enhancing their skills, reducing the severity of issues associated with the identified behaviour(s), and improving the quality and effectiveness of the behaviour support system.

Behaviour Support Practitioners should remain aware that behaviour support may be provided with varying degrees of intensity and intrusion. In general, the ***least intrusion*** required in order to achieve the best outcome for the Service User and their family is preferred.

3.2 Context

Challenging behaviour can be traced to mismatches between existing supports and individual need. It can also be linked to genetic, phenotypic, medical, sensory, psychiatric, historical, cultural, or other factors. It can be an attempt to communicate positive or negative emotions, release stress, obtain, escape, avoid or reject objects or events.

3.3 Areas of focus

A comprehensive assessment of a person's individual support needs must include due consideration of the impact of a range of contextual variables on the Service User's life.

Each of these contextual variables may be considered as interlinked ***Areas of Focus*** for purposes of the assessment:

- the Service User's ***quality of life***;
- the inherent ***risks*** of harm;
- the ***support system***, its characteristics and overall resilience;
- relevant ***diagnoses***, genetic, developmental and cognitive factors;
- ***medical*** and ***dental*** factors;
- ***mental health*** factors;
- the ***communication system***, including -
  (a) expressive and receptive ***communication skills of the Service User***, and
  (b) expressive and receptive ***communication skills of carers*** and significant others;
- the presence of characteristics associated with ***autism***;
- ***mobility*** and ***sensory*** factors;

- the many ***environments*** in which the person interacts with others;
- the ***family context*** and ***family expectations*** of service provision;
- ***cultural*** and ***linguistic*** factors;
- the wider ***social network*** of the person;
- ***life skills, experiences*** and preferences; and
- ***previous contact*** with support services (history and outcomes).

These *Areas of Focus* are discussed in more detail below. It should be remembered that the intensity or depth of consideration given to these *Areas of Focus* during assessment will vary depending on the nature of the presenting issues and the scope of the *Service Agreement*.

3.3.1 Quality of life

Positive approaches to behaviour support do not aim simply to prevent challenging behaviours from occurring. Although this is a component, the aim of the positive approach is to maximise the quality of life of the Service User. This is achieved through examination of multiple elements of the Service User's life and analysis of their interaction across domains and over time. It should include an evaluation of existing skills, achievements, future plans and broad goals of the Service User, as well as of opportunities to demonstrate choice, interact with others, access preferred partners, activities or items, convey emotions, share experiences etc.

3.3.2 Assessment of risk

There is a fundamental distinction between:

(a) assessment of risk/ management of risk; and

(b) assessment of behaviour/ provision of behaviour support.

(a) Assessment/ management of risk

Service providers have a ***Duty of Care*** towards those who receive their service. Risk management strategies should be in place to minimise or remove the risk of harm arising from activities or events across multiple domains in the Service User's life, e.g. health, nutrition, swallowing, mobility, transitioning etc.[45]

Employers also must show reasonable care for the safety of workers. Risk management strategies are required in all designated workplaces under NSW Occupational Health and Safety legislation and guidelines.[46] Additional DADHC Policies are relevant to the management of these risks.[47]

(b) Assessment/provision of behaviour support

Risk evaluation and assessment should also be pivotal components of a comprehensive behaviour assessment. Risk management strategies associated with an identified behaviour should be included in behaviour support plans.

Strategies developed only to manage an identified risk are ***NOT SUFFICIENT*** in themselves to fulfil all the requirements of behaviour support in the context of DADHC Policy.

45 See *Health Care Policy and Procedures (March 2007).*
46 *Occupational Health and Safety Act, 2000; Occupational Health and Safety Regulation, 2001.*
47 *Managing Client Risks (January 2003); Incident Management Policy (June 2006, amended January 2007).*

Behaviour support must address multiple elements of the Service User's life, promote positive approaches, and deliver positive person-centred outcomes.

In certain circumstances however, such as:

- in response to a ***new*** challenging behaviour;
- in response to a ***crisis***; or
- where a complete behaviour support plan has not yet been developed,

an ***Incident Prevention and Response Plan (IPRP)*** may be appropriate. This IPRP must be documented, endorsed by a Behaviour Support Practitioner, consented to as appropriate and maintained only until such time as a ***Behaviour Support Plan (BSP)*** is developed or reviewed. An ***IPRP*** may also be fully integrated within a ***BSP***.

▶ Refer **Section 5: *Design of Behaviour Support Plans.***

▶ Refer **Section 4: *Incident Prevention and Response Plan*** (IPRP).

3.3.3 Understanding the support system

It is important to assess not only the presenting behaviour in the context of the support system, but also to remain aware of the dynamics of the support system in the context of service provision. The capacity of a support system to meet the needs of the Service User impacts on the individual and on those around them.

Service Users are often in contact with multiple services, often episodically, which may be crisis-driven or not effectively coordinated.[48]

The Behaviour Support Practitioner should remain aware of the possibility that elements within the support system such as inadequate resources or gaps in carer skill, which can threaten the success of supports or an intervention, need to be identified. This safeguards the rights of the Service User who may be negatively impacted as a result of service deficiencies or less than "best practice"[49]. It also allows the Behaviour Support Practitioner the opportunity to consider to what extent the limitations of the system might be incorporated into a realistic support plan, or of proposing solutions which address those deficiencies among the recommendations of the assessment report, or of doing both.

In some situations the capacity of the support system to cope is placed under severe stress. In family settings stressors tend to accumulate as individuals try to adapt, and parents and siblings are at greater risk of negative outcomes such as depression, social isolation and relationship problems.[50] These factors need to be identified in the assessment in order to inform development of the support plan and its successful implementation.

48 McVilly (2004), p 9.
49 Ibid.
50 Roberts & Ridley, (2004), p 64.

3.3.4 Diagnoses, genetic factors and cognitive development

A diagnosis of intellectual disability has implications for several sets of cognitive skills, impacting negatively on the **processing, analysing** and **retention of information**. In addition, **social** and **communication skills** and **emotional development and expression** are affected. **Gross** and/or **fine motor skills** may be adversely affected.

A comprehensive behaviour assessment must gather information sufficient to allow consideration of how the level of intellectual disability and the cognitive and genetic factors associated with it might impact on the Service User, and how it might affect their experience of the world around them.

There are characteristics associated with certain syndromes which must be considered in a comprehensive behaviour assessment. Characteristics associated with Autism Spectrum Disorder (ASD), for example, will often define the goals and structure of support for a Service User with ASD (see the separate discussion on autism below). Consideration of the characteristics common to other specific syndromes will inform the Behaviour Support Practitioner as to:

- any associated predispositions for particular behaviour(s)[51]; and
- any significant features associated with the syndrome which might impact on the setting of realistic goals or achieving desired outcomes.

Some syndromes also have common health implications for the Service User as they experience the ageing process, and in some instances the ageing process itself has an earlier onset than in the general population.[52]

Consideration of the characteristics associated with a particular genetic syndrome should be a major component of the analysis stage of behaviour support practice. It will assist in determining the scope of service provision and the identification of positive solutions to the presenting behaviour.

3.3.5 Medical and dental factors

A behaviour which presents as challenging may be associated with physical pain or discomfort[53], particularly where there are systemic communication difficulties and the Service User is unable to effectively indicate the experience of pain or discomfort to carers through any other means. Failure to detect the presence of pain can lead to incorrect clinical decisions being made by the Behaviour Support Practitioner, leading to serious consequences for the Service User.[54]

As part of a comprehensive assessment the Behaviour Support Practitioner should therefore ascertain:

- whether or not a physical or dental consultation has been arranged with a medical professional in response to the presenting behaviour;
- whether or not a physical or dental examination has recently been conducted in response to the presenting behaviour;
- to what extent the medical professional experienced difficulty in obtaining appropriate information from the Service User or carer in relation to assessment and diagnosis[55]; and
- the outcome of the medical or dental examination.

51 O'Connor & Davis (1999), p75-76.
52 Balandin and Kerse (1999), p 61.
53 Banks et al (2007) p 29.
54 Lamarque (1997), p 34.
55 Burbidge & Trumble (1999), p 3.

The Behaviour Support Practitioner should then include consideration of the findings of the medical or dental examination in the behaviour assessment.

Medical or dental examinations may occur concurrently with a behaviour assessment. There may also be circumstances where a behaviour assessment may proceed prior to a medical or dental examination, provided that the behaviour assessment is reviewed to incorporate findings of any subsequent medical or dental examination as appropriate. Further information on the management of the health needs of the Service User is outlined in the Health Care Policy and Procedures (March 2007).

Comprehensive assessment should also identify details of any medication that a Service User is prescribed. Details should include:

- The name and contact details of the prescribing medical practitioner;
- Chemical and brand names of the drug;
- Purpose of the prescribed drug and the desired outcome;
- How long the drug must be taken;
- Possible side effects/ adverse effects (eg on quality of life);
- Symptoms of overdose; and
- Complications/ interactions with other medications.

Unrecognised or poorly managed medical problems can also contribute to psychiatric disorders.[56]

3.3.6 Mental health

It is estimated that mental health disorders affect people with an intellectual disability in the order of three to four times greater than the general population.[57] The prevalence of psychiatric disorder in people with an intellectual disability has been estimated to be in the order of 40%[58], and people with a developmental disability have been estimated to be at 40-50% greater risk of developing a mental illness than the general population[59]. General Practitioners are often the preferred source of psychiatric care in the general population[60], and have been estimated to manage up to 90% of patients with mental illness in the community.[61]

However, people with an intellectual disability often have significant communication difficulties and this presents a barrier to effective diagnosis and provision of health care generally.[62] The presence of mental health problems is often minimised and attributed to the intellectual disability itself.[63] Information relevant to assessment of mental health is often provided by carers based on their own observation and interpretation of external behaviours, which will vary in its usefulness depending on a range of factors.[64] In addition, the presence of co-morbidities such as epilepsy, physical illness, medication effects, autism, chronic pain, sensory deficits and others further complicates the process of effective diagnosis.[65]

56 Davis & Curran (1999), p 104.
57 DSM IV (2005), p 45.
58 Davis & Curran, op cit, p 101.
59 Einfeld (1992).
60 Keks et al (1998).
61 RACGP (1995).
62 Burbidge & Trumble op cit.
63 Davis & Curran, op cit, p 102.
64 Ibid, p 107.
65 Ibid, p 104.

Similarly, as with the focus on medical and dental factors outlined above, the Behaviour Support Practitioner should ascertain:

- whether or not a psychiatric or paediatric consultation has been arranged in response to the presenting behaviour;
- whether or not a psychiatric or paediatric consultation has recently been conducted in response to the presenting behaviour;
- to what extent the consulting psychiatrist or paediatrician experienced difficulty in obtaining appropriate information from the Service User or carer in relation to assessment and diagnosis; and
- the outcome of the mental health examination.

The Behaviour Support Practitioner should then include consideration of the findings of the psychiatric or paediatric consultation in the behaviour assessment.

Comprehensive assessment should also identify details of any psychotropic or neurological medication that a Service User is prescribed. Details should include:

- The name and contact details of the prescribing Psychiatrist/ Paediatrician/ Neurologist;
- Chemical and brand names of the drug;
- Purpose of the prescribed drug and the desired outcome;
- Instructions regarding the permissible dose, how to administer it, and how often;
- How long the drug must be taken;
- Possible side effects/ adverse effects (eg on quality of life);
- Symptoms of overdose;
- Complications/ interactions with other medications;
- Monitoring, recording, response and reporting instructions;
- Schedule of review by treating Psychiatrist/ Paediatrician/ Neurologist.

3.3.7 Understanding the communication system

Communication is a two-way process. Communication refers not only to the communicative skills of the Service User, but also to those of others in the support system, particularly carers. For people with an intellectual disability and complex communication needs it is crucial that all parties in the support system are able to communicate appropriately and effectively. This will usually require the design and consistent implementation of a formal communication system.

Where ***Augmentative and Alternative Communication (AAC) Systems*** have been developed in support of an individual, careful analysis should be made not only of the portability of the AAC system itself, the Service User's capacity to use the AAC system, but also of the competency or capacity of carers across environments to use the same AAC system effectively.[66]

AAC systems are developed in response to assessed communication preferences and skills of the Service User. These skills and preferences can best be thought of as comprising a number of types as follows:

66 CDDS (2002).

Table 7: Augmentative and Alternative Communication (AAC) Strategies[67]

Unaided strategies	Aided strategies
Body movements	Real objects
Facial expression	Object symbols
Eye contact	Photos
Natural gesture	Pictures
Pointing	Pictographs (e.g. *PCS, COMPIC*)
Idiosyncratic signals	Graphic symbols
Mime	Written text
Key Word Sign *(KWS)*	
Auslan	
Signed English	
Finger spelling	

The communication system may take the form of auditory modalities such as verbal cues or the spoken word. The system may be designed for operation using low-tech modalities such as visual timetables or access cards, or using high-tech modalities such as microcomputers and software packages.[68]

DADHC promotes ***inclusive communication and behaviour support*** practices that aim to develop skills and establish strategies which reduce reliance on behaviours that may inhibit a person with a disability from fully participating in the community.

In recognition of the growing evidence supporting a significant link between communication difficulties and challenging behaviour[69], comprehensive assessment of behaviour should be informed by a recent and detailed communication assessment, ideally undertaken by a qualified Speech Pathologist.

Where no recent communication assessment has been conducted, this should not prevent progress of the behaviour support service. However, a communication assessment report should be sought at the earliest opportunity. The behaviour supports should subsequently be reviewed to incorporate the findings of the communication assessment report.

For DADHC staff, further information and resources related to communication, AAC systems and ***Inclusive Communication and Behaviour Support (ICABS)*** is available through either:

(a) The ***Communication and Rights Library***; or

(b) The ***Communication Resource Library***.

One of these libraries, known as ***CRLs***, has been established in each of the locations listed in Table 8 following.

67 Bloomberg K., West, D. & Johnson, H. (2004).
68 CDDS (2002), p25.
69 Balandin (2002);Bloomberg & West, (1999); Bradshaw (2002, 1998); Desrochers et el (1997).

Table 8: Location of *Communication and Rights* and *Communication Resource Libraries (CRLs)*

Northern Region
Level 5, 29 Molesworth Street, **LISMORE** NSW 2480
Suite 5, 116 Gordon Street, **PORT MACQUARIE** NSW 2444
Level 1, 175 Rusden Street, **ARMIDALE** NSW 2350
Southern Region
61 North Street, **NOWRA** NSW 2541
16 Gladstone Avenue, **WOLLONGONG** NSW 2500
95-101 Auburn Street, **GOULBURN** NSW 2580
Western Region
647-653 Dean Street, **ALBURY** NSW 2640
Ground Floor, State Office Block, Corner of Kite & Anson Sts., **ORANGE** NSW 2800
130 Brisbane Street, **DUBBO** NSW 2830
Hunter Region
Hunter Residences, Stockton Centre, **STOCKTON** NSW 2295
796 Hunter Street, **NEWCASTLE** NSW 2300
Gateway Centre, 237 Mann Road, **GOSFORD** NSW 2250
Metro North Region
Ground Floor, 295 High Street, **PENRITH** NSW 2751
Metro Residences, 36 Mons Road, **WESTMEAD** NSW 2145
Level 2, 93 George St, **PARRAMATTA** NSW 2150
Level 2, 22-28 Edgeworth David Drive **HORNSBY** NSW 2077
Level 6, 12 Help Street, **CHATSWOOD** NSW 2067
Metro South Region
Level 4, 25 Smart Street, **FAIRFIELD** NSW 2165
390 Forest Road, **HURSTVILLE** NSW 2220
Grosvenor Centre, **SUMMER HILL** NSW 2130
61 Dunning Ave, **ROSEBERY** NSW 2018
State-Wide Behaviour Intervention Service
Level 1, 242 Beecroft Road, **EPPING** NSW 2121

3.3.8 Autism Spectrum Disorder

The prevalence of Autism Spectrum Disorder (ASD) concurrent with intellectual disability has been estimated at 70% with a male/female ratio of 4.3:1.[70]

Autism Spectrum Disorder (ASD) is a term which encompasses a range of autistic presentations.[71] These are a group of neuro-developmental disabilities with onset before 36 months of age and characterised by impairments in reciprocal social interactions, verbal and non-verbal communication and stereotypic behaviour, interests and activities.[72]

There are common social, communication and behavioural characteristics associated with *ASD*[73] and the diagnosis has genetic implications for the Service User and their families, and multi-agency service implications.[74] However, *ASD* is under-diagnosed among adults with intellectual disability, and many Service Users who present with characteristics consistent with *ASD* may not carry a formal diagnosis of autism.

Behaviour supports developed for Service Users often fail because the assessment does not address the implications of a formal diagnosis of *ASD* or does not recognise the presence of characteristics consistent with *ASD* in situations where there is no formal diagnosis. Analyses conducted in such circumstances can be inappropriate or inaccurate when applied to an individual with autism[75], leading to the design of supports which are ineffective and the exacerbation of an already stressful situation.

In view of the prevalence of *ASD* concurrent with intellectual disability it is crucial that any behaviour assessment effectively screens for the presence of autistic features, and that the Behaviour Support Practitioner considers the implications of these features for the purpose of support plan development and its successful implementation.

3.3.9 Mobility and sensory factors

Assessment of the Service User should always include consideration of any mobility skills and mobility support needs of the individual. These may be related to characteristics of a particular diagnosis, age or developmental stage of the individual and impact on fine and/or gross motor skills and abilities. For example, ***motor disorders*** associated with cerebral palsy include impaired control of voluntary movement of limbs or of the whole body, disorders of balance, or loss of control of body posture.[76] They can present in a range of behaviours from apparent inactivity to violent movements.

Cerebral palsy often also presents the individual with ***motor planning, hand-eye coordination*** problems[77], and difficulties with ***vision*** and ***hearing***.[78] These characteristics should never be confused with challenging behaviour even though they may present challenges to the support system.

Difficulties with ***fine motor skills*** may present as an inability to tie shoelaces or unscrew the top from a container. Again, care must be taken to consider such characteristics in the context of the individual so as to better inform the development of a realistic and person-centred support plan.

70 Fombonne (2003), p 379; Curran & Tonge (1999), p 199.
71 Also known as *Autism Spectrum Condition (ASC).*
72 Curran & Tonge (1999), p 197.
73 Ibid.
74 Brown et al (2005) p 22.
75 Banks et al (2007) p 32
76 Reddihough & Buzio (1999), p 186.
77 Ibid, p 194.
78 Ibid, p 189.

In cases where a Service User experiences difficulties with fine or ***gross motor skills*** on a particular task or activity, and where these are complicated by communication difficulties, stress, impulsiveness, mood lability or other factors, challenging behaviour may follow attempts to complete the task. In such cases it is important that the Behaviour Support Practitioner is aware of the critical role played by the mobility or motor factors at the outset.

Sensory factors must also be considered in assessment. For example, Service Users with ASD often experience sensitivity or aversion to particular smells, tastes, sounds, or tactile sensations.[79] These will be different for each individual. Assessment of the person must therefore include the identification of those specific sensory sensitivities or aversions which the Service User is known to experience. This has pivotal implications for the design of appropriate behaviour support. ***Touch cues***[80] included in the implementation of a support plan of an individual with aversion to touch, for example, are wholly inappropriate and may be in breach of Policy. Conversely, ***sensory activities*** which are developed in consideration of the known sensory sensitivities of a Service User will often enhance quality of life and provide fulfilment not available elsewhere.[81]

3.3.10 Environments

Everyone moves through ***multiple environments*** each day (e.g. leaving home, commuting to and from school or work, going shopping, accessing leisure activities etc.)

A move from one environment to another, or from one activity to another in the same environment, is known as a ***transition***, and can be stressful and difficult.

Like all of us, Service Users experience life across a range of environments, including home, neighbourhood, community, work, school, recreational and social domains. Each domain may look, smell or sound different, may require different social or behavioural skills, involve different people or numbers of people, may be more crowded, less crowded, easily accessible, less accessible, favoured or not favoured, etc.

For the general population, change often presents great difficulties, even when it involves a pleasurable or preferred activity or component. Transitioning may require careful planning in order to avoid confusion, distress or disappointment. For people with an intellectual disability it is particularly important to provide effective support at these times. Care must be taken to assess the characteristics of significant environments and activities in order to better understand the impact of each on the Service User, bearing in mind what is known about the person and how they experience different situations around them. A documented ***Transition Plan*** should provide sensitive, person-focussed, planned, structured and accessible support of Service Users moving between activities, events, environments or other changes in their day to day lives.

79 Curran & Tonge (1999), p 199.
80 Bloomberg et al (2004), p 166-169.
81 Ibid, p 170-173

3.3.11 Family context and family expectations

The Behaviour Support Practitioner should collaborate with the family of the Service User in order to reach an understanding on the outcomes expected by them from the service. This will guide the development of the support plan but should also promote engagement of the family as valued stakeholders in the behaviour support process. In addition, it should provide the Behaviour Support Practitioner with a wider understanding of the family context, may illustrate or clarify the role of various family members in the support system, and assist with identification of risks associated with inaccurate assumptions or unrealistic expectations. It may also reveal additional issues such as risks of support breakdown, or other areas of concern, which can be addressed in the support plan.

Understanding of the family context should include ***parents*** and ***siblings*** as well as the ***extended family***. Sibling relationships are usually more long-lasting than any other within families, and siblings often play a crucial role in the long-term support of a Service User.[82]

3.3.12 Cultural and linguistic factors

It is essential that the Behaviour Support Practitioner allows due consideration to cultural and linguistic factors that are present in the support system and significant to the Service User. This extends beyond use of interpreters or translators of community languages where appropriate. It involves broader consideration or awareness of the cultural domain with which the Service User identifies himself/ herself, or with which the Service User's family identifies itself. This cultural domain includes social differences which stem from nationality, ethnicity, race, religion, arts, gender, generational differences, history and socio-economic status[83], and structural hierarchies, values and beliefs.[84] The Practitioner should aim not only to become aware of key cultural values that might impact on provision of service but also to acknowledge gaps in their own understanding.[85] This applies to Service Users from ***culturally and linguistically diverse (CALD)*** communities and to Service Users from ***Aboriginal or Torres Strait Islander (ATSI)*** communities.

3.3.13 Relationships and the wider social network

Information on the social network of the Service User or how peers and others outside the family system interact with him/ her will assist in completing a useful picture of the individual. Established friendships have been linked to self-esteem and self-identity and provision of opportunities for intimacy, help and advice.[86] Being in supportive relationships contributes to enhanced quality of life[87] and improved physical and mental health.[88] It may also help to identify important stakeholders who might not otherwise have been considered for inclusion in the collaborative approach.

82 Strohm (2002), pp 194-5.
83 DIMA (2006), p 22.
84 DoCS (2005), p 9.
85 DIMA op cit, p 28.
86 Firth & Rapley (1990).
87 Velde (1998); Reinders (2002).
88 McVilly (2002), p 64.

3.3.14 Life skills, experiences and preferences

Knowledge of particular skills a Service User has, and of preferences they may have for activities or pastimes, contributes to the overall knowledge of the person. Accordingly, it informs analysis of the presenting behaviours and therefore provides the opportunity to develop a more effective support plan.

Life experiences such as grief, loss, puberty/ adolescence, ageing or other life changes should also be carefully considered in the assessment.

3.3.15 History of previous contact

Service Users and their families often have a history of involvement with multiple services, across agencies and over time. Some of these episodes of contact may not have resulted in favourable outcomes, while others may have enhanced quality of life and system resilience through the application of good practice and delivery of positive and sustainable outcomes. It is important that the Behaviour Support Practitioner is aware of the individual contact history. It is especially important that the Practitioner has a good knowledge of the behaviour support history of the Service User, including previous assessments, findings, related plans, mediator analyses and implementation outcomes.

3.4 Process

Consistent with Policy,[89] the process followed in behaviour assessment and analysis should usually consist of a combination of:

1. interview with the Service User;
2. interviews with key parties;
3. file review of relevant documentation;
4. observations of the Service User across environments;
5. data collection; and
6. research.

The completion of these elements leads into analysis of the gathered information and the formulation of hypotheses.

It is vital that the Behaviour Support Practitioner is responsive to the need to strike a balance between professional rigour and ***timely intervention***. This is especially important where issues of safety or risk of injury are present. In conducting an assessment the Behaviour Support Practitioner should not confuse comprehensive with in-depth or intensive. A ***comprehensive assessment*** can be a brief but thorough sweep of the presenting issues in the context of the person and their environments, resulting in useful recommendations or in prompt delivery of an appropriate service.

89 Refer *Behaviour Support: Policy and Practice Manual, Part 1 (A) – Behaviour Support Policy.*

3.5 Techniques

Techniques for conducting a behaviour assessment and analysis can vary, from relatively informal techniques for gathering information, through to the use of standardised and validated assessment tools. For example:

3.5.1 Orientation

Meet the Service User. At this initial stage of information gathering, meaningful interaction/ communication with the Service User, carers, and family may provide useful information. Observations of the environments in which the Service User spends time, and their behaviour in those environments, may also provide information that may be useful in the process of analysis and the eventual formulation of hypotheses.

3.5.2 Review of records including file review

The process of file review refers to the systematic analysis of documentation contained within a Service User's file. File reviews can yield information including:

- Individual Plans;
- Evidence of diagnoses;
- Lifestyle and preferred activities;
- Previous and current behaviour assessments;
- Previous and current behaviour support plans;
- Outcomes of previous support plans and intervention;
- Family and support network;
- Progress/ case notes;
- Health issues;
- Previous and current medication and related outcomes;
- Placement history, and
- Reports from other professionals.

Careful attention should be paid to dates, authorship, and the purpose of relevant documentation including reports and previous interventions. Particular attention should be made to distinguish factual information (supported by evidence on file) from innuendo, rumour, and hearsay.

3.5.3 Data collection

Data collection is the recording of information by others, usually carers or other communication partners, which is prescribed in the ***Behaviour Support Plan (BSP)***, or the ***Incident Prevention and Response Plan (IPRP)***.

Data may be recorded prior to an intervention to establish a ***baseline***, and then during an intervention in order to measure the impact of planned strategies against that baseline. Analysis of comprehensive, consistent, and reliable data is an important step in the understanding of the function of behaviour and achievement of positive outcomes for a Service User.

3.5.4 Structured interviews

Structured interviews are planned interviews designed to enable the Behaviour Support Practitioner to methodically gather information on specific areas of interest and within a set time frame. They are usually conducted with the Service User, carers, family members and significant others who know the Service User well.

3.5.5 Interdisciplinary collaboration

Interdisciplinary collaboration involves the Behaviour Support Practitioner collaborating with professionals from other disciplines who are providing a service currently or who have done so recently. This may lead to a *Service Agreement* to guide ongoing collaboration.

3.5.6 Direct observation

Direct observation is where an observer collects first-hand information on the occurrence or non occurrence of targeted behaviour, the interactions between the Service User and their environment, or on other aspects of the Service User's lifestyle relevant to the assessment. This might include recording of antecedents and consequence(s), setting variables, the skill set of the Service User, or environmental factors. Direct observations may need to be broader than a narrow focus on target behaviour(s).

DVD/ video recordings or other electronic media may also provide for more detailed analysis of behaviours and interactions.

3.5.7 Systematic manipulation

The objective of this process is to systematically manipulate specific antecedents and consequences under various conditions to determine more precisely the variables that may be related to the presenting behaviours.

3.6 Aids to analysis

3.6.1 Formulation

The process of formulation seeks to lead the clinician to an understanding of the nature and function of distinct behaviour patterns within a whole-of-life context. The formulation should be based upon the information gathered during assessment, and developed in collaboration with the Service User, their family, carers, and/ or other significant stakeholders as identified in the *Service Agreement*, and driven by a solid and genuine sense of inquiry.

It encompasses consideration of links between the contextual variables outlined in ***Section 3.3 Areas of Focus*** above, in addition to other related factors such as:

- Known implications of the diagnostic profile on adaptive functioning;
- Patterns of interaction between Service User and others;
- Changes over time and patterns that may have developed;
- Systemic features;
- Family dynamics (e.g. patterns of attachment, family history, grief and loss issues etc.); and
- Personal history and patterns of prior learning.

The process of formulation encourages consideration of functionally equivalent, but appropriate, behaviours within this whole-of-life context, which might eventually replace the presenting behaviour. In order to do this it is necessary to develop and test hypotheses surrounding the function of each behaviour.

It is important that the Behaviour Support Practitioner provides a narrative description of each hypothesis, for inclusion in the assessment report. Development of a contingency diagram is a useful method of representing a formulation about the presenting problems.

An example of a ***contingency diagram*** is provided in Doyle & Owens (2006)
Refer **Section 13: *Useful Resources*** for details of the web link to this resource.

3.7 Deliverables

A draft assessment report outlining the assessment findings, the formulation and analysis, and linked recommendations is developed. This is usually presented to the Service User and significant stakeholders for feedback before being finalised.

The final ***Behaviour Assessment Report (BAR)*** should be concise. It should be remembered that this assessment Report should not be confused with the Behaviour Support ***Plan***.

A **BAR** template is provided in Doyle & Owens (2006).
Refer **Section 13: *Useful Resources*** for details of the web link to this resource.

All DADHC staff are required to adopt this template in order to provide consistency across the Department.

3.8 Tools

Useful tools used in behaviour assessment and analysis include, but are not limited to, the following:

Table 9: Tools used in behaviour assessment and analysis

Name and Source	Description
Lifestyle and Environment Review (LER)	This is a systematic review of a Service User's environment(s), their activities within these environments, routines, lifestyle, medical needs, skills and preferences.
The Triple C Checklist of Communication Competencies - Assessment Manual and Checklist *(Bloomberg, K., & West, D., 1999).*	This is designed for use with adolescents and adults with severe or multiple disabilities. Aims to determine the communicative/ cognitive level which best represents the individual's level of functioning.
Pre Verbal Communication *Schedule – PVCS (Kiernan, C. & Reid,B.,1987)*	This is a communication assessment tool designed for use with children.
Reinforcement Inventory *(IABA)*	This seeks to identify potentially reinforcing events for a Service User. Preferred reinforcers may then be integrated into the ***Behaviour Support Plan (BSP),*** or the Incident ***Prevention and Response Plan (IPRP).***
The Motivation Assessment Scale (MAS) *(Durand and Crimmins, 1988).*	This is designed to identify possible motivating factors underpinning self injurious behaviours.
Functional Assessment Observation Form *(California Department of Education Diagnostic Center, 2004)*	This is a data recording form which is designed to capture longitudinal information on behaviour, including impressions by the observer as to possible predictors, perceived function, and actual consequences.
Functional Assessment Interview Tool (FAIT) *(Butterworth et al., 1996)*	This is designed to examine variables relating to: ■ biological and medical status; ■ setting and environment; ■ communication needs; ■ social skills; ■ meaningfulness and authenticity of curricula; ■ delivery of instruction; and ■ consequences of behaviour.

Table 9: Tools used in behaviour assessment and analysis

Name and Source	Description
Functional Behavioural Assessment Interview Form *(Kansas Institute for Positive Behaviour Support)*	This tool provides for examination of: ■ targeted behaviours, social behaviours, setting events, and consequences of behaviours; ■ the degree of physical effort involved in the targeted behaviours relative to positive behaviours; ■ the frequency of reinforcement and the time delay before reinforcement; ■ the functional alternatives already known to the Service User; ■ known triggers for presenting behaviours; ■ known settings for positive behaviour; ■ the likes and dislikes of the Service User; and ■ the history and outcomes of previous interventions.
Functional Analysis Interview Form *(O'Neill, Horner, Albin, Storey & Sprague, 1990).*	This tool provides for: ■ examination of specific behaviours of concern including their topography, frequency, duration and intensity; ■ consideration of possible links between behaviours; ■ itemisation of ecological events which may affect behaviours; ■ definition of events and situations which predict an occurrence of the behaviour; ■ consideration of the function of targeted behaviours; ■ consideration of the efficiency of the targeted behaviours; ■ assessment of expressive communication skills of the Service User; ■ definition of events, actions and objects which may be perceived by the Service User as positive; ■ examination of the history of the targeted behaviour; and ■ history of previous intervention.

Table 9: Tools used in behaviour assessment and analysis

Name and Source	Description
Behavioral Assessment Evaluation Sheet *(Willis, LaVigna, and Christian).*	Completion of this assessment should provide background information including: ■ a description of the Service Use; ■ family history and living arrangements; ■ employment or day placement details; ■ identification of distinct behaviours; ■ an outline of the current support system; ■ a history of previous supports and interventions; and ■ analysis of ecological variables, antecedents and consequences. The information gathered should inform the analysis of meaning, the mediator and motivation analyses, prior to the development of a recommended support plan.
ABC charts *(See Appendix for template)*	These are simple charts which allow for quick recording of actual behavioural events in a particular ecological/ environmental context. The chart includes articulation of antecedents and consequences, without analysis, by an observer. The information recorded is subsequently analysed to determine the relationship between ecological/ environmental variables, interactions, antecedent events, consequent events and behaviour.
Star charts	Similar to ABC charts, but which capture more background information to the situation being observed. As these are used to record identified antecedent behaviour and perceived consequences, they consequently allow more 'in depth' interpretation of the recorded behaviours.
Scatter plot	This is a data analysis tool that seeks to provide a visual representation of bivariate data, where points plotted on an X-Y graph represent data units recorded. The "scatter" of data on a Scatter Plot may suggest the strength and nature of any correlation or other relationship between the variables and inform further analysis.

4 Incident prevention and response plan (IPRP)

4.1 Definition and purpose

An ***Incident Prevention and Response Plan (IPRP)*** is a written plan containing one or a number of strategies that are developed in order to:

- **prevent** the onset of a challenging behaviour,
- **intervene** in the escalation cycle of a challenging behaviour; and
- **respond** to a behaviour when it does occur so that it can be managed as quickly and safely as possible.

The function of an *IPRP* is not to produce lasting behaviour change. This latter function is addressed by means of a ***Behaviour Support Plan (BSP)***. Where a *BSP* is already in place an *IPRP* must be fully integrated with it.

4.2 Context

An *IPRP* is often required as a first step prior to the development of other elements of a *BSP* such as focussed support strategies.

An *IPRP* developed in the absence of a *Behaviour Support Plan (BSP)* may be maintained only until such time as a *BSP* is developed. Where a *BSP* is current but the *IPRP* addresses a situation beyond its scope, such as a new behaviour, then the *IPRP* may be incorporated into the *BSP*.

An *IPRP* developed as a component of a *BSP* must be clearly identified as such and fully integrated within the *BSP*. It should clearly direct carers to the *BSP* for contextual and further information on the provision of positive practices and holistic behaviour support for the individual.

It is essential that work on development of the *BSP* occurs as soon as practicable after endorsement of an *IPRP.* This must begin with assessment and analysis and follow the sequential and systematic processes of work practice elements as outlined in this manual.

4.2.1 Areas of focus

As far as is practicable the areas of focus during development of an IPRP should be the same as those required for a comprehensive behaviour assessment (see *Section 3.2: Context and Areas of Focus*). However, time constraints and the imperative for timely action may often limit the Behaviour Support Practitioner to consideration of very few areas such as issues of quality of life and the inherent risk of harm. In urgent cases where risk of harm is immediate and there is no time for even a brief assessment an ***Interim IPRP*** may be required (see *Section 4.6 Initial Response Strategies*).

4.3 Principles

An *IPRP* should give clear instructions to guide carers through strategies which aim to ***prevent*** incidents wherever possible. Attention should be paid to known triggers or setting events and the *IPRP* should give direction on minimising the effect of these.

> An example of a ***preventative*** strategy to support a Service User prone to angry outbursts in response to changes in routine might be the use of a daily or weekly routine board. This is designed to present information to the Service User in relation to a regular sequence of events and in a format appropriate for the Service User's communication needs. It is usually and interactive strategy which encourages the Service User to exercise choice within the sequence.

An *IPRP* should give clear instructions to guide carers through strategies which aim to intervene at an early stage of a behaviour cycle in order to circumvent the progress of the behaviour through that cycle. They should also give clear instructions which guide carers through strategies for implementation in response to an episode or incident, and which aim to restore order or calm as quickly and as safely as possible.

> An example of an ***intervention*** or ***response*** strategy might be redirection of the individual to a favoured activity or an established relaxation practice in the event of agitation or escalation of a behaviour cycle.

Strategies identified in an *IPRP* should be based on the principle of the ***least restrictive alternative***. In other words they should be no more restrictive or intrusive than is necessary to prevent foreseeable harm, and applied for no longer than is necessary to contain or address the risk. Any *Restricted Practice* identified in an *IPRP* must meet consent and authorisation requirements in accordance with DADHC Behaviour Support Policy.[90]

An *IPRP* may include a range of strategies applicable for a particular behaviour or cluster of behaviours. Where this is the case these should be ordered in terms of their level of intrusiveness.[91]

90 *Behaviour Support: Policy and Practice Manual, Part 1 (A) - Behaviour Support Policy.*
91 LaVigna and Willis (1997); Carr et al (1994); Willis and LaVigna (1993).

4.4 Process

The development of the *IPRP* should be a collaborative process between those who know the Service User well, those who provide support in the setting in which the strategies are to be used, and those familiar with technical aspects of any specialised supports that may be involved. The Behaviour Support Practitioner is to assume a lead role in this process.

It is essential that the collaborative process does not unduly delay the development of the *IPRP*. Where logistical difficulties arise, the Behaviour Support Practitioner should consider limiting stakeholder involvement in the process to:

a) those with the greatest knowledge of the Service User;
b) those with the most frequent direct contact with the Service User;
c) those with parental responsibility;
d) the guardian; or
e) others whose consent must be sought for the *IPRP.*

The Behaviour Support Practitioner should review the first occasion of implementation of *IPRP* strategies and consider adjustments where necessary. Reasons for any such adjustments should be recorded, including the information considered and details of any collaboration undertaken.

The *IPRP* document should then be clearly amended or updated accordingly, and earlier versions withdrawn and discarded. The amended *IPRP* should clearly show itself to be the current version. Implementers should be advised of any changes to the *IPRP* and provided with additional training if required.

As soon as practicable after completion of an *IPRP* the development or review of the *Behaviour Support Plan (BSP)* should commence. This must follow the sequential process identified in ***Section 2.1.2*** above.

4.5 Deliverables

In accordance with DADHC Policy the *IPRP* must be a written document clearly endorsed by the Behaviour Support Practitioner and significant stakeholders as appropriate. As a minimum, this endorsement must include:

- the date;
- the author's name, position, agency, location and contact details; and
- the schedule for regular review.

Sometimes concern is voiced that *IPRP* strategies can reinforce an undesirable behaviour and that the Service User might learn to repeat the behaviour in order to get attention. It should be understood that, in the context of an *IPRP*, a strategy may be appropriate where it:

- prevents a serious incident from occurring;
- helps to minimise the duration; or
- helps to minimise the impact of an incident when it occurs.

In accordance with DADHC Policy, where an *IPRP* recommends a strategy which is a ***Restricted Practice***, it must address additional monitoring and recording requirements and will require ***Restricted Practice Authorisation (RPA)*** and legal consent prior to implementation.[92] Procedures for DADHC-direct services in relation to RPA are articulated in ***Part 2 (A)*** of this manual.[93]

An IPRP must be clearly written, logically set out and easy for the reader to follow and understand. Examples are provided in ***Part 2 (B)*** of this manual.[94]

4.6 Initial response strategies

In certain circumstances an ***initial*** or ***immediate*** behavioural response strategy may be required urgently due to an identified risk of harm. This may be associated with presentation of a new challenging behaviour, as a response to a crisis, or in situations where a complete multi-element *Behaviour Support Plan (BSP)* has not yet been developed. A response strategy often needs to be developed in a very short time frame without the benefit of informed assessment or analysis. It is also often the case that there is insufficient time for development of a *Service Agreement* in these circumstances. Recommended initial response strategies must be documented in the form of an ***Interim Incident Prevention and Response Plan (Interim IPRP)***.

4.6.1 Interim IPRP

While the development of an *Interim IPRP* will require some information gathering, the importance of timeliness may require that strategies are put in place immediately in order to minimise harm. Where information on ***setting events*** and ***triggers*** is not readily available, this should not delay development of an *Interim IPRP*. Further information can be gathered once an *Interim IPRP* is in place. Consent must still be sought for an *Interim IPRP*.

An *Interim IPRP* developed under such circumstances should be regarded as provisional only and must be reviewed as soon as practicable in the context of a comprehensive behaviour assessment. On completion of a multi-element *Behaviour Support Plan (BSP)* any *Interim IPRP* strategies must be discontinued.

92 See *Behaviour Support: Policy and Practice Manual, Part 1 (A) – Behaviour Support Policy.*
93 *Behaviour Support: Policy and Practice Manual, Part 2 (A) – DADHC Procedures.*
94 *Behaviour Support: Policy and Practice Manual, Part 2 (B) – DADHC Templates.*

5 Design of Behaviour Support Plans

5.1 Definition and purpose

The ***Behaviour Support Plan (BSP)*** is a document or series of linked documents that outline strategies designed to deliver a level of behaviour support appropriate to the needs of a Service User. A *BSP* is to have a ***preventative*** focus and is usually required also to have a ***responsive*** focus. The plan should reflect the level of complexity, assessed needs, parameters and context of the *Service Agreement.*

The BSP is required to support the Service User by providing:

- Realistic, measurable and person-centred goals based on a comprehensive *Behaviour Assessment Report;*
- Positive support strategies which address these goals;
- Time lines and outcome indicators for each goal;
- Response strategies and protocols;
- Clearly stated roles and responsibilities for effective implementation of support strategies;
- Recommendations for sustainable service delivery; and
- Schedule for review.

5.2 Process

The *BSP* should draw on the findings of the ***Behaviour Assessment Report (BAR),*** and provide guidelines for structured support for each behaviour and across each domain identified in that assessment. Strategies must be clearly linked to clearly stated person-centred outcomes and should be supported by evidence as provided in the *BAR*.

It is important that the *BSP* is developed in collaboration with the Service User, their family/guardian/advocate as necessary, communication partners, and other significant stakeholders. This approach is critical to ensuring shared ownership of the plan thereby engendering sustainability and resilience of the support system.

The *BSP* should consist of multiple elements including positive practices, interaction guidelines for carers and professionals, training and skill development, systems support, response protocols and other recommendations related to person-centred outcomes.

Where the quality of life of others is directly affected by a proposed support strategy, they should be identified as a stakeholder for the purposes of collaborative process.

Table 10: Elements of a multi-element *Behaviour Support Plan (BSP).*

No.	Element	Description
1	**Ecological / environmental strategies**	These are strategies that address the contextual features related to the presentation of a challenging behaviour.
2	**Positive behaviour support practices**	These may include teaching or encouraging functionally-related or equivalent skills, coping skills, anger management etc.
3	**Focussed support strategies**	These are designed to reduce behaviour in the short term. Strategies might include: – Differential Reinforcement of Other Behaviour (DRO); – Differential Reinforcement of Alternative Behaviour (DRA or Alt+R); – Differential Reinforcement of Low rates of Behaviour (DRL); – Stimulus Control; – Stimulus Satiation; and – The use of medication in the management of challenging behaviours.
4	**Incident Prevention and Response Plan (IPRP)**	This provides: – A brief summary of positive support strategies designed to prevent the onset or escalation of identified challenging behaviours; and – Response strategies for use by carers in the event of crisis, designed to manage risk safely and effectively.

The *BSP* is generally aimed at achieving outcomes for the Service User such as:

- Beneficial change to environmental factors;
- Development of appropriate skills which are functionally equivalent to the identified challenging behaviours;
- Reduced reliance on the identified challenging behaviour(s) for enhanced performance of a particular function; and
- Appropriate, unobtrusive response and enhanced management by carers presented with challenging behaviours.

The *BSP* must be accessible to key stakeholders, in a format and/or language that is easily understood by all carers/implementers/communication partners and decision makers.

The BSP must be informed by the findings and recommendations of the current communication profile of the Service User. It is crucial that any ***Augmentative and Alternative Communication (AAC)*** strategies are embedded into the BSP as appropriate. These strategies should be determined by a Speech Pathologist and articulated in a written report. In addition, where AAC strategies are recommended, these should be very familiar to, and in daily use by, *all* carers as well as the Service User.[95]

95 Bloomberg & West, (1999), p7.

5.3 Deliverables

In accordance with DADHC Behaviour Support Policy the *BSP* must be a written document or series of linked documents clearly endorsed by the Behaviour Support Practitioner and significant stakeholders as appropriate. As a minimum, this endorsement must include:

- the date;
- the author's name, position, agency, location and contact details; and
- the schedule for regular review.

The *BSP* is separate from, and additional to, the *Behaviour Assessment Report (BAR).* Useful formats for a *BSP* are provided in the interactive resource *Understanding the Function of Behaviour: A Practice Guide,*[96] and in Part 2 (B) of this manual. The *BSP* should be integrated into the Service User's *Individual Plan*.[97]

96 Doyle and Owens (2006).

97 See *Individual Planning for Adults in Accommodation Support Services Policy (September 2005)* and *Individual Planning for Children and Young People Living in Out-of-Home Placements: Policy and Procedures (May 2007).*

6 Training of implementers

6.1 Definition and purpose

An implementer is anyone in the support system who provides direct support to the Service User and who is responsible for the implementation of documented behaviour support strategies. Implementers may include family members, carers, staff or other stakeholders.

Implementers of *BSP* or related strategies will require training and support in order to carry out the implementation effectively. Where implementation involves a number of carers, or where it is required across a number of environments and over a period of time, it is important that each individual implements the plan or strategy in the same way and with the same understanding of the importance of consistency as a guiding principle. To this end, training of implementers should focus on the importance of following a support strategy ***as written*** in order to achieve identified goals.

This training and support should seek not only to establish procedural reliability in following a written strategy, but also to ensure a shared understanding of:

- The Service User;
- The function served by the challenging behaviour;
- The rationale behind the strategy;
- The goals or outcomes linked to the strategy; and
- The role of information recording (data recording) and monitoring.

Studies show that it is equally important to train supervisors in the procedures and principles of a support plan in order that they in turn can motivate carers to implement the plan successfully.[98]

6.2 Process

Prior to the implementation of a *BSP* or related strategy, the Behaviour Support Practitioner who developed the strategy must ensure that all relevant stakeholders are trained in how to implement it correctly and consistently.

An Action Plan should be developed which:

- Identifies those in the support system who require training in implementation of the strategy or strategies;
- Identifies those in the support system who may have capacity to take on a *Train-the-Trainer* role after the *Service Request* has been closed; and
- Articulates a timetable for this training.

Training methods should include, but are not restricted to those outlined in the following Table.

98 Pokrzywinski & Powell (2003), p 107.

Table 11: Implementer training methods

Method	Description
Presentation	Face-to-face presentation of assessment findings, summary of formulation and narrative, and details of support plan including roles, responsibilities and objectives.
Team/family meetings	Regular discussion of support plan elements during staff team/family meetings, usually by the author of the support plan, for a limited period in accordance with the service agreement.
Modelling	Correct demonstration of support strategies, equipment or interaction styles to carers by Behaviour Support Practitioners, key communication partners, or other professionals. Modelling may be presented in person or through electronic media.
Train the trainer	The Behaviour Support Practitioner may provide training to key communication partners, those who will be implementing the support plan or strategies, and/or other significant stakeholders, with the expectation that they in turn will be capable of training other parties as required.
Multi-media & technology	Training may also be provided through electronic means such as DVD, video, conferencing etc. as may be appropriate.

6.2.1 Reliability measures

It is important that implementer training instils a level of confidence in the application of a support strategy as intended. Success of training in can be measured through:

Table 12: Reliability measures

Measure	Description
Verbal reliability	A respondent verbally demonstrates their knowledge of a support plan in order to identify those areas where further training or development may be required.
Procedural reliability	A carer is observed performing components of a behaviour support plan in order to identify those areas where further training or development may be required.
Role play	Carers and *Behaviour Support Practitioners* role-play particular strategies and carers receive constructive feedback and encouragement.
Supervision	Supervision of staff work practices, in relation to support plan, by line management. Line managers of staff are responsible for the consistency with which staff implement strategies.

7 Monitoring

7.1 Definition and purpose

Monitoring follows on directly from implementation training and involves ongoing checking of any implementation issues that arise. It ensures that everyone involved understands the requirements of the plan and is supported so that the strategies are implemented correctly and consistently. Monitoring should address all aspects of plan implementation.

7.2 Process

A practical system for monitoring the implementation of strategies is established collaboratively as part of the support plan and all parties in the support system should be trained in maintaining that system. Implementation of a support plan or strategy should begin with a trial period of around 2-3 weeks where:

- any issues may be closely scrutinised by the Behaviour Support Practitioner and remedial action taken to ensure that the Service User is supported consistently in the way intended by the written plan; and
- the capacity of the support system to monitor and address implementation issues in accordance with the written support plan or strategy in long term is enhanced.

After the trial period, monitoring should continue in accordance with the written support plan or strategy. Long-term responsibility for monitoring implementation after closure of a *Service Request* should be addressed in the *Service Agreement.*

Monitoring should take into consideration any contextual difficulties, practical constraints, resource limitations and other significant factors that impact on implementation. It may involve procedural reliability checks to support implementers but should also promote sharing of information and feedback through regular forums such as family/ team meetings.

8 Review

8.1 Definition and purpose

Review involves the collection of information on the effectiveness of the various strategies that are being used to address the behaviours of concern. The aim of review is to provide data in a meaningful form that relates back to the purpose of the intervention, and is able to extend our understanding and capacity to support a person who displays challenging behaviour. Review should also prompt timely change to the support plan where evidence suggests that this is warranted.

8.2 Process

All data related to the support plan or strategy is evaluated in collaboration with the parties identified in the *Service Agreement*, but with the Behaviour Support Practitioner taking a lead role. As a result of evaluation, the effectiveness and appropriateness of the plan or strategy may be validated. In other cases the evaluation may require that amendments be made to the plan or strategy.

The method selected to review a support plan or strategy will depend on what outcomes are selected for evaluation. Generally the method should include a comparison to a baseline conditions measurement. The same method of measuring that was used during assessment is to be used during implementation. This provides a benchmark against which to compare data sets.

Reviews should include:

- analysis of data, including statistical analysis;
- examination of the relationship between the data and the presenting issues;
- examination of the relationship between the data and the objectives/ goals;
- consideration of the impact of therapeutic effects and side effects of intervention;
- consideration of the generalisation and durability of effects of the supports or intervention;
- graphing of quantitative data, and presentation of findings; and
- fade-out strategies where appropriate.

Reviews are conducted according to the schedule outlined in the support plan or written strategy. Initially the time period between reviews is to be no more than one or two weeks depending on the nature of the plan. The review should measure a plan's usefulness, desirability, practicality, appropriateness, adaptability, and its social and situational aspects. Once it is established that the plan or strategy is being implemented consistently and that no significant alteration is needed the review period may be lengthened.

9 Closure

Closure marks the completion stage of the specialist behaviour support service identified in the *Service Agreement.* The direct involvement of the Behaviour Support Practitioner ceases at this stage, while management of the Service User's support system continues in accordance with the written support plan or strategy and the *Individual Plan.*

Closure must be clearly and professionally communicated to the originator of the request for service/ referral and other significant stakeholders.

10 Documentation and administration

For DADHC staff, minimum documentation and administration requirements for provision of behaviour support are outlined in ***Part 2 (A)*** of this manual.[99] These requirements are also recommended for funded organisations.

10.1 Endorsement by Behaviour Support Practitioner

All assessment work, written reports, support plans and other interventions must be in accordance with these work practice requirements and be clearly documented and endorsed by the Behaviour Support Practitioner responsible for provision of the service. As a minimum, this endorsement must include:

- the date;
- the author's name, position, agency, location and contact details; and
- the schedule for regular review.

Similarly, behaviour support practices may be altered or reviewed only with endorsement by a Behaviour Support Practitioner.

10.2 Progress notes

All Behaviour Support Practitioners should maintain *Progress Notes* which accurately and professionally record all communications relating to work being undertaken in accordance with a *Service Agreement*.

Progress Notes should be updated after each occasion of service or contact, and be accessible to line management. Service Providers should maintain the confidentiality of *Progress Notes* in accordance with organisational policy.[100] For DADHC staff, Progress Notes also constitute records under the *NSW State Records Act (1998)*.

Progress Notes should identify issues of concern in the work process as well as particulars of the matter being recorded. *Progress Notes* should include a record of conversations and contact with the Service User about the issue of concern. Care should be taken to ensure a professional nature to entries on progress notes, including those which incorporate emails or email attachments.

99 *Behaviour Support: Policy and Practice manual, Part 2 (A) – DADHC Procedures.*
100 For DADHC staff, this includes *Records Management Policy Document (May 2002); Privacy, Dignity and Confidentiality (October 1996).*

11 Peer review and supervision

The twin processes of work practice supervision and peer review seek to maintain a culture of good practice in behaviour support services.

11.1 Peer review

Peer review is a process through which relevant information and hypotheses are shared with other Behaviour Support Practitioners with a view to obtaining informed and constructive feedback prior to implementation of a plan or strategy.

11.2 Supervision

Work practice supervision should be provided to all Behaviour Support Practitioners to ensure that work practices are consistent with Departmental policies and guidelines. It should ensure that there is adherence to work practice standards, that relevant support and professional development opportunities are provided, and that difficult or complex issues can be explored jointly by the Behaviour Support Practitioner and their supervisor in a supportive environment. Regular work practice supervision should be provided by a Behaviour Support Practitioner with the appropriate skills and experience.

Work practice supervision should be provided to a Behaviour Support Practitioner as part of, or in addition to, any other discipline specific supervision (e.g. psychological, speech pathology). Elements that should be addressed in work practice supervision include the following:

- Prioritisation, allocation and caseload management issues e.g. caseload planning;
- Work practice issues e.g. interpretation or analysis, reasoning;
- Practice standards; and
- Professional development and support e.g. availability of, and access to, internal and external training courses, seminars, conferences etc.

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13 Useful resources

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14 Supporting policies, procedures, guidelines and legislation

- *Aboriginal Policy Framework (July 2005);*
- *Abuse and Neglect Policy and Procedures (May 2007);*
- *Anti-Discrimination Act (1977);*
- *Child protection: Responding to Allegations Against Employees (June 2008);*
- *Children and Young Persons (Care and Protection) Act (1998);*
- *Children and Young Persons (Care and Protection) Regulation (2000);*
- *Children's Standards in Action (2004);*
- *Client Risk Policy and Procedures (March 2008);*
- *Code of Conduct and Ethics (2004);*
- *Consulting Effectively with Aboriginal People and Communities (July 2005);*
- *Decision Making and Consent (July 2008);*
- *Dignity of Risk and Duty of Care (1996);*
- *Disability Services Act (1993);*
- *Feedback and Complaint Handling: Principles and Guidelines (May 2005);*
- *Guardianship Act (1987);*
- *Guardianship Regulations (2005);*
- *Guidelines for the development, implementation and review of communication support systems for persons with an intellectual disability and complex communication needs (October 2002);*
- *Health Care Policy and Procedures (March 2007);*
- *Incident Management Policy (June 2006, amended January 2007);*
- *Individual Planning for Adults in Accommodation Support Services (Sept 2005);*
- *Individual Planning for Children and Young People Living in Out-of-home Placements: Policy and Procedures (May 2007);*
- *Intake Policy (December 2001);*
- *Interagency Guidelines for Child Protection Intervention (DoCS 2006)*
- *Living in the Community: Putting Children First (July 2002);*
- *Maintaining Family Relationships Policy (1996);*
- *Managing Risks and Incidents in the Workplace (January 2003);*
- *Medication Policy and Procedures (March 2008);*
- *Memorandum of Understanding between the Department of Community Services and the NSW Department of Ageing, Disability and Home Care on Children and Young Persons with a Disability (November 2003);*
- *Mental Health Act (2007);*
- *NSW Interagency Guidelines for Child Protection Intervention (DoCS 2006)*
- *NSW Out-of-Home Care Standards (NSW Office of the Children's Guardian);*
- *Occupational Health and Safety Act (2000);*
- *Occupational Health and Safety Policy (September 2004);*
- *Occupational Health and Safety Regulation (2001);*
- *Occupational Health and Safety Risk Management Policy (September 2004);*
- *Orientation to DADHC Disability Services Respite Services (August 2002);*

- *Out-of-Home Care Standards (NSW Office of the Children's Guardian);*
- *Policy Framework: Providing behaviour support services for people with an intellectual disability (June 2006, Reviewed March 2008);*
- *Prioritisation and Allocation Policy (August 2002);*
- *Privacy, Dignity and Confidentiality (October 1996);*
- *Responding to Risk of Harm to Children and Young People (March 2007);*
- *Standards in Action Manual (1998);*
- *Strategy to improve services for people from culturally diverse communities: DADHC CALD Strategy 2005-08 (December 2005).*

Appendix 1.1
Glossary of terms

Alphabetical table of terms used and their meaning within the context of the Behaviour Support: Policy and Practice Manual.

Term	Meaning
AAC	See Augmentative and Alternative Communication Systems.
Abuse	Abuse may take many forms but includes: ■ Threatened or actual physical, sexual or verbal assault; ■ Wrongful imprisonment; ■ Bullying, harassment, threatened retribution for disclosure of any potential or actual abusive or neglectful practice or strategy or situation; and ■ Taking advantage of legal or financial situations to the detriment of the Service User. Such actions are in breach of Duty of Care and are Prohibited Practices.
Assault	Any act which intentionally or recklessly causes another person to fear immediate and unlawful violence. No physical touching need be involved – a perceived and real threat is sufficient. Any actual striking or use of force against the person of the victim is technically a ***battery***. Within New South Wales the offence of assault now also covers battery. Assault is both a ***tort*** (a *civil wrongdoing)* and a ***crime***. A person guilty of an assault can be sued by the victim in the civil courts for damages. Any behaviour support strategy involving assault is prohibited by DADHC.
Augmentative and Alternative Communication (AAC) systems	A set of procedures and practices which enable a Service User and others to engage in meaningful two-way communication. It may involve verbal, visual, tactile or other sensory protocols and will be designed to augment existing skills in accordance with assessed communication competencies.
Aversion	An unpleasant stimulus (eg an unwanted cold bath, excessive chilli powder on food, liquid sprayed into a person's face etc.). Aversion is often used with the intention of manipulating behaviour. Such practices are prohibited.
Behaviour Assessment Report (BAR)	A written report prepared by a Behaviour Support Practitioner which provides evidence-based analysis of targeted behaviour(s).
Behaviour Support Plan (BSP)	A document or a series of linked documents that outline strategies designed to deliver a level of behaviour support appropriate to the needs of an individual Service User. A BSP is to have a *preventative* focus and is usually required also to have a responsive focus. The plan should include multiple elements, reflecting the level of complexity, assessed needs, parameters and context of the service agreement. A BSP may also be known as a *Behaviour Management Plan* or *Behaviour Intervention Plan*.

Term	Meaning
Behaviour Support Practitioner	Ideally, behaviour support and intervention services either in a funded service or a service provided by the Department will be provided by Behaviour Support Practitioners with tertiary qualifications in Psychology, Special Education, Speech Pathology, Social Work or other relevant discipline, and / or training and experience in the provision of behavioural support and intervention. Those engaged in the provision of a behaviour support service must meet minimum work practice requirements as outlined in this manual.
Behaviour support service	A behaviour support service is a service delivered by a Service Provider, funded by DADHC, and which specifically addresses the behaviour support needs of a Service User or service system in accordance with this Policy.
Capacity	A person has capacity to consent if they are able to demonstrate an understanding of the general nature and effect of a particular decision or action, and can communicate an intention to consent (or to refuse consent) to the decision or action. A person's capacity to make a particular decision should be doubted only where there is a factual basis to doubt it. It should not be assumed that a person lacks capacity just because he or she has a particular disability. A person may have the capacity to exercise privacy rights even if they lack the capacity to make other important life decisions.[101] See also Consent.
Carers	Family members, parents, partners, significant others, friends or neighbours who provide support or care to the Service User on an unpaid basis and who are identified within the service system, as well as paid service staff.
Challenging behaviour	Challenging behaviour may be defined as: *"Behaviour…of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion."* [102] Any behaviour displayed by a person which is considered challenging or inappropriate by others, or which gives rise to reasonable concern, may be considered as challenging. However, the use of the term challenging should be understood in terms of the social context in which behaviour occurs, rather than a symptom of individual pathology.[103]
Chemical restraint	The abuse of medication to control or influence behaviour, mood or level of arousal.

101 Adapted from *Best Practice Guide: Privacy and people with decision-making disabilities, Privacy NSW, February 2004.*
102 Banks et al, 2007, p14.
103 Emerson, 1995, p5.

Term	Meaning
Children and young persons	Under the *NSW Child and Young Persons Care and Protection Act (1998)*, a ***Child*** is defined as a person under the age of sixteen (16) years. A ***Young Person*** is defined as a person who is aged between sixteen (16) and eighteen (18) years.
Comprehensive Assessment	A comprehensive assessment is a thorough sweep of the presenting issues in the context of the person and their environments, resulting in useful recommendations or in prompt delivery of an appropriate service. The emphasis is on being *thorough* rather than *in-depth* or intensive. A comprehensive assessment can be both thorough and brief.
Consent	Generally the term *Consent* refers to permission given by a Service User with capacity to do so, or person(s) with legal authority to do so on behalf of the Service User. For consent to be valid it must be voluntary, informed, specific and current. A person must be free to exercise genuine choice about whether or not to give or withhold consent but it is only genuine if the person giving consent has the capacity and authority to do so. Consent also has specific meaning under the *NSW Guardianship Act (1987)*. See: www.lawlink.nsw.gov.au/opg See also Capacity above.
Containment	Containment is a practice used in order to support a person to regain personal control, whereby their access to events or conditions believed to maintain a particular behaviour is prevented, or the environment is manipulated so as to reduce stimuli. The person is supported throughout this strategy which should conclude when personal control is re-established.
Crisis Response	A response in situations where there is a clear and immediate risk of harm and where immediate intervention is considered necessary under the service's *Duty of Care* in order to manage the risk. There may be no Behaviour Support Plan (BSP) in place.
Critical Incident	An unexpected or unplanned action or event which results in or has the potential to result in actual harm to persons or damage to property.[104]

104 See also *Incident Management Policy (2006).*

Term	Meaning
Duty of Care	In relation to behaviour support, *Duty of Care* is the obligation incumbent on disability workers and supervisors in their regular professional dealings with Service Users to ensure that all reasonable measures are taken to prevent harm which may be reasonably foreseen. The standard of care appropriate for any given situation may depend on the level of a person's skill. For example, the standard of proficiency expected from a qualified nurse will be higher than that required from a worker without special skills. *Negligence* is a failure to exercise this Duty of Care.
Dignity of Risk	The principle that everyday risks are a part of life and the freedom to make choices, take risks and experience the consequences, good and bad, contributes to personal dignity.
Evidence-based Practice	This refers to decision-making and the determination of practice based on research and analysis of the available evidence.
Exclusionary Time Out	Planned and documented behaviour support strategy involving the denial of access to reinforcement by forcibly moving a Service User from one setting to another (e.g. room, corridor), where they are unable to leave for a period of time.
Guardian	A guardian is a person who is appointed to make decisions on behalf of a family member or friend. A guardian can be an enduring guardian or a guardian appointed by the NSW Guardianship Tribunal. See: www.lawlink.nsw.gov.au/opg
Guardianship Tribunal	The ***Guardianship Tribunal*** is a statutory body established under the *NSW Guardianship Act (1987).* Its function is to consider applications for guardianship of persons 16 years and over who cannot make their own major life decisions.
Implementer	A person or persons in the support system who is identified as responsible for the implementation of documented behaviour support strategies. Implementers may include family members, carers, staff or other stakeholders.
Incident Prevention and Response Plan (IPRP)	A written plan containing one or a number of strategies that have been developed in order to: ■ prevent the onset of a challenging behaviour; ■ intervene in the escalation cycle of a challenging behaviour; and ■ Respond to such behaviour when it does occur so that it can be managed as quickly and safely as possible.

Term	Meaning
Individual Plan	This is a document developed through the Individual Planning process. It reviews the service requirements and personal goals of a Service User and monitors related outcomes over time.
IPRP	See *Incident Prevention and Response Plan* above.
Least Intrusive Alternative	See *Least restrictive alternative* below.
Least Restrictive Alternative	A practice or intervention which is no more restrictive or intrusive than is necessary to prevent foreseeable harm to the Service User, and applied no longer than is necessary to manage an identified risk.
Negligence	***Negligence*** is a failure to exercise reasonable care and skill to avoid reasonably foreseeable harm under particular circumstances from someone who owes a Duty of Care to another. See also *Duty of Care* above.
OCCG	See *Office for Children - the Children's Guardian* below.
Office for Children - the Children's Guardian (OCCG)	The ***NSW Office for Children - the Children's Guardian (OCCG)*** is a government department set up under the *NSW Children and Young Persons (Care and Protection) Act (1998)* to promote the best interests and rights of children (under 16 years) and young people (16 - 18 years) in out-of-home care in NSW. The OCCG is an independent organisation that reports directly to the Minister for Community Services.
Over-correction	A response which is disproportionate to an event, i.e. beyond that which may be necessary to restore a disrupted situation to its original condition before the event occurred. This might include requiring a person to clean an entire dining room where they have deliberately tipped a meal on the floor, or insisting that they practise arm exercises where they have been biting their fingers inappropriately.
Person-centred	A person-centred approach is one which seeks to gather information about a Service User's lifestyle, skills, relationships, preferences, aspirations, and other significant characteristics, in order to provide a holistic framework in which appropriate, respectful and meaningful behaviour supports may be developed.
Person with parental responsibility	There is provision under the *NSW Children and Young Persons (Care and Protection) Act 1998* to enable the Department of Community Services to apply to the Children's Court to remove a child from the family home and place them under the parental responsibility of another suitable person or of the Minister for Community Services.

Term	Meaning
Person responsible	This is a person with legal authority to make decisions about medical or dental treatment for a person who lacks capacity to give informed consent. The "person responsible' is defined in the *NSW Guardianship Act 1987*. The person responsible is not the same as the next of kin. See also: www.lawlink.nsw.gov.au/opg
Physical restraint	The restriction of a person's movement or behaviour by the use of a device or physical force.
Positive approaches	An approach to behaviour support which aims to provide a respectful and sensitive environment in which the Service User is empowered to achieve and maintain their individual lifestyle goals. Positive approaches to behaviour support are non-aversive, person-centred, solution-focussed, holistic and skill-based.
Positive practices	Practices which are consistent with the principles of the positive approach.
prn	A term used generally in the administration of medication, which is an abbreviation of the Latin term "*Pro re nata"* meaning "*as required*".
Progress Notes	***Progress Notes*** accurately and professionally record all communications relating to work being undertaken in accordance with a *Service Agreement.* They are maintained by *Behaviour Support Practitioners* and identify issues of concern in the work process as well as particulars of the matter being recorded. *Progress Notes* include relevant emails or email attachments.
Prohibited Practice	Practices which interfere with basic human rights, are unlawful and unethical in nature, and are incompatible with the objects and principles of the *NSW Disability Services Act (1993).*
Psychoactive Medication	Psychoactive (or psychotropic) medications have, as their primary function, effects that influence cognitive ability (i.e. effects on thought processes, emotions and/or perception) and behaviour. In other words, psychoactive (psychotropic) medications are those medications which exert an effect upon the mind, and are capable of modifying mental activity.
Psychotropic Medication	See *psychoactive medication* above.
Quality Feedback Tool (QFT)	A tool designed to assist in the evaluation of work practices in the provision of behaviour support services to a Service User against key performance indicators. It is part of a broader sampling process to test quality assurance in relation to Policy and work practice requirements. It is recommended that this audit be conducted for multiple *Service Requests* in order to establish standard quality levels. ***Refer Appendix 1.2.***

Term	Meaning
Respite	A short-term, time-limited break for families and other voluntary carers of people with intellectual disability, to assist in supporting and maintaining the primary carer's relationship while providing a positive experience for the person with the disability.
Response Cost	This is the withholding from a person of positively valued items or activities in response to a particular behaviour or set of behaviours (e.g. access to a computer game or TV program). A response cost strategy is classified as a *Restricted Practice.*
Restricted Access	The use of physical barriers such as locks or padlocks, the use of increased supervision, or the imposition of enforceable limits or boundaries in an environment *beyond normally accepted community practices* (e.g. keeping a wardrobe door or front door locked) in order to limit a person's access to items, activities or experiences, with the intention of manipulating a particular behaviour or managing risk.
Restricted Practice	A distinct number of ***restrictive*** strategies also have significant additional safeguards placed upon their use by DADHC. Such strategies are classified as ***Restricted Practices***. The use of a Restricted Practice must be informed by strict written guidelines which provide clear conditions and limitations on their use. Implementation of a restricted Practice requires both: (a) legal consent[105]; and (b) authorisation by an internal *Restricted Practice Authorisation Panel (RPAP)*.
Restricted Practice Authorisation (RPA)	In addition to Consent, any recommendation for the use of a restricted practice requires formal authorisation by a *Restricted Practice Authorisation Panel (RPAP)* internally governed by the Service Provider. This is to ensure that the use of any Restricted Practice is clinically justifiable and can be safely implemented within the context of Policy and Practice requirements. This authorisation is formal, conditional and time-limited and is known as *Restricted Practice Authorisation (RPA).*
Restricted Practice Authorisation Panel (RPAP)	Within DADHC services the use of a Restricted Practice must be authorised and monitored by the *Regional Restricted Practice Authorisation Panel (RPAP)* in accordance with Policy and Practice requirements.
Restrictive Practice	Any practice or strategy which is inherently restrictive, impacting on the rights, freedom or dignity of a Service User.

105 Refer to the NSW Guardianship Tribunal's position statement: *Behaviour Intervention and Support in Applications Relating to a Person with a Disability; and the NSW Children and Young Persons (Care and Protection) Act (1998)* as appropriate.

Term	Meaning
Review of Service Request (RSR)	Within DADHC-direct services a *Review of Service Request (RSR)* is a team response to a *Service Request*, completed prior to allocation. Similar to a *triage* process, the *RSR* allows a Behaviour Support Practitioner to establish a snapshot of the Service User within the context of the existing support system, confirm the presenting issues, clarify the nature of the request, and consider the likely scope of service. This in turn allows a *Service Request* to be effectively prioritised relative to other *Service Requests* awaiting allocation.
Review of Service Request (RSR) Report	A written Report completed by the Behaviour Support Practitioner who has completed the Review of Service Request, prior to allocation of a Service Request for action. An RSR Report Template and Guide are located in ***Part 2 (B)*** of the manual.
Seclusion	The placement of a person in isolation for an unspecified time in an environment from which they cannot leave, usually as a crisis response.
Service	A distinct and time-limited piece of work conducted by a *Behaviour Support Practitioner* within the scope of DADHC Policy and practice requirements, clearly identified and articulated in a written *Service Agreement*.
Service Agreement	A ***Service Agreement*** is a document which identifies goals/ objectives in relation to a particular service, clarifies tasks, sets out roles and responsibilities, and time frames, and which is endorsed by the person/s requesting the service and person/s providing the service. A *Service Agreement* records a shared understanding in relation to the scope of service being provided.
Service Partner	The ***Service Partner*** is the party identified in the Service Agreement who will be most closely engaged with the Service Provider in relation to the scope of service set down in the *Service Agreement*.
Service Provider	The ***Service Provider*** is the funded organisation, team or unit responding to the *Service Request*.
Service Request	In the context of this manual a Service Request is a formal request for service directed to a behaviour support *Service Provider*.
Service Request Register	A record maintained by the Service Provider which lists all Service Requests received but not yet allocated to a Behaviour Support Practitioner for service, those currently allocated, and those completed. For DADHC-direct services this is a function of the *Client Information System (CIS).*
Service User	The ***Service User*** (or client) is the individual diagnosed with an intellectual disability, on whose behalf the *Service Partner* is delivering support.

Term	Meaning
Stakeholder	A person identified within the support system of the Service User.
Support plan	In the context of this *Behaviour Support: Policy and Practice Manual,* the term "support plan" includes any documented plan developed by a behaviour support service or for purposes of delivering a behaviour support service. See also *Behaviour Support Plan (BSP)* and *Incident Prevention and Response Plan (IPRP).*
Supported Accommodation	Community-based accommodation with person-centred daily living support which is based on the assessed needs of the individual Service User who no longer lives with his/her family and is unable to live independently.
Support System	The extended system of interactions in a Service User's life including all those which impact on their quality of life and support.
Time Out	See *Exclusionary Time Out*.
Work Practice Quality Feedback Tool (QFT)	See *Quality Feedback Tool.*
Work Practice	Pertaining to work practices of the Behaviour Support Practitioner in relation to delivery of a behaviour support service to an individual, their families, carers and/ or to their support system.

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Appendix 1.2
Work Practice
Quality Feedback Tool (QFT)

1.1 Overview

This Quality Feedback Tool (QFT) is designed to assist in the evaluation of work practices in the provision of behaviour support and intervention services to a Service User against key performance indicators. It is part of a broader sampling process to test quality assurance in relation to Policy and work practice requirements as set down in the ***Policy and Practice Manual***.[106] It is recommended that this audit be conducted for multiple *Service Requests* in order to establish standard quality levels.

The Quality Feedback Tool (QFT) is not designed as a performance management or managerial tool. It is designed for use by all Service Providers, whether DADHC-direct or DADHC-funded, to guide work practice.

Each section of this QFT is cross-referenced with relevant sections of the Policy and Practice Manual, which provides detail in relation to specific practice elements, definitions of terms, and useful reference sources. The QFT should be completed with close reference to the Policy and Practice Manual.

Information contained in this document is **confidential** and should be managed in accordance with DADHC privacy, dignity and confidentiality requirements.[107]

This Quality Feedback Tool (QFT) provides two measures of work practice quality assurance:

1. A standardised **score** relating to inclusion of required work practice elements, and;
2. Brief descriptive summaries in relation to selected work practice elements.

Neither of these two measures should be considered in isolation.

1.2 Instructions

To complete the QFT and arrive at an overall score:

1. **Complete all applicable sections** in the QFT by **circling either YES** or **NO** as appropriate in response to each question.
2. Note that not all sections will be applicable to all Service Requests.
3. As you complete each section, **add all YES responses together** to arrive at an **actual score**. (score YES = 1; NO = 0).
4. Write the actual score in the box provided in each section.
5. When you have completed all applicable sections in the same way, follow the instructions in the **summary section** at the end of the QFT.
6. Be sure to transfer the ***overall standardised score*** from the summary section at the end of the QFT to the box provided on the cover page.

106 *Behaviour Support: Policy and Practice Manual, Part 1 (B) – Work Practice.*
107 *Privacy, Dignity and Confidentiality (October 1996).*

Work Practice
Quality Feedback Tool (QFT)

Service Provider details

Name

Address

Service User details

Name

Address

Service Request (SR)

Origin of SR

Position/ Role of originator of SR

Service Provider/ region/ team

Location & contact details

Date lodged

Brief description of service (s) requested

Identifier details (eligible person with intellectual disability)

Date of Individual Plan in which the Service Request for behaviour support is identified as a goal.

Name of Service User on Individual Plan

CIS no.

Address

Date of birth | Age in years / months

Overall standardised score

To be filled in on completion of audit.
See ***calculation table*** at the end of this document.

%

Behaviour Support Practitioner (Primary)

Name

Position

Service Provider/ region/ team

Location & contact details

Date SR allocated

Behaviour Support Specialist (Secondary)

Name

Position

Service Provider/ region/ team

Location & contact details

Date SR allocated

Senior Clinical Consultant (Tertiary)

Name

Position

Service Provider/ region/ team

Location & contact details

Date SR allocated

Person(s) completing QFT

Name

Position

Service Provider/ region/ team

Location & contact details

Date QFT completed

Section 2 Preliminary work

Refer ***Behaviour Support: Policy and Practice Manual Part 1 (B)*** Section 2.[108]

Is there documentary evidence that the following issues have been formally addressed by a Behaviour Support Practitioner in relation to the Service Request (SR) prior to commencement of an assessment?[120]

	Scoping task	Response		Comment
2.1	Clarification of the purpose of the Service Request prior to allocation.	Yes	No	
2.2	Clarification of the specific issues behind the Service Request being made, prior to allocation.	Yes	No	
2.3	Confirmation of the currency and usefulness of existing supports, prior to allocation.	Yes	No	
2.4	Clarification of stakeholder expectations after allocation.	Yes	No	
2.5	Endorsement of Service Agreement.	Yes	No	

Possible score 5

Section 2 **Actual score**

108 *Behaviour Support: Policy and Practice Manual, Part 1 (B), Section 2.*

Section 3 Assessment and analysis

Refer ***Behaviour Support: Policy and Practice Manual Part 1 (B)*** Section 3.[109]

Applicable where a behaviour assessment is required by the Service Agreement.

Date of Behaviour Assessment Report (BAR)		Date of most recent review of BAR	

Does the Behaviour Assessment Report (BAR) address the following issues?

	Scoping task	Response		Comment
3.1	The conditions under which an identified behaviour does or does not occur.	Yes	No	
3.2	The complexities of the support needs of the Service User across environmental contexts.	Yes	No	
3.3	The function of the behaviour for the Service User across environmental contexts.	Yes	No	
3.4	The actions that are likely to improve the quality and effectiveness of the behaviour support system.	Yes	No	

109 *Behaviour Support: Policy and Practice Manual, Part 1 (B), Section 2.*

Is there documentary evidence provided in the Behaviour Assessment Report (BAR) that the behaviour assessment has considered the following contextual variables?

	Variable	Response		Comment
				Note key elements of the assessment findings for each variable. Note any outstanding obstacles associated with the assessment.
3.5	The Service User's **quality of life**.	Yes	No	
3.6	The inherent **risks** of harm (Assessment of Risk is further addressed below).	Yes	No	
3.7	The **support system**, its characteristics and overall resilience.	Yes	No	
3.8	Relevant **diagnoses**, genetic, developmental and cognitive factors.	Yes	No	
3.9	**Medical** and **dental** factors.	Yes	No	
3.10	**Mental health** factors.	Yes	No	
3.11	Expressive and receptive **communication skills** of the ***Service User***.	Yes	No	
3.12	Expressive and receptive **communication skills** of ***carers*** and significant others.	Yes	No	
3.13	The presence of characteristics associated with **autism**.	Yes	No	
3.14	**Mobility** and **sensory** factors.	Yes	No	
3.15	The many **environments** in which the person interacts with others.	Yes	No	
3.16	The **family context** and **family expectations** of service provision.	Yes	No	
3.17	**Cultural** and **linguistic** factors.	Yes	No	
3.18	Relationships and the wider **social network** of the person.	Yes	No	
3.19	**Life skills**, **experiences** and **preferences**.	Yes	No	
3.20	**History of previous contact** with support services (history and outcomes).	Yes	No	

Indicate which of the following techniques were used in the process of behaviour assessment.

	Technique	Response		Comment
3.21	Orientation	Yes	No	
3.22	Review of records including file review	Yes	No	
3.23	Data collection	Yes	No	
3.24	Structured interviews	Yes	No	
3.25	Interdisciplinary collaboration	Yes	No	
3.26	Direct observation	Yes	No	
3.27	Systematic manipulation	Yes	No	

Aids to analysis

	Element	Response		Comment
3.28	Has a formulation been included in the *Behaviour Assessment Report (BAR)* as either a *Contingency Diagram* or a *Narrative*?	Yes	No	
3.29	Where a formulation is evident in the *BAR*, does it encompass consideration of links between contextual variables outlined in *Section 3*?	Yes	No	

Assessment of risk

	Element	Response		Comment
3.30	Are appropriate *risk management strategies* in place to address risks to the *Service User* and to *others*?	Yes	No	List **current** strategies:
				List any **required** strategies not yet in place:
3.31	Are appropriate *risk management strategies* in place to control risks to the *service staff* in relation to behaviour support for this Service User in accordance with *OH&S* requirements?	Yes	No	List **current** strategies:
				List any **required** strategies not yet in place:

Possible score 31

Section 3 **Actual score**

Section 4 Incident Prevention and Response Plan

Refer ***Behaviour Support: Policy and Practice Manual Part 1 (B)*** Section 4.[110]

Applicable where interim prevention and response strategies are required by the Service Agreement.

Aids to analysis

	Element	Response		Comment
4.1	Have interim prevention and response strategies been recommended for the support of the ***Service User***?	Yes	No	
4.2	Are these strategies documented in an *Incident Prevention and Response Plan (IPRP)?*	Yes	No	
4.3	Does this *IPRP* constitute an 'Interim' *IPRP*?	Yes	No	
4.4	Has the *IPRP* been fully integrated into the *Service User's Behaviour Support Plan (BSP)*?	Yes	No	

Please complete the following:

Author of *IPRP*

Position

Service Provider/ region/ team

Location & contact details

Date of *IPRP*

110 *Behaviour Support: Policy and Practice Manual, Part 1 (B), Section 4.*

Does the *IPRP* provide the following?

	Element	Response		Comment
4.5	Clear description of any behaviour cycle including stages of escalation.	Yes	No	
4.6	Clear identification of all known triggers or setting events.	Yes	No	
4.7	Clear instructions to guide carers through strategies which aim to ***prevent*** episodes of challenging behaviour wherever possible.	Yes	No	
4.8	Clear instructions to guide carers through strategies for ***intervention*** at an early stage of the behaviour cycle in order to circumvent an episode of challenging behaviour.	Yes	No	
4.9	Clear instructions which guide carers through strategies for implementation in ***response*** to an episode of challenging behaviour, and which aim to restore order or calm as quickly and as safely as possible.	Yes	No	

Possible score 9

Section 4 **Actual score**

Section 5 Design of Behaviour Support Plan

Refer ***Behaviour Support: Policy and Practice Manual Part 1 (B)*** Section 5.[111]

Applicable where a *Behaviour Support Plan (BSP)* is required by the Service Agreement.

Please complete the following table:

Name of Behaviour Support Practitioner who developed the Plan:
Position:
Service Provider/ region/ team:
Location & contact details:
Date of plan:

Indicate whether or not there is evidence that the *Behaviour Support Plan (BSP)* includes the following components:

	Component	Response		Comment
5.1	Realistic, measurable and person-centred goals based on a comprehensive *Behaviour Assessment Report*.	Yes	No	
5.2	Positive support strategies which address these goals.	Yes	No	
5.3	Time lines and outcome indicators for each goal.	Yes	No	
5.4	Response strategies and protocols.	Yes	No	
5.5	Clearly stated roles and responsibilities for effective implementation of support strategies.	Yes	No	
5.6	Recommendations for sustainable service delivery.	Yes	No	
5.7	Schedule for review.	Yes	No	

111 *Behaviour Support: Policy and Practice Manual, Part 1 (B), Section 5.*

Indicate whether or not there is evidence that the *Behaviour Support Plan (BSP)*:

	Component	Response		Comment
5.8	Clearly draws on the findings of the *Behaviour Assessment Report*?	Yes	No	
5.9	Provides guidelines to structured support for **each behaviour** identified in that assessment?	Yes	No	
5.10	Provides guidelines to structured support across **each domain** identified in that assessment?	Yes	No	
5.11	Includes strategies linked to clearly identified person-centred **outcomes**?	Yes	No	
5.12	Includes strategies supported by **evidence** provided in the *Behaviour Assessment Report*?	Yes	No	
5.13	Has been developed in collaboration with the Service User?	Yes	No	
5.14	Has the *Behaviour Support Plan (BSP)* been developed in collaboration with the Service User's family/ guardian or advocate?	Yes	No	
5.15	Has been developed in collaboration with the Service User's communication partners?	Yes	No	
5.16	Has been developed in collaboration with the *other* significant stakeholders?	Yes	No	

Which of the following elements are included in the *Behaviour Support Plan (BSP)*?

	Element	Response		Comment
5.17	Incident Prevention and Response Plan (*IPRP*)	Yes	No	
5.18	Ecological and environmental strategies	Yes	No	
5.19	Positive behaviour support practices	Yes	No	
5.20	Focused support strategies	Yes	No	

Augmentative and alternative communication strategies

	Component	Response		Comment
5.21	Is the BSP informed by a Speech Pathologist's written communication assessment report?	Yes	No	
5.22	Have ***Augmentative and Alternative Communication (AAC)*** strategies been embedded into the *BSP*?	Yes	No	
5.23	Are the AAC strategies being used by *all* Carers, as well as the individual for whom they were developed?	Yes	No	

Please provide:

Name of Speech Pathologist
Position
Service Provider/ region/ team
Location & contact details
Date of Communication Assessment Report

Possible score	23
Section 5 **Actual score**	

Section 6 Training of implementers

Refer ***Behaviour Support: Policy and Practice Manual Part 1 (B)*** Section 6.[112]

Applicable where a Behaviour Support Plan (BSP) is required by the Service Agreement (SA).

	Variable	Response		Comment
6.1	Has implementer trainer been established as part of the support plan?	Yes	No	
6.2	Have **all** identified stakeholders been trained to implement the support plan?	Yes	No	

Please list the stakeholders who have been trained in implementing the support plan:

Name	Relationship/role	Date trained	Comments

Indicate which of the following training methods have been used in implementer training:

	Variable	Response		Comment
6.3	Presentation	Yes	No	
6.4	Team/ family meetings	Yes	No	
6.5	Modelling	Yes	No	
6.6	Train-the-Trainer	Yes	No	
6.7	Multi-media and technology	Yes	No	

112 *Behaviour Support: Policy and Practice Manual, Part 1 (B), Section 6.*

Indicate which of the following reliability measures have been included in implementer training:

	Variable	Response		Comment
6.8	Verbal	Yes	No	
6.9	Procedural	Yes	No	
6.10	Role play	Yes	No	
6.11	Supervision	Yes	No	
6.12	Other (describe)	Yes	No	

Possible score 12

Section 6 **Actual score**

Section 7 Monitoring

Refer ***Behaviour Support: Policy and Practice Manual Part 1 (B)*** Section 7.[113]

Applicable where a Behaviour Support Plan (BSP) or documented strategy is required under the Service Agreement (SA).

	Variable	Response		Comment
7.1	Has a practical system for monitoring implementation of support strategies been established?	Yes	No	
7.2	Does this monitoring system allow for a short trial period?	Yes	No	
7.3	Have **all** parties in the support system been trained in maintaining this monitoring system?	Yes	No	
7.4	Has long-term responsibility for monitoring been addressed?	Yes	No	

Please list the stakeholders who have been trained in maintaining this monitoring system:

Name	Relationship/role	Date trained	Comments

Possible score 4

Section 7 **Actual score**

113 *Behaviour Support: Policy and Practice Manual, Part 1 (B), Section 2.*

Section 8 Review

Refer ***Behaviour Support: Policy and Practice Manual Part 1 (B)*** Section 8.[114]

Applicable where a ***Behaviour Support Plan (BSP)*** or documented support strategy is required under the Service Agreement (SA).

	Element	Response		Comment
8.1	Does the review include comparison with baseline conditions?	Yes	No	
8.2	Does the review allow for evaluation of data collaboratively with parties identified in the SA?	Yes	No	
8.3	Is the method identified for evaluation consistent with that used in the assessment?	Yes	No	
8.4	Is a schedule for review clearly documented?	Yes	No	

Possible score 4

Section 8 **Actual score**

114 *Behaviour Support: Policy and Practice Manual, Part 1 (B), Section 8.*

Section 9 Closure

Refer ***Behaviour Support: Policy and Practice Manual Part 1 (B)*** Section 9.[115]

Applicable to ALL Service Requests.

	Element	Response		Comment
9.1	Has the required service been clearly identified and scoped in a written *Service Agreement*?	Yes	No	
9.2	Has the service been completed in accordance with the *Service Agreement*?	Yes	No	
9.3	Is there clear documentation to indicate completion of the service as identified in the *Service Agreement*?	Yes	No	
9.4	Have all stakeholders been advised in writing that the service is complete, including the originator of the *Service Request*?	Yes	No	

Possible score 4

Section 9 **Actual score**

115 *Behaviour Support: Policy and Practice Manual, Part 1 (B), Section 9.*

Section 10 Documentation and administration

For DADHC staff, minimum documentation and administration requirements relating to work practice procedures are outlined in **Parts 3** and **4** of the **Behaviour Support: Policy and Practice Manual**.

These requirements are also recommended for funded organisations.

Please refer to the ***SUMMARY*** section at the end of this document for a list of relevant documents and forms.

Section 11 Peer review and supervision

Refer ***Behaviour Support: Policy and Practice Manual Part 1 (B)*** Section 11.[116]

Applicable to all behaviour support work practice.

	Element	Response		Comment
11.1	Is a process of ***Peer Review*** conducted within your agency/ service/team?	Yes	No	

Please complete the following table:

Number of peers involved
Frequency
Intensity/depth
Deliverables/ outcomes

	Element	Response		Comment
11.2	Is a process of ***work practice supervision*** conducted within your agency/ service/ team?	Yes	No	

Please complete the following table:

Position of supervisor
Frequency
Duration
Ratio of supervisor to supervisee
Practice elements addressed
Deliverables/ outcomes

Possible score 2

Section 11 **Actual score**

116 *Behaviour Support: Policy and Practice Manual, Part 1 (B), Section 11.*

Supplemental **Restricted and prohibited practice**

Refer ***Behaviour Support: Policy and Practice Manual Part 1 (A)*** Section 4.[117]

Where a ***Behaviour Support Plan (BSP)*** or other documented strategy recommends the use of a Restricted Practice:

	Element	Response		Comment
Supp 1	Has ***Restricted Practice Authorisation (RPA)*** been obtained as required under DADHC Policy?	Yes	No	

Please complete the following table in relation to the *RPA*:

Date of RPA	Expiry date of *RPA*	Conditions	Comment

Please complete the following table:

Name of person providing *consent*	Role/ relationship to *Service User*	Date of consent	Comment

Possible score 1

Supplemental **Actual score**

117 *Behaviour Support: Policy and Practice Manual, Part 1 (A), Section 4.*

Summary section

Step 1 Outstanding issues and recommendations

Table QFT1

Review ALL information provided in response to applicable sections of the QFT including descriptive summaries and other comments. ***Note that not all sections will be applicable for all Service Requests.***

Record any issues or service deficits, any required action arising, and parties responsible for the action, in the table below.

Section	Issue / description of service deficit	Required action	Responsibility

Step 2 Transfer all applicable raw scores

Each row in the following table represents a section of the QFT. Note that not all Sections will be applicable for all *Service Requests*. In **Column A**, tick ***only those sections which are applicable*** to the particular Service Request which is the subject of interest.

Transfer the ***actual scores*** from each applicable section of the QFT (i.e. those which you have ticked) to the relevant row in **Column B**.

Add together each ***possible score*** for those applicable sections and write the total in the box at the bottom of **Column C**.

	Column A	**Column B**	**Column C**
Section	Applicable tick (✓)	**Actual score** per section	**Possible score** per section
Section 2			5
Section 3			31
Section 4			9
Section 5			23
Section 6			12
Section 7			4
Section 8			4
Section 9			4
Section 10			Not applicable
Section 11			2
Supplemental			1

Total raw scores		

Step 3 Calculation for standardised score

3.1	Transfer the values from the bottom of **Columns B** (actual score) and **C** (possible score) on the previous page:

	Divide the figure at the bottom of **Column B**…	Actual score		
	…by the figure at the bottom of **Column C**.	Possible score	=	Raw score

3.2	Multiply the product of the above calculation (the raw score) by 100 to arrive at a percentage. This percentage is the **OVERALL STANDARDISED SCORE**.	%
3.3	Transfer this overall standardised score to the box provided on the **page 99**.	

Interpretation of overall standardised score:

Score	Level	Interpretation	Action required
0 – 60%	Low	Serious deficiencies. Provision of service does not meet work practice requirements.	Completion of *QFT* and all relevant work to be immediately reviewed by work practice supervisor.
61 – 85%	Medium	Provision of service meets most work practice requirements but has significant deficiencies.	Completion of *QFT* and all relevant work to be reviewed by work practice supervisor via standard supervision calendar.
86 – 100%	High	Acceptable level of practice requirements.	As per ***Outstanding Issues and Recommendations*** listed on ***Table QFT 1***.

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