

Evidence Matters: Developing Quality Behaviour Support Plans

Prepared for the NDIS Quality and Safeguards Commission

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Suggested Citation:

Nankervis, K & Vassos, M (2023). *Evidence Matters: Developing quality behaviour support plans*. NDIS Quality and Safeguards Commission.

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Acknowledgements:

The NDIS Commission would like to acknowledge the contribution of the behaviour support practitioners that provided feedback throughout the development of this Evidence Matters summary.

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About this Evidence Matters Summary

This Evidence Matters Summary has been developed in partnership with the NDIS Commission in line with the Commissioner's core functions ([NDIS Act \(2013\)](#)), in particular:

- To uphold the rights of, and promote the health, safety and wellbeing of, people with disability receiving supports or services, including those received under the National Disability Insurance Scheme
- To promote the provision of advice, information, education and training to NDIS providers and people with a disability.
- To promote continuous improvement amongst NDIS providers and the delivery of progressively higher standards of supports and services to people with disability.

This Evidence Matter Summary has also been developed in line with the Commissioner's behaviour support function ([NDIS Act \(2013\)](#)), particular:

- Developing policy and guidance materials in relation to behaviour supports and the reduction and elimination of the use of restrictive practices by NDIS providers.
- Providing education, training and advice on the use of behaviour supports and the reduction and elimination of restrictive practices.

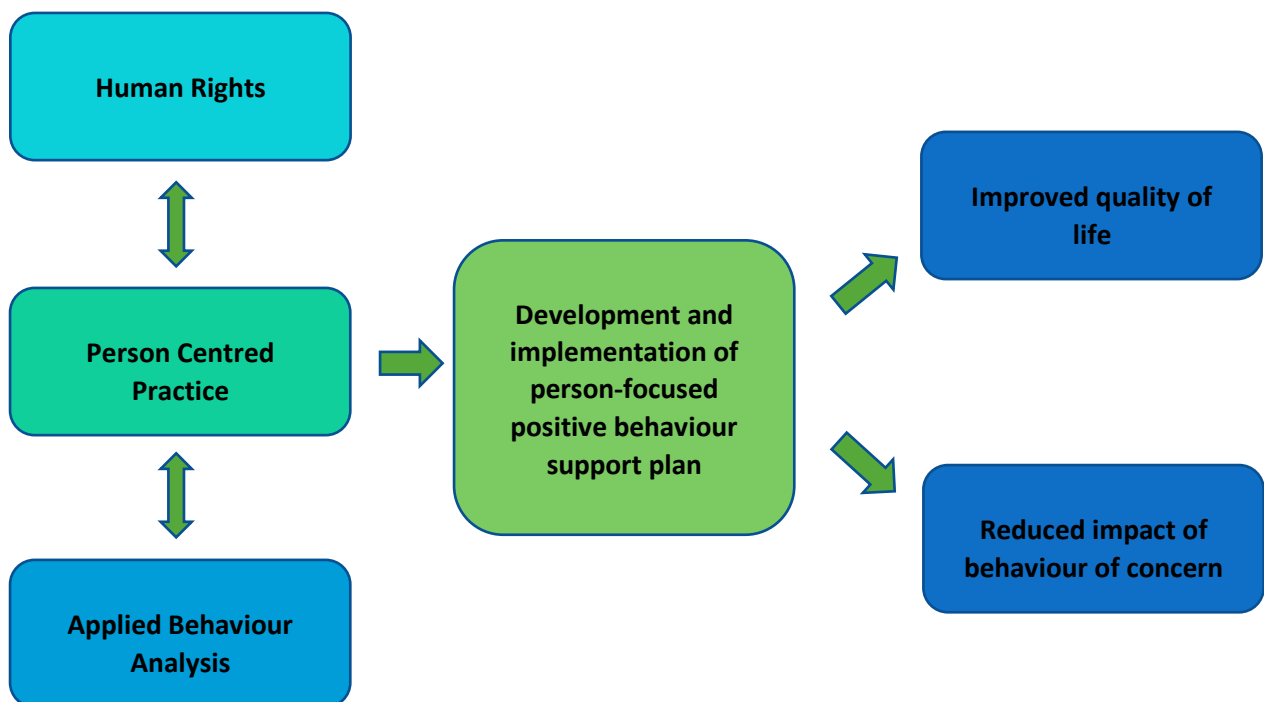
This summary has been developed through research and in collaboration with experienced behaviour support practitioners. It is intended to provide behaviour support practitioners with evidence-based advice to support the development of quality behaviour support plans. This guide is **not** intended to outline/explain in depth the concepts and practices relevant to behaviour support plan development; in line with the NDIS Commission's *Positive Behaviour Support Capability Framework*, a core level of knowledge of positive behaviour support is assumed on the part of the reader.

Introduction

Positive behaviour (or behavioural) support (PBS) was first proposed by Horner et al. [1] and has been established as an evidence-based, effective therapeutic approach for individuals who are at risk of, or are engaging in, behaviours of concern¹ [2-5] that limit their life opportunities, impact on others and/or are a risk of harm.

Accepted definitions of PBS from the literature [6-11] highlight a common understanding of the approach (as depicted in Figure 1): that PBS involves the **intersection** of the theories and principles of applied behaviour analysis (ABA), human rights and person-centred practice (PCP) to first and foremost enhance a person’s quality of life, and second, reduce behaviours of concern.

Figure 1. The Foundations of PBS [12]



In the PBS approach, functional behavioural assessment, the development of a behaviour support plan (BSP) and its implementation are the mechanisms used to effect positive quality of life and behavioural change [2, 5]. BSPs describe a person’s behaviours of concern that are the focus of the plan in observable and measurable terms, outline the assessments carried out to understand the context and contributing factors to a person’s behaviour and provide an analysis of the hypothesised

¹ In Australia and internationally, various terms are used to refer to the behaviours that are typically the focus of behaviour support plans, including behaviour of concern, challenging behaviour, behaviour of harm, and problem behaviour. To align with the language used by NDIS Quality and Safeguards Commission, the term ‘behaviour of concern’ is used throughout this guide.

reasons behind why the person may be engaging in these behaviours. Based on this behavioural analysis, the BSP outlines a set of interventions or strategies to implement to affect positive change to the person's quality of life and behaviour of concern. This may include changes to the person's immediate environment, specific support strategies or the teaching of new skills or alternative or functionally equivalent replacement behaviours.

In Australia, a BSP must be in place for a person with disability (referred to as the *person of focus* or *focus person* from here on in) who is a NDIS participant and subject to the use of restrictive practices for the purposes of responding to behaviours of harm to the person and/or others, in order to keep people safe. For information regarding regulated restrictive practices and authorisation, please refer to the NDIS Quality and Safeguards Commission website²

Only behaviour support practitioners considered suitable by the Commission can provide NDIS-funded behaviour support services (including the development and implementation of a BSP). For information about suitability assessments and the Positive Behaviour Support Capability Framework, please refer to the NDIS Quality and Safeguards Commission website³. While the use of restrictive practices is required to be documented in a BSP, restrictive practices are **not** a positive behaviour support.

In a report released by the NDIS Quality and Safeguards Commission in August 2022 [13], an audit of the quality of 2,744 BSPs submitted to the Commission using the Behaviour Support Plan Quality Evaluation, Version 2 [14] found that 80% of the BSPs evaluated were categorised as **weak** or **underdeveloped**. Areas of improvement were noted such as the identification of alternative or functionally equivalent replacement behaviours, teaching plans for such behaviours and skill development, and plans to support the processes related to implementation (e.g., team communication and coordination). Furthermore, the Commission noted that only 32% of BSPs audited consulted the person of focus.

Given the audit findings, the NDIS Quality and Safeguards Commission is investing in the development of resources to assist registered behaviour support practitioners to develop quality BSPs, including this guide.

This guide contains the following:

- A brief evidence review that outlines a suite of evidence-based markers of BSP quality.
- A description of the relevant sections of a BSP, including the evidence-based markers that demonstrate quality within each section.
- A *BSP quality tip sheet* – a summary of the advice provided in this guide – is also included that can be used as a quick reference by behaviour support practitioners to assist with BSP development (See Appendix A).

² Direct weblink: <https://www.ndiscommission.gov.au/participants/incidents-and-behaviour-support/understanding-behaviour-support-and-restrictive-0>

³ Direct weblink: <https://www.ndiscommission.gov.au/providers/understanding-behaviour-support-and-restrictive-practices-providers/positive-behaviour>

- A list of relevant publicly available online resources to support behaviour support practitioners with BSP development (see Appendix B).

Literature Summary on Behaviour Support Plan Quality

In 2022, the authors conducted a systematic literature review to collate all relevant research literature on BSP quality. Table 1 summarises the quality markers extracted from the 90 sources of evidence collated. The quality markers could be categorised into three overarching themes – *behavioural assessment*, *technical compliance with behavioural principles*, and *plan implementation*.

Table 1. The BSP Quality Markers Extracted from the Systematic Literature Review

Behavioural Assessment
<ul style="list-style-type: none"> • Person-centred approach to assessment and plan development - Collaborating with the person of focus and their families, paid support staff and any other relevant stakeholders to gather behavioural and other relevant information [15-24] • Direct observation of the focus person’s behaviour of concern in the relevant environments (e.g., home, school, employment setting) using data collection methods like ABC note cards, scatterplots, etc. [17, 25-30] • The use of indirect data collection methods such as interviews and standardised measures including the <i>Functional Assessment Interview</i>, <i>Functional Assessment Screening Tool</i>, <i>Motivation Assessment Scale</i> and <i>Questions About Behaviour Function Scale</i> [25, 27-29, 31-32] • Other sources of information consulted to understand the person of focus (e.g., reports from health professionals, case notes, person-centred support plans, funding plans, etc.) [16, 33-36]
Technical Compliance with Behavioural Principles
<ul style="list-style-type: none"> • Clear description of the focus person's behaviour(s) of concern including information their frequency, duration, and intensity/severity [14, 23, 29, 31, 35, 37-41] • An analysis of the antecedents/triggers, setting events and consequences of the focus person’s behaviour(s) [14, 16, 28-29, 33-35, 41-43] • Proposed function(s) of the focus person’s behaviour(s) and the identification of functionally equivalent replacement behaviour(s) [14-15, 23-24, 28-29, 33-36, 43-51] • Person-centred goals – Measurable and achievable goals around behaviour change <u>and</u> quality of life [14, 17, 24, 26, 29, 36, 46, 50-51]

- Person-centred **environmental change strategies** linked to setting events and antecedents (triggers) to reduce behaviour of concern and enhance quality of life [14, 16, 25, 29, 34-35, 45, 49, 52-56]
- **Skill development strategies** to teach the person of focus alternative or functionally equivalent replacement behaviours and other relevant skills [14, 24, 28-29, 32, 36-37, 41, 45, 49-50, 53, 57-58]
- Person-centred **reinforcement strategies** to support the teaching of alternative/replacement behaviours and other relevant skills [14, 19, 24, 28-29, 31, 34, 45, 50, 58]
- **Other strategies** related to meeting the physical, health, and social needs of the person of focus that impact their behaviour including sleep interventions, specific medical treatments, activity scheduling, etc. [25-26, 34, 40, 46, 59-60]
- **Reactive strategies** to deal with behaviour(s) of concern if they reoccur including strategies to maintain the safety of the person and others, prompting desired behaviours, re-direction or distraction, debriefing, etc. [14, 16, 23, 25, 29, 35, 41, 45, 58, 61]
- A plan to **fade-out the use of restrictive interventions/practices** as soon as possible with the effective implementation of PBS strategies [19, 24-25, 44-45, 51, 61-62]

Plan Implementation

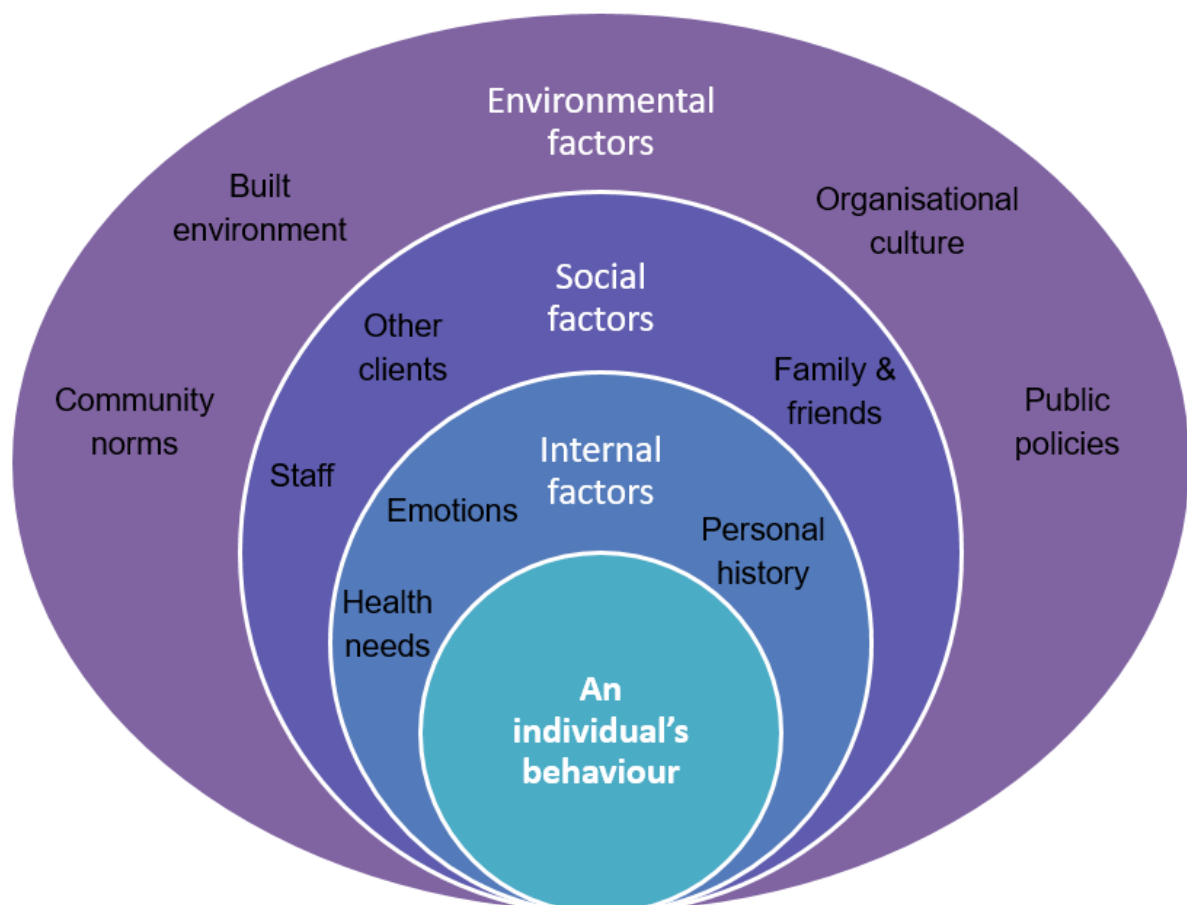
- **Social validity** - Acceptance of the proposed strategies by the person of focus, paid support staff and family members tasked with implementing the BSP or have an interest in the wellbeing of the person of focus [33-34, 46, 49, 63]
- **Training** – Paid support staff and family members provided with training in how to implement the proposed strategies, which may include role playing, coaching, feedback and mentoring [29, 31, 34, 37, 39, 64-66]
- Regular and planned **communication** between plan implementers to review and troubleshoot implementation issues on-the-go [15-16, 27, 34, 50-51, 58-59, 67-68]
- **Outcome measurement** – A planned process to collect person-centred outcome data to assess the effectiveness of the BSP to achieve the proposed goal(s) [17, 26, 33-34, 45, 59, 69-72]
- **Implementation fidelity** (also known as treatment fidelity) – A planned process to measure if the strategies is being implemented as intended [48-49, 54, 57, 73-74]
- **Plan review** – A planned process to review the BSP on a regular basis to check its effectiveness in achieving the proposed goal(s) [23, 33]
- **Readability** – Concise plans that use plain, easy to read and understand language (e.g., secondary school reading level or below) [50, 58, 68-69, 75]

Elements of a Quality Behaviour Support Plan

Identify the need for a behaviour support plan

A person's behaviours are influenced by factors that span the person themselves (internal factors) as well as their social and environmental contexts. Situating behaviours of concern within a social-ecological model of behaviour (see Figure 2) recognises that the behaviour is influenced by factors at multiple levels, across the individual, interpersonal, organisational, community and social contexts. It also recognises the importance of interventions/strategies that address social or environmental factors instead of, or in conjunction with, planned positive behaviour supports.

Figure 2. A social-ecological model of behaviour [76]



Example *internal factors* include:

- Where the person has communication difficulties and the behaviour of concern is a way to communicate their needs and preferences, their frustration, distress or protest.

- Where the person's skills are not sufficient for them to be able to meet their needs, in a way of their preference.
- Where the person has a physical condition, especially where the person is experiencing pain and is unable to communicate this.
- Where the person is experiencing symptoms associated with mental health conditions, such as depression or schizophrenia, or side-effects of medication.
- Current experience or background of trauma, abuse, or neglect.

Example *social factors* include:

- Living with co-tenants who are incompatible, or of whom the person is fearful, or not those the person chooses to live with.
- Being supported by staff and other caregivers where interactions are marked by disrespect for the person, bullying or poor communications.
- Support staff who do not have the skills, knowledge, or resources to best support the person. This includes the ability of staff to understand how the person communicates and their ability to communicate using methods other than spoken English (such as manual signing, communication devices or gestures and facial expressions).
- Being socially isolated or excluded from family or friends.
- Having a lack of access to community-based resources, activities, and opportunities.

Example *environmental factors* include:

- Environments that are barren, developmentally, or otherwise, inappropriate or environments that are abusive or restrictive, or overwhelming.
- Being subject to poverty and/or stigma or discrimination.
- Not having access to resources, medical care, or opportunities such as education and employment.

Interventions and strategies that are solely focused on supporting behaviour change at the level of the individual may not address contributing or causal social and environmental factors. Without addressing the multiple factors that influence a person's behaviour(s) of concern, planned positive behaviour supports may not be sufficient to bring about sustained behaviour change.

Further, the development of a BSP will not always be the intervention of best fit for a person's behaviour(s) of concern; there may well be situations where the person's behaviours will be better managed and perhaps eliminated completely if there is a sole focus on interventions/strategies that target social and environmental factors, such as remedying inappropriate accommodation arrangements, ensuring that staff teams and organisations are best suited to provide supports for the person, or ensuring the provision of appropriate medical treatment.

Following the **completion of a functional behavioural assessment** (to be discussed later in more detail), if it is evident that further behaviour change planning/action should solely focus on social and/or environmental factors, the behaviour support practitioner should either:

- Work in collaboration with all relevant stakeholders to support the implementation of strategies appropriate to the social or environment contributors to the person's behaviour(s) of concern. The focus person's behaviour(s) of concern and quality of life should be monitored throughout the response to ensure positive outcomes and if indicated, revisit the need for a PBS response if no behavioural change is noticed.
- If a BSP is required for regulatory purposes (e.g., restrictive practice authorisation and oversight), then the BSP needs to clearly outline all planned interventions/strategies to be implemented that address the social and environmental factors contributing to the behaviour(s) of concern and how these interventions/strategies will address their causal contribution to the behaviours of concern.
- If working off a BSP template, only complete the **relevant sections and those sections required in order to adhere to legislation**. In situations like those outlined above, BSP template sections like functionally equivalent replacement behaviours, teaching strategies and reinforcement will not be relevant.

Psychosocial disability – A special case

Psychosocial rehabilitation aims to support people with psychosocial disability to develop their cognitive, emotional and social skills to achieve goals such as employment, independent living, and interpersonal relationships. PBS is not intended to **replace** the best evidence-based therapeutic interventions for mental health conditions such as schizophrenia and psychosis, substance abuse/misuse, suicidal ideation, and bipolar disorder. However, PBS can be an important **adjunct** to these other therapeutic treatments and supports. Where it has been identified that PBS and the development of a BSP would be of benefit for the person with psychosocial disability, the BSP should reference other treatment plans (such as mental health treatment plans) and how PBS will be used alongside these other therapeutic approaches to enhance the person's quality of life, and positively impact behaviours of concern.

The introductory pages

It is important that the introductory pages of a BSP provides relevant demographic information regarding: (1) the person who is the focus of the BSP, (2) the behaviour support practitioner who developed the BSP, (3) key contacts for the person of focus including family members/guardians, (4) the service providers who will be implementing the BSP, and (5) the BSP's valid timeframe and proposed review date. Collating this information at the start of the BSP allows the reader to have all relevant information about key stakeholders and the BSP's time validity in the one accessible place.

Using the NDIS Quality and Safeguards Commission's *Behaviour Support Plan – Comprehensive*⁴ template and other available templates as a guide, the following information should be provided in as a minimum:

- Person of focus:
 - Name and contact information (address, phone number and email address).
 - birthdate, identified gender, language, country of birth, cultural background.
 - If relevant, any informal decision-making support or formal guardianship arrangements.
- Behaviour support practitioner:
 - Name and contact details (name of specialist behaviour support provider if not a sole practitioner, address, phone number and email address).
 - Qualifications, NDIS practitioner number including level of registration against the *Positive Behaviour Support Capability Framework* (e.g., core, advanced), and any other relevant registrations (e.g., registration with the Australian Health Practitioner Regulation Agency).
 - Training and expertise in PBS.
- Key contacts
 - Name and contact information for each contact (address, phone number and email address).
 - Contact's relationship to the person of focus (e.g., parent, family member, guardian, doctor).
- Implementing service providers
 - Service name, location/outlet and contact information (contact person, address, phone number and email address).
 - The service(s) provided to the person of focus (e.g., accommodation, community access, in-home support).
- BPS timeframe and review
 - Start and end date for the BSP. The end date is typically 12 months following the start date.
 - A proposed date for the BSP to be reviewed. BSP reviews should be completed and endorsed by the proposed end date.

⁴ Direct weblink: <https://www.ndiscommission.gov.au/sites/default/files/2022-02/comprehensive-behaviour-support-plan-template-final-june-2019.docx>

Understanding the person of focus and their context

Following the introductory pages of a BSP, it is important to provide the reader with **summary information** about the person who is the focus of the BSP. This section tells the reader who the person is, as a person, and enables an understanding of how the strategies outlined in the BSP are person focused. The information should also be limited to information that is of **direct relevance** to the person's behaviour and the strategies included in the BSP. This information should provide the reader with enough information to understand the person and their context without being overly detailed. The information summarised and reported in this section is typically gathered during a functional behavioural assessment (discussed later).

Example information to include (but not limited to):

- Name, basic demographics such as age and identified gender.
- Place of residence and who they live with.
- A typical day in the life of (e.g., employment, education, relevant routines, etc).
- Formal and informal supports they access and relevant support strategies that set the person up for success.
- Relevant personal history (e.g., diagnosed disabilities, cultural background, the person's family and their level of contact with them).
- Relevant health information (e.g., medical conditions, routine medication and health interventions in place).
- Relevant information regarding how the person communicates (e.g., verbal, non-verbal, sign language, communication aids used).
- Likes and dislikes including sensory experiences they seek out or avoid.
- Aspirations and goals.

Identify and describe the target behaviour(s) of concern that are the focus of the behaviour support plan

BSPs should clearly identify the behaviour(s) of concern that are the focus of the BSP. These are the **target behaviours**. Target behaviours can be grouped in a BSP if appropriate, for example, if they align to known categories or topographies of behaviour (e.g., physically aggressive behaviours, as characterised by ...) or the same function (e.g., behaviours that allow the person to avoid social interactions such as...).

There are three rules to follow to clearly identify target behaviours. These are:

1. The behaviour must be observable.
 - a. Observable means that you can see when the behaviour is and isn't occurring.

- b. A good rule of thumb is to describe the behaviour in enough detail to allow another person to act out the behaviour based on the description.
 - c. Internal states like anger and sadness are not behaviours and should not be used as a description of behaviour. The behaviours that demonstrate that the person of focus may be angry need be described instead (e.g., shouting in a loud voice).
2. The behaviour must be measurable, to allow a person to collect behavioural data related to when the behaviour happens, how often it occurs and what happens as a result of the behaviour occurring in the environment.
3. There is agreement among all relevant stakeholders on what the behaviour of concern is and how it is described.

Note: BSPs that attempt to do **too much** are less likely to be implemented due to their complexity. Given this, it is recommended that BSPs focus on no more than **three** individual target behaviours or groupings of target behaviours. BSPs are typically valid for a timeframe of 12 months and taking into consideration the long-term nature of behavioural change, focusing on a small number of target behaviours will maximise the likelihood of the BSP being effectively implemented, thus achieving positive quality of life and behavioural change for the person of focus.

Once the target behaviour(s) have been identified, grouped (if relevant), described and have been agreed upon, these will be the focus of the functional behavioural assessment (see next section). The following information derived from the functional behavioural assessment should be included in this section of the BSP alongside the description of the target behaviour(s):

- Any early warning signs that the behaviour(s) of concern may occur (e.g., specific mannerism the person may exhibit like creating fists with their hands).
- The frequency (how often), duration (how long) and intensity (how severe) of the behaviour(s) of concern.
- A summary of patterns derived from behavioural data, e.g., do behaviours tend to occur at a certain time in the day? Or in the presence of a certain person?
- The setting events and antecedents/triggers for the target behaviour(s).
Antecedents/triggers are the events that happen immediately before the behaviour of concern. Setting events occur in the hours (or days) before the behaviour of concern occurs but plays a role in the behaviour occurring in the first place. These may be related to (but not limited to):
 - Specific activities and events, or lack of activity.
 - The focus person's communication style.
 - The physical environment and/or people present in the physical environment.
 - The focus person's day-to-day routine.
 - Certain times of the day, or certain places the person of focus accesses.

- The maintaining consequences for the target behaviour(s). Consequences happen immediately after a behaviour is exhibited and plays a role in maintaining the behaviour by assisting the person to get a need met (e.g., to gain access to a desired activity, to avoid an activity or situation, etc.).

Conduct a functional behavioural assessment

Functional behavioural assessment (FBA) is an umbrella term for various direct and indirect assessment methods used to identify the environmental, social and internal factors that contribute to and maintain behaviours of concern. Information gathered through the FBA process helps in gaining an understanding of what the person gains or avoids by engaging in a specific behaviour. It also assists in the identification of strategies to improve the person's quality of life and address any environmental or social contributors to the behaviour (including best ways to support the person). FBA informs the development of function-based strategies to prevent the behaviour of concern, and to teach and reinforce alternative behaviours and skills.

A comprehensive FBA should be undertaken in collaboration with the person who is the focus of the BSP (if they have capacity to participate in the process), their support network (including family members, supports workers and service providers), and any relevant multidisciplinary professionals.

The FBA seeks relevant information about the person of focus (e.g., diagnosed disabilities, health, family contact, preferences etc.) and their context (e.g., participation in activities, living situation, best ways of being supported) that can be used to understand the person's behaviours of concern. In addition, an FBA requires behavioural data from a combination of direct and indirect sources of information. The NDIS Quality and Safeguards Commission's *Compendium of Resources for Positive Behaviour Support*⁵ summarises a suite of relevant measures that can be used for the purposes of FBA.

- Direct data collection
 - Observation and recording of incidents of the target behaviour:
 - Can be measures of intensity (how severe is the behaviour?), frequency (how often does the behaviour occur?), duration (how long does the behaviour last?) and/or permanent products of the behaviour, i.e., the end-product of the behaviour (e.g., the number of windows smashed).
 - Mapping of behavioural data using for example, scatterplots, to identify patterns of behaviour and therefore potential function of the behaviour.
 - Collating descriptions of behavioural incidents such as incident reports and ABC notecards.
- Indirect data collection (data collected from an informant)

⁵ Direct weblink: <https://hcpbs.org/wp-content/uploads/2020/04/compendium-resources-positive-behaviour-support.pdf>

- Interviews and consultations with the person of focus, their families, friends, support staff and other relevant stakeholders.
- Guided functional assessment information obtained from the use of standardised instruments such as the Functional Assessment Interview, Contextual Assessment Inventory, and the Individualised Behaviour Rating Scale to name a few.
- Case file notes, reports from other professionals (e.g., medical review, communication assessments, etc.) and any other relevant documentation.

The primary outcomes of an FBA [77-78] are listed below and information regarding each of these should be included in a BSP:

1. A clear description of the target behaviours of concern.
2. A description of the events, times, and situations that predict when the behaviours of concern will and will not occur (immediate antecedents).
3. A description of the general or more distant ecological or setting events that influence the likelihood of the behaviours of concern.
4. A description of the consequences that reinforce/maintain the behaviours of concern and therefore the potential functions that the behaviours might serve for the person.
5. One or more summary statements or hypotheses about the potential functions of the behaviours of concern (e.g., avoiding something, seeking something, etc.).
6. Where relevant, one or more desirable functionally equivalent replacement behaviours or alternative behaviours that the person can use instead of the behaviours of concern.
7. The use of a diagram to summarise the information above (e.g., the *Competing Behaviour Model* diagram).
8. A history of interventions/strategies that have been previously carried out and the success/failure of these (if relevant).
9. A summary table or statement outlining the strategies developed in line with the findings from the FBA.

A note about the inclusion of a formulation statement in the BSP

While there has been little attention paid to the development of formulation statements in BSPs, including a summary of the contextual factors contributing to a focus person's behaviour of concern in a BSP is good practice. A formulation summary is developed after the completion of the FBA and is included in the BSP to summarise the findings of the assessment.

The formulation section of a BSP summarises the person's strengths and needs, their skills and the resources available to them, and the environment, social and personal factors that contribute to the behaviour of concern. The formulation statement also identifies the function of the behaviour of concern and assists in the development of strategies to support the person in terms of enhancing their quality of life and reducing instances of behaviours of concern.

The 5P model of formulation⁶ (which contains the well-known 4P formulation domains of predisposing, precipitating, perpetuating and protective factors along with the domain of presenting problem) is commonly used by mental health professionals to understand a person's mental health and can be applied to understanding a person's behaviour of concern also.

The formulation section is critical to assisting the person's support network to understand the rationale underpinning the strategies in the BSP and why these are likely to be the most effective and suited to the individual.

Identify goals for the person of focus

In collaboration with the person who is the focus of the BSP and their support network (family, support staff, etc.), behaviours support practitioners should gain consensus on a set of goals (for the life of this plan) related to quality of life and the positive strategies outlined in the BSP. Quality of life goals are important and should also be included in a BSP as quality-of-life improvement is related to a decrease in behaviours of concern incidence.

Goals should be person-centred and could be related to the development of alternative behaviours, new skills, and engagement in activities and social interactions. Goals could also centre on services/supports provided to the person (e.g., support workers developing new skills, etc.). It is best to avoid goals that are centred on just reducing instances of behaviour(s) of concern. In line with PBS, all goals should be positive in nature. Goals focused on reducing instances of behaviour of concern are fine to include, as long as other goals related to quality of life and strategies to be implemented are also present.

The SMART approach to goal development is commonly used in behaviour support and other therapeutic domains [79]. SMART goals are **S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**ime-bound. Table 2 (on the next page) provides guidance that can assist a behaviour support practitioner to develop SMART goals specifically around functionally equivalent replacement behaviours or alternative behaviour. This approach can be adapted for other types of goals.

⁶ For more information: <https://headspace.org.au/professionals-and-educators/health-professionals/resources/formulation/>

Table 2. Guidance around goal development for replacement or alternative behaviours.

By when	Who	Instead of what	Function of behaviour	Will do	Function of behaviour	Conditions	Level of proficiency	Measurement
Specify a time frame for when full mastery of the goal is expected	Name of the person	Specify in observable, measurable terms, what the behaviour of concern looks like	Specify the hypothesised function of behaviour the new skill is for [e.g., access or avoid]	Specify in observable, measurable terms the new skill	Repeat the hypothesised function of behaviour	Specify the conditions when the person would likely use the behaviour of concern	How well will the new skill be performed, with what degree of success	Who will, measure, any considerations and data collection

Identify a suite of positive strategies to address behaviours of concern

A good BSP will outline a suite of positive strategies to address the focus person's behaviours of concern. Strategies should be person-centred and relevant to their context and environment and based on the information gleaned from the FBA (i.e., related to function of the behaviour including setting events, antecedents, and consequences).

- There are no rules around the number of strategies that should be included in a BSP however behaviour support practitioners need to keep in mind who will be implementing the BSP in practice and their capacity for implementation, and the timeframe for the BSP.
- Practitioners should avoid **strategy overload** as this will negatively impact the overall implementation of the BSP, and in turn, capacity to achieve positive behavioural and quality of life outcomes for the person of focus.
- Strategies should be described in enough detail to allow anyone tasked with BSP implementation (e.g., support staff, parents, etc.) to implement the strategies from the description if needed.

Behaviour support practitioners should make every effort to consult and collaborate with the person who is the focus of the BSP and all relevant stakeholders to:

1. Assist in the development of strategies and to gather information on strategies that are currently successful or have been successful in the past, and
2. Ensure that the strategies outlined in the BSP are acceptable (i.e., socially valid) to the person of focus and the stakeholders who will be implementing the strategies (e.g., support staff, family members, etc.).

Information regarding consultation and social validity should be briefly outlined in the BSP.

The types of strategies that could be included in a BSP are briefly discussed in this section of the practice guide. Behaviour support practitioners should include **prevent** and **other strategies to improve quality of life** as a minimum in any BSP. If the teaching of a functionally equivalent replacement behaviour or new skills is not warranted for the person, then these types of strategies should not be included in the BSP.

This guide will not go into intervention approaches and specific strategies per se – given the person-centred nature of the PBS approach and the development of a BSP, behaviour support practitioners are responsible for ensuring that the strategies they propose within a BSP are evidence-based, with known evidence of efficacy and/or effectiveness.

Prevent strategies to make the behaviour(s) of concern irrelevant

BSPs should contain **prevent** strategies to address known long-term and short-term triggers for the focus person's behaviours of concern and therefore prevent the occurrence of the behaviour in the first place. Prevent strategies address the **when/where/who/what** triggers of a target behaviour (i.e., setting events and immediate antecedents) and include ways of best support and communicate with the person, the establishment of planned routines, the removal of aversive events, and ensuring choice and access to preferred activities. A prevent strategy is intended to **remove** the trigger.

- **Setting events** are long-term triggers that occur at a distance from the behaviour and are likely to increase the possibility of the person engaging in behaviours of concern (e.g., medication, routines, sleep cycles, diet, staffing patterns, physical health, number of people in the person's space, daily schedule).
- **Antecedents** are the events that occur immediately before the behaviour of concern that directly trigger that behaviour (e.g., being asked to do something difficult or undesired, being told "no" without explanation when a request is made, noise levels).

Other support strategies that improve quality of life

BSPs should include strategies that aim to maximise opportunities through which the person of focus can improve their quality of life. These strategies can include (but are not limited to) new and improved way to best support the person on a day-to-day basis (e.g., sleep interventions to improve sleep quantity and quality), and how to ensure that the person is engaged in activities that are meaningful to them (e.g., activity scheduling).

Teach strategies to develop alternative/replacement behaviours and/or new adaptive skills

If relevant, a BSP could contain at least one **teach** strategy that teaches the person of focus: (1) a functionally equivalent replacement behaviour, replacing the function of the behaviour of concern; or (2) an alternative behaviour or skill that address the behaviour of concern but is not necessarily its proposed function. Example skills that could be taught include communication skills, problem solving, coping strategies, independent skills of daily living, and social skills. Behaviour support practitioners should seek the guidance of appropriate and relevant professionals to support the

development of teach strategies, for example, consulting a speech therapist when proposing to teach a new communication strategy.

Teach strategies will specify:

- Who will teach the behaviours/skills to the person of focus.
- How (i.e., step by step instructions) and when the person will be taught the behaviours/skills.
- Where they will be taught the behaviours/skills.
- Any required materials to assist in the teaching process.
- When instruction and prompts will be faded out in line with mastery.

Strategies to reinforce alternative/replacement behaviours and support adaptive skill development

Reinforce strategies are required when a teach strategy is proposed. These ensure that the focus person's use of an alternative/replacement behaviour or new skill is maintained in the long term. Reinforce strategies are based on what is reinforcing for the person (i.e., their likes and preferences), and are identified through the FBA. Reinforce strategies tell others supporting the person what to do when the person uses the alternative/replacement behaviour or skill and how to ensure that the person's behaviours of concern are not being unintentionally reinforced. These strategies will specify the **type of reinforcement** to be used, be it a natural reinforcement stemming from the person using a desired positive behaviour (e.g., positive interactions with others) or contrived/artificial reinforcements from an external source (e.g., additional access to a desired item), and how often/when reinforcement will be provided to the person (e.g., each time the behaviour/skill is demonstrated). Lastly, chosen reinforcers should align with what is reinforcing the behaviours of concern (i.e., the consequences that are maintaining the behaviours).

Non-aversive reactive strategies to de-escalate behaviour(s) of concern

Non-aversive reactive strategies refer to the use of strategies that are **not harmful or detrimental** to the person of focus when behaviours of concern occur. The focus is on de-escalation and ensuring the safety of the person of focus and the people around them and prompting of alternative or functionally equivalent replacement behaviours. Strategies here should be non-aversive (i.e., no punishments), least restrictive, and in the person's best interests. The use of these strategies should take precedence over any use of restrictive practices (discussed more in the next section).

In addition, the proposed strategies should be function-based, that is the strategies replace the function of the behaviour of concern, for example:

- Giving the person what they want or need, including alternative, desired activities, access to social interaction, and the provision of comfort.

- Assisting the person to avoid things they are trying to escape, such as facilitating them to leave an environment/activity, removing unpleasant stimuli or moving away from the person.

This section of the BSP should also specify a de-briefing strategy to be implemented with the person of focus and/or relevant stakeholders when the behaviour of concern has de-escalated (e.g., a one-on-one or group discussions at a suitable time). De-briefing can reduce the possibility of psychological harm for all relevant parties by discussing emotional impact, going over how the situation was managed and identifying areas of improvement when it comes to managing behaviours of concern in future.

- When it comes to de-briefing with the person of focus, behaviour support practitioners should take into consideration the person's **capacity to engage** in a de-briefing process. If the person has an intellectual or cognitive disability, any proposed de-briefing activities should match their speech, language and comprehension abilities.

A note on the use of restrictive practices

The *NDIS Quality and Safeguards Commission* website provides up to date guidance around the legislative requirements of BSPs that include regulated restrictive practices such as seclusion and restraint, therefore this guide will not focus on providing information on regulated restrictive practices.

However, behaviour support practitioners should be aware that BSPs that propose restrictive interventions for behaviour support purposes should highlight **how** the positive strategies and de-escalation strategies proposed in the BSP should be **attempted and used prior** to using a restrictive intervention as a last resort. This needs to be addressed in the section of the BSP that outlines non-aversive strategies to de-escalate behaviour (see previous section).

In addition, BSPs need to provide guidance around how the use of any restrictive intervention can be **faded out** as positive strategies are implemented to support positive behaviour, and the goals outlined in the BSP are achieved. At a minimum, a fade out plan should:

- Outline what goals need to be achieved before a reduction will be attempted.
- When the goal is achieved, what will be done to implement a gradual reduction and who will support this process (e.g., seek guidance from a medical professional on how to safely reduce the dose of a medication used as a chemical restraint, seek guidance from an occupational therapist on how to safely fade out the use of a mechanical restraint, etc.).
- Outline a plan to monitor outcomes for the person of focus to assess whether gradual reduction has not impacted behaviour or quality of life detrimentally.
 - This could be linked to the monitoring strategies that will be implemented for the BSP in general (to be discussed later in this document).

Strategies to support behaviour support plan implementation

BSPs will have no impact on a focus person's behaviour of concern and quality of life if the BSP is **not implemented** to its full extent on a consistent basis. Given this, it's important that behaviour support practitioners consider BSP implementation when developing a BSP. At a minimum, the BSP should outline how plan implementers will be **trained** to implement the BSP and how plan implementers will be in **regular contact** to review and troubleshoot BSP implementation issues on-the-go.

- When it comes to training, behaviour support practitioners should plan ahead and include in the BSP how they will train support staff and family members in how to implement the proposed strategies in the BSP, and how often the training will be provided.
 - Example training strategies include role playing, coaching, feedback and mentoring to mention a few. It is also recommended that behaviour support practitioners conduct in-person checks of BSP implementation post-training, where the practitioner can observe implementers in real-life situations and provide feedback and support as needed.
 - It's important that behaviour support practitioners consult with those tasked with BSP implementation to ensure that the proposed training processes suit their capacity and preference.
- Regarding contact, it is important for the behaviour support practitioner to set up mechanisms in advance to allow BSP implementers to have regular and planned communication to review and troubleshoot implementation issues on-the-go.
 - Some example communication strategies include weekly phone or video conferencing meetings between implementers to check in and a communication diary allowing implementers to make notes to each other.
 - Again, it's important for the behaviour support practitioner to consult with those tasked with BSP implementation to ensure that the communication strategy is accessible to all, time-effective and can be incorporated into the implementer's other commitments.

Strategies for monitoring and reviewing the behaviour support plan

It is important to monitor outcomes stemming from the implementation of a BSP and to review BSPs on a regular basis. By monitoring outcomes, behaviour support practitioners can check if:

1. Progress is being made towards achieving the focus person's goals outlined in the BSP, and
2. The strategies proposed in the BSP are being implemented as intended by the stakeholders responsible for implementation (implementation fidelity).

Outcome measurement can take many different forms and is highly dependent on the goals proposed for the person of focus. The BSP should clearly outline:

- What outcome data will be collected,
- Who is responsible for collecting this data and how often, and
- Who is responsible for collating and reporting this data, how often this will occur and who will receive this information.

To monitor **goals related to the proposed strategies in the BSP**, it is recommended that the methods used to collect behavioural data (e.g., scatterplots, standardised measures) for the purposes of FBA be maintained when the BSP is being implemented.

- By doing this, the behaviour support practitioner can track change in behaviour frequency, duration and intensity as strategies are being implemented, and compare it to pre-BSP implementation levels to assess for behavioural change.

To monitor **goals related to quality of life**, it is recommended that behaviour support practitioners source established measures of the quality-of-life indicators specifically proposed in the person's goals.

- The NDIS Quality and Safeguards Commission's *Compendium of Resources for Positive Behaviour Support*⁷ offers a good starting point to source relevant measures used for BSP development and implementation. The compendium includes information on general quality of life measures, and specific measures for outcomes like pain, adaptive behaviour, and mental health symptoms like depression and anxiety.
- If needed, the behaviour support practitioner could devise their own measure of a quality-of-life indicator of interest. For example, if a goal is proposed around increasing the number of times a person goes swimming as this positively impacts their behaviour, a specific data collection form can be created to monitor the dates the person goes swimming over a specific period.

To monitor **implementation fidelity**, it is recommended that behaviour support practitioners develop a self-monitoring checklist for BSP implementers that breakdown the steps associated with the strategies proposed for implementation. The checklist is then completed by the relevant BSP implementers on a regular basis. Collating and analysing this sort of data can allow the behaviour support practitioner to get a sense of the extent to which the proposed strategies are being implemented and if this is impacting the achievement of the goals outlined in the BSP.

Behaviour support practitioners should clearly outline a plan for **reviewing** the BSP on a **regular basis**. This should include:

- A timeframe for regular review meetings (e.g., monthly, quarterly, etc.).
- How will these review meeting be conducted (e.g., in person meeting, video conference, etc.).
- Who will attend these review meetings.

⁷ Direct weblink: <https://hcpbs.org/wp-content/uploads/2020/04/compendium-resources-positive-behaviour-support.pdf>

- A typical agenda for the meeting (e.g., to review outcome data, troubleshoot implementation issues, modify the proposed strategies as needed).

Write the behaviour support plan

BSPs need to be accessible to the target audience; for BSPs, this would be the stakeholders responsible for implementing the BSP such as direct support workers, other professionals and family members. Behaviour support practitioners need to keep in mind that these stakeholders may have limited, or no knowledge of PBS and the sometimes-complex language associated with the PBS approach. Given this, BSPs need to contain language that is **accessible** and **understandable** to the relevant stakeholder group. Also, providing care and support to people with behaviours of concern can be time intensive. Given this, document length needs to be taken into consideration, with **short and concise documents** preferred.

When writing a BSP, the following should be taken into consideration:

- Limiting the length of the document as much as possible, and only including relevant information that will help the implementer understand the person's behaviour and the strategies that can be put in place to promote positive behaviour and quality of life.
 - There is no guidance available around the ideal length of a BSP given the individualised nature of behaviour support. Given this, behaviour support practitioners will need to make a judgement call regarding BSP length on a case-by-case basis.
- Checking the language accessibility of the BSP document. *Microsoft Word*⁸ has functions embedded into the program that can provide the user with document readability statistics. Two statistics are provided:
 - Flesch Reading Ease: A 100-point scale that assesses average sentence length and average syllables per word. The higher the score, the easier it is to understand the content in the document.
 - Scores **greater than 60** are ideal.
 - Flesch-Kincaid Grade Level: A grade-level assessment of readability which is again based on average sentence length and average syllables per word. For example, a score of 8.0 implies that someone in the eighth grade would be able to understand the document.
 - Behaviour support practitioners should aim for BSP documents at a **grade level between 7.0 and 12.0**, meaning that the content in the BSP would be accessible to people who have completed secondary school.

⁸ Instructions on how to generate readability statistics in Word: <https://support.microsoft.com/en-us/office/get-your-document-s-readability-and-level-statistics-85b4969e-e80a-4777-8dd3-f7fc3c8b3fd2>

- Behaviour support practitioners should also assess the accessibility of their BSPs by providing draft BSPs to potential implementers and seeking feedback on the accessibility of the language used and the length of the document.

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Appendix A: Tips for Developing a Quality Behaviour Support Plan

This tip sheet lists the key quality markers outlined in this guide and can be used as a quick and easy to access reference to support the development of quality behaviour support plans (BSPs).

- Only develop a BSP if positive behaviour support and the implementation of a BSP is **warranted** to enhance the quality of life of the person with disability (referred to as the *person of focus* or *focus person* from here on in) and reduce instances of their behaviour(s) of concern. This decision should be informed by the functional behavioural assessment.
- Ensure that the BSP outlines all efforts made to include, consult and/or collaborate with the person who is the focus of the BSP and their support network to assist with the development of the BSP. If this was not possible, the BSP should outline why.
- If the focus person has **psychosocial disability**, the BSP references other treatment plans (e.g., mental health treatment plans) and how positive behaviour support will be used alongside these approaches to enhance the person's quality of life, and positively impact behaviours of concern.
- The length of the BSP has been minimised as much as possible, and the readability of the BSP has been assessed.
- Regarding the **introductory pages** of the BSP, ensure that:
 - Relevant demographic information about the person of focus and the behaviour support practitioner who developed the BSP is provided.
 - Key contacts for the person of focus are provided along with their contact information, including all implementing service providers.
 - A timeframe for the BSP is provided, along with specified review date(s).
- The BSP should include a short section (no more than two pages) that provides **information about the person of focus** of direct relevant to the person's behaviour(s) of concern.
- Regarding the **target behaviours of concern**, ensure that:
 - The BSP focuses on no more than three individual target behaviours or groups of target behaviours based on function or topography. Early warning signs for all target behaviours have been identified and described also.
 - All target behaviours are described in observable and measurable terms, with information regarding frequency, duration and intensity/severity provided also, and relevant observable behavioural patterns.
 - Setting events, antecedents and consequences for all target behaviours have been identified and described.

- Regarding **functional behavioural assessment**, ensure that:
 - Direct data collection methods (e.g., direct observation using scatterplots) were used to gather information alongside indirect data collection methods (e.g., interviews).
 - A summary statement outlining a functional hypothesis is provided that describes the interconnection between identified setting events, antecedents, target behaviour(s) of concern and consequences, and the proposed function of the behaviour. You could also consider a formulation statement using the 5P approach to formulation.
 - If relevant, a description of one or more functionally equivalent replacement or alternative behaviours is provided.
- Ensure that the BSP includes at least one SMART goal related to enhancing the focus person's quality of life, and one SMART goal related to the strategies outlined in the BSP.
- Regarding **positive strategies to address behaviours of concern**, please ensure that:
 - All strategies are described in enough detail to allow one to implement the strategies from the description only if needed. In addition, avoid strategy overload as this will likely impact plan implementation.
 - As a minimum, prevent strategies focused on addressing the identified setting events and antecedents, and other strategies to maximise the focus person's quality of life are included in the BSP.
 - If teach strategies have been included in the BSP (i.e., to teach the focus person a new behaviour or skill), information is provided regarding who will teach the new behaviour or skill, how, when and where they will be taught, the materials needed to support teaching, and how instruction/prompts will be faded with time.
 - If reinforce strategies have been included in the BSP, all reinforcements are described and information around how and when each reinforcement will be used is provided.
 - Outline information that demonstrates the acceptability (social validity) of the strategies included in the BSP. Socially valid strategies are more likely to be implemented.
- Regarding **non-aversive reactive strategies**, ensure that all strategies proposed are not harmful or detrimental to the person of focus, and the following is provided:
 - A strategy to maintain the focus person's safety and the safety of others (while also meeting the person's needs).
 - A strategy to prompt functionally equivalent replacement/alternative behaviours (if relevant).

- A debriefing strategy to review and discuss instances of behaviour of concern with the person of focus and/or relevant stakeholders.
- If **restrictive practices** are included in the BSP, ensure that:
 - Information is provided detailing how the positive strategies and non-aversive reactive strategies outlined in the BSP should be implemented prior to the use of any restrictive intervention.
 - A fade out plan is provided for each restrictive intervention, which should be linked to the achievement of the goals outlined in the BSP.
- Regarding **BSP implementation**, ensure that the BSP outlines:
 - A training plan indicating how and when BSP implementers will be trained in implementing the strategies.
 - A communication plan indicating how and when BSP implementers will communicate with one another to discuss their progress with implementation and to troubleshoot issues.
- Regarding **BSP monitoring and review**, ensure that the BSP outlines:
 - What outcome data will be collected, who will collect it, who will collate it, how often they will collate the data, and who they will report the collated data to.
 - A timeframe for regular review meetings (e.g., monthly), who will attend these meetings, how these meeting will be conducted (e.g., in person), and a typical meeting agenda.

Appendix B: List of Available Online Resources to Support Behaviour Support Plan Development

NDIS Quality and Safeguards Commission Website

<https://www.ndiscommission.gov.au/providers/understanding-behaviour-support-and-restrictive-practices-providers>

This website provides behaviour support practitioners working in Australia with relevant information about providing behaviour support to NDIS participants, including practitioner registration, BSP development and submission to the Commission (including BSP templates), and information regarding regulated restrictive practices and legislative requirements around their use.

Australian Capital Territory Office of the Senior Practitioner - Positive Behaviour Support Plan Guidelines

https://www.communityservices.act.gov.au/_data/assets/pdf_file/0006/1460058/Positive-Behaviour-Support-Plan-Guidelines.pdf

This guide is specific to Australian Capital Territory disability service providers, however the elements of what is required for a good quality behaviour support plan included in this guide are universal.

Victorian Department of Health and Human Services – Information for Behaviour Support Practitioners Website

<https://www.dffh.vic.gov.au/information-behaviour-support-practitioners>

This site has several resources for behaviour support practitioners, with the following resources of particular interest:

- **Behaviour support plan toolkit** – This toolkit is specific to Victorian disability service providers, however the elements of what is required for a good quality behaviour support plan included in this toolkit are universal.
- **Positive Practice Framework: A guide for behaviour support practitioners** – A comprehensive resource for behaviour support practitioners that brings together research, knowledge and practice in positive behaviour supports.

Queensland Department of Communities, Disability Services and Seniors – Preparing a positive behaviour support plan: Guidelines and model plan

<https://www.dsdsatsip.qld.gov.au/resources/dsdsatsip/disability/service-providers/centre-excellence/positive-behaviour-support-plan.pdf>

These guidelines assist practitioners to develop an effective behaviour support plan and also meet the requirements of the *Queensland Disability Services Act* (2006).

British Institute for Learning Disability (BILD) Website

<https://www.bild.org.uk/positive-behaviour-support-pbs/>

This website has a range of resources about positive behaviour support. The video introducing positive behaviour support is useful for families and staff supporting the participant.

The Challenging Behaviour Foundation Website

<https://www.challengingbehaviour.org.uk/>

A UK based charity that focuses on the needs of people with severe learning (intellectual) disabilities who show challenging behaviour (behaviours of concern). This website provides advice and resources for families and professionals.

Flinders University – Positive Behaviour Support following Brain Injury: A Family Education Workbook

<https://www.flinders.edu.au/content/dam/documents/research/research-studies/pbs-education-workbook.pdf>

The purpose of this workbook is to provide families with information regarding common behaviour changes following brain injury, and to introduce basic principles of positive behaviour support that can be utilised within community settings.