Behaviour Support Policy

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Office of the Senior Practitioner
Ageing, Disability and Home Care
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Document approval

The ***Behaviour Support Policy*** has been endorsed and approved by:

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1 Policy position and principles

1.1 Purpose of policy

This policy document outlines minimum requirements for ADHC-direct and ADHC-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***.

ADHC 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, ADHC 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 ADHC.

1.3 Position statement

ADHC 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 ADHC Behaviour Intervention Policy (February 2003).

This policy sits within, and should be read in conjunction with the ADHC 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 (2010)*** 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).*

The NSW Government is committed to ensuring its policies are consistent with the United Nations Convention on the Rights of Persons with Disabilities.

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 1: 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 2: Application of principles

Service Providers must apply the principles set out in Table 1 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].

2.3 Conditions for provision of service

A behaviour support service is a service delivered directly by ADHC or by a Service Provider funded by ADHC, 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;

[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).

- 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 ADHC ***Behaviour Support: Policy and Practice Manual (January 2009)***.

2.6 Consent

Implementation of behaviour support strategies requires the informed consent of the Service User where they have capacity, the person responsible, parent, person with parental responsibility, close friend, relative or guardian as appropriate.

Where Community Services has case management responsibility, consent should be obtained from the Supervising Manager, Casework. See also ***Section 3*** 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 for a child;
- 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. ADHC 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

ADHC 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 Community Services. Employers also must show reasonable care for the safety of workers. Risk management strategies are required in all designated workplaces under NSW Work Health and Safety legislation and regulations[10]. Additional ADHC 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.

[9] See Health Care Policy and Procedures (March 2007).
[10] Work Health and Safety Act, 2011; Work Health and Safety Regulation, 2011.
[11] Client Risk Policy and Procedures (March 2008, amended September 2010); Incident Management Policy (June 2006, amended September 2010).

Rather, behaviour support must address multiple elements of the Service User's life, promote positive approaches, and deliver positive person-centred outcomes. Any strategy developed to address risk should accommodate a balance between the minimisation of risk and the Service User's right to autonomy. In other words, Duty of Care should always be balanced with the Dignity of Risk.

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 others in the support system 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.

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 ADHC 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 author's name, position, agency, location and contact details;
- Signature and date; and

[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).
[15] For DADHC staff, this includes Records Management Policy Document (May 2002); Privacy, Dignity and Confidentiality (October 1996).

- 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

ADHC direct services report regularly to the Executive against a set of behaviour support Key Performance Indicators (KPIs).

ADHC is working towards a better balance between quality assurance and compliance with the NSW Disability Services Standards and the common Community Care Standards.

The development of a Quality Framework is part of the NSW Government's responsibilities under the National Disability Agreement and the commitment to deliver high quality services and achieve positive outcomes for people with a disability, their families and carers.

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[16]. 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 ADHC work practice requirements for behaviour support services[17]. 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 ADHC work practice requirements and may be considered for implementation only with legal consent. Such strategies may be wide-ranging and are referred to by ADHC as Restrictive Practices.

3.2 Restricted Practices

A distinct number of Restrictive Practices also have significant ***additional safeguards*** placed upon their use by ADHC. They are known as ***Restricted Practices*** and are outlined in *Table 3* following.

[16] Barry, (2007).
[17] Behaviour Support: Policy and Practice Manual, Part 2 - Work Practice.

Table 3: 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) for a period of time under supervision. Time Out must be: 1. Part of an overall ***planned*** strategy; 2. Time-limited; 3. Contingent on behaviour change; and 4. Recorded. A Service User in Exclusionary Time Out must be supervised at all times. 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 or care worker 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** on a ***prn*** basis[18] is considered a Restricted Practice. Although the medication must always be administered as prescribed by the medical practitioner, the recommended support strategies are authorised and monitored through the RPA mechanism.

In the context of ADHC 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 ADHC IP Policy[19].

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 ADHC.

[18] "Pro re nata" is a Latin term meaning "as required". It is abbreviated as "PRN" or "prn".

[19] 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 Authorisation and consent 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) authorisation by an internal ***Restricted Practice Authorisation*** (RPA) mechanism[20]; and
b) appropriate informed consent.

3.2.1(a) 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 ADHC work practice requirements for behaviour support services[21].

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 ADHC 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 ADHC this mechanism is known as the ***Restricted Practice Authorisation Panel (RPAP)***. Further details of the ADHC RPAP and associated processes are provided in the ADHC *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

[20] Within ADHC services this mechanism is the RPA Panel. Service Providers funded by ADHC are expected to maintain a similar RPA mechanism. Reference in this policy to the RPAP includes the ADHC RPA Panel and similar RPA mechanisms in the funded sector.
[21] Behaviour Support: Policy and Practice Manual (January 2009), Part 1(B) – Work Practice.

consent. The Behaviour Support Practitioner who develops the documented support plan or strategy is responsible for preparing the ***RPA Submission***[22].

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.

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 r***eplaced 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, except in cases where the RPAP has so directed (see page 17 below).

3.2.1(b) 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 other appropriate person(s) 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 4: RPA Consent Requirements.***

Consent for Children[23]

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***, Community Services. This approval must be recorded on the Community Services form "*Authorisation for Designated Agency for use of a restricted practice in a Behaviour Management Plan*".

Note The *NSW Guardianship Act 1987* defines a child as being under 18 years of age. The *NSW Children and Young Persons (Care and Protection) Act 1998* distinguishes between a child (under 16 years) and a young person (16-18 years).

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 Community Services.

Where a carer has been given written consent from Community Services 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***, Community Services. This approval

[22] This may also be done by the manager responsible for delivery of behaviour support to the Service User.
[23] Under the age of 18 years.

must be recorded on the Community Services 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 ADHC.

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.

Consent for Young People[24] and Adults[25]

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 appropriate person(s) to consent or agree to the use of the practice on their behalf, a legally appointed guardian may be required. In such cases specific authority to consent may be granted to a guardian by the ***Guardianship Tribunal***. This involves the appointment of a guardian with a ***Restrictive Practices function***.

There may be no need to appoint a guardian where:

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

Where consent requirements are unclear, clarification should be sought in the first instance from your line manager.

Where an Application to the Guardianship Tribunal has been made, a copy must be provided to the RPAP as evidence at the earliest opportunity. Responses from the Guardianship Tribunal to all Applications should also be provided to the RPAP. The RPAP will then provide direction in relation to the RPA Submission (see Clause 3.2.1(a) above.

Consent for the use of a Restricted Practice is valid only for the time specified by the guardianship order and agreed to by the guardian.

Note: Applications to the Guardianship Tribunal should be made **only where the RPAP has confirmed** that this is the most appropriate course of action for a particular RPA Submission.

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.

Where the person responsible is not immediately available to provide written consent, oral consent may be sought, clearly recorded and followed up by written confirmation as soon as practicable.

[24] Aged 16 – 18 years and over and not under the care of the Minister for Community Services.
[25] Aged 18 years and over.

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[26]. It is important to note that medication prescribed to manage challenging behaviours on a prn basis is considered a ***Restricted Practice*** by ADHC.

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.

3.2.1(c) Capacity of the RPAP in relation to consent

Under certain circumstances the RPAP has the capacity to act as a source of consent in order to meet Policy requirements. This capacity applies ***only*** to:

Category 4 Restricted Access; and

Category 5 Response Cost.

This capacity may be appropriate **only** where:

1. The strategy has been authorised by the RPAP, ***and***
2. The client is unable to consent, ***and***
3. There is no close friend or relative who can support the client to consent or agree to the use of the strategy on the client's behalf, ***and***
4. In the opinion of the RPAP, based on precedent and in consultation with relevant stakeholders, the Guardianship Tribunal is considered unlikely to appoint a Guardian with a restrictive practice function, ***or***
5. An Application has been made to the Guardianship Tribunal in accordance with a direction from the RPAP but a decision has not yet been reached, ***or***
6. An Application has been made but the Guardianship Tribunal has declined to appoint a Guardian with a restrictive practice function.

[26] Guardianship Tribunal Position Statement (March 2006).

Table 4: Summary Guide to RPA Consent requirements

SERVICE USER	PRACTICE			
	1. Exclusionary Time Out (ETO); 2. Physical Restraint.	**3. PRN Psychotropic medication**	**4. Response Cost, 5. Restricted Access**	**6. Seclusion**
Children (under 18 years) ***not*** subject to court order reallocating parental responsibility	Parent or guardian	Parent or guardian*	Parent or guardian	PROHIBITED
Children (under 18 years) subject to court order reallocating parental responsibility	Person with parental responsibility+	Person with parental responsibility+	Person with parental responsibility+	PROHIBITED
Young people (16-18 years)	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.	Either: (a) The Service User where they have the capacity; (b) A close friend or relative**; (c) Guardian with a restrictive practices function; or (d) The RPA Panel/ mechanism‡.	PROHIBITED
Adults (18 years and over)	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.	Either: (e) The Service User where they have the capacity; (f) A close friend or relative**; (g) Guardian with a restrictive practices function; or (h) The RPA Panel/ mechanism‡.	Guardian with a restrictive practices function

+ For children who are subject to a court order reallocating parental responsibility, evidence of the court order must be provided.

** With approval of the principal officer of the designated agency in accordance with Clause 15A of the Children and Young Persons (Care and Protection) Regulation 2000 as appropriate.*

******* *Evidence that a close friend or relative has agreed to or supported the Service User to consent to the use of an authorised Response Cost or Restricted Access strategy can replace the need for consent, where there is no guardian, for these categories only.*

‡ The RPA mechanism may direct that an authorised Response Cost or Restricted Access strategy may be implemented in the absence of consent in certain circumstances (see page 17).

Notes:

1. 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.

2. 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.

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

Note: 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 and care workers 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[27]. 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.

[27] 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 and care workers. 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. They are criminal offences or civil wrongs and may lead to legal action. Prohibited Practices also include those that may not be unlawful, but are unethical and violate the United Nations Convention on the Rights of Persons with Disabilities (CRPD). 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[28].

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

Table 5: 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.

[28] 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[29]. ADHC direct services must also comply with local procedural guidelines and the ***Incident Management Policy***[30].

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 ADHC work practice requirements[31].

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 n***o 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[32] 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[33].

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

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

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 and care workers 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 the *Behaviour Support: Policy and Practice Manual (January 2009)*.

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 and care workers who are untrained, inadequately trained and inadequately supported[34]. Provision of training alone is an inadequate response. Sustained behavioural change is linked to good contextual fit of the support plan[35], which has implications for resource management and regular supervision.

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

6 Supporting policies, procedures, guidelines and legislation

- Aboriginal Policy Statement (2010);
- 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, amended September 2010);
- Code of Conduct and Ethics (February 2011);
- Decision Making and Consent (July 2008, amended September 2010);
- Dignity and Respect: Anti-bullying, Discrimination and Harassment Policy (November 2010);
- Dignity of Risk and Duty of Care (1996, amended September 2010);
- Disability Services Act (1993);
- Family and Relationships Policy and Procedures (October 1996, amended September 2010)
- 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, amended September 2010);
- Incident Management Policy (June 2006, amended January 2007, amended September 2010);
- Individual Planning Policy (Sept 2005, amended September 2010);
- Individual Planning for Children and Young People Living in Out-of-home Care: Policy and Practice Guide (January 2011);
- 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);
- Medication Policy and Procedures (March 2008, amended September 2010);
- 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 Carers (Recognition) Act 2010;
- NSW Interagency Guidelines for Child Protection Intervention (DoCS 2006)
- NSW Out-of-Home Care Standards (NSW Office of the Children's Guardian);
- Work Health and Safety Act (2011);
- Work Health and Safety Regulation (2011);
- 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);
- Responding to Risk of Harm to Children and Young People (March 2007);
- Sexuality and Human Relationships Policy and Procedures (October 1996, amended September 2010);
- Standards in Action Manual (1998);
- Strategy to improve services for people from culturally diverse communities: ADHC CALD Strategy 2005-08 (December 2005);
- United Nations Convention on the Rights of Persons with Disabilities;
- Valued Status Policy (October 1996).

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

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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 ADHC directly or by a Service Provider funded by ADHC, the requirements of ADHC Policy take precedence over the content or recommendations of any other resource materials or program.

Appendix: Glossary of terms

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

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 ADHC.
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

Term	Meaning
	and context of the service agreement. A BSP may also be known as a Behaviour Management Plan or Behaviour Intervention Plan.
Behaviour Support Practitioner	Ideally, behaviour support and intervention services either in a funded service or a service provided by ADHC 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 ADHC, 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[36]. See also Consent.
Carer	Under the *NSW Carers (Recognition) Act 2010* a carer is defined as an individual who provides ongoing personal care, support and assistance to any other individual who needs it due to being in the target group of Section 5(1) of the Disability Services Act 1993, having a medical condition, a mental illness or is frail and aged. Paid staff are not included in the term "carer" but are referred to as ***care workers*** Refer to the NSW Carers (Recognition) Act 2010 for further information
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.*"[37]

[36] Adapted from Best Practice Guide: Privacy and people with decision-making disabilities, Privacy NSW, February 2004.
[37] Banks et al, 2007, p14.

Term	Meaning
	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[38].
Chemical restraint	The abuse of medication to control or influence behaviour, mood or level of arousal.
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 constitutes a form of time-out (see Exclusionary Time Out). It is the 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

[38] Emerson, 1995, p5.

Term	Meaning
	to property[39].
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. In the context of this manual the term includes evidence-informed practice.
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.

[39] See also Incident Management Policy (2006).

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.
Person responsible	This is a person with legal authority to make decisions about medical or dental treatment for a person who lacks capacity to

Term	Meaning
	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 skillbased.
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 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 medications are those medications which exert an effect upon the mind, and are capable of modifying mental activity.
Psychotropic Medication	In the context of ADHC Policy, psychotropic medication includes psychoactive medication and androgen-reducing medications used to influence behaviour.
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 ADHC. 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[40]; 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 ADHC 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.

[40] 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 ADHC-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 ADHC 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 ADHC-direct services this is a function

Term	Meaning
	of the Client Information System (CIS).
Service System	See Support System.
Service User	The Service User (or client) is the individual diagnosed with an intellectual disability, on whose behalf the Service Partner is delivering support.
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.