Practice Guide – Positive Behaviour Support and Behaviours of Concern

Contents

1. Purpose

The purpose of this Practice Guide is to guide you through the considerations, roles and responsibilities when planning for a participant who displays Behaviours of Concern (BoC).

2. To be used by

- Plan Developers – Planners and Local Area Co-ordinators [LACs])
- NDIA Plan Delegates.

3. Scope

This Practice Guide provides information to support plan developers to understand when and how positive behaviour support may be a reasonable and necessary support where the participant displays BoC. This includes the respective roles and responsibilities of the National Disability Insurance Scheme (NDIS), NDIS Quality and Safeguards Commission (NDIS Commission) and states and territories.

Behaviour supports are to be provided in accordance with the NDIS Commission's requirements for positive behaviour support. The NDIS funds reasonable and necessary supports designed to identify and reduce BoC, to improve the participant's quality of life, uphold their dignity and safeguard their rights.

The NDIS Commission is operating in all states and territories except for Western Australia. Current state requirements for quality and safeguards continue to apply in Western Australia until the NDIS Commission commences operating from 1 July 2020. Behavioural supports are provided in accordance with the NDIS Commission's requirements for positive behaviour support. The Positive Behaviour Support Capability Framework includes guiding principles to assist in delivering positive behaviour support.

The NDIS Commission and states and territories have oversight of behaviour support and restrictive practices. They are committed to a regulatory framework for behaviour support that is founded on contemporary evidence-based practice and aligned with the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Services Sector (external).

4. Legislative and Policy Context

The NDIS Commission is responsible for best practice guidance, monitoring and oversight of behaviour support service provision and the use of restrictive practices. State and territory governments remain responsible for specific legislation, policy and procedures related to the authorisation of restrictive practices. These are separate but related processes and requirements.

The NDIS Commission assesses behaviour support practitioners and providers using a Positive Behaviour Support Capability Framework. This provides guiding principles to assist in delivering specialist positive behaviour support as an NDIS behaviour support practitioner.

In all states and territories (excluding Western Australia), providers who use or are likely to use restrictive practices, or who develop behaviour support plans (BSPs) must be registered with the NDIS Commission and meet the supplementary requirements of the NDIS Practice Standards (external).

To support safeguarding for people subject to restrictive practices, any use of restrictive practice must comply with the NDIS (Restrictive Practices and Behaviour Support) Rules 2018. These safeguards include but are not limited to:

- behaviour support practitioners, and providers who use regulated restrictive practices (also known as implementing providers) must meet the requirements outlined
- state and territory governments remain responsible for the authorisation of BSPs, which include the use of a regulated restrictive practice. Providers must comply with requirements of their state or territory
- restrictive practices are clearly identified in a BSP.

The Western Australian government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices and behaviour supports in the NDIS.

Refer to Appendix 1 for state and territory restrictive practice legislation.

The NDIA is not obligated to fund supports which have been imposed by state and territory bodies, which involve the use of restrictive practices, for example where a supervision order has been imposed by a civil or criminal court. However, where a restrictive practice has been authorised, recommended, or implemented by another body, this is a relevant consideration when determining if the support is reasonable and necessary.

Behaviours of Concern, also known as challenging behaviours, refer to a wide range of behaviours of an intensity, frequency or persistence that threatens the quality of life, physical safety of the individual and/or others and generally results in limiting access to the community.

Behaviours of Concern can be any behaviour that results in an adverse impact on the person's quality of life. This may include:

- physical or verbal aggression
- property damage
- inappropriate sexual behaviour
- disinhibited and impulsive behaviour

- self-injurious behaviour also referred to as self-harm. It differs with each person and can include head banging, picking and hitting. This behaviour may not be an attempt to cause harm.

Please note the term self-harm when used in mental health settings typically refers to intentional harm without suicidal intent such as neglect, cutting, ingesting objects and self-poisoning. Mental health professionals must be consulted by the participant's supports as this is typically an indication of serious distress.

In order to provide successful interventions, it is necessary to understand the function of that behaviour for the person and the context it occurs. There may be a range of underlying factors influencing BoC including:

- underlying physical, neurological, mental or emotional health issues
- biological/physical due to experiencing pain or discomfort
- acting out a repetitive behaviour or routine
- frustration in not being able to do something
- communication/social needs due to difficulties in communication, seeking social interaction or attention
- demonstrating a learned behaviour
- the physiological effects of substances including alcohol, illegal drugs or medications
- difficulty with service systems or support networks
- attempting to avoid a situation
- interpersonal environment such as quality of social interactions
- change in routine or structure
- inflexible thinking
- attempting to manage sensory overload
- having a high pain threshold and the behaviour is intended to provide sensory stimulus
- support staff skills and turnover, perceptions and level of resources available.

4.1 Impacts of Behaviours of Concern (BoC)

Behaviours of Concern affect the quality of life of the individual. Factors such as the intensity, frequency or persistence of the behaviours may limit a participant in their opportunities to pursue social, educational, economic and/or recreational activities. Often this is due to the need to maintain the physical safety of an individual or other people (such as family, support workers or the community) and reduce the risk of unsafe social participation (such as inappropriate and/or unsafe sexual behaviours).

Where the participant exhibits BoC, they may require supports in several areas of their life. Informal supports can have difficulty in sustaining relationships and caring responsibilities due to the potential risk of harm to the participant, other people in the home or themselves. NDIS funded supports can be used to support informal and formal supports in their roles and build their capacity to effectively address the BoC with the participant. These supports may help sustain the participant's current living and/or support arrangements and encourage the participant to positively engage with others. Where the participant has complex and longstanding BoC there may be further difficulties in engaging and sustaining funded supports.

Participants with complex BoC may be at risk of breakdown of their living arrangements such as being temporarily removed from shared living arrangements to individualised accommodation support settings, or family supports no longer being able to sustain the person living in the family home. There is also the risk of increased support staff turnover that in turn can lead to further escalation in behaviours due to constant changes in their environments, formal and informal supports, and the impact of fractured relationships.

In some cases, when informal supports are unable to continue to care for the participant who displays complex BoC, an alternative accommodation arrangement may be required for short or long term periods. Where there has been an escalation of behaviours and this requires a change of circumstances refer to the Practice Guide - Unscheduled Plan Review, Practice Guide – Supported Independent Living (SIL) and the Practice Guide – Medium Term Accommodation.

In the case of a person under the age of 18, refer to the Practice Guide – Children and Young People with Disability Living in a Voluntary Agreement Outside the Family Home.

4.2 Positive behaviour support

Positive behaviour support is an effective approach for BoC as it focuses on addressing a person's needs, their home environment and overall quality of life through assessment, planning and intervention.

The positive behaviour support process typically follows similar steps.

1. **Brief functional behaviour assessment** - focussed on identifying requirements for incident prevention and response.
2. **Interim plan** - may also be referred to as a safety interim plan, incident prevention and response plan, reactive strategy response plan or reactive strategy. Interim BSPs include the provision for the use of a regulated restrictive practice developed within one month of engagement by a behaviour support practitioner while a comprehensive BSP is being developed.
3. **Comprehensive functional behaviour assessment -** the process for determining and understanding the function or purpose behind a person's behaviour, and may involve the collection of data, observations, and information to develop an

understanding of the relationship of events and circumstances that trigger and maintain the behaviour.

4. **Comprehensive positive behaviour support plan** (see 4.2.1)
5. **Training and implementation support implementation support** - this usually targets informal supports and direct support workers and may also include reports and liaison with other stakeholders, reports for the psychiatrist; reports to restrictive practice authorisation mechanisms.
6. **Monitoring** - data collection, analysis and reporting.
7. **Review** - ongoing review of effectiveness of the BSP; revisit functional behaviour assessment at least annually.

The plan developer includes the appropriate capacity building support in the participant's plan for the provision of these supports.

4.2.1 Behaviour Support Plan (BSP)

A BSP specifies a range of evidence-based, person-centred and proactive strategies which focus on the individual needs of the person. It is developed with the aim of addressing the underlying functions of BoC taking place or increasing. The plan will outline specifically designed positive behaviour support strategies for the participant, their informal and funded supports to assist in reducing BoC and supporting their quality of life and goal attainment.

There are rules regarding practitioners and BSPs that are relevant to the staff member or coordinator of supports who is assisting the participant to implement their NDIS plan. A registered specialist behaviour support practitioner must develop all functional behaviour assessments and BSPs, as positive behaviour support practice requires a specific skillset and appropriate safeguards. The Positive Behaviour Capability Framework (external) is used to determine suitability of the behaviour support practitioner required.

Behaviour support practitioners must lodge BSPs containing restrictive practices with the NDIS Commission.

If the BSP does not include restrictive practices, it does not need to be lodged with the NDIS Commission. However, the practitioner developing the positive BSP must still be registered as a specialist behaviour support practitioner and the provider implementing restrictive practices must also be a registered NDIS provider.

4.2.2 Assessment, development and review

To develop a positive BSP, a functional behaviour assessment must be completed where practitioners consult with the participant, their family, guardian and other relevant people including the service provider/s who will be implementing the plan. This is to gather historic and current information which identifies settings, triggers, actions and results according to the behaviours displayed.

The BSP is designed to address the factors identified in the assessment. It will include a range of strategies used to support the person, including proactive skill development to build on the participant's strengths and response strategies to use when the behaviour presents.

Behaviour support plans are formally reviewed annually or earlier if the participant's circumstances change. At the time of review, the effectiveness of all aspects of the plan including the preventative/environment, skill building/teaching and reinforcement strategies are measured along with step-down strategies when there is the use of restrictive practice. Importantly the progress towards the person's goals and identified quality of life measures is considered.

Assessment information can be used by the plan developer to consider effectiveness and outcomes of funded supports and determine the level and type of capacity building support for inclusion in the NDIS plan.

Refer to the Compendium of Resources for Positive Behaviour Support (external) for further information about the range of positive support assessment tools that can be used by practitioners for assessment, planning, implementation, monitoring and review.

4.2.3 Younger People in Residential Aged Care (YPIRAC)

Residential aged care providers have the same responsibilities towards NDIS participants as they do to other residents who receive services and supports under the Aged Care Act 1997. Currently, services are regulated by the Aged Care Quality and Safety Commission.

From 30 June 2020 all providers applying the use of restrictive practices with young people in residential aged care will be regulated by the NDIS Quality and Safeguards Commission.

Refer to the Practice Guide – Younger People in Residential Aged Care for further information.

4.3 Restrictive practices

A restrictive practice is any practice or intervention which has the effect of restricting the rights or freedom of movement of a person with a disability. All states and territories endorsed the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Services Sector which was reaffirmed in the NDIS Quality and Safeguarding Framework.

If there is the use of restrictive practices or request for restrictive practices, the plan developer must make a referral for advice to the Technical Advisory Team (TAT). Refer to the TAT mandatory referrals page for more information.

Restrictive practices must be authorised through a formal process which is the responsibility of each state or territory and varies across jurisdictions. Restrictive practices can be considered only if they are the least restrictive alternative, and in the context of positive behaviour support strategies.

When a person is exhibiting BoC, those around them may try to stop or modify their behaviours in a number of ways with the intention of keeping them or others safe. They may intervene physically, try to control where they go, what they do or administer mood altering medications. Where a practice is age-appropriate to keep a child safe, for example holding a child's hand while crossing the road, this would not be considered a restrictive practice.

The use of restrictive practices are a risk to the human rights of people with disability and there is a need to ensure there is appropriate reporting and scrutiny when used. The NDIS Commission has identified five forms of regulated restrictive practice:

1. **Seclusion:** The sole confinement of a person with disability in a room or a physical space where voluntary exit is prevented, not facilitated or it is implied that exit is not allowed. This may include when a person is put in a room or placed on their own and the person cannot leave when they want to as the door has been locked.
2. **Chemical restraint:** The use of medication or chemical substance for the primary purpose of influencing a person's behaviour. The medication or chemical substance provided is not treating a diagnosed illness or condition and is intended to make them calm or sleepy. This is often psychotropic medication, which affects mood and is generally prescribed by a psychiatrist.
3. **Mechanical restraint:** The use of a device to prevent, restrict or subdue a person's movement for the primary purpose of influencing a person's behaviour. This includes but is not limited to putting gloves on a person that they cannot remove independently so they are unable to scratch themselves or others, or restraining someone in a wheelchair using a harness that they are unable to undo independently for the purpose of keeping them in the wheelchair. **Note:** this does not include the use of devices for therapeutic or non-behavioural purposes.
4. **Physical restraint:** The use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury.
5. **Environmental restraint:** Restricting a person's free access to all parts of their environment, including items or activities such as locking cupboards or fridges.

4.4 Restrictive practice guidelines

The NDIS Commission is taking the lead role in reducing and eliminating the use of restrictive practices and holds responsibility for monitoring the use of all restrictive practices recommended and implemented by NDIS providers in Australia. The NDIA is not responsible for making decisions about the use of restrictive practices.

Under the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018*, restrictive practices are subject to regulation. Restrictive practices can only be used based on an assessment of behaviour with the appropriate authorisation from

the relevant State or Territory and where it is part of a BSP that has been developed by a registered behaviour support specialist.

The registered behaviour support practitioner is responsible for:

- submitting written applications to restrictive practice authorising panels or bodies seeking authorisation
- submitting regular progress reports, data summaries, and other documents to restrictive practice authorising panels or bodies
- attending restrictive practice panel meetings or other contact with the authorising body.

4.4.1 Participant with immediate needs

Where there is no current interim or comprehensive BSP in place and the participant has an immediate need for a restrictive practice due to a new or previously unexperienced degree of severity in the escalation of behaviour, the NDIS Commission outlines that:

- an interim BSP must be completed within a month of engagement by the behaviour support practitioner, and
- a comprehensive BSP must be developed within six months of the interim plan being completed by the behaviour support practitioner.

4.4.2 Implementing providers

The NDIS Commission refers to service providers who use a regulated restrictive practice as implementing providers. Implementing providers are expected to understand the context of the person's behaviour and follow the authorised BSP to make sure the use of any restrictive practice is a last resort intervention and in proportion to the risks posed by the behaviours.

Implementing providers will report monthly to the NDIS Commission regarding all restrictive practices used, monitor, and collect data as outlined in the BSP. This forms part of the ongoing focus on reducing or eliminating restrictive practices and addressing BoC. Service providers must aim to reduce the use of restrictive practices by working with the participant and their supports to obtain a greater understanding of the function of the behaviour as well as triggers, and provide preventative strategies and techniques to develop more appropriate ways to support the participant. The behaviour support practitioner will support the implementing provider where required to understand the relevant state or territory legislative and/or policy requirements.

4.5 Point of crisis

A point of crisis is a period of intense difficulty and distress experienced by a participant that disrupts and makes their usual day-to-day life hard to cope with. Participants may experience points of crisis for various reasons, such as escalation of mental health issues or the unexpected loss of formal and/or informal supports. Emergency support may also be

provided by other government services such as child protection, homelessness services, hospitals, ambulance, police and mental health assessment teams.

A crisis may often result in the escalation of BoC and may temporarily require more intensive support. While the NDIS is not responsible for the delivery of emergency support, when the participant or their informal support contacts the NDIS during times of crisis, we need to be responsive to their concerns.

This may involve supporting the participant to access other government services as required, and explaining how the funding in their plan can be used flexibly to meet their needs during a crisis. The participant may have interacted with the After Hours Crisis service as part of the Exceptionally Complex Support Needs Program.

You will need to ensure the support coordinator is aware of the situation and is responding to and supporting the participant in a timely and effective manner. The role of the support coordinator and the level of support coordination may need to be considered. For example, a specialist support coordinator to manage multiple mainstream interfaces, organise and prepare reports may be required.

In some cases, the behaviour support practitioner may be able to identify periods of crisis are likely to occur for a participant when certain circumstances arise. In these cases, the BSP and other supports should be proactively designed to respond to these situations. This may impact on the way the supports are funded in the NDIS Plan.

It may be appropriate to consider an unscheduled plan review where additional supports are required beyond the flexibility of the existing plan. Refer to Practice Guide – Unscheduled Plan Reviews.

Interactions detailing the crisis circumstances and actions taken must be recorded in the NDIS Business System (System) and an alert added if required.

4.6 Incident management

4.6.1 Registered providers

Registered service providers must have effective incident management systems and are responsible for recording and managing all incidents that happen in the delivery of NDIS supports and services, and notifying the NDIS Commission of any reportable incidents (including allegations) that occur with the provision of supports and services to an NDIS participant. Reportable incidents include:

- serious injury or death of an NDIS participant
- abuse or neglect of an NDIS participant
- unlawful sexual or physical contact with, or assault of an NDIS participant
- sexual misconduct committed against, or in the presence of, an NDIS participant, including the grooming of the NDIS participant for sexual activity

- the unauthorised use of restrictive practice.

Refer to the NDIS Commission's Reportable Incidents (external) for further information.

4.6.2 Unregistered providers

Unregistered providers must follow their internal provider reporting channels. All providers (registered and unregistered) who are providing NDIS funded supports must follow the NDIS Code of Conduct (external).

4.6.3 National Disability Insurance Agency (NDIA)

If information is provided to the NDIA which suggests or alleges a participant critical incident has occurred, refer to the National Critical Incidents Response Framework.

NDIA staff are required to report reportable incidents where appropriate. Refer to the information available on the Participant Critical Incidents page.

As noted above any unauthorised use of restrictive practice is a reportable incident. This incident may be a trigger for a section 48 plan review. The participant and/or their authorised representative can request a review or the NDIA may choose to initiate based on the information provided around the critical incident. Critical incidents highlight that the participant's supports may require adjustment or further changes are needed. It is the responsibility of the NDIS to make sure that a participant has appropriate funding for their support needs, including behaviour support.

5. Pre-planning

5.1 Streaming

Plan developers need to ensure the correct streaming decision has been recorded in the System for the participant to receive the appropriate level of support to implement their plan. Factors to change the streaming decision are dependent on the complexities presenting in the participants current life situation or environment which may be identified during your conversation.

Where a participant has complex support needs requiring a different approach, a referral to the Complex Support Needs Pathway may be appropriate.

Refer to Standard Operating Procedure – Update Participant Streaming and Standard Operating Procedure – Referral for Complex Support Needs for further information.

Note: The term streaming is for internal use only.

5.2 Plan duration

The plan duration ready reckoner guide recommends plans are developed for up to 12 months when a participant is requiring behaviour support and/or is streamed as super intensive. However the participant's individual circumstances should be considered and a shorter plan duration may be required if, for example, the BSP is being assessed,

accommodation needs/options are being assessed or close monitoring is required. Where the participant's situation is stable a longer plan duration may be also be appropriate. Refer to Standard Operating Procedure – Complete the Risk Assessment and Practice Guide - Pre-Planning for further information.

5.3 Arranging the planning meeting

Contact the participant and/or their authorised representatives (nominee/s, child representatives, and court or tribunal appointed decision makers) through their chosen method of communication and confirm/obtain consent for information sharing and exchange. A participant or their authorised representative may choose to invite other family members, friends or NDIS funded support providers to the NDIS planning meeting.

It is important to confirm all meeting attendees. This will allow for appropriate consideration of location, meeting room, time allocated and whether additional or senior staff are required to attend.

In limited circumstances, it may be necessary to appoint a plan nominee to act on behalf of, or make decisions on behalf of a participant. Refer to the Standard Operating Procedures – Appoint, Decline, Suspend or Cancel a Nominee.

Where possible and appropriate, the participant should be in attendance during the planning conversation. The participant's wellbeing is the priority and discretion is required at times to determine whether it is suitable for their attendance, such as if there is significant unrest and or concerns about safety due to events such as accommodation or relationship breakdown as a result of significantly challenging behaviours.

In these instances, efforts should be made to include the participant, and consider a shorter meeting to confirm key details or having them contribute in another way such as completing the relevant NDIS booklet prior to the meeting.

When confirming a meeting location and time, it is important to check the System for alerts and confirm the following with the participant or their authorised representative:

- Consider the participant's routine. For example, if the participant has difficulty sleeping at night they may not function well in the mornings and prefer an afternoon meeting.
- If known, consider the sensory needs of the participant and confirm an appropriate location. For example, if BoC are triggered by sensory overload, suggest a quiet office to conduct the meeting.
- Understand any specific environmental factors that may present a risk to the participant or to other members of the meeting including the NDIS staff member.
- Understand and respect any cultural sensitivities or barriers to communicate effectively for example, they may prefer to meet with someone of the same gender.

- Explore options to book a meeting for an extended period of time to allow breaks, or hold the planning meeting over multiple sessions or arrange for the participant to attend for shorter periods.
- Be aware of any behaviour response strategies that may need to be implemented during the meeting and what the role of the NDIS staff member will be, noting the service providers and informal supports who know the person well should lead the response directly with the person to de-escalate the situation or conclude the meeting.

5.3.1 Gathering documentation

Arranging the planning meeting provides an opportunity to follow-up on relevant supporting documentation that has not been provided yet. The participant, authorised representative or their support coordinator may provide this information to the NDIA. In some circumstances, the NDIA may need to follow-up directly once appropriate consent has been obtained. Behaviour support documentation may include:

- the most recent BSP
- behaviour protocols or strategies (where not collated in an interim or comprehensive plan as per the NDIS Commission)
- behaviour support recommendations report outlining next steps in behaviour support and estimated hours required
- incident reports, preferably incident summary reports
- data summary reports
- Restrictive Practice Authorisation documentation (if relevant)
- support model assessment reports including identifying housing options
- other assessment reports and support plans, such as speech pathologist, occupational therapist, psychologist, psychiatrist, paediatrician or other medical practitioner
- other relevant reports from service providers or mainstream agencies such as court reports.

All new or updated legal/court orders and other documents provided to the NDIS must be uploaded to inbound documents in the System.

5.3.2 External meetings

If a meeting is taking place at a location external to an NDIS office, follow the usual appointment booking process and ensure the following:

- complete and attach a copy of the home visit risk screen document and journey plan to the participant's record in the System
- review other information available in the System including, but not limited to previously completed planner risk assessment, guided planning questions, planning conversation

tool and inbound documents. This information will assist in ascertaining if there are any likely risks or concerns, such as other people being in the premises and the general safety of surrounds

- discuss any identified risks and take any appropriate action as determined with your team leader
- familiarise yourself with the journey management procedure and out of office best practice guide.

NDIA staff are supported to make decisions at all times to protect their personal safety. These decisions may include:

- deciding that a visit requires a second employee to be present
- arriving at a location and deciding to cancel a visit due to safety concerns
- terminating a visit part way through due to safety concerns.

Refer to the Work Health and Safety page for further information.

For circumstances where the health, safety and/or security of NDIA staff or others is put at risk due to the behaviour of a participant or other third party, NDIA staff should refer to the Work Health and Safety page and NDIA Managing Unreasonable Behaviour Framework, Policy and Guideline for information, advice, reporting and escalation protocols.

5.4 Planning conversation

The participant is at the centre of the planning process and their goals and needs are explored by discussing their strengths and what they would like to achieve. The planning conversation should identify goals, capacity, risks and safeguards and provide an opportunity to discuss any assessments and reports.

Information provided in the planning meeting about the participant's BoC must be detailed in the guided planning questions free text box and in the planning conversation tool.

The following points can support you to have a high quality conversation:

- Be mindful of the person's communication needs and preferences including whether an interpreter is required.
- Make decisions about what will be appropriate to ask the person directly and what may be triggering or distressing that can be gathered in another way.
- Read previous planning information (if applicable), interactions and inbound documents.
- Review the support coordination progress reports. These should detail information including the participant's circumstances, identified risks, strategies and outcomes for the participant's goal progression.

- Review the behaviour specialist reports and any other assessments that identify outcomes achieved, key barriers and recommendations for the new plan.
- Follow up any requested reports and/or assessments not yet provided, to assist informing the planning process.
- Use visual tools to assist in communicating. For example, if asking a participant about their schedule, use the weekly supports table in the NDIS planning booklet (external) to help break down the questions, or other format as determined appropriate to their communication needs.
- Encourage the participant to talk about/communicate their interests, what daily life is like, what challenges they face and allow time as needed for them to explain this to you.
- Discuss the previous plan (if applicable), what they found worked well and what did not. For example, they may have strong informal supports or may be at risk of losing their housing or in temporary accommodation placing them at risk of homelessness.
- Be conscious to not ask leading questions as people are likely to give the answer they think you want to hear.
- If the participant is appearing anxious or not engaging, consider asking them what would make them feel more comfortable such as having a break.
- Depending on the participant's situation, there may be multiple stakeholders with differing input present in the planning process. In these circumstances, make sure the participant and their authorised representative are the focus of your attention. Make sure they understand that they can request other people leave the room at any time.
- In some circumstances, due to the complexity of the participant's BoC further discussion may need to take place with the participant's informal supports and positive BSP practitioner to discuss current and proposed support needs, or there may need to be a second meeting.
- Where appropriate, seek consent to follow-up with specific individuals or providers. Refer to the Standard Operating Procedure – Consent and Authority for further information.

6. Planning

The Agency must be satisfied that the funded supports in the participant's NDIS plan meet each of the criteria outlined in section 34(1)(a)-(f) of the NDIS Act 2013 (NDIS Act) and the NDIS (Supports for Participants Rules) 2013.

When planning for the participant with BoC, it is important to be aware of any recent or upcoming changes in their life. Behaviours of concern may take place more frequently or at a greater severity during transitional periods for example during adolescence, leaving school or changes in living arrangements.

It is important to also be mindful that effective positive behaviour support:

- is not a linear process. For example, the practitioner may be conducting an assessment while revising the plan and training
- is highly individualised
- is holistic and integrated
- utilises a systems approach
- includes crisis response and BSP revision as required
- includes multi-disciplinary input in all elements including assessment, design, implementation and review
- varies in intensity and time required depending on the complexity of the person's situation and support needs
- cannot always be delivered in monthly amounts across the year. For example, there may be a high utilisation initially for providers to complete the initial assessment, interim planning, comprehensive assessment and comprehensive BSP development.

Refer to Practice Guide - Determine Reasonable and Necessary Supports for further information.

6.1 Core supports

Core supports are intended to assist with or supervise personal tasks of daily life to enable the participant to live as independently as possible. The BSP is expected to be used by all formal supports to build on the participant's strengths, increase their opportunities to participate in community activities and increase their life skills.

Where possible, the funds can be used to strengthen the capability and capacity of the participant and their informal supports (if applicable) by reinforcing strategies and encouraging independence towards goal attainment.

Providers for participants with complex BoC may request higher support costs, for example 2:1 or 1:1 for the participant to continue to attend a day program. This level of support can be considered an environmental constraint where it is as a response to behaviour concerns and not related to other support needs such as health.

The delegate may need to consider that the sudden removal of funded Core supports for participants with high level staff ratios and/or restrictive practices may put the participant's living arrangement, their staff, or others at risk.

It is therefore important to consider a transitional or gradual step down model to effectively reduce supports in line with the BSP. This is likely to take place over the course of multiple NDIS plans and should be guided by the registered specialist behaviour support practitioner. The TAT may be consulted as needed via TAPS and advice should be sought from TAT for all plans that contain restrictive practices. For more information refer to mandatory referral.

If the participant requires a higher intensity level of support, refer to the Standard Operating Procedure – Self-Care and Community Access Supports for further information.

6.1.1 Behaviours support provision in supported independent living (SIL)

Behaviour supports need to take a whole of house approach when a participant is living in a supported independent living (SIL) arrangement with other people with disabilities. Behaviour support may be recommended where there are high-level staffing ratios such as 2:1 or 1:1 support for individual residents and/or active overnight support are in place to manage risk to staff and residents, or there are frequent incidents such as assaults, self-harm and/ or property damage.

A whole of house approach for behaviour support involves considering reasonable and necessary funded supports allocated for each participant can be utilised in a coordinated way to meet the needs and increase the quality of life of all residents.

Behaviour supports for a whole of house approach may include:

- shared living environmental assessment, also known as ecological assessment
- behaviour support systems review
- program development
- staff training.

Some of these supports may be shared in a whole of house approach, for example, there would be one shared living environmental assessment completed by the one provider to assess the overall household situation. The cost of the environment assessment would then be broken down and shared amongst all those living in home. Refer to the Practice Guide – Supported Independent Living (SIL).

6.2 Capacity Building supports

Before including funding for behaviour supports, consider the Capacity Building funding generated by the TSP and whether these funds are sufficient to provide some or all of the required behaviour support. To do this you will need to understand what other Capacity Building supports are required by the participant and work out whether the total Capacity Building funding needs to be increased to support the participant with their BoC. For instance, a child or younger person may require a higher level of funding so their informal supports are appropriately trained to implement the BSP.

There is a guided planning question related to BoC which must have the correct responses recorded. Responses to this question are for data capturing only and do not generate any funding in the TSP. The TSP is a guide and decisions on reasonable and necessary supports should be made in accordance with S34 of the NDIS Act.

6.2.1 CB Daily Activity

Best practice in behaviour support involves a multidisciplinary approach tailored to the needs of the person. It is therefore important to ensure the relevant therapeutic assessments and services are included in CB Daily Activity area of the plan. NDIS reasonable and necessary improved daily living supports may include:

- assessments including psychological, communication and sensory
- individual skills development and training
- training for carers or parents.

As noted previously, a functional behaviour assessment can only be completed by a registered specialist behaviour support practitioner or provider.

6.2.2 CB Relationships

Behaviour supports within the category of CB Relationships may include:

- specialist behavioural intervention support for assessment and development of BSP
- behaviour management plan and training in behaviour management strategies
- individual social skills development.

Dependent on the participant's circumstances, NDIS funded support workers may require individualised training specific to the participant to maintain consistency and positive behaviour supports. Practitioners may provide training plans for the support worker or therapy assistant in the development of social skills identified as required due to BoC.

When determining reasonable and necessary funding, the specialist behaviour support practitioner would be expected to monitor the BSP implementation and review accordingly. Regular review allows opportunity for changes and updates to the BSP if the progress differs from expectations.

Questions which may help in determining the amount of funding include:

- Which stage of behaviour support currently applies? Are they at the brief assessment and safety planning stage (Refer to 5.2) or are they stable and in the monitoring stage? This indicates how many hours are still required for assessments and reporting.
- Does the participant already have a current comprehensive behaviour assessment?
  - If so, the next assessment will usually require less time.
- Does the participant already have a current comprehensive BSP?
  - If so, the next BSP update will usually require less time.
- How many BoC does the person engage in? Usually the more behaviours, the more time required for all stages of the behaviour support process.

- What is the intensity and severity of the behaviour/s of concern? More intense and high-risk behaviour is likely to require more time in assessment, design, protocol revision and implementation support.
- How many informal and formal support providers are involved? This will impact on the amount of observations, interviews, file review required; the amount of tailored strategies required for various environments and roles; and the amount of training and implementation support required.
- How many regulated restrictive practices are proposed or in place? The more practices, the more time required for assessment, design, implementation, and reporting.
- How many informal or funded supports require training and implementation support? Can this be done in one session or do multiple repeat sessions need to be factored in?
- What other reporting requirements does the specialist behaviour support practitioner have? This may include data summaries and consultation with a psychiatrist to inform medication review.
- How will the multidisciplinary team collaborate? How often will they need to meet or have other contact?
- How many other stakeholders does the specialist behaviour support practitioner need to engage with?
- How much direct contact will the specialist behaviour support practitioner have with the person for skill development? Is this sessional, what is the frequency?
- What other pieces of work are required? Are there specific assessments that can inform the behaviour assessment behaviour assessment report (such as Assessment of Sexual Knowledge); Support Model Assessment report; transition plan development and implementation (such as from one placement to another).
- Where there are regulated restrictive practices required, you should also include funding for the specialist behaviour support practitioner to meet their obligations under the NDIS Commission specific to this participant and the state or territory authorisation process.

6.2.3 Levels of behaviour intervention support

You will need to ensure the participant receives the appropriate support required to implement their plan and to address any behavioural complexities in their current life situation. There are two levels of behaviour intervention support provided as a guide however the participant's individual circumstances and supporting information must be considered in every plan to determine appropriate funding and supports required.

The levels of support include a behaviour management plan and training in the management of strategies to form a package of support to address a participant's immediate need for

behavioural intervention. You will need to make a reasonable and necessary decision to determine the appropriate level of support included in the participant's plan.

The guidance in hours has been suggested for a plan of 12 months in duration. Use your reasonable and necessary decision making for plans with durations less or more than 12 months. If a participant has significant behaviours of concern it is highly unlikely that there will be a plan over 12 months due to the need to monitor and review outcomes and circumstances.

Consult with your team leader and refer to the participant's individual supporting documents, Practice Guide - Determine Reasonable and Necessary Supports and the Standard Operating Procedure – Include Behavioural Intervention Support in a Plan for further guidance.

6.2.3.1 Level 1

Level 1 funding could be considered appropriate for participants who require intervention due to significant behavioural complexities that are impacting on the ability of the participants informal supports to sustain care at home and assist the participant to safely engage in activities.

Level 1 criteria includes:

- behaviours of concern that could require single or minimum interventions
- lack of services willing to engage with the participant due to presenting behaviours and risk to staff/participants/community
- change of participant circumstances that will result in withdrawal of service support and need for immediate intervention.

Use reasonable and necessary decision making to include specialist behavioural intervention support. Most level 1 plans should not exceed 45 hours (approx. 3-4 hours per month) which will enable the participant to receive support from a psychologist or appropriate therapist to develop a BSP, implement strategies and review interventions over a period of time.

To support carers and any other significant informal supports in the participant's life to implement the behavioural support plan and behavioural strategies, include training in behaviour management. Most level 1 plans should not exceed 20 hours (1-2 hours per month) which will ensure the behavioural intervention support plan is applied consistently in all necessary environments to best support the participant.

Participant's that may have significant 1:1 support in the community (equal to 30% of the day) or at home due to their harmful or persisting behaviours that may present risk to themselves or others.

6.2.3.2 Level 2

Level 2 funding could be considered appropriate for participants that require immediate intensive behavioural intervention support and are streamed Super Intensive. In the majority of circumstances, level 2 funding is not appropriate for children aged 7 and under.

Level 2 criteria includes:

- multiple complexities that may require multiple interventions
- extreme behaviours of concern that could require restrictive intervention
- lack of services willing to engage with the participant due to presenting behaviours and risk to staff/participants/community
- significant change of participant circumstances that will result in withdrawal of service support and need for immediate intervention
- behaviours of concern involving various stakeholders (multiple issues for intensive intervention requiring comprehensive assessment, planning, support and training for the participant and carers)
- participants who may have significant 1:1 support in the community, 1:2 support in the community (greater than 30% of the day) or exceptional circumstance supports at home due to their harmful or persisting behaviours that may present risk to themselves or others
- participants who require additional support to implement newly developed strategies in the community or within newly engaged activities/services.

Use reasonable and necessary decision making to determine how many hours of specialist behavioural intervention support to include in the plan. Most level 2 plans should not exceed 90 hours (7-8 hours per month) for specialist behavioural intervention support which will support participants with significantly harmful or persistent behaviours of concern.

This package of support would be considered in the following circumstances:

- when a participant has extreme behaviours that could require restrictive intervention
- where there is significant change of circumstances that will result in a withdrawal of service support
- where there is significant risk to support staff, other participants or the community
- to support carers and other significant informal supports in the participant's life to apply the developed BSP and behavioural strategies, include training in behaviour management. Most level 2 plans should not exceed 30 hours (2-3 hours per month) which will ensure the behavioural support plan is applied consistently in all necessary environments to best support the participant
- for participants that require additional support to implement newly developed strategies in the community or within newly engaged activities/services, include individual social skill development. Most level 2 plans should not exceed 40 hours (3-4 hours per month) which will complement recommendations in the BSP.

6.2.4 Support coordination

Support coordination is intended to strengthen the participant and/or their authorised representative's abilities to coordinate and implement supports in the plans to participate more fully in the community, and to build and maintain a resilient network of formal and informal supports. This includes addressing barriers to implementation and regular monitoring. A participant who displays BoC may require support coordination or specialist support coordination to assist where required.

You will need to consider the level of support the participant and/or their authorised representative will require to build their capacity to connect with supports and services, ensure they understand their NDIS plan and how to implement their funded supports, and strengthen their ability to self-direct services and achieve their goals.

It is also part of the support coordinator's role to build capacity of the participant and/or authorised representatives to gather supporting documents including assessments and reports and ensure these are provided to the NDIS.

Where the participant experiences a crisis, the support coordinator will assist them as required, to manage and link into appropriate supports. This information should form part of their next progress report to the NDIS where any known causes of the crisis, how it was managed, the outcome and proposed strategies to reduce the likelihood of a reoccurrence are detailed.

The reporting and monitoring requirements must be clearly outlined in the Request for Service and discussed at plan handover. Refer to Standard Operating Procedure – Include Support Coordination in a Plan.

6.3 Plan comments

Make sure your plan comments recorded in Determine Funded Supports task include a description of the behaviour supports included within each budget.

Example (Core) – only relevant where there is a regulated restrictive practice in the participant's BSP: I can use my core support funding flexibly to help with my daily activities. Assistance with self-care activities and accessing the community to be provided by a registered implementing provider.

Example (Capacity Building): Funding for XX hours of specialist behaviour intervention support, XX hours of behaviour management plan and training in behaviour management strategies. A report detailing outcomes achieved is to be provided to the NDIA by the registered specialist behaviour support practitioner before this plan is due for review.

6.4 Plan management

It is important to understand the distinction between choice and control in regards to plan management and the legislative requirements to use a registered provider.

The NDIS supports the participant to maximise their choice and control where there is not unreasonable risk or other factors impacting the participant's and/or their authorised representative's ability to manage NDIS funding.

The *NDIS (Provider Registration and Practice Standards) Rules 2018* specifies that to maintain safeguards and minimise risk to the participant, NDIS providers must be registered for:

- functional behaviour assessments
- developing BSPs, and
- regulated restrictive practices.

Behaviour support practitioners (whether a sole provider or employed by a provider) must be registered with the NDIS to provide specialist behaviour support (registration group 110).

The NDIS recommends that CB Relationships is Agency managed to ensure the use of NDIS registered providers, however participants and/or their authorised representatives may choose to have their supports plan or self-managed. It is important for participants and/or their authorised representatives to understand the distinction between choice and control in regards to plan management and the legislative requirements to use a registered provider for specific behaviour supports (functional behaviour assessments, BSPs, and regulated restrictive practices).

NDIS legislation is based on the presumed capacity to self-manage. Therefore, a request by the participant to manage their funding should be considered positively by the delegate unless there is evidence of a significant risk to the participant.

The NDIS supports the participant to maximise their choice and control where there is not unreasonable risk or other factors impacting the participant's and/or their authorised representative's ability to manage NDIS funding. The determination of unreasonable risk is assessed with every plan review, having regard to the participant's individual circumstances and considerations.

6.4.1 Restrictive practice

Where the BSP includes regulated restrictive practice, the participant and/or their authorised representatives, should be aware that the implementing service provider for the behaviour support **must** also be registered with the NDIS Quality and Safeguards Commission.

Where supports are self or plan –managed, a thorough conversation with the details recorded in the appropriate pre-planning tasks and clear NDIS plan comment (see 6.3) should follow. This is to make sure that the participant and/or their authorised representatives understand while the funding management allows for the use of unregistered service providers, there is a legislative requirement that registered providers **must** be used for BSPs and regulated restrictive practices.

Refer to Planning Operational Guideline – Managing the funding for supports under a participant's plan (the plan management decision) for further information.

7. Plan implementation and monitoring

There should be ongoing monitoring during the plan period to measure whether the participant is meeting their desired outcomes and goals. This can take place through a variety of means including support coordination reports, regular updates and Panda Live data.

It is important to check the plan utilisation to make sure that the plan is being implemented as expected and provide opportunity for earlier follow-up if there appears to be an over or under utilisation. Due to the nature of this support, there is likely to periods of intensive support and high budget utilisation, therefore the utilisation should be considered over time.

Refer to PANDA, Practice Guide – Plan Implementation and Practice Guide – Monitoring for further information.

8. Scheduled plan reviews

Make sure you have received the progress report from the support coordinator or specialist support coordinator and reviewed it to understand key issues and outcomes from the plan period.

It is expected the NDIA will be provided with supporting information demonstrating outcomes, barriers and where appropriate, recommendations for the next NDIS plan. For example where there has been successful implementation of capacity building supports, it may lead to a reduction of supports based on the behaviour support practitioner recommendations. Fade-out or step down approaches will be clearly documented based on supporting information. These approaches form a key part of reasonable and necessary decision making when a participant's BSP includes restrictive practices.

For further information refer to Practice Guidance - Scheduled Plan Reviews and Standard Operating Procedure – Complete a Plan Review (full).

9. Appendices

9.1 State and territory restrictive practice legislation

The state and territory governments remain responsible for specific legislation, policy and procedures related to the authorisation of restrictive practices. This is complementary to the NDIS Commission who is responsible for best practice guidance, monitoring and oversight of behaviour support service provision and the use of restrictive practices in all states and territories (excluding Western Australia).

Behaviour support practitioners must adhere to the requirements of the NDIS Commission and the state or territory in which they operate. Plan developers can refer practitioners, providers and plan implementers (support coordinator or LAC) to the relevant source of information. If there are concerns, discuss with your supervisor, request TAT Advice or escalate feedback that may need to be considered for report to the NDIS Commission.

9.1.1 New South Wales

- While there is no specific legislation regarding restrictive practices in New South Wales, there is the Guardianship Act (1987).
- New South Wales also have the restrictive practice authorisation policy and procedural guide outlining requirements. Approval is provided through the restrictive practices authorisation (RPA) panels.
- Service providers must comply with the New South Wales restrictive practices authorisation policy and procedural guide.
- There is expected to be an updated New South Wales policy concerning restrictive practices authorisation mechanism, which providers will also need to comply with.

9.1.2 Victoria

- The Victorian government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices and behaviour support in the NDIS.
- The Victorian Senior Practitioner has the power to issue prohibitions and directions related to restrictive practices, compulsory treatment and supervised treatment orders under the Disability Act 2006.

9.1.3 Queensland

- The Queensland government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices in the NDIS through the Disability Services Act (2006) for those over 18 years.
- The Disability Services Act (2006) helps safeguard people with an intellectual or cognitive disability and their rights against the inappropriate use of restrictive practices and provides an accountability framework that allows for transparency in the decision-making process to authorise the use of a restrictive practice by a relevant service provider with an adult with an intellectual or cognitive disability.
- The Disability Services Act (2006) sets out a number of requirements that the relevant disability service provider must follow to legally use a restrictive practice.

9.1.4 Western Australia

- The Western Australian government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices and behaviour supports in the NDIS.
- Providers are encouraged to follow the Code of Practice: A Guide for the Elimination of Restrictive Practices (external).

9.1.5 South Australia

- The South Australian government has policy and procedures outlining state requirements regarding restrictive practice authorisation.
- The Disability Services Act 1993 requires disability service providers to have restrictive practices policy and procedures in place. Seclusion of an adult with disability must only be used if specifically authorised by the South Australian Civil and Administrative Tribunal (SACAT) under Section 32 of the Guardianship and Administration Act 1993.

9.1.6 Tasmania

- The Tasmanian government remains responsible for the legislative and policy frameworks through the Disability Services Act 2011 regarding the authorisation of regulated restrictive practices, which are approved by Tasmanian Senior Practitioner.
- Chemical restraint does not have authorisation requirements in Tasmania.

9.1.7 Australian Capital Territory

- The Senior Practitioner Act (2018) remains responsible for the approval of behaviour support plans, which include the use of a regulated restrictive practice.
- The Senior Practitioner Act (2018) provides the powers and functions of the Senior Practitioner and regulates the use of restrictive practices by persons or other entities who provide any of the following services to another person:
  - education, including education and care
  - disability
  - care and protection of children.

9.1.8 Northern Territory

- The Northern Territory government will be responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices in the NDIS through the NDIS (Authorisations) Act 2019.

10. Supporting material

- NDIS Act 2013
- NDIS (Quality and Safeguards Commission and Other Measures) Transitional Rules 2018
- NDIS (Restrictive Practices and Behaviour Support) Rules 2018
- NDIS (Code of Conduct) 2018
- NDIS (Incident Management and Reportable Incidents) Rules 2018
- NDIS (Provider Registration and Practice Standards) Rules 2018

- NDIS (Plan Management) Rules 2013
- Overview of the NDIS Operational Guideline – Quality and Safeguards
- NDIS Quality and Safeguards Commission
- NDIS Quality and Safeguarding Framework
- Convention on the Rights of Persons with Disabilities (external)
- National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector (external)

10.1.1 New South Wales

- Guardianship Act 1987
- Restrictive Practice Authorisation Policy (June 2019)
- Restrictive Practice Authorisation Procedural Guide (June 2019)

10.1.2 Victoria

- Disability Act 2006: Supervised Treatment Orders, Restrictive Practices, Compulsory Treatment

10.1.3 Queensland

- Disability Services Act 2006

10.1.4 Western Australia

- Code of Practice: A Guide for the Elimination of Restrictive Practices

10.1.5 South Australia

- Safeguarding People With Disability Restrictive Practice Policy (2017)
- Restrictive Practice Reference Guide for the South Australian Disability Service Sector (2017)

10.1.6 Australian Capital Territory

- Senior Practitioner Act 2018

10.1.7 Northern Territory

- NDIS (Authorisations) Act 2019

10.1.8 Tasmania

- Disability Services Act 2011

11. Feedback

If you have any feedback about this Practice Guide please email Planning Support. In your email, remember to include the title of the resource you are referring to and to describe your suggestion or issue concisely.

12. Version change control

Version No	Amended by	Brief Description of Change	Status	Date
1.0	ZWECKM	Guidance to support staff when planning for participants who display behaviours of concern. Behavioural supports are to be provided in accordance with the NDIS Quality and Safeguard Commission's requirements for positive behaviour support. Behaviour intervention levels moved to PG from SOP – Behaviour intervention supports. Class 3 approval	APPROVED	2020-01-20

Practice Guide – Positive Behaviour Support and Behaviours of Concern

Contents

1. Purpose

The purpose of this Practice Guide is to guide you through the considerations, roles and responsibilities when planning for a participant who displays Behaviours of Concern (BoC).

2. To be used by

- Plan Developers – Planners and Local Area Co-ordinators [LACs]
- NDIA Plan Delegates.

3. Scope

This Practice Guide provides information to support plan developers to understand when and how positive behaviour support may be a reasonable and necessary support where the participant displays BoC. This includes the respective roles and responsibilities of the National Disability Insurance Scheme (NDIS), NDIS Quality and Safeguards Commission (NDIS Commission) and states and territories.

Behaviour supports are to be provided in accordance with the NDIS Commission's requirements for positive behaviour support. The NDIS funds reasonable and necessary supports designed to identify and reduce BoC, to improve the participant's quality of life, uphold their dignity and safeguard their rights.

The NDIS Commission is operating in all states and territories except for Western Australia. Current state requirements for quality and safeguards continue to apply in Western Australia until the NDIS Commission commences operating from 1 July 2020. Behavioural supports are provided in accordance with the NDIS Commission's requirements for positive behaviour support. The Positive Behaviour Support Capability Framework includes guiding principles to assist in delivering positive behaviour support.

The NDIS Commission and states and territories have oversight of behaviour support and restrictive practices. They are committed to a regulatory framework for behaviour support that is founded on contemporary evidence-based practice and aligned with the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Services Sector (external).

4. Legislative and Policy Context

The NDIS Commission is responsible for best practice guidance, monitoring and oversight of behaviour support service provision and the use of restrictive practices. State and territory governments remain responsible for specific legislation, policy and procedures related to the authorisation of restrictive practices. These are separate but related processes and requirements.

The NDIS Commission assesses behaviour support practitioners and providers using a Positive Behaviour Support Capability Framework. This provides guiding principles to assist in delivering specialist positive behaviour support as an NDIS behaviour support practitioner.

In all states and territories (excluding Western Australia), providers who use or are likely to use restrictive practices, or who develop behaviour support plans (BSPs) must be registered with the NDIS Commission and meet the supplementary requirements of the NDIS Practice Standards (external).

To support safeguarding for people subject to restrictive practices, any use of restrictive practice must comply with the NDIS (Restrictive Practices and Behaviour Support) Rules 2018. These safeguards include but are not limited to:

- behaviour support practitioners, and providers who use regulated restrictive practices (also known as implementing providers) must meet the requirements outlined
- state and territory governments remain responsible for the authorisation of BSPs, which include the use of a regulated restrictive practice. Providers must comply with requirements of their state or territory
- restrictive practices are clearly identified in a BSP.

The Western Australian government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices and behaviour supports in the NDIS.

Refer to Appendix 1 for state and territory restrictive practice legislation.

The NDIA is not obligated to fund supports which have been imposed by state and territory bodies, which involve the use of restrictive practices, for example where a supervision order has been imposed by a civil or criminal court. However, where a restrictive practice has been authorised, recommended, or implemented by another body, this is a relevant consideration when determining if the support is reasonable and necessary.

4.1 Behaviours of Concern

Behaviours of Concern, also known as challenging behaviours, refer to a wide range of behaviours of an intensity, frequency or persistence that threatens the quality of life, physical safety of the individual and/or others and generally results in limiting access to the community.

Behaviours of Concern can be any behaviour that results in an adverse impact on the person's quality of life. This may include:

- physical or verbal aggression
- property damage
- inappropriate sexual behaviour
- disinhibited and impulsive behaviour

- self-injurious behaviour also referred to as self-harm. It differs with each person and can include head banging, picking and hitting. This behaviour may not be an attempt to cause harm.

Please note the term self-harm when used in mental health settings typically refers to intentional harm without suicidal intent such as neglect, cutting, ingesting objects and self-poisoning. Mental health professionals must be consulted by the participant's supports as this is typically an indication of serious distress.

In order to provide successful interventions, it is necessary to understand the function of that behaviour for the person and the context it occurs. There may be a range of underlying factors influencing BoC including:

- underlying physical, neurological, mental or emotional health issues
- biological/physical due to experiencing pain or discomfort
- acting out a repetitive behaviour or routine
- frustration in not being able to do something
- communication/social needs due to difficulties in communication, seeking social interaction or attention
- demonstrating a learned behaviour
- the physiological effects of substances including alcohol, illegal drugs or medications
- difficulty with service systems or support networks
- attempting to avoid a situation
- interpersonal environment such as quality of social interactions
- change in routine or structure
- inflexible thinking
- attempting to manage sensory overload
- having a high pain threshold and the behaviour is intended to provide sensory stimulus
- support staff skills and turnover, perceptions and level of resources available.

4.2 Impacts of Behaviours of Concern (BoC)

Behaviours of Concern affect the quality of life of the individual. Factors such as the intensity, frequency or persistence of the behaviours may limit a participant in their opportunities to pursue social, educational, economic and/or recreational activities. Often this is due to the need to maintain the physical safety of an individual or other people (such as family, support workers or the community) and reduce the risk of unsafe social participation (such as inappropriate and/or unsafe sexual behaviours).

Where the participant exhibits BoC, they may require supports in several areas of their life. Informal supports can have difficulty in sustaining relationships and caring responsibilities due to the potential risk of harm to the participant, other people in the home or themselves. NDIS funded supports can be used to support informal and formal supports in their roles and build their capacity to effectively address the BoC with the participant. These supports may help sustain the participant's current living and/or support arrangements and encourage the participant to positively engage with others. Where the participant has complex and longstanding BoC there may be further difficulties in engaging and sustaining funded supports.

The participants with complex BoC may be at risk of breakdown of their living arrangements such as being temporarily removed from shared living arrangements to individualised accommodation support settings, or family supports no longer being able to sustain the person living in the family home. There is also the risk of increased support staff turnover that in turn can lead to further escalation in behaviours due to constant changes in their environments, formal and informal supports, and the impact of fractured relationships.

In some cases, when informal supports are unable to continue to care for the participant who displays complex BoC, an alternative accommodation arrangement may be required for short or long term periods. Where there has been an escalation of behaviours and this requires a change of circumstances refer to the Practice Guide - Unscheduled Plan Review, Practice Guide – Supported Independent Living (SIL) and the Practice Guide – Medium Term Accommodation.

In the case of a person under the age of 18, refer to the Practice Guide – Children and Young People with Disability Living in a Voluntary Agreement Outside the Family Home.

4.3 Positive behaviour support

Positive behaviour support is an effective approach for BoC as it focuses on addressing a person's needs, their home environment and overall quality of life through assessment, planning and intervention.

The positive behaviour support process typically follows similar steps.

1. **Brief functional behaviour assessment** - focussed on identifying requirements for incident prevention and response.
2. **Interim plan** - may also be referred to as a safety interim plan, incident prevention and response plan, reactive strategy response plan or reactive strategy. Interim BSPs include the provision for the use of a regulated restrictive practice developed within one month of engagement by a behaviour support practitioner while a comprehensive BSP is being developed.
3. **Comprehensive functional behaviour assessment -** the process for determining and understanding the function or purpose behind a person's behaviour, and may involve the collection of data, observations, and information to develop an

understanding of the relationship of events and circumstances that trigger and maintain the behaviour.

4. **Comprehensive positive behaviour support plan** (see 4.2.1)
5. **Training and implementation support implementation support** - this usually targets informal supports and direct support workers and may also include reports and liaison with other stakeholders, reports for the psychiatrist; reports to restrictive practice authorisation mechanisms.
6. **Monitoring** - data collection, analysis and reporting.
7. **Review** - ongoing review of effectiveness of the BSP; revisit functional behaviour assessment at least annually.

The plan developer includes the appropriate capacity building support in the participant's plan for the provision of these supports.

4.3.1 Behaviour Support Plan (BSP)

A BSP specifies a range of evidence-based, person-centred and proactive strategies which focus on the individual needs of the person. It is developed with the aim of addressing the underlying functions of BoC taking place or increasing. The plan will outline specifically designed positive behaviour support strategies for the participant, their informal and funded supports to assist in reducing BoC and supporting their quality of life and goal attainment.

There are rules regarding practitioners and BSPs that are relevant to the staff member or coordinator of supports who is assisting the participant to implement their NDIS plan. A registered specialist behaviour support practitioner must develop all functional behaviour assessments and BSPs, as positive behaviour support practice requires a specific skillset and appropriate safeguards. The Positive Behaviour Capability Framework (external) is used to determine suitability of the behaviour support practitioner required.

Behaviour support practitioners must lodge BSPs containing restrictive practices with the NDIS Commission.

If the BSP does not include restrictive practices, it does not need to be lodged with the NDIS Commission. However, the practitioner developing the positive BSP must still be registered as a specialist behaviour support practitioner and the provider implementing restrictive practices must also be a registered NDIS provider.

4.3.2 Assessment, development and review

To develop a positive BSP, a functional behaviour assessment must be completed where practitioners consult with the participant, their family, guardian and other relevant people including the service provider/s who will be implementing the plan. This is to gather historic and current information which identifies settings, triggers, actions and results according to the behaviours displayed.

The BSP is designed to address the factors identified in the assessment. It will include a range of strategies used to support the person, including proactive skill development to build on the participant's strengths and response strategies to use when the behaviour presents.

Behaviour support plans are formally reviewed annually or earlier if the participant's circumstances change. At the time of review, the effectiveness of all aspects of the plan including the preventative/environment, skill building/teaching and reinforcement strategies are measured along with step-down strategies when there is the use of restrictive practice. Importantly the progress towards the person's goals and identified quality of life measures is considered.

Assessment information can be used by the plan developer to consider effectiveness and outcomes of funded supports and determine the level and type of capacity building support for inclusion in the NDIS plan.

Refer to the Compendium of Resources for Positive Behaviour Support (external) for further information about the range of positive support assessment tools that can be used by practitioners for assessment, planning, implementation, monitoring and review.

4.3.3 Younger People in Residential Aged Care (YPIRAC)

Residential aged care providers have the same responsibilities towards NDIS participants as they do to other residents who receive services and supports under the *Aged Care Act 1997*. Currently, services are regulated by the Aged Care Quality and Safety Commission.

From 30 June 2020 all providers applying the use of restrictive practices with young people in residential aged care will be regulated by the NDIS Quality and Safeguards Commission.

Refer to the Practice Guide – Younger People in Residential Aged Care for further information.

4.4 Restrictive practices

A restrictive practice is any practice or intervention which has the effect of restricting the rights or freedom of movement of a person with a disability. All states and territories endorsed the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Services Sector which was reaffirmed in the NDIS Quality and Safeguarding Framework.

If there is the use of restrictive practices or request for restrictive practices, the plan developer must make a referral for advice to the Technical Advisory Team (TAT). Refer to the TAT mandatory referrals page for more information.

Restrictive practices must be authorised through a formal process which is the responsibility of each state or territory and varies across jurisdictions. Restrictive practices can be considered only if they are the least restrictive alternative, and in the context of positive behaviour support strategies.

When a person is exhibiting BoC, those around them may try to stop or modify their behaviours in a number of ways with the intention of keeping them or others safe. They may intervene physically, try to control where they go, what they do or administer mood altering medications. Where a practice is age-appropriate to keep a child safe, for example holding a child's hand while crossing the road, this would not be considered a restrictive practice.

The use of restrictive practices are a risk to the human rights of people with disability and there is a need to ensure there is appropriate reporting and scrutiny when used. The NDIS Commission has identified five forms of regulated restrictive practice:

1. **Seclusion:** The sole confinement of a person with disability in a room or a physical space where voluntary exit is prevented, not facilitated or it is implied that exit is not allowed. This may include when a person is put in a room or placed on their own and the person cannot leave when they want to as the door has been locked.
2. **Chemical restraint:** The use of medication or chemical substance for the primary purpose of influencing a person's behaviour. The medication or chemical substance provided is not treating a diagnosed illness or condition and is intended to make them calm or sleepy. This is often psychotropic medication, which affects mood and is generally prescribed by a psychiatrist.
3. **Mechanical restraint:** The use of a device to prevent, restrict or subdue a person's movement for the primary purpose of influencing a person's behaviour. This includes but is not limited to putting gloves on a person that they cannot remove independently so they are unable to scratch themselves or others, or restraining someone in a wheelchair using a harness that they are unable to undo independently for the purpose of keeping them in the wheelchair. **Note:** this does not include the use of devices for therapeutic or non-behavioural purposes.
4. **Physical restraint:** The use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury.
5. **Environmental restraint:** Restricting a person's free access to all parts of their environment, including items or activities such as locking cupboards or fridges.

4.5 Restrictive practice guidelines

The NDIS Commission is taking the lead role in reducing and eliminating the use of restrictive practices and holds responsibility for monitoring the use of all restrictive practices recommended and implemented by NDIS providers in Australia. The NDIA is not responsible for making decisions about the use of restrictive practices.

Under the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018*, restrictive practices are subject to regulation. Restrictive practices can only be used based on an assessment of behaviour with the appropriate authorisation from

the relevant State or Territory and where it is part of a BSP that has been developed by a registered behaviour support specialist.

The registered behaviour support practitioner is responsible for:

- submitting written applications to restrictive practice authorising panels or bodies seeking authorisation
- submitting regular progress reports, data summaries, and other documents to restrictive practice authorising panels or bodies
- attending restrictive practice panel meetings or other contact with the authorising body.

4.5.1 Participant with immediate needs

Where there is no current interim or comprehensive BSP in place and the participant has an immediate need for a restrictive practice due to a new or previously unexperienced degree of severity in the escalation of behaviour, the NDIS Commission outlines that:

- an interim BSP must be completed within a month of engagement by the behaviour support practitioner, and
- a comprehensive BSP must be developed within six months of the interim plan being completed by the behaviour support practitioner.

4.5.2 Implementing providers

The NDIS Commission refers to service providers who use a regulated restrictive practice as implementing providers. Implementing providers are expected to understand the context of the person's behaviour and follow the authorised BSP to make sure the use of any restrictive practice is a last resort intervention and in proportion to the risks posed by the behaviours.

Implementing providers will report monthly to the NDIS Commission regarding all restrictive practices used, monitor, and collect data as outlined in the BSP. This forms part of the ongoing focus on reducing or eliminating restrictive practices and addressing BoC. Service providers must aim to reduce the use of restrictive practices by working with the participant and their supports to obtain a greater understanding of the function of the behaviour as well as triggers, and provide preventative strategies and techniques to develop more appropriate ways to support the participant. The behaviour support practitioner will support the implementing provider where required to understand the relevant state or territory legislative and/or policy requirements.

4.6 Point of crisis

A point of crisis is a period of intense difficulty and distress experienced by a participant that disrupts and makes their usual day-to-day life hard to cope with. Participants may experience points of crisis for various reasons, such as escalation of mental health issues or the unexpected loss of formal and/or informal supports. Emergency support may also be

provided by other government services such as child protection, homelessness services, hospitals, ambulance, police and mental health assessment teams.

A crisis may often result in the escalation of BoC and may temporarily require more intensive support. While the NDIS is not responsible for the delivery of emergency support, when the participant or their informal support contacts the NDIS during times of crisis, we need to be responsive to their concerns.

This may involve supporting the participant to access other government services as required, and explaining how the funding in their plan can be used flexibly to meet their needs during a crisis. The participant may have interacted with the After Hours Crisis service as part of the Exceptionally Complex Support Needs Program.

You will need to ensure the support coordinator is aware of the situation and is responding to and supporting the participant in a timely and effective manner. The role of the support coordinator and the level of support coordination may need to be considered. For example, a specialist support coordinator to manage multiple mainstream interfaces, organise and prepare reports may be required.

In some cases, the behaviour support practitioner may be able to identify periods of crisis are likely to occur for a participant when certain circumstances arise. In these cases, the BSP and other supports should be proactively designed to respond to these situations. This may impact on the way the supports are funded in the NDIS Plan.

It may be appropriate to consider an unscheduled plan review where additional supports are required beyond the flexibility of the existing plan. Refer to Practice Guide – Unscheduled Plan Reviews.

Interactions detailing the crisis circumstances and actions taken must be recorded in the NDIS Business System (System) and an alert added if required.

4.7 Incident management

4.7.1 Registered providers

Registered service providers must have effective incident management systems and are responsible for recording and managing all incidents that happen in the delivery of NDIS supports and services, and notifying the NDIS Commission of any reportable incidents (including allegations) that occur with the provision of supports and services to an NDIS participant. Reportable incidents include:

- serious injury or death of an NDIS participant
- abuse or neglect of an NDIS participant
- unlawful sexual or physical contact with, or assault of an NDIS participant
- sexual misconduct committed against, or in the presence of, an NDIS participant, including the grooming of the NDIS participant for sexual activity

- the unauthorised use of restrictive practice.

Refer to the NDIS Commission's Reportable Incidents (external) for further information.

4.7.2 Unregistered providers

Unregistered providers must follow their internal provider reporting channels. All providers (registered and unregistered) who are providing NDIS funded supports must follow the NDIS Code of Conduct (external).

4.7.3 National Disability Insurance Agency (NDIA)

NDIA staff and Partners in the Community may be advised or learn of allegations of serious harm occurring to a participant from a participant, their carer, nominee or other relevant party. This is known as a participant critical incident. If information is provided to you which suggests or alleges a participant critical incident has occurred, refer to the Participant Critical Incident Framework. You must notify the Participant Critical Incidents team where appropriate, refer to Participant Critical Incidents page.

As noted above, any unauthorised use of restrictive practice is a participant critical incident. This incident may be a trigger for a section 48 plan review. The participant and/or their authorised representative can request a review or the NDIA may choose to initiate based on the information provided around the critical incident. Participant critical incidents highlight that the participant's supports may require adjustment or further changes are needed. It is the responsibility of the NDIS to make sure that a participant has appropriate funding for their support needs, including behaviour support.

5. Pre-planning

5.1 Streaming

Plan developers need to ensure the correct streaming decision has been recorded in the System for the participant to receive the appropriate level of support to implement their plan. Factors to change the streaming decision are dependent on the complexities presenting in the participants current life situation or environment which may be identified during your conversation.

Where a participant has complex support needs requiring a different approach, a referral to the Complex Support Needs Pathway may be appropriate.

Refer to Standard Operating Procedure – Update Participant Streaming and Standard Operating Procedure – Referral for Complex Support Needs for further information.

Note: The term streaming is for internal use only.

5.2 Plan duration

The plan duration ready reckoner guide recommends plans are developed for up to 12 months when a participant is requiring behaviour support and/or is streamed as super intensive. However, the participant's individual circumstances should be considered and a shorter plan duration may be required if, for example, the BSP is being assessed, accommodation needs/options are being assessed or close monitoring is required. Where the participant's situation is stable a longer plan duration may be also be appropriate. Refer to Standard Operating Procedure – Complete the Risk Assessment and Practice Guide - Pre-Planning for further information.

5.3 Arranging the planning meeting

Contact the participant and/or their authorised representatives (nominee/s, child representatives, and court or tribunal appointed decision makers) through their chosen method of communication and confirm/obtain consent for information sharing and exchange. A participant or their authorised representative may choose to invite other family members, friends or NDIS funded support providers to the NDIS planning meeting.

It is important to confirm all meeting attendees. This will allow for appropriate consideration of location, meeting room, time allocated and whether additional or senior staff are required to attend.

In limited circumstances, it may be necessary to appoint a plan nominee to act on behalf of, or make decisions on behalf of a participant. Refer to the Standard Operating Procedures – Appoint, Decline, Suspend or Cancel a Nominee.

Where possible and appropriate, the participant should be in attendance during the planning conversation. The participant's wellbeing is the priority and discretion is required at times to determine whether it is suitable for their attendance, such as if there is significant unrest and or concerns about safety due to events such as accommodation or relationship breakdown as a result of significantly challenging behaviours.

In these instances, efforts should be made to include the participant, and consider a shorter meeting to confirm key details or having them contribute in another way such as completing the relevant NDIS booklet prior to the meeting.

When confirming a meeting location and time, it is important to check the System for alerts and confirm the following with the participant or their authorised representative:

- Consider the participant's routine. For example, if the participant has difficulty sleeping at night they may not function well in the mornings and prefer an afternoon meeting.
- If known, consider the sensory needs of the participant and confirm an appropriate location. For example, if BoC are triggered by sensory overload, suggest a quiet office to conduct the meeting.

- Understand any specific environmental factors that may present a risk to the participant or to other members of the meeting including the NDIS staff member.
- Understand and respect any cultural sensitivities or barriers to communicate effectively for example, they may prefer to meet with someone of the same gender.
- Explore options to book a meeting for an extended period of time to allow breaks, or hold the planning meeting over multiple sessions or arrange for the participant to attend for shorter periods.
- Be aware of any behaviour response strategies that may need to be implemented during the meeting and what the role of the NDIS staff member will be, noting the service providers and informal supports who know the person well should lead the response directly with the person to de-escalate the situation or conclude the meeting.

5.3.1 Gathering documentation

Arranging the planning meeting provides an opportunity to follow-up on relevant supporting documentation that has not been provided yet. The participant, authorised representative or their support coordinator may provide this information to the NDIA. In some circumstances, the NDIA may need to follow-up directly once appropriate consent has been obtained. Behaviour support documentation may include:

- the most recent BSP
- behaviour protocols or strategies (where not collated in an interim or comprehensive plan as per the NDIS Commission)
- behaviour support recommendations report outlining next steps in behaviour support and estimated hours required
- incident reports, preferably incident summary reports
- data summary reports
- Restrictive Practice Authorisation documentation (if relevant)
- support model assessment reports including identifying housing options
- other assessment reports and support plans, such as speech pathologist, occupational therapist, psychologist, psychiatrist, paediatrician or other medical practitioner
- other relevant reports from service providers or mainstream agencies such as court reports.

All new or updated legal/court orders and other documents provided to the NDIS must be uploaded to inbound documents in the System.

5.3.2 External meetings

If a meeting is taking place at a location external to an NDIS office, follow the usual appointment booking process and ensure the following:

- complete and attach a copy of the home visit risk screen document and journey plan to the participant's record in the System
- review other information available in the System including, but not limited to previously completed planner risk assessment, guided planning questions, planning conversation tool and inbound documents. This information will assist in ascertaining if there are any likely risks or concerns, such as other people being in the premises and the general safety of surrounds
- discuss any identified risks and take any appropriate action as determined with your team leader
- familiarise yourself with the journey management procedure and out of office best practice guide.

NDIA staff are supported to make decisions at all times to protect their personal safety. These decisions may include:

- deciding that a visit requires a second employee to be present
- arriving at a location and deciding to cancel a visit due to safety concerns
- terminating a visit part way through due to safety concerns.

Refer to the Work Health and Safety page for further information.

For circumstances where the health, safety and/or security of NDIA staff or others is put at risk due to the behaviour of a participant or other third party, NDIA staff should refer to the Work Health and Safety page and NDIA Managing Unreasonable Behaviour Framework, Policy and Guideline for information, advice, reporting and escalation protocols.

5.4 Planning conversation

The participant is at the centre of the planning process and their goals and needs are explored by discussing their strengths and what they would like to achieve. The planning conversation should identify goals, capacity, risks and safeguards and provide an opportunity to discuss any assessments and reports.

Information provided in the planning meeting about the participant's BoC must be detailed in the guided planning questions free text box and in the planning conversation tool.

The following points can support you to have a high quality conversation:

- Be mindful of the person's communication needs and preferences including whether an interpreter is required.
- Make decisions about what will be appropriate to ask the person directly and what may be triggering or distressing that can be gathered in another way.
- Read previous planning information (if applicable), interactions and inbound documents.

- Review the support coordination progress reports. These should detail information including the participant's circumstances, identified risks, strategies and outcomes for the participant's goal progression.
- Review the behaviour specialist reports and any other assessments that identify outcomes achieved, key barriers and recommendations for the new plan.
- Follow up any requested reports and/or assessments not yet provided, to assist informing the planning process.
- Use visual tools to assist in communicating. For example, if asking a participant about their schedule, use the weekly supports table in the NDIS planning booklet (external) to help break down the questions, or other format as determined appropriate to their communication needs.
- Encourage the participant to talk about/communicate their interests, what daily life is like, what challenges they face and allow time as needed for them to explain this to you.
- Discuss the previous plan (if applicable), what they found worked well and what did not. For example, they may have strong informal supports or may be at risk of losing their housing or in temporary accommodation placing them at risk of homelessness.
- Be conscious to not ask leading questions as people are likely to give the answer they think you want to hear.
- If the participant is appearing anxious or not engaging, consider asking them what would make them feel more comfortable such as having a break.
- Depending on the participant's situation, there may be multiple stakeholders with differing input present in the planning process. In these circumstances, make sure the participant and their authorised representative are the focus of your attention. Make sure they understand that they can request other people leave the room at any time.
- In some circumstances, due to the complexity of the participant's BoC further discussion may need to take place with the participant's informal supports and positive BSP practitioner to discuss current and proposed support needs, or there may need to be a second meeting.
- Where appropriate, seek consent to follow-up with specific individuals or providers. Refer to the Standard Operating Procedure – Consent and Authority for further information.

6. Planning

The Agency must be satisfied that the funded supports in the participant's NDIS plan meet each of the criteria outlined in section 34(1)(a)-(f) of the *National Disability Insurance Scheme Act 2013* (NDIS Act) and the NDIS (Supports for Participants Rules) 2013.

When planning for the participant with BoC, it is important to be aware of any recent or upcoming changes in their life. Behaviours of concern may take place more frequently or at a greater severity during transitional periods for example during adolescence, leaving school or changes in living arrangements.

It is important to also be mindful that effective positive behaviour support:

- is not a linear process. For example, the practitioner may be conducting an assessment while revising the plan and training
- is highly individualised
- is holistic and integrated
- utilises a systems approach
- includes crisis response and BSP revision as required
- includes multi-disciplinary input in all elements including assessment, design, implementation and review
- varies in intensity and time required depending on the complexity of the person's situation and support needs
- cannot always be delivered in monthly amounts across the year. For example, there may be a high utilisation initially for providers to complete the initial assessment, interim planning, comprehensive assessment and comprehensive BSP development.

Refer to Practice Guide - Determine Reasonable and Necessary Supports for further information.

6.1 Core supports

Core supports are intended to assist with or supervise personal tasks of daily life to enable the participant to live as independently as possible. The BSP is expected to be used by all formal supports to build on the participant's strengths, increase their opportunities to participate in community activities and increase their life skills.

Where possible, the funds can be used to strengthen the capability and capacity of the participant and their informal supports (if applicable) by reinforcing strategies and encouraging independence towards goal attainment.

Providers for participants with complex BoC may request higher support costs, for example 2:1 or 1:1 for the participant to continue to attend a day program. This level of support can be considered an environmental constraint where it is as a response to behaviour concerns and not related to other support needs such as health.

The delegate may need to consider that the sudden removal of funded Core supports for participants with high level staff ratios and/or restrictive practices may put the participant's living arrangement, their staff, or others at risk.

It is therefore important to consider a transitional or gradual step down model to effectively reduce supports in line with the BSP. This is likely to take place over the course of multiple NDIS plans and should be guided by the registered specialist behaviour support practitioner. The TAT may be consulted as needed via TAPS and advice should be sought from TAT for all plans that contain restrictive practices. For more information refer to mandatory referral.

If the participant requires a higher intensity level of support, refer to the Standard Operating Procedure – Self-Care and Community Access Supports for further information.

6.1.1 Behaviours support provision in supported independent living (SIL)

Behaviour supports need to take a whole of house approach when a participant is living in a supported independent living (SIL) arrangement with other people with disabilities. Behaviour support may be recommended where there are high-level staffing ratios such as 2:1 or 1:1 support for individual residents and/or active overnight support are in place to manage risk to staff and residents, or there are frequent incidents such as assaults, self-harm and/ or property damage.

A whole of house approach for behaviour support involves considering reasonable and necessary funded supports allocated for each participant can be utilised in a coordinated way to meet the needs and increase the quality of life of all residents.

Behaviour supports for a whole of house approach may include:

- shared living environmental assessment, also known as ecological assessment
- behaviour support systems review
- program development
- staff training.

Some of these supports may be shared in a whole of house approach, for example, there would be one shared living environmental assessment completed by the one provider to assess the overall household situation. The cost of the environment assessment would then be broken down and shared amongst all those living in home. Refer to the Practice Guide – Supported Independent Living (SIL).

6.2 Capacity Building supports

Before including funding for behaviour supports, consider the Capacity Building funding generated by the TSP and whether these funds are sufficient to provide some or all of the required behaviour support. To do this you will need to understand what other Capacity Building supports are required by the participant and work out whether the total Capacity Building funding needs to be increased to support the participant with their BoC. For instance, a child or younger person may require a higher level of funding so their informal supports are appropriately trained to implement the BSP.

There is a guided planning question related to BoC which must have the correct responses recorded. Responses to this question are for data capturing only and do not generate any

funding in the TSP. The TSP is a guide and decisions on reasonable and necessary supports should be made in accordance with S34 of the NDIS Act.

6.2.1 CB Daily Activity

Best practice in behaviour support involves a multidisciplinary approach tailored to the needs of the person. It is therefore important to ensure the relevant therapeutic assessments and services are included in CB Daily Activity area of the plan. NDIS reasonable and necessary improved daily living supports may include:

- assessments including psychological, communication and sensory
- individual skills development and training
- training for carers or parents.

As noted previously, a functional behaviour assessment can only be completed by a registered specialist behaviour support practitioner or provider.

6.2.2 CB Relationships

Behaviour supports within the category of CB Relationships may include:

- specialist behavioural intervention support for assessment and development of BSP
- behaviour management plan and training in behaviour management strategies
- individual social skills development.

Dependent on the participant's circumstances, NDIS funded support workers may require individualised training specific to the participant to maintain consistency and positive behaviour supports. Practitioners may provide training plans for the support worker or therapy assistant in the development of social skills identified as required due to BoC.

When determining reasonable and necessary funding, the specialist behaviour support practitioner would be expected to monitor the BSP implementation and review accordingly. Regular review allows opportunity for changes and updates to the BSP if the progress differs from expectations.

Questions which may help in determining the amount of funding include:

- Which stage of behaviour support currently applies? Are they at the brief assessment and safety planning stage (Refer to 5.2) or are they stable and in the monitoring stage? This indicates how many hours are still required for assessments and reporting.
- Does the participant already have a current comprehensive behaviour assessment?
  - If so, the next assessment will usually require less time.
- Does the participant already have a current comprehensive BSP?
  - If so, the next BSP update will usually require less time.

- How many BoC does the person engage in? Usually the more behaviours, the more time required for all stages of the behaviour support process.
- What is the intensity and severity of the behaviour/s of concern? More intense and high-risk behaviour is likely to require more time in assessment, design, protocol revision and implementation support.
- How many informal and formal support providers are involved? This will impact on the amount of observations, interviews, file review required; the amount of tailored strategies required for various environments and roles; and the amount of training and implementation support required.
- How many regulated restrictive practices are proposed or in place? The more practices, the more time required for assessment, design, implementation, and reporting.
- How many informal or funded supports require training and implementation support? Can this be done in one session or do multiple repeat sessions need to be factored in?
- What other reporting requirements does the specialist behaviour support practitioner have? This may include data summaries and consultation with a psychiatrist to inform medication review.
- How will the multidisciplinary team collaborate? How often will they need to meet or have other contact?
- How many other stakeholders does the specialist behaviour support practitioner need to engage with?
- How much direct contact will the specialist behaviour support practitioner have with the person for skill development? Is this sessional, what is the frequency?
- What other pieces of work are required? Are there specific assessments that can inform the behaviour assessment behaviour assessment report (such as Assessment of Sexual Knowledge); Support Model Assessment report; transition plan development and implementation (such as from one placement to another).
- Where there are regulated restrictive practices required, you should also include funding for the specialist behaviour support practitioner to meet their obligations under the NDIS Commission specific to this participant and the state or territory authorisation process.

6.2.3 Levels of behaviour intervention support

You will need to ensure the participant receives the appropriate support required to implement their plan and to address any behavioural complexities in their current life situation. There are two levels of behaviour intervention support provided as a guide however the participant's individual circumstances and supporting information must be considered in every plan to determine appropriate funding and supports required.

The levels of support include a behaviour management plan and training in the management of strategies to form a package of support to address a participant's immediate need for behavioural intervention. You will need to make a reasonable and necessary decision to determine the appropriate level of support included in the participant's plan.

The guidance in hours has been suggested for a plan of 12 months in duration. Use your reasonable and necessary decision making for plans with durations less or more than 12 months. If a participant has significant behaviours of concern it is highly unlikely that there will be a plan over 12 months due to the need to monitor and review outcomes and circumstances.

Consult with your team leader and refer to the participant's individual supporting documents, Practice Guide - Determine Reasonable and Necessary Supports and the Standard Operating Procedure – Include Behavioural Intervention Support in a Plan for further guidance.

6.2.3.1 Level 1

Level 1 funding could be considered appropriate for participants who require intervention due to significant behavioural complexities that are impacting on the ability of the participants informal supports to sustain care at home and assist the participant to safely engage in activities.

Level 1 criteria includes:

- behaviours of concern that could require single or minimum interventions
- lack of services willing to engage with the participant due to presenting behaviours and risk to staff/participants/community
- change of participant circumstances that will result in withdrawal of service support and need for immediate intervention.

Use reasonable and necessary decision making to include specialist behavioural intervention support. Most level 1 plans should not exceed 45 hours (approx. 3-4 hours per month) which will enable the participant to receive support from a psychologist or appropriate therapist to develop a BSP, implement strategies and review interventions over a period of time.

To support carers and any other significant informal supports in the participant's life to implement the behavioural support plan and behavioural strategies, include training in behaviour management. Most level 1 plans should not exceed 20 hours (1-2 hours per month) which will ensure the behavioural intervention support plan is applied consistently in all necessary environments to best support the participant.

Participant's that may have significant 1:1 support in the community (equal to 30% of the day) or at home due to their harmful or persisting behaviours that may present risk to themselves or others.

6.2.3.2 Level 2

Level 2 funding could be considered appropriate for participants that require immediate intensive behavioural intervention support and are streamed Super Intensive. In the majority of circumstances, level 2 funding is not appropriate for children aged 7 and under.

Level 2 criteria includes:

- multiple complexities that may require multiple interventions
- extreme behaviours of concern that could require restrictive intervention
- lack of services willing to engage with the participant due to presenting behaviours and risk to staff/participants/community
- significant change of participant circumstances that will result in withdrawal of service support and need for immediate intervention
- behaviours of concern involving various stakeholders (multiple issues for intensive intervention requiring comprehensive assessment, planning, support and training for the participant and carers)
- participants who may have significant 1:1 support in the community, 1:2 support in the community (greater than 30% of the day) or exceptional circumstance supports at home due to their harmful or persisting behaviours that may present risk to themselves or others
- participants who require additional support to implement newly developed strategies in the community or within newly engaged activities/services.

Use reasonable and necessary decision making to determine how many hours of specialist behavioural intervention support to include in the plan. Most level 2 plans should not exceed 90 hours (7-8 hours per month) for specialist behavioural intervention support which will support participants with significantly harmful or persistent behaviours of concern.

This package of support would be considered in the following circumstances:

- when a participant has extreme behaviours that could require restrictive intervention
- where there is significant change of circumstances that will result in a withdrawal of service support
- where there is significant risk to support staff, other participants or the community
- to support carers and other significant informal supports in the participant's life to apply the developed BSP and behavioural strategies, include training in behaviour management. Most level 2 plans should not exceed 30 hours (2-3 hours per month) which will ensure the behavioural support plan is applied consistently in all necessary environments to best support the participant
- for participants that require additional support to implement newly developed strategies in the community or within newly engaged activities/services, include

individual social skill development. Most level 2 plans should not exceed 40 hours (3-4 hours per month) which will complement recommendations in the BSP.

6.2.4 Support coordination

Support coordination is intended to strengthen the participant and/or their authorised representative's abilities to coordinate and implement supports in the plans to participate more fully in the community, and to build and maintain a resilient network of formal and informal supports. This includes addressing barriers to implementation and regular monitoring. A participant who displays BoC may require support coordination or specialist support coordination to assist where required.

You will need to consider the level of support the participant and/or their authorised representative will require to build their capacity to connect with supports and services, ensure they understand their NDIS plan and how to implement their funded supports, and strengthen their ability to self-direct services and achieve their goals.

It is also part of the support coordinator's role to build capacity of the participant and/or authorised representatives to gather supporting documents including assessments and reports and ensure these are provided to the NDIS.

Where the participant experiences a crisis, the support coordinator will assist them as required, to manage and link into appropriate supports. This information should form part of their next progress report to the NDIS where any known causes of the crisis, how it was managed, the outcome and proposed strategies to reduce the likelihood of a reoccurrence are detailed.

The reporting and monitoring requirements must be clearly outlined in the Request for Service and discussed at plan handover. Refer to Standard Operating Procedure – Include Support Coordination in a Plan.

6.3 Plan comments

Make sure your plan comments recorded in Determine Funded Supports task include a description of the behaviour supports included within each budget.

Example (Core) – only relevant where there is a regulated restrictive practice in the participant's BSP: I can use my core support funding flexibly to help with my daily activities. Assistance with self-care activities and accessing the community to be provided by a registered implementing provider.

Example (Capacity Building): Funding for XX hours of specialist behaviour intervention support, XX hours of behaviour management plan and training in behaviour management strategies. A report detailing outcomes achieved is to be provided to the NDIA by the registered specialist behaviour support practitioner before this plan is due for review.

6.4 Plan management

It is important to understand the distinction between choice and control in regards to plan management and the legislative requirements to use a registered provider.

The NDIS supports the participant to maximise their choice and control where there is not unreasonable risk or other factors impacting the participant's and/or their authorised representative's ability to manage NDIS funding.

The *NDIS (Provider Registration and Practice Standards) Rules 2018* specifies that to maintain safeguards and minimise risk to the participant, NDIS providers must be registered for:

- functional behaviour assessments
- developing BSPs, and
- regulated restrictive practices.

Behaviour support practitioners (whether a sole provider or employed by a provider) must be registered with the NDIS to provide specialist behaviour support (registration group 110).

The NDIS recommends that CB Relationships is Agency managed to ensure the use of NDIS registered providers, however participants and/or their authorised representatives may choose to have their supports plan or self-managed. It is important for participants and/or their authorised representatives to understand the distinction between choice and control in regards to plan management and the legislative requirements to use a registered provider for specific behaviour supports (functional behaviour assessments, BSPs, and regulated restrictive practices).

NDIS legislation is based on the presumed capacity to self-manage. Therefore, a request by the participant to manage their funding should be considered positively by the delegate unless there is evidence of a significant risk to the participant.

The NDIS supports the participant to maximise their choice and control where there is not unreasonable risk or other factors impacting the participant's and/or their authorised representative's ability to manage NDIS funding. The determination of unreasonable risk is assessed with every plan review, having regard to the participant's individual circumstances and considerations.

6.4.1 Restrictive practice

Where the BSP includes regulated restrictive practice, the participant and/or their authorised representatives, should be aware that the implementing service provider for the behaviour support **must** also be registered with the NDIS Quality and Safeguards Commission.

Where supports are self or plan –managed, a thorough conversation with the details recorded in the appropriate pre-planning tasks and clear NDIS plan comment (see 6.3) should follow. This is to make sure that the participant and/or their authorised representatives understand while the funding management allows for the use of unregistered service

providers, there is a legislative requirement that registered providers **must** be used for BSPs and regulated restrictive practices.

Refer to Planning Operational Guideline – Managing the funding for supports under a participant's plan (the plan management decision) for further information.

7. Plan implementation and monitoring

There should be ongoing monitoring during the plan period to measure whether the participant is meeting their desired outcomes and goals. This can take place through a variety of means including support coordination reports, regular updates and Panda Live data.

It is important to check the plan utilisation to make sure that the plan is being implemented as expected and provide opportunity for earlier follow-up if there appears to be an over or under utilisation. Due to the nature of this support, there is likely to periods of intensive support and high budget utilisation, therefore the utilisation should be considered over time.

Refer to PANDA, Practice Guide – Plan Implementation and Practice Guide – Monitoring for further information.

8. Scheduled plan reviews

Make sure you have received the progress report from the support coordinator or specialist support coordinator and reviewed it to understand key issues and outcomes from the plan period.

It is expected the NDIA will be provided with supporting information demonstrating outcomes, barriers and where appropriate, recommendations for the next NDIS plan. For example where there has been successful implementation of capacity building supports, it may lead to a reduction of supports based on the behaviour support practitioner recommendations. Fade-out or step down approaches will be clearly documented based on supporting information. These approaches form a key part of reasonable and necessary decision making when a participant's BSP includes restrictive practices.

For further information refer to Practice Guidance - Scheduled Plan Reviews and Standard Operating Procedure – Complete a Plan Review (full).

9. Appendices

9.1 State and territory restrictive practice legislation

The state and territory governments remain responsible for specific legislation, policy and procedures related to the authorisation of restrictive practices. This is complementary to the NDIS Commission who is responsible for best practice guidance, monitoring and oversight of behaviour support service provision and the use of restrictive practices in all states and territories (excluding Western Australia).

Behaviour support practitioners must adhere to the requirements of the NDIS Commission and the state or territory in which they operate. Plan developers can refer practitioners, providers and plan implementers (support coordinator or LAC) to the relevant source of information. If there are concerns, discuss with your supervisor, request TAT Advice or escalate feedback that may need to be considered for report to the NDIS Commission.

9.1.1 New South Wales

- While there is no specific legislation regarding restrictive practices in New South Wales, there is the *Guardianship Act (1987)*.
- New South Wales also have the restrictive practice authorisation policy and procedural guide outlining requirements. Approval is provided through the restrictive practices authorisation (RPA) panels.
- Service providers must comply with the New South Wales restrictive practices authorisation policy and procedural guide.
- There is expected to be an updated New South Wales policy concerning restrictive practices authorisation mechanism, which providers will also need to comply with.

9.1.2 Victoria

- The Victorian government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices and behaviour support in the NDIS.
- The Victorian Senior Practitioner has the power to issue prohibitions and directions related to restrictive practices, compulsory treatment and supervised treatment orders under the *Disability Act 2006*.

9.1.3 Queensland

- The Queensland government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices in the NDIS through the *Disability Services Act (2006)* for those over 18 years.
- The *Disability Services Act (2006)* helps safeguard people with an intellectual or cognitive disability and their rights against the inappropriate use of restrictive practices and provides an accountability framework that allows for transparency in the decision-making process to authorise the use of a restrictive practice by a relevant service provider with an adult with an intellectual or cognitive disability.
- The *Disability Services Act (2006)* sets out a number of requirements that the relevant disability service provider must follow to legally use a restrictive practice.

9.1.4 Western Australia

- The Western Australian government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices and behaviour supports in the NDIS.
- Providers are encouraged to follow the Code of Practice: A Guide for the Elimination of Restrictive Practices (external).

9.1.5 South Australia

- The South Australian government has policy and procedures outlining state requirements regarding restrictive practice authorisation.
- The *Disability Services Act 1993* requires disability service providers to have restrictive practices policy and procedures in place. Seclusion of an adult with disability must only be used if specifically authorised by the South Australian Civil and Administrative Tribunal (SACAT) under Section 32 of the *Guardianship and Administration Act 1993.*

9.1.6 Tasmania

- The Tasmanian government remains responsible for the legislative and policy frameworks through the *Disability Services Act 2011* regarding the authorisation of regulated restrictive practices, which are approved by Tasmanian Senior Practitioner.
- Chemical restraint does not have authorisation requirements in Tasmania.

9.1.7 Australian Capital Territory

- The *Senior Practitioner Act (2018)* remains responsible for the approval of behaviour support plans, which include the use of a regulated restrictive practice.
- The *Senior Practitioner Act (2018)* provides the powers and functions of the Senior Practitioner and regulates the use of restrictive practices by persons or other entities who provide any of the following services to another person:
  - education, including education and care
  - disability
  - care and protection of children.

9.1.8 Northern Territory

- The Northern Territory government will be responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices in the NDIS through the *NDIS (Authorisations) Act 2019*.

10. Supporting material

- NDIS Act 2013
- NDIS (Quality and Safeguards Commission and Other Measures) Transitional Rules 2018
- NDIS (Restrictive Practices and Behaviour Support) Rules 2018
- NDIS (Code of Conduct) 2018
- NDIS (Incident Management and Reportable Incidents) Rules 2018
- NDIS (Provider Registration and Practice Standards) Rules 2018
- NDIS (Plan Management) Rules 2013
- Overview of the NDIS Operational Guideline – Quality and Safeguards
- NDIS Quality and Safeguards Commission
- NDIS Quality and Safeguarding Framework
- Convention on the Rights of Persons with Disabilities (external)
- National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector (external)

10.1.1 New South Wales

- *Guardianship Act 1987*
- Restrictive Practice Authorisation Policy (June 2019)
- Restrictive Practice Authorisation Procedural Guide (June 2019)

10.1.2 Victoria

- *Disability Act 2006: Supervised Treatment Orders, Restrictive Practices, Compulsory Treatment*

10.1.3 Queensland

- *Disability Services Act 2006*

10.1.4 Western Australia

- Code of Practice: A Guide for the Elimination of Restrictive Practices

10.1.5 South Australia

- Safeguarding People With Disability Restrictive Practice Policy (2017)
- Restrictive Practice Reference Guide for the South Australian Disability Service Sector (2017)

10.1.6 Australian Capital Territory

- *Senior Practitioner Act 2018*

10.1.7 Northern Territory

- *NDIS (Authorisations) Act 2019*

10.1.8 Tasmania

- *Disability Services Act 2011*

11. Feedback

If you have any feedback about this Practice Guide please email Planning Support. In your email, remember to include the title of the resource you are referring to and to describe your suggestion or issue concisely.

12. Version change control

Version No	Amended by	Brief Description of Change	Status	Date
1.0	ZWECKM P19702	Guidance to support staff when planning for participants who display behaviours of concern. Behavioural supports are to be provided in accordance with the NDIS Quality and Safeguard Commission's requirements for positive behaviour support. Behaviour intervention levels moved to PG from SOP – Behaviour intervention supports. Class 3 approval	APPROVED	2020-01-20
2.0	KN0014	Replacing National Critical Incident Response with Participant Critical Incidents Framework Class one approval	APPROVED	2020-02-26

Practice Guide – Positive Behaviour Support and Behaviours of Concern

Contents

1. Purpose

The purpose of this Practice Guide is to guide you through the considerations, roles and responsibilities when planning for a participant who displays Behaviours of Concern (BoC).

2. To be used by

- Plan Developers – Planners and Local Area Coordinators [LACs]
- NDIA Plan Delegates.

3. Scope

This Practice Guide provides information to support plan developers to understand when and how positive behaviour support may be a reasonable and necessary support where the participant displays BoC. This includes the respective roles and responsibilities of the National Disability Insurance Scheme (NDIS), NDIS Quality and Safeguards Commission (NDIS Commission) and states and territories.

Behaviour supports are to be provided in accordance with the NDIS Commission's requirements for positive behaviour support. The NDIS funds reasonable and necessary supports designed to identify and reduce BoC, to improve the participant's quality of life, uphold their dignity and safeguard their rights.

The NDIS Commission is operating in all states and territories (except for Western Australia). The NDIS Commission starts operating from 1 December 2020 in Western Australia. Until this time, the current state requirements for quality and safeguards continue to apply.

The NDIS Commission, states and territories governments have oversight of behaviour support and restrictive practices. They are committed to a regulatory framework for behaviour support that is founded on contemporary evidence-based practice and aligned with the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Services Sector (external).

4. Legislative and Policy Context

The NDIS Commission is responsible for best practice guidance, monitoring and oversight of behaviour support service provision and the use of restrictive practices. State and territory governments remain responsible for specific legislation, policy and procedures related to the authorisation of restrictive practices. These are separate but related processes and requirements.

The NDIS Commission assesses behaviour support practitioners and providers using a Positive Behaviour Support Capability Framework. This provides guiding principles to assist in delivering specialist positive behaviour support as an NDIS behaviour support practitioner.

In all states and territories (excluding Western Australia), providers who use or are likely to use restrictive practices, or who develop behaviour support plans (BSPs) must be registered with the NDIS Commission and meet the supplementary requirements of the NDIS Practice Standards (external).

To support safeguarding for people subject to restrictive practices, any use of restrictive practice must comply with the NDIS (Restrictive Practices and Behaviour Support) Rules 2018. These safeguards include but are not limited to:

- behaviour support practitioners, and providers who use regulated restrictive practices (also known as implementing providers) must meet the requirements outlined
- state and territory governments remain responsible for the authorisation of regulated restrictive practice/s in an individual's BSPs. Providers must comply with requirements of their state or territory
- restrictive practices are clearly identified in a BSP.

The Western Australian government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices and behaviour supports in the NDIS.

Refer to Appendix 1 for state and territory restrictive practice legislation.

The National Disability Insurance Agency (NDIA) is not obligated to fund supports which have been imposed by state and territory bodies, which involve the use of restrictive practices, for example where a supervision order has been imposed by a civil or criminal court. However, where a restrictive practice has been authorised, recommended, or implemented by another body, this is a relevant consideration when determining if the NDIS funded behaviour support is reasonable and necessary. If unsure, discuss with your team leader. Further guidance can be sought by making an enquiry with the Technical Advisory Branch (TAB) via the Technical Advisory Phone Service (TAPS) or submitting a request for written advice.

5. Behaviours of Concern

Behaviours of Concern, also known as challenging behaviours, refer to a wide range of behaviours of an intensity, frequency or persistence that threatens the quality of life, physical safety of the individual and/or others and generally results in limiting access to the community.

Behaviours of Concern can be any behaviour that results in an adverse impact on the person's quality of life. This may include:

- physical or verbal aggression
- property damage
- inappropriate sexual behaviour
- disinhibited and impulsive behaviour

- self-injurious behaviour also referred to as self-harm. It differs with each person and can include head banging, picking and hitting. This behaviour may not be an attempt to cause harm.

Please note the term self-harm when used in mental health settings typically refers to intentional harm without suicidal intent such as neglect, cutting, ingesting objects and self-poisoning. Mental health professionals must be consulted by the participant's supports as this is typically an indication of serious distress.

In order to provide successful interventions, it is necessary to understand the function of that behaviour for the person and the context it occurs. There may be a range of underlying factors influencing BoC including:

- underlying physical, neurological, mental or emotional health issues
- biological/physical due to experiencing pain or discomfort
- acting out a repetitive behaviour or routine
- frustration in not being able to do something
- communication/social needs due to difficulties in communication, seeking social interaction or attention
- demonstrating a learned behaviour
- the physiological effects of substances including alcohol, illegal drugs or medications
- response to difficulties encountered with service systems or support networks
- attempting to avoid a situation
- interpersonal environment such as quality of social interactions
- change or lack of in routine or structure
- inflexible thinking
- attempting to manage sensory overload
- having a high pain threshold and the behaviour is intended to provide sensory stimulus
- support staff skills and turnover, perceptions and level of resources available.

5.1 Impacts of Behaviours of Concern (BoC)

Behaviours of Concern affect the quality of life of the individual. Factors such as the intensity, frequency or persistence of the behaviours may limit a participant in their opportunities to pursue social, educational, economic and/or recreational activities. Often this is due to the need to maintain the physical safety of an individual or other people (such as family, support workers or the community) and reduce the risk of unsafe social participation (such as inappropriate and/or unsafe sexual behaviours).

Where the participant exhibits BoC, they may require supports in several areas of their life. Informal supports can have difficulty in sustaining relationships and caring responsibilities due to the potential risk of harm to the participant, other people in the home or themselves. NDIS funded supports can be used to support informal and formal supports in their roles and build their capacity to effectively address the BoC with the participant. These supports may help sustain the participant's current living and/or support arrangements and encourage the participant to positively engage with others. Where the participant has complex and longstanding BoC there may be further difficulties in engaging and sustaining funded supports.

Participants with complex BoC may be at risk of breakdown of their living arrangements such as being temporarily removed from shared living arrangements to individualised accommodation support settings, or family supports no longer being able to sustain the person living in the family home. There is also the risk of increased support staff turnover that in turn can lead to further escalation in behaviours due to constant changes in their environments, formal and informal supports, and the impact of fractured relationships.

In some cases, when informal supports are unable to continue to care for the participant who displays complex BoC, an alternative accommodation arrangement may be required for short or long term periods. Where there has been an escalation of behaviours and this requires a change of circumstances refer to the Practice Guide – Unscheduled Plan Reviews, Practice Guide – Supported Independent Living (SIL) and the Practice Guide – Medium Term Accommodation.

In the case of a person under the age of 18, refer to the Practice Guide – Children and Young People with Disability Living in a Voluntary Agreement Outside the Family Home, Practice Guide – Children at Risk of Requiring Accommodation Outside the Family Home and Practice Guide – Children Living in Statutory Out of Home Care.

5.2 Positive behaviour support

Positive behaviour support is an effective approach for BoC as it focuses on addressing a person's needs, their home environment and overall quality of life through assessment, planning and intervention.

The positive behaviour support process typically follows similar steps.

1. **Brief functional behaviour assessment** - focussed on identifying requirements for incident prevention and response.
2. **Interim plan** - may also be referred to as a safety interim plan, incident prevention and response plan, reactive strategy response plan or reactive strategy. Interim BSPs include the provision for the use of a regulated restrictive practice developed within one month of engagement by a behaviour support practitioner while a comprehensive BSP is being developed.

3. **Comprehensive functional behaviour assessment -** the process for determining and understanding the function or purpose behind a person's behaviour, and may involve the collection of data, observations, and information to develop an understanding of the relationship of events and circumstances that trigger and maintain the behaviour.
4. **Comprehensive positive behaviour support plan** (see 5.2.1)
5. **Training and implementation support** - this usually targets informal supports and direct support workers and may also include reports and liaison with other stakeholders, reports for the psychiatrist; reports to restrictive practice authorisation mechanisms.
6. **Monitoring** - data collection, analysis and reporting.
7. **Review** - ongoing review of effectiveness of the BSP; revisit functional behaviour assessment at least annually.

The plan developer includes the appropriate capacity building support in the participant's plan for the provision of these supports.

5.2.1 Behaviour Support Plan (BSP)

A BSP specifies a range of evidence-based, person-centred and proactive strategies which focus on the individual needs of the person. It is developed with the aim of addressing the underlying functions of BoC taking place or increasing. The plan will outline specifically designed positive behaviour support strategies for the participant, their informal and funded supports to assist in reducing BoC and supporting their quality of life and goal attainment.

A registered specialist behaviour support practitioner must develop all functional behaviour assessments and BSPs, as positive behaviour support practice requires a specific skillset and appropriate safeguards. The Positive Behaviour Capability Framework (external) provides information about knowledge and skills required by the specialist behaviour support practitioners. The framework allows self-assessment to determine their suitability to provide the behaviour support practitioner requires.

Behaviour support practitioners must lodge BSPs containing restrictive practices with the NDIS Commission.

If the BSP does not include restrictive practices, it does not need to be lodged with the NDIS Commission. However, the practitioner developing the BSP must still be registered as a specialist behaviour support practitioner as noted above.

5.2.2 Assessment, development and review

A functional behaviour assessment must be completed when practitioners are developing a BSP. The practitioners will consult with the participant, their family, guardian, service providers and others who will be implementing the plan. By doing this the practitioners are able to gather historic and current information about behaviours displayed to identify settings, triggers, actions and results.

The BSP is designed to address the factors identified in the assessment. It will include a range of strategies used to support the person, including proactive skill development to build on the participant's strengths and response strategies to use when the behaviour presents.

Behaviour support plans are formally reviewed annually or earlier if the participant's circumstances change. At review, the effectiveness of all aspects of the plan including the preventative/environment, skill building/teaching and reinforcement strategies are measured along with step-down strategies. Importantly the progress towards the person's goals and identified quality of life measures is considered.

Plan developers can use assessment information to consider effectiveness and outcomes of funded supports and determine the level and type of capacity building support for inclusion in the NDIS plan.

Refer to the Compendium of Resources for Positive Behaviour Support (external) for further information about the range of positive support assessment tools that can be used by practitioners for assessment, planning, implementation, monitoring and review.

5.2.3 Younger People in Residential Aged Care (YPIRAC)

Residential aged care providers have the same responsibilities towards NDIS participants as they do to other residents who receive services and supports under the *Aged Care Act 1997*. Currently, services are regulated by the Aged Care Quality and Safety Commission.

From 30 June 2020 all providers applying the use of restrictive practices with young people in residential aged care will be regulated by the NDIS Quality and Safeguards Commission.

Refer to the Practice Guide – Younger People in Residential Aged Care for further information.

5.3 Restrictive practices

A restrictive practice is any practice or intervention which has the effect of restricting the rights or freedom of movement of a person with a disability. All states and territories endorsed the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Services Sector which was reaffirmed in the NDIS Quality and Safeguarding Framework.

For participants not supported by the Complex Support Needs team, if there is the use of restrictive practices or request for restrictive practices, the plan developer must make a referral for advice to the TAB via the TAPS. The referral must take place prior to inclusion or exclusion in the participant's NDIS plan. Refer to the TAB mandatory referrals page for more information.

Restrictive practices must be authorised through a formal process which is the responsibility of each state or territory and varies across jurisdictions. Restrictive practices can be considered only if they are the least restrictive alternative, and in the context of positive behaviour support strategies.

When a person is exhibiting BoC, those around them may try to stop or modify their behaviours in a number of ways with the intention of keeping them or others safe. They may intervene physically, try to control where they go, what they do or administer mood-altering medications.

The use of restrictive practices are a risk to the human rights of people with disability and there is a need to ensure there is appropriate reporting and scrutiny when used. The NDIS Commission has identified five forms of regulated restrictive practice:

1. **Seclusion:** The sole confinement of a person with disability in a room or a physical space where voluntary exit is prevented, not facilitated or it is implied that exit is not allowed. This may include when a person is put in a room or placed on their own and the person cannot leave when they want to as the door has been locked.
2. **Chemical restraint:** The use of medication or chemical substance for the primary purpose of influencing a person's behaviour. The medication or chemical substance provided is not treating a diagnosed illness or condition and is intended to make them calm or sleepy. This is often psychotropic medication, which affects mood and is generally prescribed by a psychiatrist.
3. **Mechanical restraint:** The use of a device to prevent, restrict or subdue a person's movement for the primary purpose of influencing a person's behaviour. This includes but is not limited to putting gloves on a person that they cannot remove independently so they are unable to scratch themselves or others, or restraining someone in a wheelchair using a harness that they are unable to undo independently for the purpose of keeping them in the wheelchair.

   Note: This does not include the use of devices for therapeutic or non-behavioural purposes.
4. **Physical restraint:** The use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury.
5. **Environmental restraint:** Restricting a person's free access to all parts of their environment including items or activities such as locking cupboards, fridges or the use of an enclosed bed.

   Note: Enclosed beds, where appropriate restrictive practice concerns have not been addressed, are a mandatory referral to the TAB via the TAPS.

5.3.1 Children and Restrictive Practice

For children, restrictive practices will need to be considered on a case-by-case basis, taking into account their developmental age and cultural context and information detailed in the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018*,

Child-safe practices age, such as the use of a car seat restraint for a child under seven would be considered age appropriate. However, the use of a car seat restraint for a 12-year old child to stop them from kicking others in the car may be considered a restrictive practice. Similarly, using child gates to prevent a toddler or child from falling down the stairs would not be a restrictive practice, however using a child gate to prevent a young person accessing the kitchen at all times would be considered a restrictive practice.

5.4 Restrictive practice guidelines

The NDIS Commission is taking the lead role in reducing and eliminating the use of restrictive practices and holds responsibility for monitoring the use of all restrictive practices recommended and implemented by NDIS providers in Australia. The NDIA is not responsible for making decisions about the use of restrictive practices.

Under the *NDIS (Restrictive Practices and Behaviour Support) Rules 2018*, restrictive practices are subject to regulation. Restrictive practices can only be used based on an assessment of behaviour with the appropriate authorisation from the relevant state or territory and where it is part of a BSP that has been developed by a registered behaviour support specialist.

The registered behaviour support practitioner is responsible for:

- undertaking a functional behaviour assessment
- developing a BSP for the participant
- submitting written applications seeking authorisation to restrictive practice authorising panels or bodies
- submitting regular progress reports, data summaries, and other documents to restrictive practice authorising panels or bodies
- attending restrictive practice panel meetings or other contact with the authorising body.

5.4.1 Participant with immediate needs

Where there is no current interim or comprehensive BSP in place and the participant has an immediate need for a restrictive practice due to a new or previously unexperienced degree of severity in the escalation of behaviour, the NDIS Commission outlines that:

- an interim BSP must be completed within a month of engagement by the behaviour support practitioner, and
- a comprehensive BSP must be developed within six months of the interim plan being completed by the behaviour support practitioner.

The use of regulated restrictive practice that has not been authorised in accordance with any state or territory legislation or policy requirements represents a reportable incident that must

be reported to the NDIS Commission. The provider must notify the NDIS Commission within five business days of becoming aware of the use of the restricted practice.

NDIS Staff and Partners in the Community should report any suspected use of unauthorised restrictive practice to the Participant Critical Incident Team.

Advice can by sought via the Participant Critical Incident Team or the TAPS service if clarification is needed about whether an event/practice represents the unauthorised use of restrictive practice, or the use of prohibited practice.

5.4.2 Implementing providers

The NDIS Commission refers to service providers who use a regulated restrictive practice as implementing providers. Implementing providers are expected to understand the context of the person's behaviour and follow the authorised BSP to make sure the use of any restrictive practice is a last resort intervention and in proportion to the risks posed by the behaviours.

The implementing provider is responsible for:

- being registered with the NDIS Commission for the type of support they are providing
- report regularly as per agreed schedule to the NDIS Commission
- ensure staff are appropriately trained to implement positive behaviour strategies or use restrictive practices
- notifying the NDIS Commission in the event of any unplanned or unapproved use of a restrictive practice as per the NDIS Commission reportable incident process.

Implementing provider reporting will include any use of unrestrictive practices and other reportable incidents, monitoring, and collected data as outlined in the BSP. This forms part of the ongoing focus on reducing or eliminating restrictive practices and addressing BoC.

Service providers must aim to reduce the use of restrictive practices by working with the participant and their supports to obtain a greater understanding of the function of the behaviour as well as triggers, and provide preventative strategies and techniques to develop more appropriate ways to support the participant. The behaviour support practitioner will support the implementing provider where required to understand the relevant state or territory legislative and policy requirements.

5.5 Point of crisis

A point of crisis is a period of intense difficulty and distress experienced by a participant that disrupts and makes their usual day-to-day life hard to cope with. Participants may experience points of crisis for various reasons, such as escalation of mental health issues or the unexpected loss of formal and/or informal supports. Emergency support may also be provided by other government services such as child protection, homelessness services, hospitals, ambulance, police and mental health assessment teams.

A crisis may often result in the escalation of BoC and may temporarily require more intensive support. While the NDIS is not responsible for the delivery of emergency support, when the participant or their informal support contacts the NDIS during times of crisis, we need to be responsive to their concerns.

This may involve supporting the participant to access other government services as required, and explaining how the funding in their plan can be used flexibly to meet their needs during a crisis. The participant may have interacted with the After Hours Crisis service as part of the Exceptionally Complex Support Needs Program.

In some instances, reconsideration of the participant's streaming may be required to ensure they are appropriately supported through this period. Refer to section 6.1 for further information.

You will need to ensure the support coordinator (if relevant) is aware of the situation and is responding to and supporting the participant in a timely and effective manner. The role of the support coordinator and the level of support coordination may need to be considered. For example, a specialist support coordinator to manage multiple mainstream interfaces, organise and prepare reports may be required.

In some cases, the behaviour support practitioner may be able to identify the circumstances that could lead to periods of crisis for the participant. In these cases, the BSP and other supports should be proactively designed to respond to these situations. This may impact on the way the supports are funded in the NDIS Plan.

Where additional supports beyond the flexibility of the existing plan is required, it may be appropriate to consider whether an unscheduled plan review is required. Refer to Practice Guide – Unscheduled Plan Reviews.

Interactions detailing the crisis circumstances and actions taken must be recorded in the NDIS Business System (System) and an alert added if required.

5.6 Incident management

5.6.1 Registered providers

Registered service providers must have effective incident management systems and are responsible for recording and managing all incidents that happen in the delivery of NDIS supports and services. They are also responsible for notifying the NDIS Commission of any reportable incidents (including allegations) that occur with the provision of supports and services to an NDIS participant. Reportable incidents include:

- serious injury or death of an NDIS participant
- abuse or neglect of an NDIS participant
- unlawful sexual or physical contact with, or assault of an NDIS participant
- sexual misconduct committed against, or in the presence of, an NDIS participant, including the grooming of the NDIS participant for sexual activity

- the unauthorised use of restrictive practice.

Refer to the NDIS Commission's Reportable Incidents (external) for further information.

5.6.2 Unregistered providers

Unregistered providers must follow their internal provider reporting channels. All providers (registered and unregistered) who are providing NDIS funded supports must follow the NDIS Code of Conduct (external).

5.6.3 National Disability Insurance Agency (NDIA)

NDIA staff and Partners in the Community may be advised or learn of allegations of serious harm occurring to a participant from a participant, their carer, nominee or other relevant party. This is known as a participant critical incident. If information is provided to you which suggests or alleges a participant critical incident has occurred, refer to the Participant Critical Incident Framework. You must notify the Participant Critical Incidents team where appropriate, refer to Participant Critical Incidents page.

As noted above, any unauthorised use of restrictive practice is a participant critical incident. This incident may be a reason for a section 48 plan review. The participant or their authorised representative can request a review, or the NDIA may choose to initiate based on the information provided around the critical incident. Participant critical incidents highlight that the participant's supports may require adjustment or further changes are needed. It is the responsibility of the NDIS to make sure that a participant has appropriate funding for their support needs, including behaviour support.

6. Pre-planning

6.1 Streaming

Plan developers need to ensure the correct streaming decision has been recorded in the System for the participant to receive the appropriate level of support to implement their plan. Factors to change the streaming decision are dependent on the complexities presenting in the participants current life situation or environment which may be identified during your conversation.

Where a participant has complex support needs requiring a different approach, a referral to the Complex Support Needs Pathway may be appropriate.

Refer to Standard Operating Procedure – Update Participant Streaming and Standard Operating Procedure – Referral for Complex Support Needs for further information.

Note: The term streaming is for internal use only.

6.2 Plan duration

The plan duration ready reckoner guide recommends plans are developed for up to 12 months when a participant is requiring behaviour support and/or is streamed as Super Intensive. However, the participant's individual circumstances should be considered and a shorter plan duration may be required if, for example, the BSP is being assessed, accommodation needs/options are being assessed or close monitoring is required. Where the participant's situation is stable a longer plan duration may be also be appropriate. Refer to Standard Operating Procedure – Complete the Risk Assessment and Practice Guide - Pre-Planning for further information.

6.3 Arranging the planning meeting

Contact the participant and/or their authorised representatives (nominee/s, child representatives, and court or tribunal appointed decision makers) through their chosen method of communication and confirm/obtain consent for information sharing and exchange. A participant or their authorised representative may choose to invite other family members, friends or NDIS funded support providers to the NDIS planning meeting.

You should confirm all meeting attendees to allow for appropriate consideration of location, meeting room, time allocated and whether additional or senior staff are required to attend.

In limited circumstances, it may be necessary to appoint a plan nominee to act on behalf of, or make decisions on behalf of a participant. Refer to the Standard Operating Procedures – Appoint, Decline, Suspend or Cancel a Nominee.

Where possible and appropriate, the participant should be in attendance during the planning conversation. The participant's wellbeing is the priority and discretion is required at times to determine whether it is suitable for their attendance, such as if there is significant unrest and or concerns about safety due to events such as accommodation or relationship breakdown as a result of significantly challenging behaviours.

In these instances, efforts should be made to include the participant, and consider a shorter meeting to confirm key details or having them contribute in another way such as completing the relevant NDIS booklet prior to the meeting.

When confirming a meeting location and time, you should check the System for alerts and confirm the following with the participant or their authorised representative:

- Consider the participant's routine. For example, if the participant has difficulty sleeping at night they may not function well in the mornings and prefer an afternoon meeting.
- If known, consider the sensory needs of the participant and confirm an appropriate location. For example, if BoC are triggered by sensory overload, suggest a quiet office to conduct the meeting.
- Understand any specific environmental factors that may present a risk to the participant or to other members of the meeting including the NDIS staff member.

- Understand and respect any cultural sensitivities or barriers to communicate effectively for example, they may prefer to meet with someone of the same gender.
- Explore options to book a meeting for an extended period of time to allow breaks, or hold the planning meeting over multiple sessions or arrange for the participant to attend for shorter periods.
- Be aware of any behaviour response strategies that may need to be implemented during the meeting and what the role of the NDIS staff member will be, noting the service providers and informal supports who know the person well should lead the response directly with the person to de-escalate the situation or conclude the meeting.

6.3.1 Gathering documentation

Arranging the planning meeting provides an opportunity to follow-up on relevant supporting documentation that has not been provided yet. The participant, authorised representative or their support coordinator may provide this information to the NDIA. In some circumstances, the NDIA may need to follow-up directly once appropriate consent has been obtained. Behaviour support documentation may include:

- the most recent BSP
- behaviour protocols or strategies (where not collated in an interim or comprehensive plan as per the NDIS Commission)
- behaviour support recommendations report outlining next steps in behaviour support and estimated hours required
- incident reports, preferably incident summary reports
- data summary reports
- Restrictive Practice Authorisation documentation (if relevant)
- support model assessment reports including identifying housing options
- other assessment reports and support plans, such as speech pathologist, occupational therapist, psychologist, psychiatrist, paediatrician or other medical practitioner
- other relevant reports from service providers or mainstream agencies such as court reports.

All new or updated legal/court orders and other documents provided to the NDIS must be uploaded to inbound documents in the System.

6.3.2 External meetings

If a meeting is taking place at a location external to an NDIS office, follow the usual appointment booking process and ensure the following:

- complete and attach a copy of the home visit risk screen document and journey plan to the participant's record in the System

- review other information available in the System including, but not limited to previously completed planner risk assessment, guided planning questions, planning conversation tool and inbound documents. This information will help you identify any likely risks or concerns, such as other people being in the premises and the general safety of surrounds
- discuss any identified risks and take any appropriate action as determined with your team leader
- familiarise yourself with the journey management procedure and out of office best practice guide.

NDIA staff are supported to make decisions at all times to protect their personal safety. These decisions may include:

- deciding that a visit requires a second employee to be present
- arriving at a location and deciding to cancel a visit due to safety concerns
- terminating a visit part way through due to safety concerns.

Refer to the Work Health and Safety page for further information.

For circumstances where the health, safety and/or security of NDIA staff or others is put at risk due to the behaviour of a participant or other third party, NDIA staff should refer to the Work Health and Safety page and NDIA Managing Unreasonable Behaviour Framework, Policy and Guideline for information, advice, reporting and escalation protocols.

6.4 Planning conversation

The participant is at the centre of the planning process and their goals and needs are explored by discussing their strengths and what they would like to achieve. The planning conversation should identify goals, capacity, risks and safeguards and provide an opportunity to discuss any assessments and reports.

Information provided in the planning meeting about the participant's BoC must be detailed in the guided planning questions free text box and in the planning conversation tool.

The following points can support you to have a high quality conversation:

- Be mindful of the person's communication needs and preferences including whether an interpreter is required.
- Make decisions about what will be appropriate to ask the person directly and what may be triggering or distressing that can be gathered in another way.
- Read previous planning information (if applicable), interactions and inbound documents.
- Review the support coordination progress reports. These should detail information including the participant's circumstances, identified risks, strategies and outcomes for the participant's goal progression.

- Review the behaviour specialist reports and any other assessments that identify outcomes achieved, key barriers and recommendations for the new plan.
- If there are known restrictive practices in use, ask if the BSP has been lodged with NDIS Commission and the relevant state or territory has authorised the use.
- Follow up any requested reports and/or assessments not yet provided, to assist informing the planning process.
- Use visual tools to assist in communicating. For example, if asking a participant about their schedule, use the weekly supports table in the NDIS planning booklet (external) to help break down the questions, or other format as determined appropriate to their communication needs.
- Encourage the participant to talk about/communicate their interests, what daily life is like, what challenges they face and allow time as needed for them to explain this to you.
- Discuss the previous plan (if applicable), what they found worked well and what did not. For example, they may have strong informal supports or may be at risk of losing their housing or in temporary accommodation placing them at risk of homelessness.
- Be conscious to not ask leading questions as people are likely to give the answer they think you want to hear.
- If the participant is appearing anxious or not engaging, consider asking them what would make them feel more comfortable such as having a break.
- Depending on the participant's situation, there may be multiple stakeholders with differing input present in the planning process. In these circumstances, make sure the participant and their authorised representative are the focus of your attention. Make sure they understand that they can request other people leave the room at any time.
- In some circumstances, due to the complexity of the participant's BoC further discussion may need to take place with the participant's informal supports and positive BSP practitioner to discuss current and proposed support needs, or there may need to be a second meeting.
- Where appropriate, seek consent to follow-up with specific individuals or providers. Refer to the Standard Operating Procedure – Consent and Authority for further information.

7. Planning

The Agency must be satisfied that the funded supports in the participant's NDIS plan meet each of the criteria outlined in section 34(1)(a)-(f) of the *National Disability Insurance Scheme Act 2013* (NDIS Act) and the *NDIS (Supports for Participants Rules) 2013*.

When planning for the participant with BoC, it is important to be aware of any recent or upcoming changes in their life. Behaviours of concern may take place more frequently or at a greater severity during transitional periods for example during adolescence, leaving school or changes in living arrangements.

It is important to also be mindful that effective positive behaviour support:

- is not a linear process. For example, the practitioner may be conducting an assessment while revising the plan and training
- is highly individualised
- is holistic and integrated
- utilises a systems approach
- includes crisis response and BSP revision as required
- includes multi-disciplinary input in all elements including assessment, design, implementation and review
- varies in intensity and time required depending on the complexity of the person's situation and support needs
- cannot always be delivered in monthly amounts across the year. For example, there may be a high utilisation initially for providers to complete the initial assessment, interim planning, comprehensive assessment and comprehensive BSP development.

Refer to Practice Guide - Determine Reasonable and Necessary Supports for further information.

7.1 Core supports

Core supports are intended to assist with or supervise personal tasks of daily life to enable the participant to live as independently as possible. The BSP is expected to be used by all formal supports to build on the participant's strengths, increase their opportunities to participate in community activities and increase their life skills.

Where possible, the funds can be used to strengthen the capability and capacity of the participant and their informal supports (if applicable) by reinforcing strategies and encouraging independence towards goal attainment.

Providers may request higher support costs for participants with complex BoC. Consider the participant's individual circumstances and needs using the information available to understand the purpose of the support. For example in some circumstances, the proposal

may be considered a restrictive practice or it may be required as the participant has health or physical support needs.

If a regulated restrictive practice is used, review the participant's BSP which will record whether the relevant state or territory body has authorised the use.

The delegate may need to consider that the sudden removal of funded Core supports for participants with high level staff ratios and/or restrictive practices may put the participant's living arrangement, their staff, or others at risk.

It is therefore important to consider a transitional or gradual step down model to effectively reduce supports in line with the BSP. This is likely to take place over the course of multiple NDIS plans and should be guided by the registered specialist behaviour support practitioner. A mandatory referral to the TAB via TAPS is required all plans that contain restrictive practices.

If the participant requires a higher intensity level of support, refer to the Standard Operating Procedure – Determine Self-Care and Community Access Supports for further information.

7.1.1 Behaviours support provision in supported independent living (SIL)

Behaviour supports need to take a whole of house approach when a participant is living in a supported independent living (SIL) arrangement with other people with disabilities. Behaviour support may be recommended where there are frequent incidents such as assaults, self-harm, property damage or high-level staffing ratios to manage risk to staff and residents. There may also be use the use of restrictive practices which are not targeted towards all the residents such as a locked fridge or the removal of people to a safe area during an incident.

Behaviour supports for a whole of house approach may include:

- shared living environmental assessment, also known as ecological assessment
- behaviour support systems review
- program development
- staff training.

Some of these supports may be shared in a whole of house approach, for example, there would be one shared living environmental assessment completed by the one provider to assess the overall household situation. The cost of the environment assessment would then be broken down and shared amongst all those living in home. Refer to the Practice Guide – Supported Independent Living (SIL).

7.2 Capacity Building supports

Before including funding for behaviour supports, consider the Capacity Building funding generated by the TSP and whether these funds are sufficient to provide some or all of the required behaviour support. To do this you will need to understand what other Capacity Building supports are required by the participant and work out whether the total Capacity

Building funding needs to be increased to support the participant with their BoC. For instance, a child or younger person may require a higher level of funding so their informal supports are appropriately trained to implement the BSP.

There is a guided planning question related to BoC which must have the correct responses recorded. Responses to this question are for data capturing only and do not generate any funding in the TSP. The TSP is a guide and decisions on reasonable and necessary supports should be made in accordance with s34 of the NDIS Act.

7.2.1 CB Daily Activity

Best practice in behaviour support involves a multidisciplinary approach tailored to the needs of the person. It is therefore important to ensure the relevant therapeutic assessments and services are included in CB Daily Activity area of the plan. NDIS reasonable and necessary improved daily living supports may include:

- assessments including psychological, communication and sensory
- individual skills development and training
- training for carers or parents.

As noted previously, a functional behaviour assessment can only be completed by a registered specialist behaviour support practitioner or provider.

Where an ecological assessment is required, a total of 10 hours per household should be funded. Where multiple participants in the same household require a BSP, if appropriate their plans should be developed at the same time and the hours divided amongst plans.

7.2.2 CB Relationships

Behaviour supports within the category of CB Relationships may include:

- specialist behavioural intervention support for assessment and development of BSP
- behaviour management plan and training in behaviour management strategies
- individual social skills development.

Dependent on the participant's circumstances, NDIS funded support workers may require individualised training specific to the participant to maintain consistency and positive behaviour supports. Practitioners may provide training plans for the support worker or therapy assistant in the development of social skills identified as required due to BoC.

When determining reasonable and necessary funding, the specialist behaviour support practitioner would be expected to monitor the BSP implementation and review accordingly. Regular review allows opportunity for changes and updates to the BSP if the progress differs from expectations.

Questions which may help in determining the amount of funding include:

- Which stage of behaviour support currently applies? Are they at the brief assessment and safety planning stage (Refer to 6.2) or are they stable and in the monitoring

stage? This indicates how many hours are still required for assessments and reporting.

- Does the participant already have a current comprehensive behaviour assessment?
  - If so, the next assessment will usually require less time.
- Does the participant already have a current comprehensive BSP?
  - If so, the next BSP update will usually require less time.
- How many BoC does the person engage in? Usually the more behaviours, the more time required for all stages of the behaviour support process.
- What is the intensity and severity of the behaviour/s of concern? More intense and high-risk behaviour is likely to require more time in assessment, design, protocol revision and implementation support.
- How many informal and formal support providers are involved? This will impact on the amount of observations, interviews, file review required; the amount of tailored strategies required for various environments and roles; and the amount of training and implementation support required.
- How many regulated restrictive practices are proposed or in place? The more practices, the more time required for assessment, design, implementation, and reporting.
- How many informal or funded supports require training and implementation support? Can this be done in one session or do multiple repeat sessions need to be factored in?
- What other reporting requirements does the specialist behaviour support practitioner have? This may include data summaries and consultation with a psychiatrist to inform medication review.
- How will the multidisciplinary team collaborate? How often will they need to meet or have other contact?
- How many other stakeholders does the specialist behaviour support practitioner need to engage with?
- How much direct contact will the specialist behaviour support practitioner have with the person for skill development? Is this sessional, what is the frequency?
- What other pieces of work are required? Are there specific assessments that can inform the behaviour assessment behaviour assessment report (such as Assessment of Sexual Knowledge); Support Model Assessment report; transition plan development and implementation (such as from one placement to another).
- Where there are regulated restrictive practices required, you should also include funding for the specialist behaviour support practitioner to meet their obligations under

the NDIS Commission specific to this participant and the state or territory authorisation process.

7.2.3 Behaviour intervention support levels

You will need to make sure the participant receives the appropriate support required to implement their plan and to address any behavioural complexities in their current life situation.

There are two levels of behaviour intervention support provided as a guide however the participant's individual circumstances and supporting information must be considered in every plan to determine appropriate funding and supports required.

The levels of support include a behaviour management plan and training in the management of strategies to form a package of support to address a participant's immediate need for behavioural intervention. You will need to make a reasonable and necessary decision to determine the appropriate level of support included in the participant's plan.

The guidance in hours has been suggested for a plan of 12 months in duration. Use your reasonable and necessary decision making for plans with durations less or more than 12 months. If a participant has significant behaviours of concern it is highly unlikely that there will be a plan over 12 months due to the need to monitor and review outcomes and circumstances.

Consult with your team leader and refer to the participant's individual supporting documents, Practice Guide - Determine Reasonable and Necessary Supports and the Standard Operating Procedure – Include Behavioural Intervention Support in a Plan for further guidance.

7.2.3.1 Level 1

Level 1 funding could be considered appropriate for participants who require intervention due to significant behavioural complexities that are impacting on the ability of the participants informal supports to sustain care at home and assist the participant to safely engage in activities.

Level 1 criteria includes:

- behaviours of concern that could require single or minimum interventions
- lack of services willing to engage with the participant due to presenting behaviours and risk to staff/participants/community
- change of participant circumstances that will result in withdrawal of service support and need for immediate intervention.

Use reasonable and necessary decision making to fund the following supports:

- **Specialist behavioural intervention support** - Most level 1 plans should not exceed 45 hours (approx. 3-4 hours per month) which will enable the participant to receive

support from a psychologist or appropriate therapist to develop a BSP, implement strategies and review interventions over a period of time.

- **Training in behaviour management strategies** - To support carers and any other significant informal supports in the participant's life to implement the behavioural support plan and behavioural strategies, include training in behaviour management. Most level 1 plans should not exceed 20 hours (1-2 hours per month) which will ensure the behavioural intervention support plan is applied consistently in all necessary environments to best support the participant.

7.2.3.2 Level 2

Level 2 funding could be considered appropriate for participants that require immediate intensive behavioural intervention support and are streamed Super Intensive or Complex. In the majority of circumstances, level 2 funding is not appropriate for children aged seven and under.

Level 2 criteria includes:

- multiple complexities that may require multiple interventions
- extreme behaviours of concern where there is the use of regulated restrictive practice
- lack of services willing to engage with the participant due to presenting behaviours and risk to staff/participants/community
- significant change of participant circumstances that will result in withdrawal of service support and need for immediate intervention
- behaviours of concern involving various stakeholders (multiple issues for intensive intervention requiring comprehensive assessment, planning, support and training for the participant and carers)
- participants who may have significant 1:1 support in the community, 1:2 support in the community (greater than 30% of the day) or exceptional circumstance supports at home due to their harmful or persisting behaviours that may present risk to themselves or others
- participants who require additional support to implement newly developed strategies in the community or within newly engaged activities/services
- participants who are anticipated to experience a significant transition during the plan period such as moving into SIL or from school to day program.

This package of support would be considered in the following circumstances:

- when a participant has extreme behaviours that could require restrictive intervention
- where there is significant change of circumstances that will result in a withdrawal of service support
- where there is significant risk to support staff, other participants or the community.

Use reasonable and necessary decision making to fund the following supports:

- **Specialist behavioural intervention support** – Most level 2 plans should not exceed 90 hours (7-8 hours per month) for specialist behavioural intervention support which will support participants with significantly harmful or persistent behaviours of concern.
- **Training in behaviour management strategies** – To support carers and other significant informal supports in the participant's life to apply the developed BSP and behavioural strategies, include training in behaviour management. Most level 2 plans should not exceed 30 hours (2-3 hours per month) which will ensure the behavioural support plan is applied consistently in all necessary environments to best support the participant.
- **Individual social skills development** – For participants that require additional support to implement newly developed strategies in the community or within newly engaged activities/services, include individual social skill development. Most level 2 plans should not exceed 40 hours (3-4 hours per month) which will complement recommendations in the BSP.

7.2.4 Support coordination

Support coordination is intended to strengthen the participant and/or their authorised representative's abilities to coordinate and implement supports in the plans to participate more fully in the community, and to build and maintain a resilient network of formal and informal supports. This includes addressing barriers to implementation and regular monitoring. A participant who displays BoC may require support coordination or specialist support coordination to assist where required.

You will need to consider the level of support the participant and/or their authorised representative will require to build their capacity to connect with supports and services, ensure they understand their NDIS plan and how to implement their funded supports, and strengthen their ability to self-direct services and achieve their goals.

It is also part of the support coordinator's role to build capacity of the participant and/or authorised representatives to gather supporting documents including assessments and reports and ensure these are provided to the NDIS.

Where the participant experiences a crisis, the support coordinator will assist them as required, to manage and link into appropriate supports. This information should form part of their next progress report to the NDIS where any known causes of the crisis, how it was managed, the outcome and proposed strategies to reduce the likelihood of a reoccurrence are detailed.

The reporting and monitoring requirements must be discussed at the plan handover and clearly outlined in the Request for Service. Refer to Standard Operating Procedure – Include Support Coordination in a Plan.

7.3 Plan comments

Make sure your plan comments recorded in Determine Funded Supports task include a description of the behaviour supports included within each budget.

Example (Core) – only relevant where there is a regulated restrictive practice in the participant's BSP: I can use my core support funding flexibly to help with my daily activities. Assistance with self-care activities and accessing the community to be provided by a registered implementing provider.

Example (Capacity Building): Funding for XX hours of specialist behaviour intervention support, XX hours of behaviour management plan and training in behaviour management strategies. A report detailing outcomes achieved is to be provided to the NDIA by the registered specialist behaviour support practitioner before this plan is due for review.

7.4 Plan management

It is important to understand the distinction between choice and control in regards to plan management and the legislative requirements to use a registered provider.

The NDIS supports the participant to maximise their choice and control where there is not unreasonable risk or other factors impacting the participant's and/or their authorised representative's ability to manage NDIS funding.

The *NDIS (Provider Registration and Practice Standards) Rules 2018* specifies that to maintain safeguards and minimise risk to the participant, NDIS providers must be registered for:

- functional behaviour assessments
- developing BSPs, and
- regulated restrictive practices.

Behaviour support practitioners (whether a sole provider or employed by a provider) must be registered with the NDIS to provide specialist behaviour support (registration group 110).

The NDIS recommends that CB Relationships is Agency managed to ensure the use of NDIS registered providers, however participants and/or their authorised representatives may choose to have their supports plan or self-managed. It is important for participants and/or their authorised representatives to understand the distinction between choice and control in regards to plan management and the legislative requirements to use a registered provider for specific behaviour supports (functional behaviour assessments, BSPs, and regulated restrictive practices).

NDIS legislation is based on the presumed capacity to self-manage. Therefore, a request by the participant to manage their funding should be considered positively by the delegate unless there is evidence of a significant risk to the participant.

The NDIS supports the participant to maximise their choice and control where there is not unreasonable risk or other factors impacting the participant's and/or their authorised representative's ability to manage NDIS funding. The determination of unreasonable risk is assessed with every plan review, having regard to the participant's individual circumstances and considerations.

7.4.1 Restrictive practice

Where the BSP includes regulated restrictive practice, the participant and/or their authorised representatives, should be aware that the implementing service provider for the behaviour support **must** also be registered with the NDIS Quality and Safeguards Commission.

Where supports are self or plan –managed, a thorough conversation with the details recorded in the appropriate pre-planning tasks and clear NDIS plan comment (see 7.3) should follow. This is to make sure that the participant and/or their authorised representatives understand while the funding management allows for the use of unregistered service providers, there is a legislative requirement that registered providers **must** be used for BSPs and regulated restrictive practices.

Refer to Planning Operational Guideline – Managing the funding for supports under a participant's plan (the plan management decision) for further information.

8. Plan implementation and monitoring

There should be ongoing monitoring during the plan period to measure whether the participant is meeting their desired outcomes and goals. This can take place through a variety of means including support coordination reports, regular updates and Panda Live data.

You should check the plan utilisation to make sure the plan is being implemented as expected and provide opportunity for earlier follow-up if there appears to be an over or under utilisation. Due to the nature of this support, there is likely to periods of intensive support and high budget utilisation, therefore the utilisation should be considered over time.

Refer to PANDA, Practice Guide – Plan Implementation and Practice Guide – Monitoring for further information.

9. Scheduled plan reviews

Make sure you have received the progress report from the support coordinator or specialist support coordinator and reviewed it to understand key issues and outcomes from the plan period.

It is expected the NDIA will be provided with supporting information demonstrating outcomes, barriers and where appropriate, recommendations for the next NDIS plan. For example, where there has been successful implementation of capacity building supports, it may lead to a reduction of supports based on the behaviour support practitioner recommendations. Fade-

out or step down approaches will be clearly documented based on supporting information. These approaches form a key part of reasonable and necessary decision making when a participant's BSP includes restrictive practices.

For further information, refer to Practice Guidance - Scheduled Plan Reviews and Standard Operating Procedure – Complete a Plan Review (full).

10. Case examples

10.1 Example 1 - Kim

Kim is a 20-year-old woman and lives at home with her parents and two younger siblings. She has a primary disability of autism spectrum disorder and a secondary disability of mild intellectual disability.

10.1.1 Planning meeting

At Kim's planning meeting, her parents discuss how they are struggling to maintain support and are concerned about the impact Kim's behaviours of concern are having on her and her younger siblings. When asked further about her behaviours, they explain that Kim bites and hits out at people around her at home and at her day program. When upset, she will also hit her head against walls and run away from those she is with.

Kim enjoyed attending a specialist school and after completing year 12, she started at a day program. The identified behaviours escalated when she left school. Kim has not settled at the day program. She is reluctant to leave home to attend and while at the day program, Kim displays increased levels of BoC.

Kim's parents and the day program provider have tried several different strategies to support her, however the BoC have not reduced. She has not been provided with any behaviour support previously.

10.1.2 Outcome

Kim is considered to meet the criteria for level one behaviour intervention support for the following reasons:

- Kim has informal supports who are engaged and available.
- Kim is still attending a regular day program and the provider is willing to work with her and her family to implement the BSP.
- the BoC have not been longstanding having escalated only since Kim left school.

Kim's 12-month plan provides funding for the following reasonable and necessary supports:

- Social community and civic participation for continued day program attendance allowing for higher-intensity supports while Kim is connected with a specialist behaviour support practitioner. The NDIS is awaiting further recommendations in the

report by the specialist behaviour support practitioner for the associated training hours required in the BSP.

- Functional capacity assessment (10 hours).
- Specialist behavioural intervention support for functional behaviour assessment, development of a BSP, implementation, monitoring and review of behavioural support interventions in her home and day program (45 hours).
- Behavioural management plan including training in behaviour management strategies to provide training to informal/formal supports to understand and implement Kim's BSP consistently in all environments (20 hours).
- Coordination of Supports (72 hours).

10.2 Example 2 – Joe

In the following two case examples, Joe and Hassan, two NDIS participants are living in a SIL arrangement and sharing supports. At the scheduled plan reviews, the SIL provider has provided information detailing an increase in BoC for both Joe and Hassan. After trying a number of different strategies to resolve conflict and reduce the BoC, the provider has requested an increase in both SIL and Capacity Building funding to better support them.

Joe is a 30-year-old man and lives in a SIL arrangement with two others. His primary disability is a moderate intellectual disability. Joe works at an Australian Disability Enterprise (ADE) four days per week. Joe is well supported by his parents and family and spends every Sunday with them. His family use supported decision making to make sure he is active in his life decisions.

10.2.1 Planning meeting

All the participants in the home are undertaking a scheduled plan review. Prior to Joe's NDIS meeting, the completed provider SIL pack and quoting tool along with supporting information including his BSP are provided to the NDIS. Joe's BSP notes his behaviour will escalate quickly if there is any unexpected change or interruption to his routine or life and he generally begins to shout, punch walls and becomes agitated. Some of Joe's triggers include:

- Reminders of the recent death of a close friend.
- When his housemate Hassan is displaying BoC.
- Returning to his home after a family visit on Sundays.
- Varying triggers at his ADE including when there is unexpected change and loud noises, approximately twice per week.

10.2.2 Outcome

Joe is considered to meet the criteria for level one behaviour support for the following reasons:

- Joe has informal supports who are engaged and available.
- Joe works at an ADE four days per week and goes to regular activities in the community on the other weekday. The ADE provider is willing to work with Joe, his family and support workers to implement his BSP.
- The BoC have not been longstanding having escalated since Joe's friend passed away.

Joe's 12-month plan provides funding for the following reasonable and necessary supports:

- Supported independent living included as per SIL pack and quoting tool. The NDIS is awaiting further recommendations in the report by the specialist behaviour support practitioner for the associated training hours required in the BSP.
- Support for his continued employment at the ADE.
- Shared living environmental assessment (ecological assessment) (5 hours).

  Although Joe has been assessed as meeting the criteria for a level 1 behaviour support plan, he lives in a shared environment, and it has been identified that triggers for BoC are occurring within the home. Funding has been added to enable an ecological assessment to be undertaken to better understand contributors from within Joe's living arrangement.
- Specialist behavioural intervention support for functional behaviour assessment, development of a BSP, implementation, monitoring and review of behavioural support interventions in his SIL home, family home and ADE (45 hours).
- Behavioural management plan including training in behaviour management strategies to provide training to informal and formal supports to understand and implement Joe's BSP consistently in all environments (20 hours).
- Coordination of Supports (72 hours).

10.3 Example 3 – Hassan

Hassan is a 45-year-old man and lives in a SIL arrangement with Joe and one other. His primary disability is autism spectrum disorder and his secondary disability is schizophrenia. During the week, he attends a day program for two days where he consistently exhibits BoC. He does not currently have family support, usually seeing his sister on his birthday. Hassan gets distressed by many triggers that substantially increase his anxiety levels and tends to result in him scratching his own skin or hitting or kicking property or anyone who tries to intervene. He is prescribed risperidone to manage these BoC. Staff also administer a muscle

relaxant medication when becomes agitated to help calm Hassan. Some of the known triggers are as follows:

- Exposure to sensory stimulation especially loud noises, music and bright lights.
- When his housemate Joe becomes agitated and yells.
- When his formal supports prompt him with daily activities.

As the direct result of an assault on a house staff member, there is an active Mental Health Community Treatment Order in place that states Hassan must attend and receive treatment weekly.

10.3.1 Planning Meeting

All the participants in the home are undertaking a scheduled plan review. Prior to Hassan's NDIS meeting, the completed provider SIL pack and quoting tool along with supporting information including his BSP are provided to the NDIS. The day program provider is considering withdrawing services due to the risks involved.

Hassan's parents have both passed away. He has a sister who lives interstate and is not involved in his daily life. Hassan has the public guardian in place as his decision maker and the Public/State Trustee manages his finances.

10.3.2 Outcome

Hassan is considered to meet the criteria for level two behaviour support for the following reasons:

- Hassan is experiencing problems maintaining service providers.
- Hassan's only informal support is his sister and he sees her once a year on his birthday.
- He is subject to restrictive practice (chemical restraint) to address BoC.

Hassan's 12-month plan provides funding for the following reasonable and necessary supports:

- Supported independent living included as per SIL pack and quoting tool. The NDIS is awaiting further recommendations in the report by the specialist behaviour support practitioner for the associated training hours required in the BSP.
- Support for his continued attendance at his day program.
- Shared living environmental assessment (ecological assessment) (5 hours).

  It has been identified that Hassan will have his BSP reviewed at the same as Joe. As a result, the 10 hours to develop the ecological assessment has been shared between Joe and Hassan's plan.

- Specialist behavioural intervention support for functional behaviour assessment, development of a BSP, implementation, monitoring and review of behavioural support interventions in his SIL home and day program (90 hours).
- Behavioural management plan including training in behaviour management strategies to provide training to informal/formal supports to understand and implement Hassan's BSP consistently in all environments (30 hours).
- Coordination of Supports (108 hours).

10.4 Example 4 – Daniel

Daniel is a 12-year-old boy. He lives with his mother and younger siblings. He attends his local primary school. His primary disability is autism spectrum disorder and secondary disability is intellectual disability. It has been identified that Daniel has sensory aversion to loud noises and to sensations such as silky or synthetic fabrics. He has difficulty communicating his needs to others, and seems to have difficulties following instructions, leading to frustration and BoC.

10.4.1 Planning Meeting

During the planning meeting, Daniel's mother said he was attending school three days per week. He would like to establish friendships with his peers and increase his social participation however experiences heightened anxiety due to bullying at school including verbal threats, teasing and pushing.

Daniel's mother and school have identified that his BoC are high in intensity. They include self-harm (suicide attempts, absconding) and harm towards others (physical aggression and assault). At home, cutlery needs to be stored safely. Daniel's mother has identified that she has locked away to maintain his safety due to self-harming behaviours. Usually, the cutlery would be in an unlocked drawer, as a child of Daniel's age would generally be expected to safely use cutlery to eat or prepare food. He does not have a behaviour support plan.

His attendance at school, the bullying and identified BoC make it challenging for Daniel to form and maintain relationships and participate in social activities. His mother spoke about finding it increasingly difficult to care for Daniel. The school have funded an additional staff member to increase his attendance at school.

Daniel's mother is requesting Core supports to support her in the home, and support for Daniel while at school and participating in his learning activities and increase his social participation. The planner provides further details of NDIS and education responsibilities, noting that service systems obligations must be met before any funding by the NDIS could be considered to meet the disability support needs that are deemed beyond 'reasonable adjustment'.

10.4.2 Outcome

Daniel is considered to meet the criteria for level two behaviour support for the following reasons:

- Daniel is experiencing issues with school attendance.
- Daniel's only informal support is his mother and she has expressed carer fatigue.
- Daniel's BoC have been identified as high in intensity, particularly given his age.
- Daniel is experiencing challenges with social participation.

Daniel's 12-month plan provides funding for the following reasonable and necessary supports:

- CB Daily Activity as it has been identified that Daniel has sensory difficulties and communication difficulties. Funds within this category will be utilised for an occupational therapist to undertake a sensory assessment and a speech pathologist to undertake a communication assessment and collaborate with the behaviour support practitioner to enable strategies to address these needs to be included within the Positive BSP.
- Specialist behavioural intervention support for a functional behaviour assessment, development of a BSP, implementation, monitoring and review of behavioural support interventions in all environments (home, education setting, any other identified setting) (84 hours).
- Behavioural management plan including training in behaviour management strategies to provide training to informal and formal supports to understand and implement Daniel's BSP consistently in all environments (30 hours).
- Coordination of Supports (60 hours)

As discussed in the planning meeting, it was not determined to be reasonable and necessary for the NDIS to fund Core supports for Daniel in his educational environment to assist with her learning support needs and school attendance supports.

11. Appendices

11.1 State and territory restrictive practice legislation

The state and territory governments remain responsible for specific legislation, policy and procedures related to the authorisation of restrictive practices. This is complementary to the NDIS Commission who is responsible for best practice guidance, monitoring and oversight of behaviour support service provision and the use of restrictive practices in all states and territories (excluding Western Australia). It is important to note that BSPs containing regulated restrictive practices must be lodged with the NDIS Commission, even if authorisation of the use of the restrictive practice is not a requirement of that state or territory.

Behaviour support practitioners must adhere to the requirements of the NDIS Commission and the state or territory in which they operate. Plan developers can refer practitioners, providers and plan implementers (support coordinator or LAC) to the relevant source of information. If there are concerns, discuss with your supervisor, request TAB advice or escalate feedback that may need to be considered for report to the NDIS Commission.

11.1.1 New South Wales

- While there is no specific legislation regarding restrictive practices in New South Wales, there is the *Guardianship Act (1987)*.
- New South Wales also have the restrictive practice authorisation policy and procedural guide outlining requirements. Approval is provided through the restrictive practices authorisation (RPA) panels.
- Service providers must comply with the New South Wales restrictive practices authorisation policy and procedural guide.
- There is expected to be an updated New South Wales policy concerning restrictive practices authorisation mechanism, which providers will also need to comply with.

11.1.2 Victoria

- The Victorian government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices and behaviour support in the NDIS.
- The Victorian Senior Practitioner has the power to issue prohibitions and directions related to restrictive practices, compulsory treatment and supervised treatment orders under the *Disability Act 2006*.

11.1.3 Queensland

- The Queensland government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices in the NDIS through the *Disability Services Act (2006)* for those over 18 years.
- The *Disability Services Act (2006)* helps safeguard people with an intellectual or cognitive disability and their rights against the inappropriate use of restrictive practices and provides an accountability framework that allows for transparency in the decision-making process to authorise the use of a restrictive practice by a relevant service provider with an adult with an intellectual or cognitive disability.
- The *Disability Services Act (2006)* sets out a number of requirements that the relevant disability service provider must follow to legally use a restrictive practice and for any use of containment/seclusion to be approved by the Queensland Civil and Administrative Tribunal.

11.1.4 Western Australia

- The Western Australian government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices and behaviour supports in the NDIS.
- Providers are encouraged to follow the Code of Practice: A Guide for the Elimination of Restrictive Practices (external).

11.1.5 South Australia

- The South Australian government has policy and procedures outlining state requirements regarding restrictive practice authorisation.
- The *Disability Services Act 1993* requires disability service providers to have restrictive practices policy and procedures in place. Seclusion of an adult with disability must only be used if specifically authorised by the South Australian Civil and Administrative Tribunal (SACAT) under Section 32 of the *Guardianship and Administration Act 1993.*

11.1.6 Tasmania

- The Tasmanian government remains responsible for the legislative and policy frameworks through the *Disability Services Act 2011* regarding the authorisation of regulated restrictive practices, which are approved by Tasmanian Senior Practitioner.
- Chemical restraint does not have authorisation requirements in Tasmania.

11.1.7 Australian Capital Territory

- The *Senior Practitioner Act (2018)* remains responsible for the approval of behaviour support plans, which include the use of a regulated restrictive practice.
- The *Senior Practitioner Act (2018)* provides the powers and functions of the Senior Practitioner and regulates the use of restrictive practices by persons or other entities who provide any of the following services to another person:
  - education, including education and care
  - disability
  - care and protection of children.

11.1.8 Northern Territory

- The Northern Territory government will be responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices in the NDIS through the *NDIS (Authorisations) Act 2019*.

12. Supporting material

- *NDIS Act 2013*
- *NDIS (Quality and Safeguards Commission and Other Measures) Transitional Rules 2018*
- *NDIS (Restrictive Practices and Behaviour Support) Rules 2018*
- *NDIS (Code of Conduct) 2018*
- *NDIS (Incident Management and Reportable Incidents) Rules 2018*
- *NDIS (Provider Registration and Practice Standards) Rules 2018*
- *NDIS (Plan Management) Rules 2013*
- *Overview of the NDIS Operational Guideline – Quality and Safeguards*
- *NDIS Quality and Safeguards Commission*
- *NDIS Quality and Safeguarding Framework*
- *Convention on the Rights of Persons with Disabilities (external)*
- *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector (external)*
- Operational Protocols between the NDIA and the NDIS Commission intranet page

12.1 New South Wales

- *Guardianship Act 1987*
- *Restrictive Practice Authorisation Policy (June 2019)*
- *Restrictive Practice Authorisation Procedural Guide (June 2019)*

12.2 Victoria

- *Disability Act 2006*
- *Disability Act 2006: Supervised Treatment Orders, Restrictive Practices, Compulsory Treatment*

12.3 Queensland

- *Disability Services Act 2006*

12.4 Western Australia

- *Code of Practice: A Guide for the Elimination of Restrictive Practices*

12.5 South Australia

- *Disability Services Act 1993*
- *Safeguarding People With Disability Restrictive Practice Policy (2017)*

12.6 Australian Capital Territory

- *Senior Practitioner Act 2018*

12.7 Northern Territory

- *NDIS (Authorisations) Act 2019*

12.8 Tasmania

- *Disability Services Act 2011*

13. Feedback

If you have any feedback about this Practice Guide please email Service Guidance and Practice. In your email, remember to include the title of the resource you are referring to and to describe your suggestion or issue concisely.

14. Version change control

Version No	Amended by	Brief Description of Change	Status	Date
1.0	ZWECKM P19702	Guidance to support staff when planning for participants who display behaviours of concern. Behavioural supports are to be provided in accordance with the NDIS Quality and Safeguard Commission's requirements for positive behaviour support. Behaviour intervention levels moved to PG from SOP – Behaviour intervention supports. Class 3 approval.	APPROVED	2020-01-20
2.0	KN0014	Replacing National Critical Incident Response with Participant Critical Incidents Framework. Class one approval.	APPROVED	2020-02-26
2.8	KRN451, DCP167	Review and endorsement by TAB	DRAFT	2020-05-06
3.0	KN0014	Class 1 Approval. Updated Technical Advisory Team to Technical Advisory Branch. Updated Scope as WA has deferred transitioning to the NDIS Commission from 1 July 2020 to 1 December 2020. Restrictive practices section to note that enclosed beds are considered an environmental restraint Case examples included.	APPROVED	2020-05-25

Practice Guide – Positive Behaviour Support and Behaviours of Concern

Contents

1. Purpose

The purpose of this Practice Guide is to guide you through the considerations, roles and responsibilities when planning for a participant who displays Behaviours of Concern (BoC).

2. To be used by

- Plan Developers – Planners and Local Area Coordinators [LACs]
- NDIA Plan Delegates.

3. Scope

This Practice Guide provides information to support plan developers to understand when and how positive behaviour support may be a reasonable and necessary support where the participant displays BoC. This includes the respective roles and responsibilities of the National Disability Insurance Scheme (NDIS), NDIS Quality and Safeguards Commission (NDIS Commission) and states and territories.

Behaviour supports are to be provided in accordance with the NDIS Commission's requirements for positive behaviour support. The NDIS funds reasonable and necessary supports designed to identify and reduce BoC, to improve the participant's quality of life, uphold their dignity and safeguard their rights.

The NDIS Commission is operating in all states and territories (except for Western Australia). The NDIS Commission starts operating from 1 December 2020 in Western Australia. Until this time, the current state requirements for quality and safeguards continue to apply.

The NDIS Commission, states and territories governments have oversight of behaviour support and restrictive practices. They are committed to a regulatory framework for behaviour support that is founded on contemporary evidence-based practice and aligned with the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Services Sector (external).

4. Legislative and Policy Context

The NDIS Commission is responsible for best practice guidance, monitoring and oversight of behaviour support service provision and the use of restrictive practices. State and territory governments remain responsible for specific legislation, policy and procedures related to the authorisation of restrictive practices. These are separate but related processes and requirements.

The NDIS Commission assesses behaviour support practitioners and providers using a Positive Behaviour Support Capability Framework. This provides guiding principles to assist in delivering specialist positive behaviour support as an NDIS behaviour support practitioner.

In all states and territories (excluding Western Australia), providers who use or are likely to use restrictive practices, or who develop behaviour support plans (BSPs) must be registered with the NDIS Commission and meet the supplementary requirements of the NDIS Practice Standards (external).

To support safeguarding for people subject to restrictive practices, any use of restrictive practice must comply with the NDIS (Restrictive Practices and Behaviour Support) Rules 2018. These safeguards include but are not limited to:

- behaviour support practitioners, and providers who use regulated restrictive practices (also known as implementing providers) must meet the requirements outlined
- state and territory governments remain responsible for the authorisation of regulated restrictive practice/s in an individual's BSPs. Providers must comply with requirements of their state or territory
- restrictive practices are clearly identified in a BSP.

The Western Australian government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices and behaviour supports in the NDIS.

Refer to section 11.1 for information on state and territory restrictive practice legislation.

The National Disability Insurance Agency (NDIA) is not obligated to fund supports which have been imposed by state and territory bodies, which involve the use of restrictive practices, for example where a supervision order has been imposed by a civil or criminal court. However, where a restrictive practice has been authorised, recommended, or implemented by another body, this is a relevant consideration when determining if the NDIS funded behaviour support is reasonable and necessary. If unsure, discuss with your team leader. Further guidance can be sought by making an enquiry with the Technical Advisory Branch (TAB) via the Technical Advisory Phone Service (TAPS) or submitting a request for written advice.

5. Behaviours of Concern

Behaviours of Concern, also known as challenging behaviours, refer to a wide range of behaviours of an intensity, frequency or persistence that threatens the quality of life, physical safety of the individual and/or others and generally results in limiting access to the community.

Behaviours of Concern can be any behaviour that results in an adverse impact on the person's quality of life. This may include:

- physical or verbal aggression
- property damage
- inappropriate sexual behaviour
- disinhibited and impulsive behaviour

- self-injurious behaviour also referred to as self-harm. It differs with each person and can include head banging, picking and hitting. This behaviour may not be an attempt to cause harm.

Please note the term self-harm when used in mental health settings typically refers to intentional harm without suicidal intent such as neglect, cutting, ingesting objects and self-poisoning. Mental health professionals must be consulted by the participant's supports as this is typically an indication of serious distress.

In order to provide successful interventions, it is necessary to understand the function of that behaviour for the person and the context it occurs. There may be a range of underlying factors influencing BoC including:

- underlying physical, neurological, mental or emotional health issues
- biological/physical due to experiencing pain or discomfort
- acting out a repetitive behaviour or routine
- frustration in not being able to do something
- communication/social needs due to difficulties in communication, seeking social interaction or attention
- demonstrating a learned behaviour
- the physiological effects of substances including alcohol, illegal drugs or medications
- response to difficulties encountered with service systems or support networks
- attempting to avoid a situation
- interpersonal environment such as quality of social interactions
- change or lack of in routine or structure
- inflexible thinking
- attempting to manage sensory overload
- having a high pain threshold and the behaviour is intended to provide sensory stimulus
- support staff skills and turnover, perceptions and level of resources available.

5.1 Impacts of Behaviours of Concern (BoC)

Behaviours of Concern affect the quality of life of the individual. Factors such as the intensity, frequency or persistence of the behaviours may limit a participant in their opportunities to pursue social, educational, economic and/or recreational activities. Often this is due to the need to maintain the physical safety of an individual or other people (such as family, support workers or the community) and reduce the risk of unsafe social participation (such as inappropriate and/or unsafe sexual behaviours).

Where the participant exhibits BoC, they may require supports in several areas of their life. Informal supports can have difficulty in sustaining relationships and caring responsibilities due to the potential risk of harm to the participant, other people in the home or themselves. NDIS funded supports can be used to support informal and formal supports in their roles and build their capacity to effectively address the BoC with the participant. These supports may help sustain the participant's current living and/or support arrangements and encourage the participant to positively engage with others. Where the participant has complex and longstanding BoC there may be further difficulties in engaging and sustaining funded supports.

Participants with complex BoC may be at risk of breakdown of their living arrangements such as being temporarily removed from shared living arrangements to individualised accommodation support settings, or family supports no longer being able to sustain the person living in the family home. There is also the risk of increased support staff turnover that in turn can lead to further escalation in behaviours due to constant changes in their environments, formal and informal supports, and the impact of fractured relationships.

In some cases, when informal supports are unable to continue to care for the participant who displays complex BoC, an alternative accommodation arrangement may be required for short or long term periods. Where there has been an escalation of behaviours and this requires a change of circumstances refer to the Practice Guide – Unscheduled Plan Reviews, Operational Guideline – Supported Independent Living (SIL) and the Practice Guide – Medium Term Accommodation.

In the case of a person under the age of 18, refer to the Practice Guide – Children and Young People with Disability Living in a Voluntary Agreement Outside the Family Home, Practice Guide – Children at Risk of Requiring Accommodation Outside the Family Home and Practice Guide – Children Living in Statutory Out of Home Care.

5.2 Positive behaviour support

Positive behaviour support is an effective approach for BoC as it focuses on addressing a person's needs, their home environment and overall quality of life through assessment, planning and intervention.

The positive behaviour support process typically follows similar steps.

1. **Brief functional behaviour assessment** - focussed on identifying requirements for incident prevention and response.
2. **Interim plan** - may also be referred to as a safety interim plan, incident prevention and response plan, reactive strategy response plan or reactive strategy. Interim BSPs include the provision for the use of a regulated restrictive practice developed within one month of engagement by a behaviour support practitioner while a comprehensive BSP is being developed.

3. **Comprehensive functional behaviour assessment -** the process for determining and understanding the function or purpose behind a person's behaviour, and may involve the collection of data, observations, and information to develop an understanding of the relationship of events and circumstances that trigger and maintain the behaviour.
4. **Comprehensive positive behaviour support plan** (see 5.2.1)
5. **Training and implementation support** - this usually targets informal supports and direct support workers and may also include reports and liaison with other stakeholders, reports for the psychiatrist; reports to restrictive practice authorisation mechanisms.
6. **Monitoring** - data collection, analysis and reporting.
7. **Review** - ongoing review of effectiveness of the BSP; revisit functional behaviour assessment at least annually.

The plan developer includes the appropriate capacity building support in the participant's plan for the provision of these supports.

5.2.1 Behaviour Support Plan (BSP)

A BSP specifies a range of evidence-based, person-centred and proactive strategies which focus on the individual needs of the person. It is developed with the aim of addressing the underlying functions of BoC taking place or increasing. The plan will outline specifically designed positive behaviour support strategies for the participant, their informal and funded supports to assist in reducing BoC and supporting their quality of life and goal attainment.

A registered specialist behaviour support practitioner must develop all functional behaviour assessments and BSPs, as positive behaviour support practice requires a specific skillset and appropriate safeguards. The Positive Behaviour Capability Framework (external) provides information about knowledge and skills required by the specialist behaviour support practitioners. The framework allows self-assessment to determine their suitability to provide the behaviour support practitioner requires.

Behaviour support practitioners must lodge BSPs containing restrictive practices with the NDIS Commission.

If the BSP does not include restrictive practices, it does not need to be lodged with the NDIS Commission. However, the practitioner developing the BSP must still be registered as a specialist behaviour support practitioner as noted above.

5.2.2 Assessment, development and review

A functional behaviour assessment must be completed when practitioners are developing a BSP. The practitioners will consult with the participant, their family, guardian, service providers and others who will be implementing the plan. By doing this the practitioners are able to gather historic and current information about behaviours displayed to identify settings, triggers, actions and results.

The BSP is designed to address the factors identified in the assessment. It will include a range of strategies used to support the person, including proactive skill development to build on the participant's strengths and response strategies to use when the behaviour presents.

Behaviour support plans are formally reviewed annually or earlier if the participant's circumstances change. At review, the effectiveness of all aspects of the plan including the preventative/environment, skill building/teaching and reinforcement strategies are measured along with step-down strategies. Importantly the progress towards the person's goals and identified quality of life measures is considered.

Plan developers can use assessment information to consider effectiveness and outcomes of funded supports and determine the level and type of capacity building support for inclusion in the NDIS plan.

Refer to the Compendium of Resources for Positive Behaviour Support (external) for further information about the range of positive support assessment tools that can be used by practitioners for assessment, planning, implementation, monitoring and review.

5.2.3 Younger People in Residential Aged Care (YPIRAC)

Residential aged care providers have the same responsibilities towards NDIS participants as they do to other residents who receive services and supports under the *Aged Care Act 1997*. Currently, services are regulated by the Aged Care Quality and Safety Commission.

From 30 June 2020 all providers applying the use of restrictive practices with young people in residential aged care will be regulated by the NDIS Quality and Safeguards Commission.

Refer to the Practice Guide – Younger People in Residential Aged Care for further information.

5.3 Restrictive practices

A restrictive practice is any practice or intervention which has the effect of restricting the rights or freedom of movement of a person with a disability. All states and territories endorsed the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Services Sector which was reaffirmed in the NDIS Quality and Safeguarding Framework.

For participants not supported by the Complex Support Needs team, if there is the use of restrictive practices or request for restrictive practices, the plan developer must make a referral for advice to the TAB via the TAPS. The referral must take place prior to inclusion or exclusion in the participant's NDIS plan. Refer to the TAB mandatory referrals page for more information.

Restrictive practices must be authorised through a formal process which is the responsibility of each state or territory and varies across jurisdictions. Restrictive practices can be considered only if they are the least restrictive alternative, and in the context of positive behaviour support strategies.

When a person is exhibiting BoC, those around them may try to stop or modify their behaviours in a number of ways with the intention of keeping them or others safe. They may intervene physically, try to control where they go, what they do or administer mood-altering medications.

The use of restrictive practices are a risk to the human rights of people with disability and there is a need to ensure there is appropriate reporting and scrutiny when used. The NDIS Commission has identified five forms of regulated restrictive practice:

1. **Seclusion:** The sole confinement of a person with disability in a room or a physical space where voluntary exit is prevented, not facilitated or it is implied that exit is not allowed. This may include when a person is put in a room or placed on their own and the person cannot leave when they want to as the door has been locked.
2. **Chemical restraint:** The use of medication or chemical substance for the primary purpose of influencing a person's behaviour. The medication or chemical substance provided is not treating a diagnosed illness or condition and is intended to make them calm or sleepy. This is often psychotropic medication, which affects mood and is generally prescribed by a psychiatrist.
3. **Mechanical restraint:** The use of a device to prevent, restrict or subdue a person's movement for the primary purpose of influencing a person's behaviour. This includes but is not limited to putting gloves on a person that they cannot remove independently so they are unable to scratch themselves or others, or restraining someone in a wheelchair using a harness that they are unable to undo independently for the purpose of keeping them in the wheelchair.

   Note: This does not include the use of devices for therapeutic or non-behavioural purposes.
4. **Physical restraint:** The use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury.
5. **Environmental restraint:** Restricting a person's free access to all parts of their environment including items or activities such as locking cupboards, fridges or the use of an enclosed bed.

   Note: Enclosed beds, where appropriate restrictive practice concerns have not been addressed, are a mandatory referral to the TAB via the TAPS.

5.3.1 Children and Restrictive Practice

For children, restrictive practices will need to be considered on a case-by-case basis, taking into account their developmental age and cultural context and information detailed in the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018,

Child-safe practices age, such as the use of a car seat restraint for a child under seven would be considered age appropriate. However, the use of a car seat restraint for a 12-year old child to stop them from kicking others in the car may be considered a restrictive practice. Similarly, using child gates to prevent a toddler or child from falling down the stairs would not be a restrictive practice, however using a child gate to prevent a young person accessing the kitchen at all times would be considered a restrictive practice.

5.4 Restrictive practice guidelines

The NDIS Commission is taking the lead role in reducing and eliminating the use of restrictive practices and holds responsibility for monitoring the use of all restrictive practices recommended and implemented by NDIS providers in Australia. The NDIA is not responsible for making decisions about the use of restrictive practices.

Under the NDIS (Restrictive Practices and Behaviour Support) Rules 2018, restrictive practices are subject to regulation. Restrictive practices can only be used based on an assessment of behaviour with the appropriate authorisation from the relevant state or territory and where it is part of a BSP that has been developed by a registered behaviour support specialist.

The registered behaviour support practitioner is responsible for:

- undertaking a functional behaviour assessment
- developing a BSP for the participant
- submitting written applications seeking authorisation to restrictive practice authorising panels or bodies
- submitting regular progress reports, data summaries, and other documents to restrictive practice authorising panels or bodies
- attending restrictive practice panel meetings or other contact with the authorising body.

5.4.1 Participant with immediate needs

Where there is no current interim or comprehensive BSP in place and the participant has an immediate need for a restrictive practice due to a new or previously unexperienced degree of severity in the escalation of behaviour, the NDIS Commission outlines that:

- an interim BSP must be completed within a month of engagement by the behaviour support practitioner, and
- a comprehensive BSP must be developed within six months of the interim plan being completed by the behaviour support practitioner.

The use of regulated restrictive practice that has not been authorised in accordance with any state or territory legislation or policy requirements represents a reportable incident that must

be reported to the NDIS Commission. The provider must notify the NDIS Commission within five business days of becoming aware of the use of the restricted practice.

NDIS Staff and Partners in the Community should report any suspected use of unauthorised restrictive practice to the Participant Critical Incident Team.

Advice can by sought via the Participant Critical Incident Team or the TAPS service if clarification is needed about whether an event/practice represents the unauthorised use of restrictive practice, or the use of prohibited practice.

5.4.2 Implementing providers

The NDIS Commission refers to service providers who use a regulated restrictive practice as implementing providers. Implementing providers are expected to understand the context of the person's behaviour and follow the authorised BSP to make sure the use of any restrictive practice is a last resort intervention and in proportion to the risks posed by the behaviours.

The implementing provider is responsible for:

- being registered with the NDIS Commission for the type of support they are providing
- report regularly as per agreed schedule to the NDIS Commission
- ensure staff are appropriately trained to implement positive behaviour strategies or use restrictive practices
- notifying the NDIS Commission in the event of any unplanned or unapproved use of a restrictive practice as per the NDIS Commission reportable incident process.

Implementing provider reporting will include any use of unrestrictive practices and other reportable incidents, monitoring, and collected data as outlined in the BSP. This forms part of the ongoing focus on reducing or eliminating restrictive practices and addressing BoC.

Service providers must aim to reduce the use of restrictive practices by working with the participant and their supports to obtain a greater understanding of the function of the behaviour as well as triggers, and provide preventative strategies and techniques to develop more appropriate ways to support the participant. The behaviour support practitioner will support the implementing provider where required to understand the relevant state or territory legislative and policy requirements.

5.5 Point of crisis

A point of crisis is a period of intense difficulty and distress experienced by a participant that disrupts and makes their usual day-to-day life hard to cope with. Participants may experience points of crisis for various reasons, such as escalation of mental health issues or the unexpected loss of formal and/or informal supports. Emergency support may also be provided by other government services such as child protection, homelessness services, hospitals, ambulance, police and mental health assessment teams.

A crisis may often result in the escalation of BoC and may temporarily require more intensive support. While the NDIS is not responsible for the delivery of emergency support, when the participant or their informal support contacts the NDIS during times of crisis, we need to be responsive to their concerns.

This may involve supporting the participant to access other government services as required, and explaining how the funding in their plan can be used flexibly to meet their needs during a crisis. The participant may have interacted with the After Hours Crisis service as part of the Exceptionally Complex Support Needs Program.

In some instances, reconsideration of the participant's streaming may be required to ensure they are appropriately supported through this period. Refer to section 6.1 for further information.

You will need to ensure the support coordinator (if relevant) is aware of the situation and is responding to and supporting the participant in a timely and effective manner. The role of the support coordinator and the level of support coordination may need to be considered. For example, a specialist support coordinator to manage multiple mainstream interfaces, organise and prepare reports may be required.

In some cases, the behaviour support practitioner may be able to identify the circumstances that could lead to periods of crisis for the participant. In these cases, the BSP and other supports should be proactively designed to respond to these situations. This may impact on the way the supports are funded in the NDIS Plan.

Where additional supports beyond the flexibility of the existing plan is required, it may be appropriate to consider whether an unscheduled plan review is required. Refer to Practice Guide – Unscheduled Plan Reviews.

Interactions detailing the crisis circumstances and actions taken must be recorded in the NDIS Business System (System) and an alert added if required.

5.6 Incident management

5.6.1 Registered providers

Registered service providers must have effective incident management systems and are responsible for recording and managing all incidents that happen in the delivery of NDIS supports and services. They are also responsible for notifying the NDIS Commission of any reportable incidents (including allegations) that occur with the provision of supports and services to an NDIS participant. Reportable incidents include:

- serious injury or death of an NDIS participant
- abuse or neglect of an NDIS participant
- unlawful sexual or physical contact with, or assault of an NDIS participant
- sexual misconduct committed against, or in the presence of, an NDIS participant, including the grooming of the NDIS participant for sexual activity

- the unauthorised use of restrictive practice.

Refer to the NDIS Commission's Reportable Incidents (external) for further information.

5.6.2 Unregistered providers

Unregistered providers must follow their internal provider reporting channels. All providers (registered and unregistered) who are providing NDIS funded supports must follow the NDIS Code of Conduct (external).

5.6.3 National Disability Insurance Agency (NDIA)

NDIA staff and Partners in the Community may be advised or learn of allegations of serious harm occurring to a participant from a participant, their carer, nominee or other relevant party. This is known as a participant critical incident. If information is provided to you which suggests or alleges a participant critical incident has occurred, refer to the Participant Critical Incident Framework. You must notify the Participant Critical Incidents team where appropriate, refer to Participant Critical Incidents page.

As noted above, any unauthorised use of restrictive practice is a participant critical incident. This incident may be a reason for a section 48 plan review. The participant or their authorised representative can request a review, or the NDIA may choose to initiate based on the information provided around the critical incident. Participant critical incidents highlight that the participant's supports may require adjustment or further changes are needed. It is the responsibility of the NDIS to make sure that a participant has appropriate funding for their support needs, including behaviour support.

6. Pre-planning

6.1 Streaming

Plan developers need to ensure the correct streaming decision has been recorded in the System for the participant to receive the appropriate level of support to implement their plan. Factors to change the streaming decision are dependent on the complexities presenting in the participants current life situation or environment which may be identified during your conversation.

Where a participant has complex support needs requiring a different approach, a referral to the Complex Support Needs Pathway may be appropriate.

Refer to Standard Operating Procedure – Update Participant Streaming and Standard Operating Procedure – Referral for Complex Support Needs for further information.

Note: The term streaming is for internal use only.

6.2 Plan duration

The plan duration ready reckoner guide recommends plans are developed for up to 12 months when a participant is requiring behaviour support and/or is streamed as Super Intensive. However, the participant's individual circumstances should be considered and a shorter plan duration may be required if, for example, the BSP is being assessed, accommodation needs/options are being assessed or close monitoring is required. Where the participant's situation is stable a longer plan duration may be also be appropriate. Refer to Standard Operating Procedure – Complete the Risk Assessment and Practice Guide - Pre-Planning for further information.

6.3 Arranging the planning meeting

Contact the participant and/or their authorised representatives (nominee/s, child representatives, and court or tribunal appointed decision makers) through their chosen method of communication and confirm/obtain consent for information sharing and exchange. A participant or their authorised representative may choose to invite other family members, friends or NDIS funded support providers to the NDIS planning meeting.

You should confirm all meeting attendees to allow for appropriate consideration of location, meeting room, time allocated and whether additional or senior staff are required to attend.

In limited circumstances, it may be necessary to appoint a plan nominee to act on behalf of, or make decisions on behalf of a participant. Refer to the Standard Operating Procedures – Appoint, Decline, Suspend or Cancel a Nominee.

Where possible and appropriate, the participant should be in attendance during the planning conversation. The participant's wellbeing is the priority and discretion is required at times to determine whether it is suitable for their attendance, such as if there is significant unrest and or concerns about safety due to events such as accommodation or relationship breakdown as a result of significantly challenging behaviours.

In these instances, efforts should be made to include the participant, and consider a shorter meeting to confirm key details or having them contribute in another way such as completing the relevant NDIS booklet prior to the meeting.

When confirming a meeting location and time, you should check the System for alerts and confirm the following with the participant or their authorised representative:

- Consider the participant's routine. For example, if the participant has difficulty sleeping at night they may not function well in the mornings and prefer an afternoon meeting.
- If known, consider the sensory needs of the participant and confirm an appropriate location. For example, if BoC are triggered by sensory overload, suggest a quiet office to conduct the meeting.
- Understand any specific environmental factors that may present a risk to the participant or to other members of the meeting including the NDIS staff member.

- Understand and respect any cultural sensitivities or barriers to communicate effectively for example, they may prefer to meet with someone of the same gender.
- Explore options to book a meeting for an extended period of time to allow breaks, or hold the planning meeting over multiple sessions or arrange for the participant to attend for shorter periods.
- Be aware of any behaviour response strategies that may need to be implemented during the meeting and what the role of the NDIS staff member will be, noting the service providers and informal supports who know the person well should lead the response directly with the person to de-escalate the situation or conclude the meeting.

6.3.1 Gathering documentation

Arranging the planning meeting provides an opportunity to follow-up on relevant supporting documentation that has not been provided yet. The participant, authorised representative or their support coordinator may provide this information to the NDIA. In some circumstances, the NDIA may need to follow-up directly once appropriate consent has been obtained. Behaviour support documentation may include:

- the most recent BSP
- behaviour protocols or strategies (where not collated in an interim or comprehensive plan as per the NDIS Commission)
- behaviour support recommendations report outlining next steps in behaviour support and estimated hours required
- incident reports, preferably incident summary reports
- data summary reports
- Restrictive Practice Authorisation documentation (if relevant)
- support model assessment reports including identifying housing options
- other assessment reports and support plans, such as speech pathologist, occupational therapist, psychologist, psychiatrist, paediatrician or other medical practitioner
- other relevant reports from service providers or mainstream agencies such as court reports.

All new or updated legal/court orders and other documents provided to the NDIS must be uploaded to inbound documents in the System.

6.3.2 External meetings

If a meeting is taking place at a location external to an NDIS office, follow the usual appointment booking process and ensure the following:

- complete and attach a copy of the home visit risk screen document and journey plan to the participant's record in the System

- review other information available in the System including, but not limited to previously completed planner risk assessment, guided planning questions, planning conversation tool and inbound documents. This information will help you identify any likely risks or concerns, such as other people being in the premises and the general safety of surrounds
- discuss any identified risks and take any appropriate action as determined with your team leader
- familiarise yourself with the journey management procedure and out of office best practice guide.

NDIA staff are supported to make decisions at all times to protect their personal safety. These decisions may include:

- deciding that a visit requires a second employee to be present
- arriving at a location and deciding to cancel a visit due to safety concerns
- terminating a visit part way through due to safety concerns.

Refer to the Work Health and Safety page for further information.

For circumstances where the health, safety and/or security of NDIA staff or others is put at risk due to the behaviour of a participant or other third party, NDIA staff should refer to the Work Health and Safety page and NDIA Managing Unreasonable Behaviour Framework, Policy and Guideline for information, advice, reporting and escalation protocols.

6.4 Planning conversation

The participant is at the centre of the planning process and their goals and needs are explored by discussing their strengths and what they would like to achieve. The planning conversation should identify goals, capacity, risks and safeguards and provide an opportunity to discuss any assessments and reports.

Information provided in the planning meeting about the participant's BoC must be detailed in the guided planning questions free text box and in the planning conversation tool.

The following points can support you to have a high quality conversation:

- Be mindful of the person's communication needs and preferences including whether an interpreter is required.
- Make decisions about what will be appropriate to ask the person directly and what may be triggering or distressing that can be gathered in another way.
- Read previous planning information (if applicable), interactions and inbound documents.
- Review the support coordination progress reports. These should detail information including the participant's circumstances, identified risks, strategies and outcomes for the participant's goal progression.

- Review the behaviour specialist reports and any other assessments that identify outcomes achieved, key barriers and recommendations for the new plan.
- If there are known restrictive practices in use, ask if the BSP has been lodged with NDIS Commission and the relevant state or territory has authorised the use.
- Follow up any requested reports and/or assessments not yet provided, to assist informing the planning process.
- Use visual tools to assist in communicating. For example, if asking a participant about their schedule, use the weekly supports table in the NDIS planning booklet (external) to help break down the questions, or other format as determined appropriate to their communication needs.
- Encourage the participant to talk about/communicate their interests, what daily life is like, what challenges they face and allow time as needed for them to explain this to you.
- Discuss the previous plan (if applicable), what they found worked well and what did not. For example, they may have strong informal supports or may be at risk of losing their housing or in temporary accommodation placing them at risk of homelessness.
- Be conscious to not ask leading questions as people are likely to give the answer they think you want to hear.
- If the participant is appearing anxious or not engaging, consider asking them what would make them feel more comfortable such as having a break.
- Depending on the participant's situation, there may be multiple stakeholders with differing input present in the planning process. In these circumstances, make sure the participant and their authorised representative are the focus of your attention. Make sure they understand that they can request other people leave the room at any time.
- In some circumstances, due to the complexity of the participant's BoC further discussion may need to take place with the participant's informal supports and positive BSP practitioner to discuss current and proposed support needs, or there may need to be a second meeting.
- Where appropriate, seek consent to follow-up with specific individuals or providers. Refer to the Standard Operating Procedure – Consent and Authority for further information.

7. Planning

The Agency must be satisfied that the funded supports in the participant's NDIS plan meet each of the criteria outlined in section 34(1)(a)-(f) of the National Disability Insurance Scheme Act 2013 (NDIS Act) and the NDIS (Supports for Participants Rules) 2013.

When planning for the participant with BoC, it is important to be aware of any recent or upcoming changes in their life. Behaviours of concern may take place more frequently or at a greater severity during transitional periods for example during adolescence, leaving school or changes in living arrangements.

It is important to also be mindful that effective positive behaviour support:

- is not a linear process. For example, the practitioner may be conducting an assessment while revising the plan and training
- is highly individualised
- is holistic and integrated
- utilises a systems approach
- includes crisis response and BSP revision as required
- includes multi-disciplinary input in all elements including assessment, design, implementation and review
- varies in intensity and time required depending on the complexity of the person's situation and support needs
- cannot always be delivered in monthly amounts across the year. For example, there may be a high utilisation initially for providers to complete the initial assessment, interim planning, comprehensive assessment and comprehensive BSP development.

Refer to Practice Guide - Determine Reasonable and Necessary Supports for further information.

7.1 Core supports

Core supports are intended to assist with or supervise personal tasks of daily life to enable the participant to live as independently as possible. The BSP is expected to be used by all formal supports to build on the participant's strengths, increase their opportunities to participate in community activities and increase their life skills.

Where possible, the funds can be used to strengthen the capability and capacity of the participant and their informal supports (if applicable) by reinforcing strategies and encouraging independence towards goal attainment.

Providers may request higher support costs for participants with complex BoC. Consider the participant's individual circumstances and needs using the information available to understand the purpose of the support. For example in some circumstances, the proposal

may be considered a restrictive practice or it may be required as the participant has health or physical support needs.

If a regulated restrictive practice is used, review the participant's BSP which will record whether the relevant state or territory body has authorised the use.

The delegate may need to consider that the sudden removal of funded Core supports for participants with high level staff ratios and/or restrictive practices may put the participant's living arrangement, their staff, or others at risk.

It is therefore important to consider a transitional or gradual step down model to effectively reduce supports in line with the BSP. This is likely to take place over the course of multiple NDIS plans and should be guided by the registered specialist behaviour support practitioner. A mandatory referral to the TAB via TAPS is required all plans that contain restrictive practices.

If the participant requires a higher intensity level of support, refer to the Standard Operating Procedure – Determine Self-Care and Community Access Supports for further information.

7.1.1 Behaviours support provision in supported independent living (SIL)

Behaviour supports need to take a whole of house approach when a participant is living in a supported independent living (SIL) arrangement with other people with disabilities. Behaviour support may be recommended where there are frequent incidents such as assaults, self-harm, property damage or high-level staffing ratios to manage risk to staff and residents. There may also be use the use of restrictive practices which are not targeted towards all the residents such as a locked fridge or the removal of people to a safe area during an incident.

Behaviour supports for a whole of house approach may include:

- shared living environmental assessment, also known as ecological assessment
- behaviour support systems review
- program development
- staff training.

Some of these supports may be shared in a whole of house approach, for example, there would be one shared living environmental assessment completed by the one provider to assess the overall household situation. The cost of the environment assessment would then be broken down and shared amongst all those living in home. Refer to the Operational Guideline – Supported Independent Living (SIL).

7.2 Capacity Building supports

Before including funding for behaviour supports, consider the Capacity Building funding generated by the TSP and whether these funds are sufficient to provide some or all of the required behaviour support. To do this you will need to understand what other Capacity Building supports are required by the participant and work out whether the total Capacity

Building funding needs to be increased to support the participant with their BoC. For instance, a child or younger person may require a higher level of funding so their informal supports are appropriately trained to implement the BSP.

There is a guided planning question related to BoC which must have the correct responses recorded. Responses to this question are for data capturing only and do not generate any funding in the TSP. The TSP is a guide and decisions on reasonable and necessary supports should be made in accordance with s34 of the NDIS Act.

7.2.1 CB Daily Activity

Best practice in behaviour support involves a multidisciplinary approach tailored to the needs of the person. It is therefore important to ensure the relevant therapeutic assessments and services are included in CB Daily Activity area of the plan. NDIS reasonable and necessary improved daily living supports may include:

- assessments including psychological, communication and sensory
- individual skills development and training
- training for carers or parents.

As noted previously, a functional behaviour assessment can only be completed by a registered specialist behaviour support practitioner or provider.

Where an ecological assessment is required, a total of 10 hours per household should be funded. Where multiple participants in the same household require a BSP, if appropriate their plans should be developed at the same time and the hours divided amongst plans.

7.2.2 CB Relationships

Behaviour supports within the category of CB Relationships may include:

- specialist behavioural intervention support for assessment and development of BSP
- behaviour management plan and training in behaviour management strategies
- individual social skills development.

Dependent on the participant's circumstances, NDIS funded support workers may require individualised training specific to the participant to maintain consistency and positive behaviour supports. Practitioners may provide training plans for the support worker or therapy assistant in the development of social skills identified as required due to BoC.

When determining reasonable and necessary funding, the specialist behaviour support practitioner would be expected to monitor the BSP implementation and review accordingly. Regular review allows opportunity for changes and updates to the BSP if the progress differs from expectations.

Questions which may help in determining the amount of funding include:

- Which stage of behaviour support currently applies? Are they at the brief assessment and safety planning stage (Refer to 6.2) or are they stable and in the monitoring

stage? This indicates how many hours are still required for assessments and reporting.

- Does the participant already have a current comprehensive behaviour assessment?
  - If so, the next assessment will usually require less time.
- Does the participant already have a current comprehensive BSP?
  - If so, the next BSP update will usually require less time.
- How many BoC does the person engage in? Usually the more behaviours, the more time required for all stages of the behaviour support process.
- What is the intensity and severity of the behaviour/s of concern? More intense and high-risk behaviour is likely to require more time in assessment, design, protocol revision and implementation support.
- How many informal and formal support providers are involved? This will impact on the amount of observations, interviews, file review required; the amount of tailored strategies required for various environments and roles; and the amount of training and implementation support required.
- How many regulated restrictive practices are proposed or in place? The more practices, the more time required for assessment, design, implementation, and reporting.
- How many informal or funded supports require training and implementation support? Can this be done in one session or do multiple repeat sessions need to be factored in?
- What other reporting requirements does the specialist behaviour support practitioner have? This may include data summaries and consultation with a psychiatrist to inform medication review.
- How will the multidisciplinary team collaborate? How often will they need to meet or have other contact?
- How many other stakeholders does the specialist behaviour support practitioner need to engage with?
- How much direct contact will the specialist behaviour support practitioner have with the person for skill development? Is this sessional, what is the frequency?
- What other pieces of work are required? Are there specific assessments that can inform the behaviour assessment behaviour assessment report (such as Assessment of Sexual Knowledge); Support Model Assessment report; transition plan development and implementation (such as from one placement to another).
- Where there are regulated restrictive practices required, you should also include funding for the specialist behaviour support practitioner to meet their obligations under

the NDIS Commission specific to this participant and the state or territory authorisation process.

7.2.3 Behaviour intervention support levels

You will need to make sure the participant receives the appropriate support required to implement their plan and to address any behavioural complexities in their current life situation.

There are two levels of behaviour intervention support provided as a guide however the participant's individual circumstances and supporting information must be considered in every plan to determine appropriate funding and supports required.

The levels of support include a behaviour management plan and training in the management of strategies to form a package of support to address a participant's immediate need for behavioural intervention. You will need to make a reasonable and necessary decision to determine the appropriate level of support included in the participant's plan.

The guidance in hours has been suggested for a plan of 12 months in duration. Use your reasonable and necessary decision making for plans with durations less or more than 12 months. If a participant has significant behaviours of concern it is highly unlikely that there will be a plan over 12 months due to the need to monitor and review outcomes and circumstances.

Consult with your team leader and refer to the participant's individual supporting documents, Practice Guide - Determine Reasonable and Necessary Supports and the Standard Operating Procedure – Behaviour Intervention Supports for further guidance.

7.2.3.1 Level 1

Level 1 funding could be considered appropriate for participants who require intervention due to significant behavioural complexities that are impacting on the ability of the participants informal supports to sustain care at home and assist the participant to safely engage in activities.

Level 1 criteria includes:

- behaviours of concern that could require single or minimum interventions
- lack of services willing to engage with the participant due to presenting behaviours and risk to staff/participants/community
- change of participant circumstances that will result in withdrawal of service support and need for immediate intervention.

Use reasonable and necessary decision making to fund the following supports:

- **Specialist behavioural intervention support** - Most level 1 plans should not exceed 45 hours (approx. 3-4 hours per month) which will enable the participant to receive support from a psychologist or appropriate therapist to develop a BSP, implement strategies and review interventions over a period of time.

- **Training in behaviour management strategies** - To support carers and any other significant informal supports in the participant's life to implement the behavioural support plan and behavioural strategies, include training in behaviour management. Most level 1 plans should not exceed 20 hours (1-2 hours per month) which will ensure the behavioural intervention support plan is applied consistently in all necessary environments to best support the participant.

7.2.3.2 Level 2

Level 2 funding could be considered appropriate for participants that require immediate intensive behavioural intervention support and are streamed Super Intensive or Complex. In the majority of circumstances, level 2 funding is not appropriate for children aged seven and under.

Level 2 criteria includes:

- multiple complexities that may require multiple interventions
- extreme behaviours of concern where there is the use of regulated restrictive practice
- lack of services willing to engage with the participant due to presenting behaviours and risk to staff/participants/community
- significant change of participant circumstances that will result in withdrawal of service support and need for immediate intervention
- behaviours of concern involving various stakeholders (multiple issues for intensive intervention requiring comprehensive assessment, planning, support and training for the participant and carers)
- participants who may have significant 1:1 support in the community, 1:2 support in the community (greater than 30% of the day) or exceptional circumstance supports at home due to their harmful or persisting behaviours that may present risk to themselves or others
- participants who require additional support to implement newly developed strategies in the community or within newly engaged activities/services
- participants who are anticipated to experience a significant transition during the plan period such as moving into SIL or from school to day program.

This package of support would be considered in the following circumstances:

- when a participant has extreme behaviours that could require restrictive intervention
- where there is significant change of circumstances that will result in a withdrawal of service support
- where there is significant risk to support staff, other participants or the community.

Use reasonable and necessary decision making to fund the following supports:

- **Specialist behavioural intervention support** – Most level 2 plans should not exceed 90 hours (7-8 hours per month) for specialist behavioural intervention support which will support participants with significantly harmful or persistent behaviours of concern.
- **Training in behaviour management strategies** – To support carers and other significant informal supports in the participant's life to apply the developed BSP and behavioural strategies, include training in behaviour management. Most level 2 plans should not exceed 30 hours (2-3 hours per month) which will ensure the behavioural support plan is applied consistently in all necessary environments to best support the participant.
- **Individual social skills development** – For participants that require additional support to implement newly developed strategies in the community or within newly engaged activities/services, include individual social skill development. Most level 2 plans should not exceed 40 hours (3-4 hours per month) which will complement recommendations in the BSP.

7.2.4 Support coordination

Support coordination is intended to strengthen the participant and/or their authorised representative's abilities to coordinate and implement supports in the plans to participate more fully in the community, and to build and maintain a resilient network of formal and informal supports. This includes addressing barriers to implementation and regular monitoring. A participant who displays BoC may require support coordination or specialist support coordination to assist where required.

You will need to consider the level of support the participant and/or their authorised representative will require to build their capacity to connect with supports and services, ensure they understand their NDIS plan and how to implement their funded supports, and strengthen their ability to self-direct services and achieve their goals.

It is also part of the support coordinator's role to build capacity of the participant and/or authorised representatives to gather supporting documents including assessments and reports and ensure these are provided to the NDIS.

Where the participant experiences a crisis, the support coordinator will assist them as required, to manage and link into appropriate supports. This information should form part of their next progress report to the NDIS where any known causes of the crisis, how it was managed, the outcome and proposed strategies to reduce the likelihood of a reoccurrence are detailed.

The reporting and monitoring requirements must be discussed at the plan handover and clearly outlined in the Request for Service. Refer to Standard Operating Procedure – Include Support Coordination in a Plan.

7.3 Plan comments

Make sure your plan comments recorded in Determine Funded Supports task include a description of the behaviour supports included within each budget.

Example (Core) – only relevant where there is a regulated restrictive practice in the participant's BSP: I can use my core support funding flexibly to help with my daily activities. Assistance with self-care activities and accessing the community to be provided by a registered implementing provider.

Example (Capacity Building): Funding for XX hours of specialist behaviour intervention support, XX hours of behaviour management plan and training in behaviour management strategies. A report detailing outcomes achieved is to be provided to the NDIA by the registered specialist behaviour support practitioner before this plan is due for review.

7.4 Plan management

It is important to understand the distinction between choice and control in regards to plan management and the legislative requirements to use a registered provider.

The NDIS supports the participant to maximise their choice and control where there is not unreasonable risk or other factors impacting the participant's and/or their authorised representative's ability to manage NDIS funding.

The NDIS (Provider Registration and Practice Standards) Rules 2018 (Part 2, section 7) specifies that to maintain safeguards and minimise risk to the participant, NDIS providers must be registered for:

- functional behaviour assessments
- developing BSPs, and
- regulated restrictive practices.

Behaviour support practitioners (whether a sole provider or employed by a provider) must be registered with the NDIS to provide specialist behaviour support (registration group 110).

The NDIS recommends that CB Relationships is Agency managed to ensure the use of NDIS registered providers, however participants and/or their authorised representatives may choose to have their supports plan or self-managed. It is important for participants and/or their authorised representatives to understand the distinction between choice and control in regards to plan management and the legislative requirements to use a registered provider for specific behaviour supports (functional behaviour assessments, BSPs, and regulated restrictive practices).

NDIS legislation is based on the presumed capacity to self-manage. Therefore, a request by the participant to manage their funding should be considered positively by the delegate unless there is evidence of a significant risk to the participant.

The NDIS supports the participant to maximise their choice and control where there is not unreasonable risk or other factors impacting the participant's and/or their authorised representative's ability to manage NDIS funding. The determination of unreasonable risk is assessed with every plan review, having regard to the participant's individual circumstances and considerations.

7.4.1 Restrictive practice

Where the BSP includes regulated restrictive practice, the participant and/or their authorised representatives, should be aware that the implementing service provider for the behaviour support **must** also be registered with the NDIS Quality and Safeguards Commission.

Where supports are self or plan –managed, a thorough conversation with the details recorded in the appropriate pre-planning tasks and clear NDIS plan comment (see 7.3) should follow. This is to make sure that the participant and/or their authorised representatives understand while the funding management allows for the use of unregistered service providers, there is a legislative requirement that registered providers **must** be used for BSPs and regulated restrictive practices.

Refer to Planning Operational Guideline – Managing the funding for supports under a participant's plan (the plan management decision) for further information.

8. Plan implementation and monitoring

There should be ongoing monitoring during the plan period to measure whether the participant is meeting their desired outcomes and goals. This can take place through a variety of means including support coordination reports, regular updates and Panda Live data.

You should check the plan utilisation to make sure the plan is being implemented as expected and provide opportunity for earlier follow-up if there appears to be an over or under utilisation. Due to the nature of this support, there is likely to periods of intensive support and high budget utilisation, therefore the utilisation should be considered over time.

Refer to PANDA, Practice Guide – Plan Implementation and Practice Guide – Monitoring for further information.

9. Scheduled plan reviews

Make sure you have received the progress report from the support coordinator or specialist support coordinator and reviewed it to understand key issues and outcomes from the plan period.

It is expected the NDIA will be provided with supporting information demonstrating outcomes, barriers and where appropriate, recommendations for the next NDIS plan. For example, where there has been successful implementation of capacity building supports, it may lead to a reduction of supports based on the behaviour support practitioner recommendations. Fade-

out or step down approaches will be clearly documented based on supporting information. These approaches form a key part of reasonable and necessary decision making when a participant's BSP includes restrictive practices.

For further information, refer to Practice Guidance - Scheduled Plan Reviews and Standard Operating Procedure – Complete a Plan Review (full).

10. Case examples

10.1 Example 1 - Kim

Kim is a 20-year-old woman and lives at home with her parents and two younger siblings. She has a primary disability of autism spectrum disorder and a secondary disability of mild intellectual disability.

10.1.1 Planning meeting

At Kim's planning meeting, her parents discuss how they are struggling to maintain support and are concerned about the impact Kim's behaviours of concern are having on her and her younger siblings. When asked further about her behaviours, they explain that Kim bites and hits out at people around her at home and at her day program. When upset, she will also hit her head against walls and run away from those she is with.

Kim enjoyed attending a specialist school and after completing year 12, she started at a day program. The identified behaviours escalated when she left school. Kim has not settled at the day program. She is reluctant to leave home to attend and while at the day program, Kim displays increased levels of BoC.

Kim's parents and the day program provider have tried several different strategies to support her, however the BoC have not reduced. She has not been provided with any behaviour support previously.

10.1.2 Outcome

Kim is considered to meet the criteria for level one behaviour intervention support for the following reasons:

- Kim has informal supports who are engaged and available.
- Kim is still attending a regular day program and the provider is willing to work with her and her family to implement the BSP.
- the BoC have not been longstanding having escalated only since Kim left school.

Kim's 12-month plan provides funding for the following reasonable and necessary supports:

- Social community and civic participation for continued day program attendance allowing for higher-intensity supports while Kim is connected with a specialist behaviour support practitioner. The NDIS is awaiting further recommendations in the

report by the specialist behaviour support practitioner for the associated training hours required in the BSP.

- Functional capacity assessment (10 hours).
- Specialist behavioural intervention support for functional behaviour assessment, development of a BSP, implementation, monitoring and review of behavioural support interventions in her home and day program (45 hours).
- Behavioural management plan including training in behaviour management strategies to provide training to informal/formal supports to understand and implement Kim's BSP consistently in all environments (20 hours).
- Coordination of Supports (72 hours).

10.2 Example 2 – Joe

In the following two case examples, Joe and Hassan, two NDIS participants are living in a SIL arrangement and sharing supports. At the scheduled plan reviews, the SIL provider has provided information detailing an increase in BoC for both Joe and Hassan. After trying a number of different strategies to resolve conflict and reduce the BoC, the provider has requested an increase in both SIL and Capacity Building funding to better support them.

Joe is a 30-year-old man and lives in a SIL arrangement with two others. His primary disability is a moderate intellectual disability. Joe works at an Australian Disability Enterprise (ADE) four days per week. Joe is well supported by his parents and family and spends every Sunday with them. His family use supported decision making to make sure he is active in his life decisions.

10.2.1 Planning meeting

All the participants in the home are undertaking a scheduled plan review. Prior to Joe's NDIS meeting, the completed provider SIL pack and quoting tool along with supporting information including his BSP are provided to the NDIS. Joe's BSP notes his behaviour will escalate quickly if there is any unexpected change or interruption to his routine or life and he generally begins to shout, punch walls and becomes agitated. Some of Joe's triggers include:

- Reminders of the recent death of a close friend.
- When his housemate Hassan is displaying BoC.
- Returning to his home after a family visit on Sundays.
- Varying triggers at his ADE including when there is unexpected change and loud noises, approximately twice per week.

10.2.2 Outcome

Joe is considered to meet the criteria for level one behaviour support for the following reasons:

- Joe has informal supports who are engaged and available.
- Joe works at an ADE four days per week and goes to regular activities in the community on the other weekday. The ADE provider is willing to work with Joe, his family and support workers to implement his BSP.
- The BoC have not been longstanding having escalated since Joe's friend passed away.

Joe's 12-month plan provides funding for the following reasonable and necessary supports:

- Supported independent living included as per SIL pack and quoting tool. The NDIS is awaiting further recommendations in the report by the specialist behaviour support practitioner for the associated training hours required in the BSP.
- Support for his continued employment at the ADE.
- Shared living environmental assessment (ecological assessment) (5 hours).

  Although Joe has been assessed as meeting the criteria for a level 1 behaviour support plan, he lives in a shared environment, and it has been identified that triggers for BoC are occurring within the home. Funding has been added to enable an ecological assessment to be undertaken to better understand contributors from within Joe's living arrangement.
- Specialist behavioural intervention support for functional behaviour assessment, development of a BSP, implementation, monitoring and review of behavioural support interventions in his SIL home, family home and ADE (45 hours).
- Behavioural management plan including training in behaviour management strategies to provide training to informal and formal supports to understand and implement Joe's BSP consistently in all environments (20 hours).
- Coordination of Supports (72 hours).

10.3 Example 3 – Hassan

Hassan is a 45-year-old man and lives in a SIL arrangement with Joe and one other. His primary disability is autism spectrum disorder and his secondary disability is schizophrenia. During the week, he attends a day program for two days where he consistently exhibits BoC. He does not currently have family support, usually seeing his sister on his birthday. Hassan gets distressed by many triggers that substantially increase his anxiety levels and tends to result in him scratching his own skin or hitting or kicking property or anyone who tries to intervene. He is prescribed risperidone to manage these BoC. Staff also administer a muscle

relaxant medication when becomes agitated to help calm Hassan. Some of the known triggers are as follows:

- Exposure to sensory stimulation especially loud noises, music and bright lights.
- When his housemate Joe becomes agitated and yells.
- When his formal supports prompt him with daily activities.

As the direct result of an assault on a house staff member, there is an active Mental Health Community Treatment Order in place that states Hassan must attend and receive treatment weekly.

10.3.1 Planning Meeting

All the participants in the home are undertaking a scheduled plan review. Prior to Hassan's NDIS meeting, the completed provider SIL pack and quoting tool along with supporting information including his BSP are provided to the NDIS. The day program provider is considering withdrawing services due to the risks involved.

Hassan's parents have both passed away. He has a sister who lives interstate and is not involved in his daily life. Hassan has the public guardian in place as his decision maker and the Public/State Trustee manages his finances.

10.3.2 Outcome

Hassan is considered to meet the criteria for level two behaviour support for the following reasons:

- Hassan is experiencing problems maintaining service providers.
- Hassan's only informal support is his sister and he sees her once a year on his birthday.
- He is subject to restrictive practice (chemical restraint) to address BoC.

Hassan's 12-month plan provides funding for the following reasonable and necessary supports:

- Supported independent living included as per SIL pack and quoting tool. The NDIS is awaiting further recommendations in the report by the specialist behaviour support practitioner for the associated training hours required in the BSP.
- Support for his continued attendance at his day program.
- Shared living environmental assessment (ecological assessment) (5 hours).

  It has been identified that Hassan will have his BSP reviewed at the same as Joe. As a result, the 10 hours to develop the ecological assessment has been shared between Joe and Hassan's plan.

- Specialist behavioural intervention support for functional behaviour assessment, development of a BSP, implementation, monitoring and review of behavioural support interventions in his SIL home and day program (90 hours).
- Behavioural management plan including training in behaviour management strategies to provide training to informal/formal supports to understand and implement Hassan's BSP consistently in all environments (30 hours).
- Coordination of Supports (108 hours).

10.4 Example 4 – Daniel

Daniel is a 12-year-old boy. He lives with his mother and younger siblings. He attends his local primary school. His primary disability is autism spectrum disorder and secondary disability is intellectual disability. It has been identified that Daniel has sensory aversion to loud noises and to sensations such as silky or synthetic fabrics. He has difficulty communicating his needs to others, and seems to have difficulties following instructions, leading to frustration and BoC.

10.4.1Planning Meeting

During the planning meeting, Daniel's mother said he was attending school three days per week. He would like to establish friendships with his peers and increase his social participation however experiences heightened anxiety due to bullying at school including verbal threats, teasing and pushing.

Daniel's mother and school have identified that his BoC are high in intensity. They include self-harm (suicide attempts, absconding) and harm towards others (physical aggression and assault). At home, cutlery needs to be stored safely. Daniel's mother has identified that she has locked away to maintain his safety due to self-harming behaviours. Usually, the cutlery would be in an unlocked drawer, as a child of Daniel's age would generally be expected to safely use cutlery to eat or prepare food. He does not have a behaviour support plan.

His attendance at school, the bullying and identified BoC make it challenging for Daniel to form and maintain relationships and participate in social activities. His mother spoke about finding it increasingly difficult to care for Daniel. The school have funded an additional staff member to increase his attendance at school.

Daniel's mother is requesting Core supports to support her in the home, and support for Daniel while at school and participating in his learning activities and increase his social participation. The planner provides further details of NDIS and education responsibilities, noting that service systems obligations must be met before any funding by the NDIS could be considered to meet the disability support needs that are deemed beyond 'reasonable adjustment'.

10.4.2 Outcome

Daniel is considered to meet the criteria for level two behaviour support for the following reasons:

- Daniel is experiencing issues with school attendance.
- Daniel's only informal support is his mother and she has expressed carer fatigue.
- Daniel's BoC have been identified as high in intensity, particularly given his age.
- Daniel is experiencing challenges with social participation.

Daniel's 12-month plan provides funding for the following reasonable and necessary supports:

- CB Daily Activity as it has been identified that Daniel has sensory difficulties and communication difficulties. Funds within this category will be utilised for an occupational therapist to undertake a sensory assessment and a speech pathologist to undertake a communication assessment and collaborate with the behaviour support practitioner to enable strategies to address these needs to be included within the Positive BSP.
- Specialist behavioural intervention support for a functional behaviour assessment, development of a BSP, implementation, monitoring and review of behavioural support interventions in all environments (home, education setting, any other identified setting) (84 hours).
- Behavioural management plan including training in behaviour management strategies to provide training to informal and formal supports to understand and implement Daniel's BSP consistently in all environments (30 hours).
- Coordination of Supports (60 hours)

As discussed in the planning meeting, it was not determined to be reasonable and necessary for the NDIS to fund Core supports for Daniel in his educational environment to assist with her learning support needs and school attendance supports.

11. Appendices

11.1 State and territory restrictive practice legislation

The state and territory governments remain responsible for specific legislation, policy and procedures related to the authorisation of restrictive practices. This is complementary to the NDIS Commission who is responsible for best practice guidance, monitoring and oversight of behaviour support service provision and the use of restrictive practices in all states and territories (excluding Western Australia). It is important to note that BSPs containing regulated restrictive practices must be lodged with the NDIS Commission, even if authorisation of the use of the restrictive practice is not a requirement of that state or territory.

Behaviour support practitioners must adhere to the requirements of the NDIS Commission and the state or territory in which they operate. Plan developers can refer practitioners, providers and plan implementers (support coordinator or LAC) to the relevant source of information. If there are concerns, discuss with your supervisor, request TAB advice or escalate feedback that may need to be considered for report to the NDIS Commission.

11.1.1 New South Wales

- While there is no specific legislation regarding restrictive practices in New South Wales, there is the Guardianship Act (1987).
- New South Wales also have the restrictive practice authorisation policy and procedural guide outlining requirements. Approval is provided through the restrictive practices authorisation (RPA) panels.
- Service providers must comply with the New South Wales restrictive practices authorisation policy and procedural guide.
- There is expected to be an updated New South Wales policy concerning restrictive practices authorisation mechanism, which providers will also need to comply with.

11.1.2 Victoria

- The Victorian government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices and behaviour support in the NDIS.
- The Victorian Senior Practitioner has the power to issue prohibitions and directions related to restrictive practices, compulsory treatment and supervised treatment orders under the Disability Act 2006.

11.1.3 Queensland

- The Queensland government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices in the NDIS through the Disability Services Act (2006) for those over 18 years.
- The *Disability Services Act (2006)* helps safeguard people with an intellectual or cognitive disability and their rights against the inappropriate use of restrictive practices and provides an accountability framework that allows for transparency in the decision-making process to authorise the use of a restrictive practice by a relevant service provider with an adult with an intellectual or cognitive disability.
- The *Disability Services Act (2006)* sets out a number of requirements that the relevant disability service provider must follow to legally use a restrictive practice and for any use of containment/seclusion to be approved by the Queensland Civil and Administrative Tribunal.

11.1.4 Western Australia

- The Western Australian government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices and behaviour supports in the NDIS.
- Providers are encouraged to follow the Code of Practice: A Guide for the Elimination of Restrictive Practices (external).

11.1.5 South Australia

- The South Australian government has policy and procedures outlining state requirements regarding restrictive practice authorisation.
- The Disability Services Act 1993 requires disability service providers to have restrictive practices policy and procedures in place. Seclusion of an adult with disability must only be used if specifically authorised by the South Australian Civil and Administrative Tribunal (SACAT) under Section 32 of the *Guardianship and Administration Act 1993.*

11.1.6 Tasmania

- The Tasmanian government remains responsible for the legislative and policy frameworks through the Disability Services Act 2011 regarding the authorisation of regulated restrictive practices, which are approved by Tasmanian Senior Practitioner.
- Chemical restraint does not have authorisation requirements in Tasmania.

11.1.7 Australian Capital Territory

- The Senior Practitioner Act (2018) remains responsible for the approval of behaviour support plans, which include the use of a regulated restrictive practice.
- The *Senior Practitioner Act (2018)* provides the powers and functions of the Senior Practitioner and regulates the use of restrictive practices by persons or other entities who provide any of the following services to another person:
  - education, including education and care
  - disability
  - care and protection of children.

11.1.8 Northern Territory

- The Northern Territory government will be responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices in the NDIS through the NDIS (Authorisations) Act 2019.

12. Supporting material

- NDIS Act 2013
- NDIS (Quality and Safeguards Commission and Other Measures) Transitional Rules 2018
- NDIS (Restrictive Practices and Behaviour Support) Rules 2018
- NDIS (Code of Conduct) 2018
- NDIS (Incident Management and Reportable Incidents) Rules 2018
- NDIS (Provider Registration and Practice Standards) Rules 2018
- NDIS (Plan Management) Rules 2013
- Overview of the NDIS Operational Guideline – Quality and Safeguards
- NDIS Quality and Safeguards Commission
- NDIS Quality and Safeguarding Framework
- Convention on the Rights of Persons with Disabilities (external)
- National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector (external)
- Operational Protocols between the NDIA and the NDIS Commission intranet page

12.1 New South Wales

- Guardianship Act 1987
- Restrictive Practice Authorisation Policy (June 2019)
- Restrictive Practice Authorisation Procedural Guide (June 2019)

12.2 Victoria

- Disability Act 2006
- Disability Act 2006: Supervised Treatment Orders, Restrictive Practices, Compulsory Treatment

12.3 Queensland

- Disability Services Act 2006

12.4 Western Australia

- Code of Practice: A Guide for the Elimination of Restrictive Practices

12.5 South Australia

- Disability Services Act 1993

12.6 Australian Capital Territory

- Senior Practitioner Act 2018

12.7 Northern Territory

- NDIS (Authorisations) Act 2019

12.8 Tasmania

- Disability Services Act 2011

13. Feedback

If you have any feedback about this Practice Guide please email Service Guidance and Practice. In your email, remember to include the title of the resource you are referring to and to describe your suggestion or issue concisely.

14. Version change control

Version No	Amended by	Brief Description of Change	Status	Date
3.0	KN0014	Class 1 Approval.	APPROVED	2020-05-25
4.0	NAP927	Class 1 approval. Updated hyperlink and legislative reference in section 7.4.	APPROVED	2020-07-17

Practice Guide – Positive Behaviour Support and Behaviours of Concern

Contents

1. Purpose

The purpose of this Practice Guide is to guide you through the considerations, roles and responsibilities when planning for a participant who displays Behaviours of Concern (BoC).

2. To be used by

- Plan Developers – Planners and Local Area Coordinators [LACs]
- NDIA Plan Delegates.

3. Scope

This Practice Guide provides information to support plan developers to understand when and how positive behaviour support may be a reasonable and necessary support where the participant displays BoC. This includes the respective roles and responsibilities of the National Disability Insurance Scheme (NDIS), NDIS Quality and Safeguards Commission (NDIS Commission) and states and territories.

Behaviour supports are to be provided in accordance with the NDIS Commission's requirements for positive behaviour support. The NDIS funds reasonable and necessary supports designed to identify and reduce BoC, to improve the participant's quality of life, uphold their dignity and safeguard their rights.

The NDIS Commission is operating in all states and territories (except for Western Australia). The NDIS Commission starts operating from 1 December 2020 in Western Australia. Until this time, the current state requirements for quality and safeguards continue to apply.

The NDIS Commission, states and territories governments have oversight of behaviour support and restrictive practices. They are committed to a regulatory framework for behaviour support that is founded on contemporary evidence-based practice and aligned with the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Services Sector (external).

4. Legislative and Policy Context

The NDIS Commission is responsible for best practice guidance, monitoring and oversight of behaviour support service provision and the use of restrictive practices. State and territory governments remain responsible for specific legislation, policy and procedures related to the authorisation of restrictive practices. These are separate but related processes and requirements.

The NDIS Commission assesses behaviour support practitioners and providers using a Positive Behaviour Support Capability Framework. This provides guiding principles to assist in delivering specialist positive behaviour support as an NDIS behaviour support practitioner.

In all states and territories providers who use or are likely to use restrictive practices, or who develop behaviour support plans (BSPs) must be registered with the NDIS Commission and meet the supplementary requirements of the NDIS Practice Standards (external).

To support safeguarding for people subject to restrictive practices, any use of restrictive practice must comply with the NDIS (Restrictive Practices and Behaviour Support) Rules 2018. These safeguards include but are not limited to:

- behaviour support practitioners, and providers who use regulated restrictive practices (also known as implementing providers) must meet the requirements outlined
- state and territory governments remain responsible for the authorisation of regulated restrictive practice/s in an individual's BSPs. Providers must comply with requirements of their state or territory
- restrictive practices are clearly identified in a BSP.

Refer to section 11.1 for information on state and territory restrictive practice legislation.

The National Disability Insurance Agency (NDIA) is not obligated to fund supports which have been imposed by state and territory bodies, which involve the use of restrictive practices, for example where a supervision order has been imposed by a civil or criminal court. However, where a restrictive practice has been authorised, recommended, or implemented by another body, this is a relevant consideration when determining if the NDIS funded behaviour support is reasonable and necessary. If unsure, discuss with your team leader.

In response to the concerns raised by the NDIS Quality and Safeguards Commission, the NDIA has committed to reviewing all requests for supports that include Regulated Restrictive Practices.

Where the use of regulated restrictive practice is proposed, or in use, a Technical Advisory Branch (TAB) advice request must be prior to plan approval. For information on how to request advice, refer to the mandatory advice section of the TAB Requesting Advice intranet page.

5. Behaviours of Concern

Behaviours of Concern, also known as challenging behaviours, refer to a wide range of behaviours of an intensity, frequency or persistence that threatens the quality of life, physical safety of the individual and/or others and generally results in limiting access to the community.

Behaviours of Concern can be any behaviour that results in an adverse impact on the person's quality of life. This may include:

- physical or verbal aggression
- property damage
- inappropriate sexual behaviour

- disinhibited and impulsive behaviour
- self-injurious behaviour also referred to as self-harm. It differs with each person and can include head banging, picking and hitting. This behaviour may not be an attempt to cause harm.

Please note the term self-harm when used in mental health settings typically refers to intentional harm without suicidal intent such as neglect, cutting, ingesting objects and self-poisoning. Mental health professionals must be consulted by the participant's supports as this is typically an indication of serious distress.

In order to provide successful interventions, it is necessary to understand the function of that behaviour for the person and the context it occurs. There may be a range of underlying factors influencing BoC including:

- underlying physical, neurological, mental or emotional health issues
- biological/physical due to experiencing pain or discomfort
- acting out a repetitive behaviour or routine
- frustration in not being able to do something
- communication/social needs due to difficulties in communication, seeking social interaction or attention
- demonstrating a learned behaviour
- the physiological effects of substances including alcohol, illegal drugs or medications
- response to difficulties encountered with service systems or support networks
- attempting to avoid a situation
- interpersonal environment such as quality of social interactions
- change or lack of in routine or structure
- inflexible thinking
- attempting to manage sensory overload
- having a high pain threshold and the behaviour is intended to provide sensory stimulus
- support staff skills and turnover, perceptions and level of resources available.

5.1 Impacts of Behaviours of Concern (BoC)

Behaviours of Concern affect the quality of life of the individual. Factors such as the intensity, frequency or persistence of the behaviours may limit a participant in their opportunities to pursue social, educational, economic and/or recreational activities. Often this is due to the need to maintain the physical safety of an individual or other people (such as family, support workers or the community) and reduce the risk of unsafe social participation (such as inappropriate and/or unsafe sexual behaviours).

Where the participant exhibits BoC, they may require supports in several areas of their life. Informal supports can have difficulty in sustaining relationships and caring responsibilities due to the potential risk of harm to the participant, other people in the home or themselves. NDIS funded supports can be used to support informal and formal supports in their roles and build their capacity to effectively address the BoC with the participant. These supports may help sustain the participant's current living and/or support arrangements and encourage the participant to positively engage with others. Where the participant has complex and longstanding BoC there may be further difficulties in engaging and sustaining funded supports.

Participants with complex BoC may be at risk of breakdown of their living arrangements such as being temporarily removed from shared living arrangements to individualised accommodation support settings, or family supports no longer being able to sustain the person living in the family home. There is also the risk of increased support staff turnover that in turn can lead to further escalation in behaviours due to constant changes in their environments, formal and informal supports, and the impact of fractured relationships.

In some cases, when informal supports are unable to continue to care for the participant who displays complex BoC, an alternative accommodation arrangement may be required for short or long term periods. Where there has been an escalation of behaviours and this requires a change of circumstances refer to the Practice Guide – Unscheduled Plan Reviews, Operational Guideline – Supported Independent Living (SIL) and the Medium Term Accommodation Operational Guideline.

In the case of a person under the age of 18, refer to the Practice Guide – Children Living in a Formal Voluntary Arrangement Outside their Family Home, Practice Guide – Children at Risk of Requiring Accommodation Outside the Family Home and Practice Guide – Children Living in Statutory Out of Home Care.

5.2 Positive behaviour support

Positive behaviour support is an effective approach for BoC as it focuses on addressing a person's needs, their home environment and overall quality of life through assessment, planning and intervention.

The positive behaviour support process typically follows similar steps.

1. **Brief functional behaviour assessment** - focussed on identifying requirements for incident prevention and response.
2. **Interim plan** - may also be referred to as a safety interim plan, incident prevention and response plan, reactive strategy response plan or reactive strategy. Interim BSPs include the provision for the use of a regulated restrictive practice developed within one month of engagement by a behaviour support practitioner while a comprehensive BSP is being developed.

3. **Comprehensive functional behaviour assessment -** the process for determining and understanding the function or purpose behind a person's behaviour, and may involve the collection of data, observations, and information to develop an understanding of the relationship of events and circumstances that trigger and maintain the behaviour.
4. **Comprehensive positive behaviour support plan** (see 5.2.1)
5. **Training and implementation support** - this usually targets informal supports and direct support workers and may also include reports and liaison with other stakeholders, reports for the psychiatrist; reports to restrictive practice authorisation mechanisms.
6. **Monitoring** - data collection, analysis and reporting.
7. **Review** - ongoing review of effectiveness of the BSP; revisit functional behaviour assessment at least annually.

The plan developer includes the appropriate capacity building support in the participant's plan for the provision of these supports.

5.2.1 Behaviour Support Plan (BSP)

A BSP specifies a range of evidence-based, person-centred and proactive strategies which focus on the individual needs of the person. It is developed with the aim of addressing the underlying functions of BoC taking place or increasing. The plan will outline specifically designed positive behaviour support strategies for the participant, their informal and funded supports to assist in reducing BoC and supporting their quality of life and goal attainment.

A registered specialist behaviour support practitioner must develop all functional behaviour assessments and BSPs, as positive behaviour support practice requires a specific skillset and appropriate safeguards. The Positive Behaviour Capability Framework (external) provides information about knowledge and skills required by the specialist behaviour support practitioners. The framework allows self-assessment to determine their suitability to provide the behaviour support practitioner requires.

Behaviour support practitioners must lodge BSPs containing restrictive practices with the NDIS Commission.

If the BSP does not include restrictive practices, it does not need to be lodged with the NDIS Commission. However, the practitioner developing the BSP must still be registered as a specialist behaviour support practitioner as noted above.

5.2.2 Assessment, development and review

A functional behaviour assessment must be completed when practitioners are developing a BSP. The practitioners will consult with the participant, their family, guardian, service providers and others who will be implementing the plan. By doing this the practitioners are able to gather historic and current information about behaviours displayed to identify settings, triggers, actions and results.

The BSP is designed to address the factors identified in the assessment. It will include a range of strategies used to support the person, including proactive skill development to build on the participant's strengths and response strategies to use when the behaviour presents.

Behaviour support plans are formally reviewed annually or earlier if the participant's circumstances change. At review, the effectiveness of all aspects of the plan including the preventative/environment, skill building/teaching and reinforcement strategies are measured along with step-down strategies. Importantly the progress towards the person's goals and identified quality of life measures is considered.

Plan developers can use assessment information to consider effectiveness and outcomes of funded supports and determine the level and type of capacity building support for inclusion in the NDIS plan.

Refer to the Compendium of Resources for Positive Behaviour Support (external) for further information about the range of positive support assessment tools that can be used by practitioners for assessment, planning, implementation, monitoring and review.

5.2.3 Younger People in Residential Aged Care (YPIRAC)

Residential aged care providers have the same responsibilities towards NDIS participants as they do to other residents who receive services and supports under the *Aged Care Act 1997*. Currently, services are regulated by the Aged Care Quality and Safety Commission.

From 1 December 2020 all providers applying the use of restrictive practices with young people in residential aged care will be regulated by the NDIS Quality and Safeguards Commission.

Refer to Our Guidelines - Younger People in Residential Aged Care for further information.

5.3 Restrictive practices

A restrictive practice is any practice or intervention which has the effect of restricting the rights or freedom of movement of a person with a disability. All states and territories endorsed the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Services Sector which was reaffirmed in the NDIS Quality and Safeguarding Framework.

If supports will include the use of restrictive practices the plan developer must make a referral for advice to the TAB. The referral must take place prior to including or excluding the supports in the participant's NDIS plan. Refer to the mandatory advice section of the TAB Requesting Advice intranets page for more information.

Restrictive practices must be authorised through a formal process which is the responsibility of each state or territory and varies across jurisdictions. Restrictive practices can be considered only if they are the least restrictive alternative, and in the context of positive behaviour support strategies.

When a person is exhibiting BoC, those around them may try to stop or modify their behaviours in a number of ways with the intention of keeping them or others safe. They may intervene physically, try to control where they go, what they do or administer mood-altering medications.

The use of restrictive practices are a risk to the human rights of people with disability and there is a need to ensure there is appropriate reporting and scrutiny when used. The NDIS Commission has identified five forms of regulated restrictive practice:

1. **Seclusion:** The sole confinement of a person with disability in a room or a physical space where voluntary exit is prevented, not facilitated or it is implied that exit is not allowed. This may include when a person is put in a room or placed on their own and the person cannot leave when they want to as the door has been locked.
2. **Chemical restraint:** The use of medication or chemical substance for the primary purpose of influencing a person's behaviour. The medication or chemical substance provided is not treating a diagnosed illness or condition and is intended to make them calm or sleepy. This is often psychotropic medication, which affects mood and is generally prescribed by a psychiatrist.
3. **Mechanical restraint:** The use of a device to prevent, restrict or subdue a person's movement for the primary purpose of influencing a person's behaviour. This includes but is not limited to putting gloves on a person that they cannot remove independently so they are unable to scratch themselves or others, or restraining someone in a wheelchair using a harness that they are unable to undo independently for the purpose of keeping them in the wheelchair.

   Note: This does not include the use of devices for therapeutic or non-behavioural purposes.
4. **Physical restraint:** The use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury.
5. **Environmental restraint:** Restricting a person's free access to all parts of their environment including items or activities such as locking cupboards, fridges or the use of an enclosed bed.

Note: All supports that include the use of a regulated restrictive practice must be referred to the TAB for advice. Refer to the mandatory advice section of the TAB Requesting Advice intranet page.

5.3.1 Children and Restrictive Practice

For children, restrictive practices will need to be considered on a case-by-case basis, taking into account their developmental age and cultural context and information detailed in the

National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018,

Child-safe practices age, such as the use of a car seat restraint for a child under seven would be considered age appropriate. However, the use of a car seat restraint for a 12-year old child to stop them from kicking others in the car may be considered a restrictive practice. Similarly, using child gates to prevent a toddler or child from falling down the stairs would not be a restrictive practice, however using a child gate to prevent a young person accessing the kitchen at all times would be considered a restrictive practice.

It is mandatory to seek advice for the use of assistive technology related to behaviours of concern or regulated practice eg stroller or prams for children older than 7 years, restrains, harnesses excluding standard mandatory vehicle restraints/seat belts

Refer to the mandatory referral advice section of the to the TAB Requesting Advice intranet page.

5.4 Restrictive practice guidelines

The NDIS Commission is taking the lead role in reducing and eliminating the use of restrictive practices and holds responsibility for monitoring the use of all restrictive practices recommended and implemented by NDIS providers in Australia. The NDIA is not responsible for making decisions about the use of restrictive practices.

Under the NDIS (Restrictive Practices and Behaviour Support) Rules 2018, restrictive practices are subject to regulation. Restrictive practices can only be used based on an assessment of behaviour with the appropriate authorisation from the relevant state or territory and where it is part of a BSP that has been developed by a registered behaviour support specialist.

The registered behaviour support practitioner is responsible for:

- undertaking a functional behaviour assessment
- developing a BSP for the participant
- submitting written applications seeking authorisation to restrictive practice authorising panels or bodies
- submitting regular progress reports, data summaries, and other documents to restrictive practice authorising panels or bodies
- attending restrictive practice panel meetings or other contact with the authorising body.

5.4.1 Participant with immediate needs

Where there is no current interim or comprehensive BSP in place and the participant has an immediate need for a restrictive practice due to a new or previously unexperienced degree of severity in the escalation of behaviour, the NDIS Commission outlines that:

- an interim BSP must be completed within a month of engagement by the behaviour support practitioner, and
- a comprehensive BSP must be developed within six months of the interim plan being completed by the behaviour support practitioner.

The use of regulated restrictive practice that has not been authorised in accordance with any state or territory legislation or policy requirements represents a reportable incident that must be reported to the NDIS Commission. The provider must notify the NDIS Commission within five business days of becoming aware of the use of the restricted practice.

NDIS Staff and Partners in the Community should report any suspected use of unauthorised restrictive practice to the Participant Critical Incident Team.

Advice can by sought via the Participant Critical Incident Team or the TAB if clarification is needed about whether an event/practice represents the unauthorised use of restrictive practice, or the use of prohibited practice.

5.4.2 Implementing providers

The NDIS Commission refers to service providers who use a regulated restrictive practice as implementing providers. Implementing providers are expected to understand the context of the person's behaviour and follow the authorised BSP to make sure the use of any restrictive practice is a last resort intervention and in proportion to the risks posed by the behaviours.

The implementing provider is responsible for:

- being registered with the NDIS Commission for the type of support they are providing
- report regularly as per agreed schedule to the NDIS Commission
- ensure staff are appropriately trained to implement positive behaviour strategies or use restrictive practices
- notifying the NDIS Commission in the event of any unplanned or unapproved use of a restrictive practice as per the NDIS Commission reportable incident process.

Implementing provider reporting will include any use of unrestrictive practices and other reportable incidents, monitoring, and collected data as outlined in the BSP. This forms part of the ongoing focus on reducing or eliminating restrictive practices and addressing BoC.

Service providers must aim to reduce the use of restrictive practices by working with the participant and their supports to obtain a greater understanding of the function of the behaviour as well as triggers, and provide preventative strategies and techniques to develop more appropriate ways to support the participant. The behaviour support practitioner will support the implementing provider where required to understand the relevant state or territory legislative and policy requirements.

5.5 Point of crisis

A point of crisis is a period of intense difficulty and distress experienced by a participant that disrupts and makes their usual day-to-day life hard to cope with. Participants may experience points of crisis for various reasons, such as escalation of mental health issues or the unexpected loss of formal and/or informal supports. Emergency support may also be provided by other government services such as child protection, homelessness services, hospitals, ambulance, police and mental health assessment teams.

A crisis may often result in the escalation of BoC and may temporarily require more intensive support. While the NDIS is not responsible for the delivery of emergency support, when the participant or their informal support contacts the NDIS during times of crisis, we need to be responsive to their concerns.

This may involve supporting the participant to access other government services as required, and explaining how the funding in their plan can be used flexibly to meet their needs during a crisis. The participant may have interacted with the After Hours Crisis service as part of the Exceptionally Complex Support Needs Program.

In some instances, reconsideration of the participant's streaming may be required to ensure they are appropriately supported through this period. Refer to section 6.1 for further information.

You will need to ensure the support coordinator (if relevant) is aware of the situation and is responding to and supporting the participant in a timely and effective manner. The role of the support coordinator and the level of support coordination may need to be considered. For example, a specialist support coordinator to manage multiple mainstream interfaces, organise and prepare reports may be required.

In some cases, the behaviour support practitioner may be able to identify the circumstances that could lead to periods of crisis for the participant. In these cases, the BSP and other supports should be proactively designed to respond to these situations. This may impact on the way the supports are funded in the NDIS Plan.

Where additional supports beyond the flexibility of the existing plan is required, it may be appropriate to consider whether an unscheduled plan review is required. Refer to Practice Guide – Unscheduled Plan Reviews.

Interactions detailing the crisis circumstances and actions taken must be recorded in the NDIS Business System (System) and an alert added if required.

5.6 Incident management

5.6.1 Registered providers

Registered service providers must have effective incident management systems and are responsible for recording and managing all incidents that happen in the delivery of NDIS supports and services. They are also responsible for notifying the NDIS Commission of any reportable incidents (including allegations) that occur with the provision of supports and services to an NDIS participant. Reportable incidents include:

- serious injury or death of an NDIS participant
- abuse or neglect of an NDIS participant
- unlawful sexual or physical contact with, or assault of an NDIS participant
- sexual misconduct committed against, or in the presence of, an NDIS participant, including the grooming of the NDIS participant for sexual activity
- the unauthorised use of restrictive practice.

Refer to the NDIS Commission's Reportable Incidents (external) for further information.

5.6.2 Unregistered providers

Unregistered providers must follow their internal provider reporting channels. All providers (registered and unregistered) who are providing NDIS funded supports must follow the NDIS Code of Conduct (external).

5.6.3 National Disability Insurance Agency (NDIA)

NDIA staff and Partners in the Community may be advised or learn of allegations of serious harm occurring to a participant from a participant, their carer, nominee or other relevant party. This is known as a participant critical incident. If information is provided to you which suggests or alleges a participant critical incident has occurred, refer to the Participant Critical Incident Framework. You must notify the Participant Critical Incidents team where appropriate, refer to Participant Critical Incidents page.

As noted above, any unauthorised use of restrictive practice is a participant critical incident. This incident may be a reason for a section 48 plan review. The participant or their authorised representative can request a review, or the NDIA may choose to initiate based on the information provided around the critical incident. Participant critical incidents highlight that the participant's supports may require adjustment or further changes are needed. It is the responsibility of the NDIS to make sure that a participant has appropriate funding for their support needs, including behaviour support.

6. Pre-planning

6.1 Streaming

Plan developers need to ensure the correct streaming decision has been recorded in the System for the participant to receive the appropriate level of support to implement their plan. Factors to change the streaming decision are dependent on the complexities presenting in the participants current life situation or environment which may be identified during your conversation.

Where a participant has complex support needs requiring a different approach, a referral to the Complex Support Needs Pathway may be appropriate.

Refer to Standard Operating Procedure – Update Participant Streaming and Standard Operating Procedure – Referral for Complex Support Needs for further information.

Note: The term streaming is for internal use only.

6.2 Plan duration

The plan duration ready reckoner guide recommends plans are developed for up to 12 months when a participant is requiring behaviour support and/or is streamed as Super Intensive. However, the participant's individual circumstances should be considered and a shorter plan duration may be required if, for example, the BSP is being assessed, accommodation needs/options are being assessed or close monitoring is required. Where the participant's situation is stable a longer plan duration may be also be appropriate. Refer to Standard Operating Procedure – Complete the Risk Assessment and Practice Guide - Pre-Planning for further information.

6.3 Arranging the planning meeting

Contact the participant and/or their authorised representatives (nominee/s, child representatives, and court or tribunal appointed decision makers) through their chosen method of communication and confirm/obtain consent for information sharing and exchange. A participant or their authorised representative may choose to invite other family members, friends or NDIS funded support providers to the NDIS planning meeting.

You should confirm all meeting attendees to allow for appropriate consideration of location, meeting room, time allocated and whether additional or senior staff are required to attend.

In limited circumstances, it may be necessary to appoint a plan nominee to act on behalf of, or make decisions on behalf of a participant. Refer to the Standard Operating Procedures – Appoint, Decline, Suspend or Cancel a Nominee.

Where possible and appropriate, the participant should be in attendance during the planning conversation. The participant's wellbeing is the priority and discretion is required at times to determine whether it is suitable for their attendance, such as if there is significant unrest and or concerns about safety due to events such as accommodation or relationship breakdown as a result of significantly challenging behaviours.

In these instances, efforts should be made to include the participant, and consider a shorter meeting to confirm key details or having them contribute in another way such as completing the relevant NDIS booklet prior to the meeting.

When confirming a meeting location and time, you should check the System for alerts and confirm the following with the participant or their authorised representative:

- Consider the participant's routine. For example, if the participant has difficulty sleeping at night they may not function well in the mornings and prefer an afternoon meeting.

- If known, consider the sensory needs of the participant and confirm an appropriate location. For example, if BoC are triggered by sensory overload, suggest a quiet office to conduct the meeting.
- Understand any specific environmental factors that may present a risk to the participant or to other members of the meeting including the NDIS staff member.
- Understand and respect any cultural sensitivities or barriers to communicate effectively for example, they may prefer to meet with someone of the same gender.
- Explore options to book a meeting for an extended period of time to allow breaks, or hold the planning meeting over multiple sessions or arrange for the participant to attend for shorter periods.
- Be aware of any behaviour response strategies that may need to be implemented during the meeting and what the role of the NDIS staff member will be, noting the service providers and informal supports who know the person well should lead the response directly with the person to de-escalate the situation or conclude the meeting.

6.3.1 Gathering documentation

Arranging the planning meeting provides an opportunity to follow-up on relevant supporting documentation that has not been provided yet. The participant, authorised representative or their support coordinator may provide this information to the NDIA. In some circumstances, the NDIA may need to follow-up directly once appropriate consent has been obtained. Behaviour support documentation may include:

- the most recent BSP
- behaviour protocols or strategies (where not collated in an interim or comprehensive plan as per the NDIS Commission)
- behaviour support recommendations report outlining next steps in behaviour support and estimated hours required
- incident reports, preferably incident summary reports
- data summary reports
- Restrictive Practice Authorisation documentation (if relevant)
- support model assessment reports including identifying housing options
- other assessment reports and support plans, such as speech pathologist, occupational therapist, psychologist, psychiatrist, paediatrician or other medical practitioner
- other relevant reports from service providers or mainstream agencies such as court reports.

All new or updated legal/court orders and other documents provided to the NDIS must be uploaded to inbound documents in the System.

6.3.2 External meetings

If a meeting is taking place at a location external to an NDIS office, follow the usual appointment booking process and ensure the following:

- complete and attach a copy of the home visit risk screen document and journey plan to the participant's record in the System
- review other information available in the System including, but not limited to previously completed planner risk assessment, guided planning questions, planning conversation tool and inbound documents. This information will help you identify any likely risks or concerns, such as other people being in the premises and the general safety of surrounds.
- discuss any identified risks and take any appropriate action as determined with your team leader
- familiarise yourself with the journey management procedure and out of office best practice guide.

NDIA staff are supported to make decisions at all times to protect their personal safety. These decisions may include:

- deciding that a visit requires a second employee to be present
- arriving at a location and deciding to cancel a visit due to safety concerns
- terminating a visit part way through due to safety concerns.

Refer to the Work Health and Safety page for further information.

For circumstances where the health, safety and/or security of NDIA staff or others is put at risk due to the behaviour of a participant or other third party, NDIA staff should refer to the Work Health and Safety page and NDIA Managing Unreasonable Behaviour Framework, Policy and Guideline for information, advice, reporting and escalation protocols.

6.4 Planning conversation

The participant is at the centre of the planning process and their goals and needs are explored by discussing their strengths and what they would like to achieve. The planning conversation should identify goals, capacity, risks and safeguards and provide an opportunity to discuss any assessments and reports.

Information provided in the planning meeting about the participant's BoC must be detailed in the guided planning questions free text box and in the planning conversation tool.

The following points can support you to have a high quality conversation:

- Be mindful of the person's communication needs and preferences including whether an interpreter is required.
- Make decisions about what will be appropriate to ask the person directly and what may be triggering or distressing that can be gathered in another way.

- Read previous planning information (if applicable), interactions and inbound documents.
- Review the support coordination progress reports. These should detail information including the participant's circumstances, identified risks, strategies and outcomes for the participant's goal progression.
- Review the behaviour specialist reports and any other assessments that identify outcomes achieved, key barriers and recommendations for the new plan.
- If there are known restrictive practices in use, ask if the BSP has been lodged with NDIS Commission and the relevant state or territory has authorised the use.
- Follow up any requested reports and/or assessments not yet provided, to assist informing the planning process.
- Use visual tools to assist in communicating. For example, if asking a participant about their schedule, use the weekly supports table in the NDIS planning booklet (external) to help break down the questions, or other format as determined appropriate to their communication needs.
- Encourage the participant to talk about/communicate their interests, what daily life is like, what challenges they face and allow time as needed for them to explain this to you.
- Discuss the previous plan (if applicable), what they found worked well and what did not. For example, they may have strong informal supports or may be at risk of losing their housing or in temporary accommodation placing them at risk of homelessness.
- Be conscious to not ask leading questions as people are likely to give the answer they think you want to hear.
- If the participant is appearing anxious or not engaging, consider asking them what would make them feel more comfortable such as having a break.
- Depending on the participant's situation, there may be multiple stakeholders with differing input present in the planning process. In these circumstances, make sure the participant and their authorised representative are the focus of your attention. Make sure they understand that they can request other people leave the room at any time.
- In some circumstances, due to the complexity of the participant's BoC further discussion may need to take place with the participant's informal supports and positive BSP practitioner to discuss current and proposed support needs, or there may need to be a second meeting.
- Where appropriate, seek consent to follow-up with specific individuals or providers. Refer to the Standard Operating Procedure – Consent and Authority for further information.

7. Planning

The Agency must be satisfied that the funded supports in the participant's NDIS plan meet each of the criteria outlined in section 34(1)(a)-(f) of the National Disability Insurance Scheme Act 2013 (NDIS Act) and the NDIS (Supports for Participants Rules) 2013.

When planning for the participant with BoC, it is important to be aware of any recent or upcoming changes in their life. Behaviours of concern may take place more frequently or at a greater severity during transitional periods for example during adolescence, leaving school or changes in living arrangements.

It is important to also be mindful that effective positive behaviour support:

- is not a linear process. For example, the practitioner may be conducting an assessment while revising the plan and training
- is highly individualised
- is holistic and integrated
- utilises a systems approach
- includes crisis response and BSP revision as required
- includes multi-disciplinary input in all elements including assessment, design, implementation and review
- varies in intensity and time required depending on the complexity of the person's situation and support needs
- cannot always be delivered in monthly amounts across the year. For example, there may be a high utilisation initially for providers to complete the initial assessment, interim planning, comprehensive assessment and comprehensive BSP development.

Refer to Practice Guide - Determine Reasonable and Necessary Supports for further information.

7.1 Core supports

Core supports are intended to assist with or supervise personal tasks of daily life to enable the participant to live as independently as possible. The BSP is expected to be used by all formal supports to build on the participant's strengths, increase their opportunities to participate in community activities and increase their life skills.

Where possible, the funds can be used to strengthen the capability and capacity of the participant and their informal supports (if applicable) by reinforcing strategies and encouraging independence towards goal attainment.

Providers may request higher support costs for participants with complex BoC. Consider the participant's individual circumstances and needs using the information available to understand the purpose of the support. For example in some circumstances, the proposal

may be considered a restrictive practice or it may be required as the participant has health or physical support needs.

If a regulated restrictive practice is used, review the participant's BSP which will record whether the relevant state or territory body has authorised the use.

The delegate may need to consider that the sudden removal of funded Core supports for participants with high level staff ratios and/or restrictive practices may put the participant's living arrangement, their staff, or others at risk.

It is therefore important to consider a transitional or gradual step down model to effectively reduce supports in line with the BSP. This is likely to take place over the course of multiple NDIS plans and should be guided by the registered specialist behaviour support practitioner. A mandatory referral to the TAB is required for all NDIS funded supports that may result in the use of regulated restrictive practices.

If the participant requires a higher intensity level of support, refer to the Standard Operating Procedure – Determine Self-Care and Community Access Supports for further information.

7.1.1 Behaviours support provision in supported independent living (SIL)

Behaviour supports need to take a whole of house approach when a participant is living in a supported independent living (SIL) arrangement with other people with disabilities. Behaviour support may be recommended where there are frequent incidents such as assaults, self-harm, property damage or high-level staffing ratios to manage risk to staff and residents. There may also be use the use of restrictive practices which are not targeted towards all the residents such as a locked fridge or the removal of people to a safe area during an incident.

Behaviour supports for a whole of house approach may include:

- shared living environmental assessment, also known as ecological assessment
- behaviour support systems review
- program development
- staff training.

Some of these supports may be shared in a whole of house approach, for example, there would be one shared living environmental assessment completed by the one provider to assess the overall household situation. The cost of the environment assessment would then be broken down and shared amongst all those living in home. Refer to the Operational Guideline – Supported Independent Living (SIL).

7.2 Capacity Building supports

Before including funding for behaviour supports, consider the Capacity Building funding generated by the TSP and whether these funds are sufficient to provide some or all of the required behaviour support. To do this you will need to understand what other Capacity Building supports are required by the participant and work out whether the total Capacity

Building funding needs to be increased to support the participant with their BoC. For instance, a child or younger person may require a higher level of funding so their informal supports are appropriately trained to implement the BSP.

There is a guided planning question related to BoC which must have the correct responses recorded. Responses to this question are for data capturing only and do not generate any funding in the TSP. The TSP is a guide and decisions on reasonable and necessary supports should be made in accordance with s34 of the NDIS Act.

7.2.1 CB Daily Activity

Best practice in behaviour support involves a multidisciplinary approach tailored to the needs of the person. It is therefore important to ensure the relevant therapeutic assessments and services are included in CB Daily Activity area of the plan. NDIS reasonable and necessary improved daily living supports may include:

- assessments including psychological, communication and sensory
- individual skills development and training
- training for carers or parents.

As noted previously, a functional behaviour assessment can only be completed by a registered specialist behaviour support practitioner or provider.

Where an ecological assessment is required, a total of 10 hours per household should be funded. Where multiple participants in the same household require a BSP, if appropriate their plans should be developed at the same time and the hours divided amongst plans.

7.2.2 CB Relationships

Behaviour supports within the category of CB Relationships may include:

- specialist behavioural intervention support for assessment and development of BSP
- behaviour management plan and training in behaviour management strategies
- individual social skills development.

Dependent on the participant's circumstances, NDIS funded support workers may require individualised training specific to the participant to maintain consistency and positive behaviour supports. Practitioners may provide training plans for the support worker or therapy assistant in the development of social skills identified as required due to BoC.

When determining reasonable and necessary funding, the specialist behaviour support practitioner would be expected to monitor the BSP implementation and review accordingly. Regular review allows opportunity for changes and updates to the BSP if the progress differs from expectations.

Questions which may help in determining the amount of funding include:

- Which stage of behaviour support currently applies? Are they at the brief assessment and safety planning stage (Refer to 6.2) or are they stable and in the monitoring

stage? This indicates how many hours are still required for assessments and reporting.

- Does the participant already have a current comprehensive behaviour assessment?
  - If so, the next assessment will usually require less time.
- Does the participant already have a current comprehensive BSP?
  - If so, the next BSP update will usually require less time.
- How many BoC does the person engage in? Usually the more behaviours, the more time required for all stages of the behaviour support process.
- What is the intensity and severity of the behaviour/s of concern? More intense and high-risk behaviour is likely to require more time in assessment, design, protocol revision and implementation support.
- How many informal and formal support providers are involved? This will impact on the amount of observations, interviews, file review required; the amount of tailored strategies required for various environments and roles; and the amount of training and implementation support required.
- How many regulated restrictive practices are proposed or in place? The more practices, the more time required for assessment, design, implementation, and reporting.
- How many informal or funded supports require training and implementation support? Can this be done in one session or do multiple repeat sessions need to be factored in?
- What other reporting requirements does the specialist behaviour support practitioner have? This may include data summaries and consultation with a psychiatrist to inform medication review.
- How will the multidisciplinary team collaborate? How often will they need to meet or have other contact?
- How many other stakeholders does the specialist behaviour support practitioner need to engage with?
- How much direct contact will the specialist behaviour support practitioner have with the person for skill development? Is this sessional, what is the frequency?
- What other pieces of work are required? Are there specific assessments that can inform the behaviour assessment behaviour assessment report (such as Assessment of Sexual Knowledge); Support Model Assessment report; transition plan development and implementation (such as from one placement to another).
- Where there are regulated restrictive practices required, you should also include funding for the specialist behaviour support practitioner to meet their obligations under

the NDIS Commission specific to this participant and the state or territory authorisation process.

7.2.3 Behaviour intervention support levels

You will need to make sure the participant receives the appropriate support required to implement their plan and to address any behavioural complexities in their current life situation.

There are two levels of behaviour intervention support provided as a guide however the participant's individual circumstances and supporting information must be considered in every plan to determine appropriate funding and supports required.

The levels of support include a behaviour management plan and training in the management of strategies to form a package of support to address a participant's immediate need for behavioural intervention. You will need to make a reasonable and necessary decision to determine the appropriate level of support included in the participant's plan.

The guidance in hours has been suggested for a plan of 12 months in duration. Use your reasonable and necessary decision making for plans with durations less or more than 12 months. If a participant has significant behaviours of concern it is highly unlikely that there will be a plan over 12 months due to the need to monitor and review outcomes and circumstances.

Consult with your team leader and refer to the participant's individual supporting documents, Practice Guide - Determine Reasonable and Necessary Supports and the Standard Operating Procedure – Behaviour Intervention Supports for further guidance.

7.2.3.1 Level 1

Level 1 funding could be considered appropriate for participants who require intervention due to significant behavioural complexities that are impacting on the ability of the participants informal supports to sustain care at home and assist the participant to safely engage in activities.

Level 1 criteria includes:

- behaviours of concern that could require single or minimum interventions
- lack of services willing to engage with the participant due to presenting behaviours and risk to staff/participants/community
- change of participant circumstances that will result in withdrawal of service support and need for immediate intervention.

Use reasonable and necessary decision making to fund the following supports:

- **Specialist behavioural intervention support** - Most level 1 plans should not exceed 45 hours (approx. 3-4 hours per month) which will enable the participant to receive support from a psychologist or appropriate therapist to develop a BSP, implement strategies and review interventions over a period of time.

- **Training in behaviour management strategies** - To support carers and any other significant informal supports in the participant's life to implement the behavioural support plan and behavioural strategies, include training in behaviour management. Most level 1 plans should not exceed 20 hours (1-2 hours per month) which will ensure the behavioural intervention support plan is applied consistently in all necessary environments to best support the participant.

7.2.3.2 Level 2

Level 2 funding could be considered appropriate for participants that require immediate intensive behavioural intervention support and are streamed Super Intensive or Complex. In the majority of circumstances, level 2 funding is not appropriate for children aged seven and under.

Level 2 criteria includes:

- multiple complexities that may require multiple interventions
- extreme behaviours of concern where there is the use of regulated restrictive practice
- lack of services willing to engage with the participant due to presenting behaviours and risk to staff/participants/community
- significant change of participant circumstances that will result in withdrawal of service support and need for immediate intervention
- behaviours of concern involving various stakeholders (multiple issues for intensive intervention requiring comprehensive assessment, planning, support and training for the participant and carers)
- participants who may have significant 1:1 support in the community, 1:2 support in the community (greater than 30% of the day) or exceptional circumstance supports at home due to their harmful or persisting behaviours that may present risk to themselves or others
- participants who require additional support to implement newly developed strategies in the community or within newly engaged activities/services
- participants who are anticipated to experience a significant transition during the plan period such as moving into SIL or from school to day program.

This package of support would be considered in the following circumstances:

- when a participant has extreme behaviours that could require restrictive intervention
- where there is significant change of circumstances that will result in a withdrawal of service support
- where there is significant risk to support staff, other participants or the community.

Use reasonable and necessary decision making to fund the following supports:

- **Specialist behavioural intervention support** – Most level 2 plans should not exceed 90 hours (7-8 hours per month) for specialist behavioural intervention support which will support participants with significantly harmful or persistent behaviours of concern.
- **Training in behaviour management strategies** – To support carers and other significant informal supports in the participant's life to apply the developed BSP and behavioural strategies, include training in behaviour management. Most level 2 plans should not exceed 30 hours (2-3 hours per month) which will ensure the behavioural support plan is applied consistently in all necessary environments to best support the participant.
- **Individual social skills development** – For participants that require additional support to implement newly developed strategies in the community or within newly engaged activities/services, include individual social skill development. Most level 2 plans should not exceed 40 hours (3-4 hours per month) which will complement recommendations in the BSP.

7.2.4 Support coordination

Support coordination is intended to strengthen the participant and/or their authorised representative's abilities to coordinate and implement supports in the plans to participate more fully in the community, and to build and maintain a resilient network of formal and informal supports. This includes addressing barriers to implementation and regular monitoring. A participant who displays BoC may require support coordination or specialist support coordination to assist where required.

You will need to consider the level of support the participant and/or their authorised representative will require to build their capacity to connect with supports and services, ensure they understand their NDIS plan and how to implement their funded supports, and strengthen their ability to self-direct services and achieve their goals.

It is also part of the support coordinator's role to build capacity of the participant and/or authorised representatives to gather supporting documents including assessments and reports and ensure these are provided to the NDIS.

Where the participant experiences a crisis, the support coordinator will assist them as required, to manage and link into appropriate supports. This information should form part of their next progress report to the NDIS where any known causes of the crisis, how it was managed, the outcome and proposed strategies to reduce the likelihood of a reoccurrence are detailed.

The reporting and monitoring requirements must be discussed at the plan handover and clearly outlined in the Request for Service. Refer to Standard Operating Procedure – Include Support Coordination in a Plan.

7.3 Plan comments

Make sure your plan comments recorded in Determine Funded Supports task include a description of the behaviour supports included within each budget.

Example (Core) – only relevant where there is a regulated restrictive practice in the participant's BSP: I can use my core support funding flexibly to help with my daily activities. Assistance with self-care activities and accessing the community to be provided by a registered implementing provider.

Example (Capacity Building): Funding for XX hours of specialist behaviour intervention support, XX hours of behaviour management plan and training in behaviour management strategies. A report detailing outcomes achieved is to be provided to the NDIA by the registered specialist behaviour support practitioner before this plan is due for review.

7.4 Plan management

It is important to understand the distinction between choice and control in regards to plan management and the legislative requirements to use a registered provider.

The NDIS supports the participant to maximise their choice and control where there is not unreasonable risk or other factors impacting the participant's and/or their authorised representative's ability to manage NDIS funding.

The NDIS (Provider Registration and Practice Standards) Rules 2018 (Part 2, section 7) specifies that to maintain safeguards and minimise risk to the participant, NDIS providers must be registered for:

- functional behaviour assessments
- developing BSPs, and
- regulated restrictive practices.

Behaviour support practitioners (whether a sole provider or employed by a provider) must be registered with the NDIS to provide specialist behaviour support (registration group 110).

The NDIS recommends that CB Relationships is Agency managed to ensure the use of NDIS registered providers, however participants and/or their authorised representatives may choose to have their supports plan or self-managed. It is important for participants and/or their authorised representatives to understand the distinction between choice and control in regards to plan management and the legislative requirements to use a registered provider for specific behaviour supports (functional behaviour assessments, BSPs, and regulated restrictive practices).

NDIS legislation is based on the presumed capacity to self-manage. Therefore, a request by the participant to manage their funding should be considered positively by the delegate unless there is evidence of a significant risk to the participant.

The NDIS supports the participant to maximise their choice and control where there is not unreasonable risk or other factors impacting the participant's and/or their authorised representative's ability to manage NDIS funding. The determination of unreasonable risk is assessed with every plan review, having regard to the participant's individual circumstances and considerations.

7.4.1 Restrictive practice

Where the BSP includes regulated restrictive practice, the participant and/or their authorised representatives, should be aware that the implementing service provider for the behaviour support **must** also be registered with the NDIS Quality and Safeguards Commission.

Where supports are self or plan –managed, a thorough conversation with the details recorded in the appropriate pre-planning tasks and clear NDIS plan comment (see 7.3) should follow. This is to make sure that the participant and/or their authorised representatives understand while the funding management allows for the use of unregistered service providers, there is a legislative requirement that registered providers **must** be used for BSPs and regulated restrictive practices.

Refer to Planning Operational Guideline – Managing the funding for supports under a participant's plan (the plan management decision) for further information.

8. Plan implementation and monitoring

There should be ongoing monitoring during the plan period to measure whether the participant is meeting their desired outcomes and goals. This can take place through a variety of means including support coordination reports, regular updates and Panda Live data.

You should check the plan utilisation to make sure the plan is being implemented as expected and provide opportunity for earlier follow-up if there appears to be an over or under utilisation. Due to the nature of this support, there is likely to periods of intensive support and high budget utilisation, therefore the utilisation should be considered over time.

Refer to PANDA, Practice Guide – Plan Implementation and Practice Guide – Monitoring for further information.

9. Scheduled plan reviews

Make sure you have received the progress report from the support coordinator or specialist support coordinator and reviewed it to understand key issues and outcomes from the plan period.

It is expected the NDIA will be provided with supporting information demonstrating outcomes, barriers and where appropriate, recommendations for the next NDIS plan. For example, where there has been successful implementation of capacity building supports, it may lead to a reduction of supports based on the behaviour support practitioner recommendations. Fade-

out or step down approaches will be clearly documented based on supporting information. These approaches form a key part of reasonable and necessary decision making when a participant's BSP includes restrictive practices.

For further information, refer to Practice Guidance - Scheduled Plan Reviews and Standard Operating Procedure – Complete a Plan Review (full).

10. Case examples

10.1 Example 1 - Kim

Kim is a 20-year-old woman and lives at home with her parents and two younger siblings. She has a primary disability of autism spectrum disorder and a secondary disability of mild intellectual disability.

10.1.1 Planning meeting

At Kim's planning meeting, her parents discuss how they are struggling to maintain support and are concerned about the impact Kim's behaviours of concern are having on her and her younger siblings. When asked further about her behaviours, they explain that Kim bites and hits out at people around her at home and at her day program. When upset, she will also hit her head against walls and run away from those she is with.

Kim enjoyed attending a specialist school and after completing year 12, she started at a day program. The identified behaviours escalated when she left school. Kim has not settled at the day program. She is reluctant to leave home to attend and while at the day program, Kim displays increased levels of BoC.

Kim's parents and the day program provider have tried several different strategies to support her, however the BoC have not reduced. She has not been provided with any behaviour support previously.

10.1.2 Outcome

Kim is considered to meet the criteria for level one behaviour intervention support for the following reasons:

- Kim has informal supports who are engaged and available.
- Kim is still attending a regular day program and the provider is willing to work with her and her family to implement the BSP.
- the BoC have not been longstanding having escalated only since Kim left school.

Kim's 12-month plan provides funding for the following reasonable and necessary supports:

- Social community and civic participation for continued day program attendance allowing for higher-intensity supports while Kim is connected with a specialist behaviour support practitioner. The NDIS is awaiting further recommendations in the

report by the specialist behaviour support practitioner for the associated training hours required in the BSP.

- Functional capacity assessment (10 hours).
- Specialist behavioural intervention support for functional behaviour assessment, development of a BSP, implementation, monitoring and review of behavioural support interventions in her home and day program (45 hours).
- Behavioural management plan including training in behaviour management strategies to provide training to informal/formal supports to understand and implement Kim's BSP consistently in all environments (20 hours).
- Coordination of Supports (72 hours).

10.2 Example 2 – Joe

In the following two case examples, Joe and Hassan, two NDIS participants are living in a SIL arrangement and sharing supports. At the scheduled plan reviews, the SIL provider has provided information detailing an increase in BoC for both Joe and Hassan. After trying a number of different strategies to resolve conflict and reduce the BoC, the provider has requested an increase in both SIL and Capacity Building funding to better support them.

Joe is a 30-year-old man and lives in a SIL arrangement with two others. His primary disability is a moderate intellectual disability. Joe works at an Australian Disability Enterprise (ADE) four days per week. Joe is well supported by his parents and family and spends every Sunday with them. His family use supported decision making to make sure he is active in his life decisions.

10.2.1 Planning meeting

All the participants in the home are undertaking a scheduled plan review. Prior to Joe's NDIS meeting, the completed provider SIL pack and quoting tool along with supporting information including his BSP are provided to the NDIS. Joe's BSP notes his behaviour will escalate quickly if there is any unexpected change or interruption to his routine or life and he generally begins to shout, punch walls and becomes agitated. Some of Joe's triggers include:

- Reminders of the recent death of a close friend.
- When his housemate Hassan is displaying BoC.
- Returning to his home after a family visit on Sundays.
- Varying triggers at his ADE including when there is unexpected change and loud noises, approximately twice per week.

10.2.2 Outcome

Joe is considered to meet the criteria for level one behaviour support for the following reasons:

- Joe has informal supports who are engaged and available.
- Joe works at an ADE four days per week and goes to regular activities in the community on the other weekday. The ADE provider is willing to work with Joe, his family and support workers to implement his BSP.
- The BoC have not been longstanding having escalated since Joe's friend passed away.

Joe's 12-month plan provides funding for the following reasonable and necessary supports:

- Supported independent living included as per SIL pack and quoting tool. The NDIS is awaiting further recommendations in the report by the specialist behaviour support practitioner for the associated training hours required in the BSP.
- Support for his continued employment at the ADE.
- Shared living environmental assessment (ecological assessment) (5 hours).

  Although Joe has been assessed as meeting the criteria for a level 1 behaviour support plan, he lives in a shared environment, and it has been identified that triggers for BoC are occurring within the home. Funding has been added to enable an ecological assessment to be undertaken to better understand contributors from within Joe's living arrangement.
- Specialist behavioural intervention support for functional behaviour assessment, development of a BSP, implementation, monitoring and review of behavioural support interventions in his SIL home, family home and ADE (45 hours).
- Behavioural management plan including training in behaviour management strategies to provide training to informal and formal supports to understand and implement Joe's BSP consistently in all environments (20 hours).
- Coordination of Supports (72 hours).

10.3 Example 3 – Hassan

Hassan is a 45-year-old man and lives in a SIL arrangement with Joe and one other. His primary disability is autism spectrum disorder and his secondary disability is schizophrenia. During the week, he attends a day program for two days where he consistently exhibits BoC. He does not currently have family support, usually seeing his sister on his birthday. Hassan gets distressed by many triggers that substantially increase his anxiety levels and tends to result in him scratching his own skin or hitting or kicking property or anyone who tries to intervene. He is prescribed risperidone to manage these BoC. Staff also administer a muscle

relaxant medication when becomes agitated to help calm Hassan. Some of the known triggers are as follows:

- Exposure to sensory stimulation especially loud noises, music and bright lights.
- When his housemate Joe becomes agitated and yells.
- When his formal supports prompt him with daily activities.

As the direct result of an assault on a house staff member, there is an active Mental Health Community Treatment Order in place that states Hassan must attend and receive treatment weekly.

10.3.1 Planning Meeting

All the participants in the home are undertaking a scheduled plan review. Prior to Hassan's NDIS meeting, the completed provider SIL pack and quoting tool along with supporting information including his BSP are provided to the NDIS. The day program provider is considering withdrawing services due to the risks involved.

Hassan's parents have both passed away. He has a sister who lives interstate and is not involved in his daily life. Hassan has the public guardian in place as his decision maker and the Public/State Trustee manages his finances.

10.3.2 Outcome

Hassan is considered to meet the criteria for level two behaviour support for the following reasons:

- Hassan is experiencing problems maintaining service providers.
- Hassan's only informal support is his sister and he sees her once a year on his birthday.
- He is subject to restrictive practice (chemical restraint) to address BoC.

Hassan's 12-month plan provides funding for the following reasonable and necessary supports:

- Supported independent living included as per SIL pack and quoting tool. The NDIS is awaiting further recommendations in the report by the specialist behaviour support practitioner for the associated training hours required in the BSP.
- Support for his continued attendance at his day program.
- Shared living environmental assessment (ecological assessment) (5 hours).

  It has been identified that Hassan will have his BSP reviewed at the same as Joe. As a result, the 10 hours to develop the ecological assessment has been shared between Joe and Hassan's plan.

- Specialist behavioural intervention support for functional behaviour assessment, development of a BSP, implementation, monitoring and review of behavioural support interventions in his SIL home and day program (90 hours).
- Behavioural management plan including training in behaviour management strategies to provide training to informal/formal supports to understand and implement Hassan's BSP consistently in all environments (30 hours).
- Coordination of Supports (108 hours).

10.4 Example 4 – Daniel

Daniel is a 12-year-old boy. He lives with his mother and younger siblings. He attends his local primary school. His primary disability is autism spectrum disorder and secondary disability is intellectual disability. It has been identified that Daniel has sensory aversion to loud noises and to sensations such as silky or synthetic fabrics. He has difficulty communicating his needs to others, and seems to have difficulties following instructions, leading to frustration and BoC.

10.4.1 Planning Meeting

During the planning meeting, Daniel's mother said he was attending school three days per week. He would like to establish friendships with his peers and increase his social participation however experiences heightened anxiety due to bullying at school including verbal threats, teasing and pushing.

Daniel's mother and school have identified that his BoC are high in intensity. They include self-harm (suicide attempts, absconding) and harm towards others (physical aggression and assault). At home, cutlery needs to be stored safely. Daniel's mother has identified that she has locked away to maintain his safety due to self-harming behaviours. Usually, the cutlery would be in an unlocked drawer, as a child of Daniel's age would generally be expected to safely use cutlery to eat or prepare food. He does not have a behaviour support plan.

His attendance at school, the bullying and identified BoC make it challenging for Daniel to form and maintain relationships and participate in social activities. His mother spoke about finding it increasingly difficult to care for Daniel. The school have funded an additional staff member to increase his attendance at school.

Daniel's mother is requesting Core supports to support her in the home, and support for Daniel while at school and participating in his learning activities and increase his social participation. The planner provides further details of NDIS and education responsibilities, noting that service systems obligations must be met before any funding by the NDIS could be considered to meet the disability support needs that are deemed beyond 'reasonable adjustment'.

10.4.2 Outcome

Daniel is considered to meet the criteria for level two behaviour support for the following reasons:

- Daniel is experiencing issues with school attendance.
- Daniel's only informal support is his mother and she has expressed carer fatigue.
- Daniel's BoC have been identified as high in intensity, particularly given his age.
- Daniel is experiencing challenges with social participation.

Daniel's 12-month plan provides funding for the following reasonable and necessary supports:

- CB Daily Activity as it has been identified that Daniel has sensory difficulties and communication difficulties. Funds within this category will be utilised for an occupational therapist to undertake a sensory assessment and a speech pathologist to undertake a communication assessment and collaborate with the behaviour support practitioner to enable strategies to address these needs to be included within the Positive BSP.
- Specialist behavioural intervention support for a functional behaviour assessment, development of a BSP, implementation, monitoring and review of behavioural support interventions in all environments (home, education setting, any other identified setting) (84 hours).
- Behavioural management plan including training in behaviour management strategies to provide training to informal and formal supports to understand and implement Daniel's BSP consistently in all environments (30 hours).
- Coordination of Supports (60 hours)

As discussed in the planning meeting, it was not determined to be reasonable and necessary for the NDIS to fund Core supports for Daniel in his educational environment to assist with her learning support needs and school attendance supports.

11. Appendices

11.1 State and territory restrictive practice legislation

The state and territory governments remain responsible for specific legislation, policy and procedures related to the authorisation of restrictive practices. This is complementary to the NDIS Commission who is responsible for best practice guidance, monitoring and oversight of behaviour support service provision and the use of restrictive practices in all states and territories (excluding Western Australia). It is important to note that BSPs containing regulated restrictive practices must be lodged with the NDIS Commission, even if authorisation of the use of the restrictive practice is not a requirement of that state or territory.

Behaviour support practitioners must adhere to the requirements of the NDIS Commission and the state or territory in which they operate. Plan developers can refer practitioners, providers and plan implementers (support coordinator or LAC) to the relevant source of information. If there are concerns, discuss with your supervisor, request TAB advice or escalate feedback that may need to be considered for report to the NDIS Commission.

11.1.1 New South Wales

- While there is no specific legislation regarding restrictive practices in New South Wales, there is the Guardianship Act (1987).
- New South Wales also have the restrictive practice authorisation policy and procedural guide outlining requirements. Approval is provided through the restrictive practices authorisation (RPA) panels.
- Service providers must comply with the New South Wales restrictive practices authorisation policy and procedural guide.
- There is expected to be an updated New South Wales policy concerning restrictive practices authorisation mechanism, which providers will also need to comply with.

11.1.2 Victoria

- The Victorian government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices and behaviour support in the NDIS.
- The Victorian Senior Practitioner has the power to issue prohibitions and directions related to restrictive practices, compulsory treatment and supervised treatment orders under the Disability Act 2006.

11.1.3 Queensland

- The Queensland government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices in the NDIS through the Disability Services Act (2006) for those over 18 years.
- The *Disability Services Act (2006)* helps safeguard people with an intellectual or cognitive disability and their rights against the inappropriate use of restrictive practices and provides an accountability framework that allows for transparency in the decision-making process to authorise the use of a restrictive practice by a relevant service provider with an adult with an intellectual or cognitive disability.
- The *Disability Services Act (2006)* sets out a number of requirements that the relevant disability service provider must follow to legally use a restrictive practice and for any use of containment/seclusion to be approved by the Queensland Civil and Administrative Tribunal.

11.1.4 Western Australia

- The Western Australian government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices and behaviour supports in the NDIS.
- Providers are encouraged to follow the Code of Practice: A Guide for the Elimination of Restrictive Practices (external).

11.1.5 South Australia

- The South Australian government has policy and procedures outlining state requirements regarding restrictive practice authorisation.
- The Disability Services Act 1993 requires disability service providers to have restrictive practices policy and procedures in place. Seclusion of an adult with disability must only be used if specifically authorised by the South Australian Civil and Administrative Tribunal (SACAT) under Section 32 of the *Guardianship and Administration Act 1993.*

11.1.6 Tasmania

- The Tasmanian government remains responsible for the legislative and policy frameworks through the Disability Services Act 2011 regarding the authorisation of regulated restrictive practices, which are approved by Tasmanian Senior Practitioner.
- Chemical restraint does not have authorisation requirements in Tasmania.

11.1.7 Australian Capital Territory

- The Senior Practitioner Act (2018) remains responsible for the approval of behaviour support plans, which include the use of a regulated restrictive practice.
- The *Senior Practitioner Act (2018)* provides the powers and functions of the Senior Practitioner and regulates the use of restrictive practices by persons or other entities who provide any of the following services to another person:
  - education, including education and care
  - disability
  - care and protection of children.

11.1.8 Northern Territory

- The Northern Territory government will be responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices in the NDIS through the NDIS (Authorisations) Act 2019.

12. Supporting material

- NDIS Act 2013
- NDIS (Quality and Safeguards Commission and Other Measures) Transitional Rules 2018
- NDIS (Restrictive Practices and Behaviour Support) Rules 2018
- NDIS (Code of Conduct) 2018
- NDIS (Incident Management and Reportable Incidents) Rules 2018
- NDIS (Provider Registration and Practice Standards) Rules 2018
- NDIS (Plan Management) Rules 2013
- Overview of the NDIS Operational Guideline – Quality and Safeguards
- NDIS Quality and Safeguards Commission
- NDIS Quality and Safeguarding Framework
- Convention on the Rights of Persons with Disabilities (external)
- National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector (external)
- Operational Protocols between the NDIA and the NDIS Commission intranet page

12.1 New South Wales

- Guardianship Act 1987
- Restrictive Practice Authorisation Policy (June 2019)
- Restrictive Practice Authorisation Procedural Guide (June 2019)

12.2 Victoria

- Disability Act 2006
- Disability Act 2006: Supervised Treatment Orders, Restrictive Practices, Compulsory Treatment

12.3 Queensland

- Disability Services Act 2006

12.4 Western Australia

- Code of Practice: A Guide for the Elimination of Restrictive Practices

12.5 South Australia

- Disability Services Act 1993

12.6 Australian Capital Territory

- Senior Practitioner Act 2018

12.7 Northern Territory

- NDIS (Authorisations) Act 2019

12.8 Tasmania

- Disability Services Act 2011

13. Feedback

If you have any feedback about this Practice Guide, please complete our Feedback form.

14. Version change control

Version No	Amended by	Brief Description of Change	Status	Date
3.0	KN0014	Class 1 Approval.	APPROVED	2020-05-25
4.0	NAP927	Class 1 approval. Updated hyperlink and legislative reference in section 7.4.	APPROVED	2020-07-17
5.0	JC0075	Update for plan developers to refer to the Technical Advisory Branch intranet page for supports that require mandatory TAB advice. Updated date for NDIS Quality and Safeguards Commission regulating the use of restrictive practices Class 2 approval	APPROVED	2020-12-04

Practice Guide – Positive Behaviour Support and Behaviours of Concern

Contents

1. Purpose

The purpose of this Practice Guide is to guide you through the considerations, roles and responsibilities when planning for a participant who displays Behaviours of Concern (BoC).

2. To be used by

- Plan Developers – Planners and Local Area Coordinators [LACs]
- NDIA Plan Delegates.

3. Scope

This Practice Guide provides information to support plan developers to understand when and how positive behaviour support may be a reasonable and necessary support where the participant displays BoC. This includes the respective roles and responsibilities of the National Disability Insurance Scheme (NDIS), NDIS Quality and Safeguards Commission (NDIS Commission) and states and territories.

Behaviour supports are to be provided in accordance with the NDIS Commission's requirements for positive behaviour support. The NDIS funds reasonable and necessary supports designed to identify and reduce BoC, to improve the participant's quality of life, uphold their dignity and safeguard their rights.

The NDIS Commission is operating in all states and territories (except for Western Australia). The NDIS Commission starts operating from 1 December 2020 in Western Australia. Until this time, the current state requirements for quality and safeguards continue to apply.

The NDIS Commission, states and territories governments have oversight of behaviour support and restrictive practices. They are committed to a regulatory framework for behaviour support that is founded on contemporary evidence-based practice and aligned with the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Services Sector (external).

4. Legislative and Policy Context

The NDIS Commission is responsible for best practice guidance, monitoring and oversight of behaviour support service provision and the use of restrictive practices. State and territory governments remain responsible for specific legislation, policy and procedures related to the authorisation of restrictive practices. These are separate but related processes and requirements.

The NDIS Commission assesses behaviour support practitioners and providers using a Positive Behaviour Support Capability Framework. This provides guiding principles to assist in delivering specialist positive behaviour support as an NDIS behaviour support practitioner.

In all states and territories providers who use or are likely to use restrictive practices, or who develop behaviour support plans (BSPs) must be registered with the NDIS Commission and meet the supplementary requirements of the NDIS Practice Standards (external).

To support safeguarding for people subject to restrictive practices, any use of restrictive practice must comply with the NDIS (Restrictive Practices and Behaviour Support) Rules 2018. These safeguards include but are not limited to:

- behaviour support practitioners, and providers who use regulated restrictive practices (also known as implementing providers) must meet the requirements outlined
- state and territory governments remain responsible for the authorisation of regulated restrictive practice/s in an individual's BSPs. Providers must comply with requirements of their state or territory
- restrictive practices are clearly identified in a BSP.

Refer to section 11.1 for information on state and territory restrictive practice legislation.

The National Disability Insurance Agency (NDIA) is not obligated to fund supports which have been imposed by state and territory bodies, which involve the use of restrictive practices, for example where a supervision order has been imposed by a civil or criminal court. However, where a restrictive practice has been authorised, recommended, or implemented by another body, this is a relevant consideration when determining if the NDIS funded behaviour support is reasonable and necessary. If unsure, discuss with your team leader.

In response to the concerns raised by the NDIS Quality and Safeguards Commission, the NDIA has committed to reviewing all requests for supports that include Regulated Restrictive Practices.

Where the use of regulated restrictive practice is proposed, or in use, a Technical Advisory Branch (TAB) advice request must be prior to plan approval. For information on how to request advice, refer to the mandatory advice section of the TAB Requesting Advice intranet page.

5. Behaviours of Concern

Behaviours of Concern, also known as challenging behaviours, refer to a wide range of behaviours of an intensity, frequency or persistence that threatens the quality of life, physical safety of the individual and/or others and generally results in limiting access to the community.

Behaviours of Concern can be any behaviour that results in an adverse impact on the person's quality of life. This may include:

- physical or verbal aggression
- property damage
- inappropriate sexual behaviour

- disinhibited and impulsive behaviour
- self-injurious behaviour also referred to as self-harm. It differs with each person and can include head banging, picking and hitting. This behaviour may not be an attempt to cause harm.

Please note the term self-harm when used in mental health settings typically refers to intentional harm without suicidal intent such as neglect, cutting, ingesting objects and self-poisoning. Mental health professionals must be consulted by the participant's supports as this is typically an indication of serious distress.

In order to provide successful interventions, it is necessary to understand the function of that behaviour for the person and the context it occurs. There may be a range of underlying factors influencing BoC including:

- underlying physical, neurological, mental or emotional health issues
- biological/physical due to experiencing pain or discomfort
- acting out a repetitive behaviour or routine
- frustration in not being able to do something
- communication/social needs due to difficulties in communication, seeking social interaction or attention
- demonstrating a learned behaviour
- the physiological effects of substances including alcohol, illegal drugs or medications
- response to difficulties encountered with service systems or support networks
- attempting to avoid a situation
- interpersonal environment such as quality of social interactions
- change or lack of in routine or structure
- inflexible thinking
- attempting to manage sensory overload
- having a high pain threshold and the behaviour is intended to provide sensory stimulus
- support staff skills and turnover, perceptions and level of resources available.

5.1 Impacts of Behaviours of Concern (BoC)

Behaviours of Concern affect the quality of life of the individual. Factors such as the intensity, frequency or persistence of the behaviours may limit a participant in their opportunities to pursue social, educational, economic and/or recreational activities. Often this is due to the need to maintain the physical safety of an individual or other people (such as family, support workers or the community) and reduce the risk of unsafe social participation (such as inappropriate and/or unsafe sexual behaviours).

Where the participant exhibits BoC, they may require supports in several areas of their life. Informal supports can have difficulty in sustaining relationships and caring responsibilities due to the potential risk of harm to the participant, other people in the home or themselves. NDIS funded supports can be used to support informal and formal supports in their roles and build their capacity to effectively address the BoC with the participant. These supports may help sustain the participant's current living and/or support arrangements and encourage the participant to positively engage with others. Where the participant has complex and longstanding BoC there may be further difficulties in engaging and sustaining funded supports.

Participants with complex BoC may be at risk of breakdown of their living arrangements such as being temporarily removed from shared living arrangements to individualised accommodation support settings, or family supports no longer being able to sustain the person living in the family home. There is also the risk of increased support staff turnover that in turn can lead to further escalation in behaviours due to constant changes in their environments, formal and informal supports, and the impact of fractured relationships.

In some cases, when informal supports are unable to continue to care for the participant who displays complex BoC, an alternative accommodation arrangement may be required for short or long term periods. Where there has been an escalation of behaviours and this requires a change of circumstances refer to the Practice Guide – Unscheduled Plan Reviews, Operational Guideline – Supported Independent Living (SIL) and the Medium Term Accommodation Operational Guideline.

In the case of a person under the age of 18, refer to the Practice Guide – Children Living in a Formal Voluntary Arrangement Outside their Family Home, Practice Guide – Children at Risk of Requiring Accommodation Outside the Family Home and Practice Guide – Children Living in Statutory Out of Home Care.

5.2 Positive behaviour support

Positive behaviour support is an effective approach for BoC as it focuses on addressing a person's needs, their home environment and overall quality of life through assessment, planning and intervention.

The positive behaviour support process typically follows similar steps.

1. **Brief functional behaviour assessment** - focussed on identifying requirements for incident prevention and response.
2. **Interim plan** - may also be referred to as a safety interim plan, incident prevention and response plan, reactive strategy response plan or reactive strategy. Interim BSPs include the provision for the use of a regulated restrictive practice developed within one month of engagement by a behaviour support practitioner while a comprehensive BSP is being developed.

3. **Comprehensive functional behaviour assessment -** the process for determining and understanding the function or purpose behind a person's behaviour, and may involve the collection of data, observations, and information to develop an understanding of the relationship of events and circumstances that trigger and maintain the behaviour.
4. **Comprehensive positive behaviour support plan** (see 5.2.1)
5. **Training and implementation support** - this usually targets informal supports and direct support workers and may also include reports and liaison with other stakeholders, reports for the psychiatrist; reports to restrictive practice authorisation mechanisms.
6. **Monitoring** - data collection, analysis and reporting.
7. **Review** - ongoing review of effectiveness of the BSP; revisit functional behaviour assessment at least annually.

The plan developer includes the appropriate capacity building support in the participant's plan for the provision of these supports.

5.2.1 Behaviour Support Plan (BSP)

A BSP specifies a range of evidence-based, person-centred and proactive strategies which focus on the individual needs of the person. It is developed with the aim of addressing the underlying functions of BoC taking place or increasing. The plan will outline specifically designed positive behaviour support strategies for the participant, their informal and funded supports to assist in reducing BoC and supporting their quality of life and goal attainment.

A registered specialist behaviour support practitioner must develop all functional behaviour assessments and BSPs, as positive behaviour support practice requires a specific skillset and appropriate safeguards. The Positive Behaviour Capability Framework (external) provides information about knowledge and skills required by the specialist behaviour support practitioners. The framework allows self-assessment to determine their suitability to provide the behaviour support practitioner requires.

Behaviour support practitioners must lodge BSPs containing restrictive practices with the NDIS Commission.

If the BSP does not include restrictive practices, it does not need to be lodged with the NDIS Commission. However, the practitioner developing the BSP must still be registered as a specialist behaviour support practitioner as noted above.

5.2.2 Assessment, development and review

A functional behaviour assessment must be completed when practitioners are developing a BSP. The practitioners will consult with the participant, their family, guardian, service providers and others who will be implementing the plan. By doing this the practitioners are able to gather historic and current information about behaviours displayed to identify settings, triggers, actions and results.

The BSP is designed to address the factors identified in the assessment. It will include a range of strategies used to support the person, including proactive skill development to build on the participant's strengths and response strategies to use when the behaviour presents.

Behaviour support plans are formally reviewed annually or earlier if the participant's circumstances change. At review, the effectiveness of all aspects of the plan including the preventative/environment, skill building/teaching and reinforcement strategies are measured along with step-down strategies. Importantly the progress towards the person's goals and identified quality of life measures is considered.

Plan developers can use assessment information to consider effectiveness and outcomes of funded supports and determine the level and type of capacity building support for inclusion in the NDIS plan.

Refer to the Compendium of Resources for Positive Behaviour Support (external) for further information about the range of positive support assessment tools that can be used by practitioners for assessment, planning, implementation, monitoring and review.

5.2.3 Younger People in Residential Aged Care (YPIRAC)

Residential aged care providers have the same responsibilities towards NDIS participants as they do to other residents who receive services and supports under the *Aged Care Act 1997*. Currently, services are regulated by the Aged Care Quality and Safety Commission.

From 1 December 2020 all providers applying the use of restrictive practices with young people in residential aged care will be regulated by the NDIS Quality and Safeguards Commission.

Refer to Our Guidelines - Younger People in Residential Aged Care for further information.

5.3 Restrictive practices

A restrictive practice is any practice or intervention which has the effect of restricting the rights or freedom of movement of a person with a disability. All states and territories endorsed the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Services Sector which was reaffirmed in the NDIS Quality and Safeguarding Framework.

If supports will include the use of restrictive practices the plan developer must make a referral for advice to the TAB. The referral must take place prior to including or excluding the supports in the participant's NDIS plan. Refer to the mandatory advice section of the TAB Requesting Advice intranets page for more information.

Restrictive practices must be authorised through a formal process which is the responsibility of each state or territory and varies across jurisdictions. Restrictive practices can be considered only if they are the least restrictive alternative, and in the context of positive behaviour support strategies.

When a person is exhibiting BoC, those around them may try to stop or modify their behaviours in a number of ways with the intention of keeping them or others safe. They may intervene physically, try to control where they go, what they do or administer mood-altering medications.

The use of restrictive practices are a risk to the human rights of people with disability and there is a need to ensure there is appropriate reporting and scrutiny when used. The NDIS Commission has identified five forms of regulated restrictive practice:

1. **Seclusion:** The sole confinement of a person with disability in a room or a physical space where voluntary exit is prevented, not facilitated or it is implied that exit is not allowed. This may include when a person is put in a room or placed on their own and the person cannot leave when they want to as the door has been locked.
2. **Chemical restraint:** The use of medication or chemical substance for the primary purpose of influencing a person's behaviour. The medication or chemical substance provided is not treating a diagnosed illness or condition and is intended to make them calm or sleepy. This is often psychotropic medication, which affects mood and is generally prescribed by a psychiatrist.
3. **Mechanical restraint:** The use of a device to prevent, restrict or subdue a person's movement for the primary purpose of influencing a person's behaviour. This includes but is not limited to putting gloves on a person that they cannot remove independently so they are unable to scratch themselves or others, or restraining someone in a wheelchair using a harness that they are unable to undo independently for the purpose of keeping them in the wheelchair.

   Note: This does not include the use of devices for therapeutic or non-behavioural purposes.
4. **Physical restraint:** The use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury.
5. **Environmental restraint:** Restricting a person's free access to all parts of their environment including items or activities such as locking cupboards, fridges or the use of an enclosed bed.

Note: All supports that include the use of a regulated restrictive practice must be referred to the TAB for advice. Refer to the mandatory advice section of the TAB Requesting Advice intranet page.

5.3.1 Children and Restrictive Practice

For children, restrictive practices will need to be considered on a case-by-case basis, taking into account their developmental age and cultural context and information detailed in the

National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018,

Child-safe practices age, such as the use of a car seat restraint for a child under seven would be considered age appropriate. However, the use of a car seat restraint for a 12-year old child to stop them from kicking others in the car may be considered a restrictive practice. Similarly, using child gates to prevent a toddler or child from falling down the stairs would not be a restrictive practice, however using a child gate to prevent a young person accessing the kitchen at all times would be considered a restrictive practice.

It is mandatory to seek advice for the use of assistive technology related to behaviours of concern or regulated practice eg stroller or prams for children older than 7 years, restrains, harnesses excluding standard mandatory vehicle restraints/seat belts

Refer to the mandatory referral advice section of the to the TAB Requesting Advice intranet page.

5.4 Restrictive practice guidelines

The NDIS Commission is taking the lead role in reducing and eliminating the use of restrictive practices and holds responsibility for monitoring the use of all restrictive practices recommended and implemented by NDIS providers in Australia. The NDIA is not responsible for making decisions about the use of restrictive practices.

Under the NDIS (Restrictive Practices and Behaviour Support) Rules 2018, restrictive practices are subject to regulation. Restrictive practices can only be used based on an assessment of behaviour with the appropriate authorisation from the relevant state or territory and where it is part of a BSP that has been developed by a registered behaviour support specialist.

The registered behaviour support practitioner is responsible for:

- undertaking a functional behaviour assessment
- developing a BSP for the participant
- submitting written applications seeking authorisation to restrictive practice authorising panels or bodies
- submitting regular progress reports, data summaries, and other documents to restrictive practice authorising panels or bodies
- attending restrictive practice panel meetings or other contact with the authorising body.

5.4.1 Participant with immediate needs

Where there is no current interim or comprehensive BSP in place and the participant has an immediate need for a restrictive practice due to a new or previously unexperienced degree of severity in the escalation of behaviour, the NDIS Commission outlines that:

- an interim BSP must be completed within a month of engagement by the behaviour support practitioner, and
- a comprehensive BSP must be developed within six months of the interim plan being completed by the behaviour support practitioner.

The use of regulated restrictive practice that has not been authorised in accordance with any state or territory legislation or policy requirements represents a reportable incident that must be reported to the NDIS Commission. The provider must notify the NDIS Commission within five business days of becoming aware of the use of the restricted practice.

NDIS Staff and Partners in the Community should report any suspected use of unauthorised restrictive practice to the Participant Critical Incident Team.

Advice can by sought via the Participant Critical Incident Team or the TAB if clarification is needed about whether an event/practice represents the unauthorised use of restrictive practice, or the use of prohibited practice.

5.4.2 Implementing providers

The NDIS Commission refers to service providers who use a regulated restrictive practice as implementing providers. Implementing providers are expected to understand the context of the person's behaviour and follow the authorised BSP to make sure the use of any restrictive practice is a last resort intervention and in proportion to the risks posed by the behaviours.

The implementing provider is responsible for:

- being registered with the NDIS Commission for the type of support they are providing
- report regularly as per agreed schedule to the NDIS Commission
- ensure staff are appropriately trained to implement positive behaviour strategies or use restrictive practices
- notifying the NDIS Commission in the event of any unplanned or unapproved use of a restrictive practice as per the NDIS Commission reportable incident process.

Implementing provider reporting will include any use of unrestrictive practices and other reportable incidents, monitoring, and collected data as outlined in the BSP. This forms part of the ongoing focus on reducing or eliminating restrictive practices and addressing BoC.

Service providers must aim to reduce the use of restrictive practices by working with the participant and their supports to obtain a greater understanding of the function of the behaviour as well as triggers, and provide preventative strategies and techniques to develop more appropriate ways to support the participant. The behaviour support practitioner will support the implementing provider where required to understand the relevant state or territory legislative and policy requirements.

5.5 Point of crisis

A point of crisis is a period of intense difficulty and distress experienced by a participant that disrupts and makes their usual day-to-day life hard to cope with. Participants may experience points of crisis for various reasons, such as escalation of mental health issues or the unexpected loss of formal and/or informal supports. Emergency support may also be provided by other government services such as child protection, homelessness services, hospitals, ambulance, police and mental health assessment teams.

A crisis may often result in the escalation of BoC and may temporarily require more intensive support. While the NDIS is not responsible for the delivery of emergency support, when the participant or their informal support contacts the NDIS during times of crisis, we need to be responsive to their concerns.

This may involve supporting the participant to access other government services as required, and explaining how the funding in their plan can be used flexibly to meet their needs during a crisis. The participant may have interacted with the After Hours Crisis service as part of the Exceptionally Complex Support Needs Program.

In some instances, reconsideration of the participant's streaming may be required to ensure they are appropriately supported through this period. Refer to section 6.1 for further information.

You will need to ensure the support coordinator (if relevant) is aware of the situation and is responding to and supporting the participant in a timely and effective manner. The role of the support coordinator and the level of support coordination may need to be considered. For example, a specialist support coordinator to manage multiple mainstream interfaces, organise and prepare reports may be required.

In some cases, the behaviour support practitioner may be able to identify the circumstances that could lead to periods of crisis for the participant. In these cases, the BSP and other supports should be proactively designed to respond to these situations. This may impact on the way the supports are funded in the NDIS Plan.

Where additional supports beyond the flexibility of the existing plan is required, it may be appropriate to consider whether an unscheduled plan review is required. Refer to Practice Guide – Unscheduled Plan Reviews.

Interactions detailing the crisis circumstances and actions taken must be recorded in the NDIS Business System (System) and an alert added if required.

5.6 Incident management

5.6.1 Registered providers

Registered service providers must have effective incident management systems and are responsible for recording and managing all incidents that happen in the delivery of NDIS supports and services. They are also responsible for notifying the NDIS Commission of any reportable incidents (including allegations) that occur with the provision of supports and services to an NDIS participant. Reportable incidents include:

- serious injury or death of an NDIS participant
- abuse or neglect of an NDIS participant
- unlawful sexual or physical contact with, or assault of an NDIS participant
- sexual misconduct committed against, or in the presence of, an NDIS participant, including the grooming of the NDIS participant for sexual activity
- the unauthorised use of restrictive practice.

Refer to the NDIS Commission's Reportable Incidents (external) for further information.

5.6.2 Unregistered providers

Unregistered providers must follow their internal provider reporting channels. All providers (registered and unregistered) who are providing NDIS funded supports must follow the NDIS Code of Conduct (external).

5.6.3 National Disability Insurance Agency (NDIA)

NDIA staff and Partners in the Community may be advised or learn of allegations of serious harm occurring to a participant from a participant, their carer, nominee or other relevant party. This is known as a participant critical incident. If information is provided to you which suggests or alleges a participant critical incident has occurred, refer to the Participant Critical Incident Framework. You must notify the Participant Critical Incidents team where appropriate, refer to Participant Critical Incidents page.

As noted above, any unauthorised use of restrictive practice is a participant critical incident. This incident may be a reason for a section 48 plan review. The participant or their authorised representative can request a review, or the NDIA may choose to initiate based on the information provided around the critical incident. Participant critical incidents highlight that the participant's supports may require adjustment or further changes are needed. It is the responsibility of the NDIS to make sure that a participant has appropriate funding for their support needs, including behaviour support.

6. Pre-planning

6.1 Streaming

Plan developers need to ensure the correct streaming decision has been recorded in the System for the participant to receive the appropriate level of support to implement their plan. Factors to change the streaming decision are dependent on the complexities presenting in the participants current life situation or environment which may be identified during your conversation.

Where a participant has complex support needs requiring a different approach, a referral to the Complex Support Needs Pathway may be appropriate.

Refer to Standard Operating Procedure – Update Participant Streaming and Standard Operating Procedure – Referral for Complex Support Needs for further information.

Note: The term streaming is for internal use only.

6.2 Plan duration

The plan duration ready reckoner guide recommends plans are developed for up to 12 months when a participant is requiring behaviour support and/or is streamed as Super Intensive. However, the participant's individual circumstances should be considered and a shorter plan duration may be required if, for example, the BSP is being assessed, accommodation needs/options are being assessed or close monitoring is required. Where the participant's situation is stable a longer plan duration may be also be appropriate. Refer to Standard Operating Procedure – Complete the Risk Assessment and Practice Guide - Pre-Planning for further information.

6.3 Arranging the planning meeting

Contact the participant and/or their authorised representatives (nominee/s, child representatives, and court or tribunal appointed decision makers) through their chosen method of communication and confirm/obtain consent for information sharing and exchange. A participant or their authorised representative may choose to invite other family members, friends or NDIS funded support providers to the NDIS planning meeting.

You should confirm all meeting attendees to allow for appropriate consideration of location, meeting room, time allocated and whether additional or senior staff are required to attend.

In limited circumstances, it may be necessary to appoint a plan nominee to act on behalf of, or make decisions on behalf of a participant. Refer to the Standard Operating Procedure – Appoint a Nominee.

Where possible and appropriate, the participant should be in attendance during the planning conversation. The participant's wellbeing is the priority and discretion is required at times to determine whether it is suitable for their attendance, such as if there is significant unrest and or concerns about safety due to events such as accommodation or relationship breakdown as a result of significantly challenging behaviours.

In these instances, efforts should be made to include the participant, and consider a shorter meeting to confirm key details or having them contribute in another way such as completing the relevant NDIS booklet prior to the meeting.

When confirming a meeting location and time, you should check the System for alerts and confirm the following with the participant or their authorised representative:

- Consider the participant's routine. For example, if the participant has difficulty sleeping at night they may not function well in the mornings and prefer an afternoon meeting.

- If known, consider the sensory needs of the participant and confirm an appropriate location. For example, if BoC are triggered by sensory overload, suggest a quiet office to conduct the meeting.
- Understand any specific environmental factors that may present a risk to the participant or to other members of the meeting including the NDIS staff member.
- Understand and respect any cultural sensitivities or barriers to communicate effectively for example, they may prefer to meet with someone of the same gender.
- Explore options to book a meeting for an extended period of time to allow breaks, or hold the planning meeting over multiple sessions or arrange for the participant to attend for shorter periods.
- Be aware of any behaviour response strategies that may need to be implemented during the meeting and what the role of the NDIS staff member will be, noting the service providers and informal supports who know the person well should lead the response directly with the person to de-escalate the situation or conclude the meeting.

6.3.1 Gathering documentation

Arranging the planning meeting provides an opportunity to follow-up on relevant supporting documentation that has not been provided yet. The participant, authorised representative or their support coordinator may provide this information to the NDIA. In some circumstances, the NDIA may need to follow-up directly once appropriate consent has been obtained. Behaviour support documentation may include:

- the most recent BSP
- behaviour protocols or strategies (where not collated in an interim or comprehensive plan as per the NDIS Commission)
- behaviour support recommendations report outlining next steps in behaviour support and estimated hours required
- incident reports, preferably incident summary reports
- data summary reports
- Restrictive Practice Authorisation documentation (if relevant)
- support model assessment reports including identifying housing options
- other assessment reports and support plans, such as speech pathologist, occupational therapist, psychologist, psychiatrist, paediatrician or other medical practitioner
- other relevant reports from service providers or mainstream agencies such as court reports.

All new or updated legal/court orders and other documents provided to the NDIS must be uploaded to inbound documents in the System.

6.3.2 External meetings

If a meeting is taking place at a location external to an NDIS office, follow the usual appointment booking process and ensure the following:

- complete and attach a copy of the home visit risk screen document and journey plan to the participant's record in the System
- review other information available in the System including, but not limited to previously completed planner risk assessment, guided planning questions, planning conversation tool and inbound documents. This information will help you identify any likely risks or concerns, such as other people being in the premises and the general safety of surrounds.
- discuss any identified risks and take any appropriate action as determined with your team leader
- familiarise yourself with the journey management procedure and out of office best practice guide.

NDIA staff are supported to make decisions at all times to protect their personal safety. These decisions may include:

- deciding that a visit requires a second employee to be present
- arriving at a location and deciding to cancel a visit due to safety concerns
- terminating a visit part way through due to safety concerns.

Refer to the Work Health and Safety page for further information.

For circumstances where the health, safety and/or security of NDIA staff or others is put at risk due to the behaviour of a participant or other third party, NDIA staff should refer to the Work Health and Safety page and NDIA Managing Unreasonable Behaviour Framework, Policy and Guideline for information, advice, reporting and escalation protocols.

6.4 Planning conversation

The participant is at the centre of the planning process and their goals and needs are explored by discussing their strengths and what they would like to achieve. The planning conversation should identify goals, capacity, risks and safeguards and provide an opportunity to discuss any assessments and reports.

Information provided in the planning meeting about the participant's BoC must be detailed in the guided planning questions free text box and in the planning conversation tool.

The following points can support you to have a high quality conversation:

- Be mindful of the person's communication needs and preferences including whether an interpreter is required.
- Make decisions about what will be appropriate to ask the person directly and what may be triggering or distressing that can be gathered in another way.

- Read previous planning information (if applicable), interactions and inbound documents.
- Review the support coordination progress reports. These should detail information including the participant's circumstances, identified risks, strategies and outcomes for the participant's goal progression.
- Review the behaviour specialist reports and any other assessments that identify outcomes achieved, key barriers and recommendations for the new plan.
- If there are known restrictive practices in use, ask if the BSP has been lodged with NDIS Commission and the relevant state or territory has authorised the use.
- Follow up any requested reports and/or assessments not yet provided, to assist informing the planning process.
- Use visual tools to assist in communicating. For example, if asking a participant about their schedule, use the weekly supports table in the NDIS planning booklet (external) to help break down the questions, or other format as determined appropriate to their communication needs.
- Encourage the participant to talk about/communicate their interests, what daily life is like, what challenges they face and allow time as needed for them to explain this to you.
- Discuss the previous plan (if applicable), what they found worked well and what did not. For example, they may have strong informal supports or may be at risk of losing their housing or in temporary accommodation placing them at risk of homelessness.
- Be conscious to not ask leading questions as people are likely to give the answer they think you want to hear.
- If the participant is appearing anxious or not engaging, consider asking them what would make them feel more comfortable such as having a break.
- Depending on the participant's situation, there may be multiple stakeholders with differing input present in the planning process. In these circumstances, make sure the participant and their authorised representative are the focus of your attention. Make sure they understand that they can request other people leave the room at any time.
- In some circumstances, due to the complexity of the participant's BoC further discussion may need to take place with the participant's informal supports and positive BSP practitioner to discuss current and proposed support needs, or there may need to be a second meeting.
- Where appropriate, seek consent to follow-up with specific individuals or providers. Refer to the Standard Operating Procedure – Consent and Authority for further information.

7. Planning

The Agency must be satisfied that the funded supports in the participant's NDIS plan meet each of the criteria outlined in section 34(1)(a)-(f) of the National Disability Insurance Scheme Act 2013 (NDIS Act) and the NDIS (Supports for Participants Rules) 2013.

When planning for the participant with BoC, it is important to be aware of any recent or upcoming changes in their life. Behaviours of concern may take place more frequently or at a greater severity during transitional periods for example during adolescence, leaving school or changes in living arrangements.

It is important to also be mindful that effective positive behaviour support:

- is not a linear process. For example, the practitioner may be conducting an assessment while revising the plan and training
- is highly individualised
- is holistic and integrated
- utilises a systems approach
- includes crisis response and BSP revision as required
- includes multi-disciplinary input in all elements including assessment, design, implementation and review
- varies in intensity and time required depending on the complexity of the person's situation and support needs
- cannot always be delivered in monthly amounts across the year. For example, there may be a high utilisation initially for providers to complete the initial assessment, interim planning, comprehensive assessment and comprehensive BSP development.

Refer to Practice Guide - Determine Reasonable and Necessary Supports for further information.

7.1 Core supports

Core supports are intended to assist with or supervise personal tasks of daily life to enable the participant to live as independently as possible. The BSP is expected to be used by all formal supports to build on the participant's strengths, increase their opportunities to participate in community activities and increase their life skills.

Where possible, the funds can be used to strengthen the capability and capacity of the participant and their informal supports (if applicable) by reinforcing strategies and encouraging independence towards goal attainment.

Providers may request higher support costs for participants with complex BoC. Consider the participant's individual circumstances and needs using the information available to understand the purpose of the support. For example in some circumstances, the proposal

may be considered a restrictive practice or it may be required as the participant has health or physical support needs.

If a regulated restrictive practice is used, review the participant's BSP which will record whether the relevant state or territory body has authorised the use.

The delegate may need to consider that the sudden removal of funded Core supports for participants with high level staff ratios and/or restrictive practices may put the participant's living arrangement, their staff, or others at risk.

It is therefore important to consider a transitional or gradual step down model to effectively reduce supports in line with the BSP. This is likely to take place over the course of multiple NDIS plans and should be guided by the registered specialist behaviour support practitioner. A mandatory referral to the TAB is required for all NDIS funded supports that may result in the use of regulated restrictive practices.

If the participant requires a higher intensity level of support, refer to the Standard Operating Procedure – Determine Self-Care and Community Access Supports for further information.

7.1.1 Behaviours support provision in supported independent living (SIL)

Behaviour supports need to take a whole of house approach when a participant is living in a supported independent living (SIL) arrangement with other people with disabilities. Behaviour support may be recommended where there are frequent incidents such as assaults, self-harm, property damage or high-level staffing ratios to manage risk to staff and residents. There may also be use the use of restrictive practices which are not targeted towards all the residents such as a locked fridge or the removal of people to a safe area during an incident.

Behaviour supports for a whole of house approach may include:

- shared living environmental assessment, also known as ecological assessment
- behaviour support systems review
- program development
- staff training.

Some of these supports may be shared in a whole of house approach, for example, there would be one shared living environmental assessment completed by the one provider to assess the overall household situation. The cost of the environment assessment would then be broken down and shared amongst all those living in home. Refer to the Operational Guideline – Supported Independent Living (SIL).

7.2 Capacity Building supports

Before including funding for behaviour supports, consider the Capacity Building funding generated by the TSP and whether these funds are sufficient to provide some or all of the required behaviour support. To do this you will need to understand what other Capacity Building supports are required by the participant and work out whether the total Capacity

Building funding needs to be increased to support the participant with their BoC. For instance, a child or younger person may require a higher level of funding so their informal supports are appropriately trained to implement the BSP.

There is a guided planning question related to BoC which must have the correct responses recorded. Responses to this question are for data capturing only and do not generate any funding in the TSP. The TSP is a guide and decisions on reasonable and necessary supports should be made in accordance with s34 of the NDIS Act.

7.2.1 CB Daily Activity

Best practice in behaviour support involves a multidisciplinary approach tailored to the needs of the person. It is therefore important to ensure the relevant therapeutic assessments and services are included in CB Daily Activity area of the plan. NDIS reasonable and necessary improved daily living supports may include:

- assessments including psychological, communication and sensory
- individual skills development and training
- training for carers or parents.

As noted previously, a functional behaviour assessment can only be completed by a registered specialist behaviour support practitioner or provider.

Where an ecological assessment is required, a total of 10 hours per household should be funded. Where multiple participants in the same household require a BSP, if appropriate their plans should be developed at the same time and the hours divided amongst plans.

7.2.2 CB Relationships

Behaviour supports within the category of CB Relationships may include:

- specialist behavioural intervention support for assessment and development of BSP
- behaviour management plan and training in behaviour management strategies
- individual social skills development.

Dependent on the participant's circumstances, NDIS funded support workers may require individualised training specific to the participant to maintain consistency and positive behaviour supports. Practitioners may provide training plans for the support worker or therapy assistant in the development of social skills identified as required due to BoC.

When determining reasonable and necessary funding, the specialist behaviour support practitioner would be expected to monitor the BSP implementation and review accordingly. Regular review allows opportunity for changes and updates to the BSP if the progress differs from expectations.

Questions which may help in determining the amount of funding include:

- Which stage of behaviour support currently applies? Are they at the brief assessment and safety planning stage (Refer to 6.2) or are they stable and in the monitoring

stage? This indicates how many hours are still required for assessments and reporting.

- Does the participant already have a current comprehensive behaviour assessment?
  - If so, the next assessment will usually require less time.
- Does the participant already have a current comprehensive BSP?
  - If so, the next BSP update will usually require less time.
- How many BoC does the person engage in? Usually the more behaviours, the more time required for all stages of the behaviour support process.
- What is the intensity and severity of the behaviour/s of concern? More intense and high-risk behaviour is likely to require more time in assessment, design, protocol revision and implementation support.
- How many informal and formal support providers are involved? This will impact on the amount of observations, interviews, file review required; the amount of tailored strategies required for various environments and roles; and the amount of training and implementation support required.
- How many regulated restrictive practices are proposed or in place? The more practices, the more time required for assessment, design, implementation, and reporting.
- How many informal or funded supports require training and implementation support? Can this be done in one session or do multiple repeat sessions need to be factored in?
- What other reporting requirements does the specialist behaviour support practitioner have? This may include data summaries and consultation with a psychiatrist to inform medication review.
- How will the multidisciplinary team collaborate? How often will they need to meet or have other contact?
- How many other stakeholders does the specialist behaviour support practitioner need to engage with?
- How much direct contact will the specialist behaviour support practitioner have with the person for skill development? Is this sessional, what is the frequency?
- What other pieces of work are required? Are there specific assessments that can inform the behaviour assessment behaviour assessment report (such as Assessment of Sexual Knowledge); Support Model Assessment report; transition plan development and implementation (such as from one placement to another).
- Where there are regulated restrictive practices required, you should also include funding for the specialist behaviour support practitioner to meet their obligations under

the NDIS Commission specific to this participant and the state or territory authorisation process.

7.2.3 Behaviour intervention support levels

You will need to make sure the participant receives the appropriate support required to implement their plan and to address any behavioural complexities in their current life situation.

There are two levels of behaviour intervention support provided as a guide however the participant's individual circumstances and supporting information must be considered in every plan to determine appropriate funding and supports required.

The levels of support include a behaviour management plan and training in the management of strategies to form a package of support to address a participant's immediate need for behavioural intervention. You will need to make a reasonable and necessary decision to determine the appropriate level of support included in the participant's plan.

The guidance in hours has been suggested for a plan of 12 months in duration. Use your reasonable and necessary decision making for plans with durations less or more than 12 months. If a participant has significant behaviours of concern it is highly unlikely that there will be a plan over 12 months due to the need to monitor and review outcomes and circumstances.

Consult with your team leader and refer to the participant's individual supporting documents, Practice Guide - Determine Reasonable and Necessary Supports and the Standard Operating Procedure – Behaviour Intervention Supports for further guidance.

7.2.3.1 Level 1

Level 1 funding could be considered appropriate for participants who require intervention due to significant behavioural complexities that are impacting on the ability of the participants informal supports to sustain care at home and assist the participant to safely engage in activities.

Level 1 criteria includes:

- behaviours of concern that could require single or minimum interventions
- lack of services willing to engage with the participant due to presenting behaviours and risk to staff/participants/community
- change of participant circumstances that will result in withdrawal of service support and need for immediate intervention.

Use reasonable and necessary decision making to fund the following supports:

- **Specialist behavioural intervention support** - Most level 1 plans should not exceed 45 hours (approx. 3-4 hours per month) which will enable the participant to receive support from a psychologist or appropriate therapist to develop a BSP, implement strategies and review interventions over a period of time.

- **Training in behaviour management strategies** - To support carers and any other significant informal supports in the participant's life to implement the behavioural support plan and behavioural strategies, include training in behaviour management. Most level 1 plans should not exceed 20 hours (1-2 hours per month) which will ensure the behavioural intervention support plan is applied consistently in all necessary environments to best support the participant.

7.2.3.2 Level 2

Level 2 funding could be considered appropriate for participants that require immediate intensive behavioural intervention support and are streamed Super Intensive or Complex. In the majority of circumstances, level 2 funding is not appropriate for children aged seven and under.

Level 2 criteria includes:

- multiple complexities that may require multiple interventions
- extreme behaviours of concern where there is the use of regulated restrictive practice
- lack of services willing to engage with the participant due to presenting behaviours and risk to staff/participants/community
- significant change of participant circumstances that will result in withdrawal of service support and need for immediate intervention
- behaviours of concern involving various stakeholders (multiple issues for intensive intervention requiring comprehensive assessment, planning, support and training for the participant and carers)
- participants who may have significant 1:1 support in the community, 1:2 support in the community (greater than 30% of the day) or exceptional circumstance supports at home due to their harmful or persisting behaviours that may present risk to themselves or others
- participants who require additional support to implement newly developed strategies in the community or within newly engaged activities/services
- participants who are anticipated to experience a significant transition during the plan period such as moving into SIL or from school to day program.

This package of support would be considered in the following circumstances:

- when a participant has extreme behaviours that could require restrictive intervention
- where there is significant change of circumstances that will result in a withdrawal of service support
- where there is significant risk to support staff, other participants or the community.

Use reasonable and necessary decision making to fund the following supports:

- **Specialist behavioural intervention support** – Most level 2 plans should not exceed 90 hours (7-8 hours per month) for specialist behavioural intervention support which will support participants with significantly harmful or persistent behaviours of concern.
- **Training in behaviour management strategies** – To support carers and other significant informal supports in the participant's life to apply the developed BSP and behavioural strategies, include training in behaviour management. Most level 2 plans should not exceed 30 hours (2-3 hours per month) which will ensure the behavioural support plan is applied consistently in all necessary environments to best support the participant.
- **Individual social skills development** – For participants that require additional support to implement newly developed strategies in the community or within newly engaged activities/services, include individual social skill development. Most level 2 plans should not exceed 40 hours (3-4 hours per month) which will complement recommendations in the BSP.

7.2.4 Support coordination

Support coordination is intended to strengthen the participant and/or their authorised representative's abilities to coordinate and implement supports in the plans to participate more fully in the community, and to build and maintain a resilient network of formal and informal supports. This includes addressing barriers to implementation and regular monitoring. A participant who displays BoC may require support coordination or specialist support coordination to assist where required.

You will need to consider the level of support the participant and/or their authorised representative will require to build their capacity to connect with supports and services, ensure they understand their NDIS plan and how to implement their funded supports, and strengthen their ability to self-direct services and achieve their goals.

It is also part of the support coordinator's role to build capacity of the participant and/or authorised representatives to gather supporting documents including assessments and reports and ensure these are provided to the NDIS.

Where the participant experiences a crisis, the support coordinator will assist them as required, to manage and link into appropriate supports. This information should form part of their next progress report to the NDIS where any known causes of the crisis, how it was managed, the outcome and proposed strategies to reduce the likelihood of a reoccurrence are detailed.

The reporting and monitoring requirements must be discussed at the plan handover and clearly outlined in the Request for Service. Refer to Standard Operating Procedure – Include Support Coordination in a Plan.

7.3 Plan comments

Make sure your plan comments recorded in Determine Funded Supports task include a description of the behaviour supports included within each budget.

Example (Core) – only relevant where there is a regulated restrictive practice in the participant's BSP: I can use my core support funding flexibly to help with my daily activities. Assistance with self-care activities and accessing the community to be provided by a registered implementing provider.

Example (Capacity Building): Funding for XX hours of specialist behaviour intervention support, XX hours of behaviour management plan and training in behaviour management strategies. A report detailing outcomes achieved is to be provided to the NDIA by the registered specialist behaviour support practitioner before this plan is due for review.

7.4 Plan management

It is important to understand the distinction between choice and control in regards to plan management and the legislative requirements to use a registered provider.

The NDIS supports the participant to maximise their choice and control where there is not unreasonable risk or other factors impacting the participant's and/or their authorised representative's ability to manage NDIS funding.

The NDIS (Provider Registration and Practice Standards) Rules 2018 (Part 2, section 7) specifies that to maintain safeguards and minimise risk to the participant, NDIS providers must be registered for:

- functional behaviour assessments
- developing BSPs, and
- regulated restrictive practices.

Behaviour support practitioners (whether a sole provider or employed by a provider) must be registered with the NDIS to provide specialist behaviour support (registration group 110).

The NDIS recommends that CB Relationships is Agency managed to ensure the use of NDIS registered providers, however participants and/or their authorised representatives may choose to have their supports plan or self-managed. It is important for participants and/or their authorised representatives to understand the distinction between choice and control in regards to plan management and the legislative requirements to use a registered provider for specific behaviour supports (functional behaviour assessments, BSPs, and regulated restrictive practices).

NDIS legislation is based on the presumed capacity to self-manage. Therefore, a request by the participant to manage their funding should be considered positively by the delegate unless there is evidence of a significant risk to the participant.

The NDIS supports the participant to maximise their choice and control where there is not unreasonable risk or other factors impacting the participant's and/or their authorised representative's ability to manage NDIS funding. The determination of unreasonable risk is assessed with every plan review, having regard to the participant's individual circumstances and considerations.

7.4.1 Restrictive practice

Where the BSP includes regulated restrictive practice, the participant and/or their authorised representatives, should be aware that the implementing service provider for the behaviour support **must** also be registered with the NDIS Quality and Safeguards Commission.

Where supports are self or plan –managed, a thorough conversation with the details recorded in the appropriate pre-planning tasks and clear NDIS plan comment (see 7.3) should follow. This is to make sure that the participant and/or their authorised representatives understand while the funding management allows for the use of unregistered service providers, there is a legislative requirement that registered providers **must** be used for BSPs and regulated restrictive practices.

Refer to Planning Operational Guideline – Managing the funding for supports under a participant's plan (the plan management decision) for further information.

8. Plan implementation and monitoring

There should be ongoing monitoring during the plan period to measure whether the participant is meeting their desired outcomes and goals. This can take place through a variety of means including support coordination reports, regular updates and Panda Live data.

You should check the plan utilisation to make sure the plan is being implemented as expected and provide opportunity for earlier follow-up if there appears to be an over or under utilisation. Due to the nature of this support, there is likely to periods of intensive support and high budget utilisation, therefore the utilisation should be considered over time.

Refer to PANDA, Practice Guide – Plan Implementation and Practice Guide – Monitoring for further information.

9. Scheduled plan reviews

Make sure you have received the progress report from the support coordinator or specialist support coordinator and reviewed it to understand key issues and outcomes from the plan period.

It is expected the NDIA will be provided with supporting information demonstrating outcomes, barriers and where appropriate, recommendations for the next NDIS plan. For example, where there has been successful implementation of capacity building supports, it may lead to a reduction of supports based on the behaviour support practitioner recommendations. Fade-

out or step down approaches will be clearly documented based on supporting information. These approaches form a key part of reasonable and necessary decision making when a participant's BSP includes restrictive practices.

For further information, refer to Practice Guidance - Scheduled Plan Reviews and Standard Operating Procedure – Complete a Plan Review (full).

10. Case examples

10.1 Example 1 - Kim

Kim is a 20-year-old woman and lives at home with her parents and two younger siblings. She has a primary disability of autism spectrum disorder and a secondary disability of mild intellectual disability.

10.1.1 Planning meeting

At Kim's planning meeting, her parents discuss how they are struggling to maintain support and are concerned about the impact Kim's behaviours of concern are having on her and her younger siblings. When asked further about her behaviours, they explain that Kim bites and hits out at people around her at home and at her day program. When upset, she will also hit her head against walls and run away from those she is with.

Kim enjoyed attending a specialist school and after completing year 12, she started at a day program. The identified behaviours escalated when she left school. Kim has not settled at the day program. She is reluctant to leave home to attend and while at the day program, Kim displays increased levels of BoC.

Kim's parents and the day program provider have tried several different strategies to support her, however the BoC have not reduced. She has not been provided with any behaviour support previously.

10.1.2 Outcome

Kim is considered to meet the criteria for level one behaviour intervention support for the following reasons:

- Kim has informal supports who are engaged and available.
- Kim is still attending a regular day program and the provider is willing to work with her and her family to implement the BSP.
- the BoC have not been longstanding having escalated only since Kim left school.

Kim's 12-month plan provides funding for the following reasonable and necessary supports:

- Social community and civic participation for continued day program attendance allowing for higher-intensity supports while Kim is connected with a specialist behaviour support practitioner. The NDIS is awaiting further recommendations in the

report by the specialist behaviour support practitioner for the associated training hours required in the BSP.

- Functional capacity assessment (10 hours).
- Specialist behavioural intervention support for functional behaviour assessment, development of a BSP, implementation, monitoring and review of behavioural support interventions in her home and day program (45 hours).
- Behavioural management plan including training in behaviour management strategies to provide training to informal/formal supports to understand and implement Kim's BSP consistently in all environments (20 hours).
- Coordination of Supports (72 hours).

10.2 Example 2 – Joe

In the following two case examples, Joe and Hassan, two NDIS participants are living in a SIL arrangement and sharing supports. At the scheduled plan reviews, the SIL provider has provided information detailing an increase in BoC for both Joe and Hassan. After trying a number of different strategies to resolve conflict and reduce the BoC, the provider has requested an increase in both SIL and Capacity Building funding to better support them.

Joe is a 30-year-old man and lives in a SIL arrangement with two others. His primary disability is a moderate intellectual disability. Joe works at an Australian Disability Enterprise (ADE) four days per week. Joe is well supported by his parents and family and spends every Sunday with them. His family use supported decision making to make sure he is active in his life decisions.

10.2.1 Planning meeting

All the participants in the home are undertaking a scheduled plan review. Prior to Joe's NDIS meeting, the completed provider SIL pack and quoting tool along with supporting information including his BSP are provided to the NDIS. Joe's BSP notes his behaviour will escalate quickly if there is any unexpected change or interruption to his routine or life and he generally begins to shout, punch walls and becomes agitated. Some of Joe's triggers include:

- Reminders of the recent death of a close friend.
- When his housemate Hassan is displaying BoC.
- Returning to his home after a family visit on Sundays.
- Varying triggers at his ADE including when there is unexpected change and loud noises, approximately twice per week.

10.2.2 Outcome

Joe is considered to meet the criteria for level one behaviour support for the following reasons:

- Joe has informal supports who are engaged and available.
- Joe works at an ADE four days per week and goes to regular activities in the community on the other weekday. The ADE provider is willing to work with Joe, his family and support workers to implement his BSP.
- The BoC have not been longstanding having escalated since Joe's friend passed away.

Joe's 12-month plan provides funding for the following reasonable and necessary supports:

- Supported independent living included as per SIL pack and quoting tool. The NDIS is awaiting further recommendations in the report by the specialist behaviour support practitioner for the associated training hours required in the BSP.
- Support for his continued employment at the ADE.
- Shared living environmental assessment (ecological assessment) (5 hours).

  Although Joe has been assessed as meeting the criteria for a level 1 behaviour support plan, he lives in a shared environment, and it has been identified that triggers for BoC are occurring within the home. Funding has been added to enable an ecological assessment to be undertaken to better understand contributors from within Joe's living arrangement.
- Specialist behavioural intervention support for functional behaviour assessment, development of a BSP, implementation, monitoring and review of behavioural support interventions in his SIL home, family home and ADE (45 hours).
- Behavioural management plan including training in behaviour management strategies to provide training to informal and formal supports to understand and implement Joe's BSP consistently in all environments (20 hours).
- Coordination of Supports (72 hours).

10.3 Example 3 – Hassan

Hassan is a 45-year-old man and lives in a SIL arrangement with Joe and one other. His primary disability is autism spectrum disorder and his secondary disability is schizophrenia. During the week, he attends a day program for two days where he consistently exhibits BoC. He does not currently have family support, usually seeing his sister on his birthday. Hassan gets distressed by many triggers that substantially increase his anxiety levels and tends to result in him scratching his own skin or hitting or kicking property or anyone who tries to intervene. He is prescribed risperidone to manage these BoC. Staff also administer a muscle

relaxant medication when becomes agitated to help calm Hassan. Some of the known triggers are as follows:

- Exposure to sensory stimulation especially loud noises, music and bright lights.
- When his housemate Joe becomes agitated and yells.
- When his formal supports prompt him with daily activities.

As the direct result of an assault on a house staff member, there is an active Mental Health Community Treatment Order in place that states Hassan must attend and receive treatment weekly.

10.3.1 Planning Meeting

All the participants in the home are undertaking a scheduled plan review. Prior to Hassan's NDIS meeting, the completed provider SIL pack and quoting tool along with supporting information including his BSP are provided to the NDIS. The day program provider is considering withdrawing services due to the risks involved.

Hassan's parents have both passed away. He has a sister who lives interstate and is not involved in his daily life. Hassan has the public guardian in place as his decision maker and the Public/State Trustee manages his finances.

10.3.2 Outcome

Hassan is considered to meet the criteria for level two behaviour support for the following reasons:

- Hassan is experiencing problems maintaining service providers.
- Hassan's only informal support is his sister and he sees her once a year on his birthday.
- He is subject to restrictive practice (chemical restraint) to address BoC.

Hassan's 12-month plan provides funding for the following reasonable and necessary supports:

- Supported independent living included as per SIL pack and quoting tool. The NDIS is awaiting further recommendations in the report by the specialist behaviour support practitioner for the associated training hours required in the BSP.
- Support for his continued attendance at his day program.
- Shared living environmental assessment (ecological assessment) (5 hours).

  It has been identified that Hassan will have his BSP reviewed at the same as Joe. As a result, the 10 hours to develop the ecological assessment has been shared between Joe and Hassan's plan.

- Specialist behavioural intervention support for functional behaviour assessment, development of a BSP, implementation, monitoring and review of behavioural support interventions in his SIL home and day program (90 hours).
- Behavioural management plan including training in behaviour management strategies to provide training to informal/formal supports to understand and implement Hassan's BSP consistently in all environments (30 hours).
- Coordination of Supports (108 hours).

10.4 Example 4 – Daniel

Daniel is a 12-year-old boy. He lives with his mother and younger siblings. He attends his local primary school. His primary disability is autism spectrum disorder and secondary disability is intellectual disability. It has been identified that Daniel has sensory aversion to loud noises and to sensations such as silky or synthetic fabrics. He has difficulty communicating his needs to others, and seems to have difficulties following instructions, leading to frustration and BoC.

10.4.1 Planning Meeting

During the planning meeting, Daniel's mother said he was attending school three days per week. He would like to establish friendships with his peers and increase his social participation however experiences heightened anxiety due to bullying at school including verbal threats, teasing and pushing.

Daniel's mother and school have identified that his BoC are high in intensity. They include self-harm (suicide attempts, absconding) and harm towards others (physical aggression and assault). At home, cutlery needs to be stored safely. Daniel's mother has identified that she has locked away to maintain his safety due to self-harming behaviours. Usually, the cutlery would be in an unlocked drawer, as a child of Daniel's age would generally be expected to safely use cutlery to eat or prepare food. He does not have a behaviour support plan.

His attendance at school, the bullying and identified BoC make it challenging for Daniel to form and maintain relationships and participate in social activities. His mother spoke about finding it increasingly difficult to care for Daniel. The school have funded an additional staff member to increase his attendance at school.

Daniel's mother is requesting Core supports to support her in the home, and support for Daniel while at school and participating in his learning activities and increase his social participation. The planner provides further details of NDIS and education responsibilities, noting that service systems obligations must be met before any funding by the NDIS could be considered to meet the disability support needs that are deemed beyond 'reasonable adjustment'.

10.4.2 Outcome

Daniel is considered to meet the criteria for level two behaviour support for the following reasons:

- Daniel is experiencing issues with school attendance.
- Daniel's only informal support is his mother and she has expressed carer fatigue.
- Daniel's BoC have been identified as high in intensity, particularly given his age.
- Daniel is experiencing challenges with social participation.

Daniel's 12-month plan provides funding for the following reasonable and necessary supports:

- CB Daily Activity as it has been identified that Daniel has sensory difficulties and communication difficulties. Funds within this category will be utilised for an occupational therapist to undertake a sensory assessment and a speech pathologist to undertake a communication assessment and collaborate with the behaviour support practitioner to enable strategies to address these needs to be included within the Positive BSP.
- Specialist behavioural intervention support for a functional behaviour assessment, development of a BSP, implementation, monitoring and review of behavioural support interventions in all environments (home, education setting, any other identified setting) (84 hours).
- Behavioural management plan including training in behaviour management strategies to provide training to informal and formal supports to understand and implement Daniel's BSP consistently in all environments (30 hours).
- Coordination of Supports (60 hours)

As discussed in the planning meeting, it was not determined to be reasonable and necessary for the NDIS to fund Core supports for Daniel in his educational environment to assist with her learning support needs and school attendance supports.

11. Appendices

11.1 State and territory restrictive practice legislation

The state and territory governments remain responsible for specific legislation, policy and procedures related to the authorisation of restrictive practices. This is complementary to the NDIS Commission who is responsible for best practice guidance, monitoring and oversight of behaviour support service provision and the use of restrictive practices in all states and territories (excluding Western Australia). It is important to note that BSPs containing regulated restrictive practices must be lodged with the NDIS Commission, even if authorisation of the use of the restrictive practice is not a requirement of that state or territory.

Behaviour support practitioners must adhere to the requirements of the NDIS Commission and the state or territory in which they operate. Plan developers can refer practitioners, providers and plan implementers (support coordinator or LAC) to the relevant source of information. If there are concerns, discuss with your supervisor, request TAB advice or escalate feedback that may need to be considered for report to the NDIS Commission.

11.1.1 New South Wales

- While there is no specific legislation regarding restrictive practices in New South Wales, there is the Guardianship Act (1987).
- New South Wales also have the restrictive practice authorisation policy and procedural guide outlining requirements. Approval is provided through the restrictive practices authorisation (RPA) panels.
- Service providers must comply with the New South Wales restrictive practices authorisation policy and procedural guide.
- There is expected to be an updated New South Wales policy concerning restrictive practices authorisation mechanism, which providers will also need to comply with.

11.1.2 Victoria

- The Victorian government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices and behaviour support in the NDIS.
- The Victorian Senior Practitioner has the power to issue prohibitions and directions related to restrictive practices, compulsory treatment and supervised treatment orders under the Disability Act 2006.

11.1.3 Queensland

- The Queensland government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices in the NDIS through the Disability Services Act (2006) for those over 18 years.
- The *Disability Services Act (2006)* helps safeguard people with an intellectual or cognitive disability and their rights against the inappropriate use of restrictive practices and provides an accountability framework that allows for transparency in the decision-making process to authorise the use of a restrictive practice by a relevant service provider with an adult with an intellectual or cognitive disability.
- The *Disability Services Act (2006)* sets out a number of requirements that the relevant disability service provider must follow to legally use a restrictive practice and for any use of containment/seclusion to be approved by the Queensland Civil and Administrative Tribunal.

11.1.4 Western Australia

- The Western Australian government remains responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices and behaviour supports in the NDIS.
- Providers are encouraged to follow the Code of Practice: A Guide for the Elimination of Restrictive Practices (external).

11.1.5 South Australia

- The South Australian government has policy and procedures outlining state requirements regarding restrictive practice authorisation.
- The Disability Services Act 1993 requires disability service providers to have restrictive practices policy and procedures in place. Seclusion of an adult with disability must only be used if specifically authorised by the South Australian Civil and Administrative Tribunal (SACAT) under Section 32 of the *Guardianship and Administration Act 1993.*

11.1.6 Tasmania

- The Tasmanian government remains responsible for the legislative and policy frameworks through the Disability Services Act 2011 regarding the authorisation of regulated restrictive practices, which are approved by Tasmanian Senior Practitioner.
- Chemical restraint does not have authorisation requirements in Tasmania.

11.1.7 Australian Capital Territory

- The Senior Practitioner Act (2018) remains responsible for the approval of behaviour support plans, which include the use of a regulated restrictive practice.
- The *Senior Practitioner Act (2018)* provides the powers and functions of the Senior Practitioner and regulates the use of restrictive practices by persons or other entities who provide any of the following services to another person:
  - education, including education and care
  - disability
  - care and protection of children.

11.1.8 Northern Territory

- The Northern Territory government will be responsible for the legislative and policy frameworks regarding the authorisation of regulated restrictive practices in the NDIS through the NDIS (Authorisations) Act 2019.

12. Supporting material

- NDIS Act 2013
- NDIS (Quality and Safeguards Commission and Other Measures) Transitional Rules 2018
- NDIS (Restrictive Practices and Behaviour Support) Rules 2018
- NDIS (Code of Conduct) 2018
- NDIS (Incident Management and Reportable Incidents) Rules 2018
- NDIS (Provider Registration and Practice Standards) Rules 2018
- NDIS (Plan Management) Rules 2013
- Overview of the NDIS Operational Guideline – Quality and Safeguards
- NDIS Quality and Safeguards Commission
- NDIS Quality and Safeguarding Framework
- Convention on the Rights of Persons with Disabilities (external)
- National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector (external)
- Operational Protocols between the NDIA and the NDIS Commission intranet page

12.1 New South Wales

- Guardianship Act 1987
- Restrictive Practice Authorisation Policy (June 2019)
- Restrictive Practice Authorisation Procedural Guide (June 2019)

12.2 Victoria

- Disability Act 2006
- Disability Act 2006: Supervised Treatment Orders, Restrictive Practices, Compulsory Treatment

12.3 Queensland

- Disability Services Act 2006

12.4 Western Australia

- Code of Practice: A Guide for the Elimination of Restrictive Practices

12.5 South Australia

- Disability Services Act 1993

12.6 Australian Capital Territory6.0

- Senior Practitioner Act 2018

12.7 Northern Territory

- NDIS (Authorisations) Act 2019

12.8 Tasmania

- Disability Services Act 2011

13. Feedback

If you have any feedback about this Practice Guide, please complete our Feedback form.

14. Version change control

Version No	Amended by	Brief Description of Change	Status	Date
3.0	KN0014	Class 1 Approval.	APPROVED	2020-05-25
4.0	NAP927	Class 1 approval. Updated hyperlink and legislative reference in section 7.4.	APPROVED	2020-07-17
5.0	JC0075	Update for plan developers to refer to the Technical Advisory Branch intranet page for supports that require mandatory TAB advice. Updated date for NDIS Quality and Safeguards Commission regulating the use of restrictive practices Class 2 approval	APPROVED	2020-12-04
6.0	CS0074	Class 1 Approval Links updated to nominee resources	APPROVED	2021-01-08

Behaviourally based interventions in children on the autism spectrum: A systematic review and dose-response meta-analysis

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Research and Evaluation Branch

The Research and Evaluation Branch is responsible for ensuring that National Disability Insurance Agency (NDIA) policies, practices and priorities are informed by trustworthy and robust evidence so that decisions can be based on an understanding of what works, what doesn't and the benefit to participants and the Agency.

This document

This report presents research findings from a systematic review and meta-analysis investigating the overall efficacy of behaviourally based interventions for children on the autism spectrum, as well as an investigation of contributing factors such as amount (dose) of intervention and other design (intervention type, person delivering, setting) and participant (age) factors.

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Abbreviations

ABA	Applied behaviour analysis
ASELCCs	Autism Specific Early Learning and Care Centres
CABAS	Comprehensive Application of Behaviour Analysis to Schooling
CI	Confidence interval
CRC	Cooperative Research Centre
DIR	Developmental Individual-Difference Relationship-Based
DTT	Discrete Trial Teaching
EIBI	Early Intensive Behavioural Intervention
ESDM	Early Start Denver Model
GOLIAH	Gaming Open Library for Intervention in Autism at Home
IQ	Intelligence quotient
JASPER	Joint Attention, Symbolic Play, Engagement, and Regulation
LEAP	Learning Experiences and Alternative Program for Preschoolers and their Parents
NA	Not applicable
NDBI	Naturalistic developmental behavioural intervention
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
PACT	Paediatric Autism and Communication Therapy
PCIT	Parent-Child Interaction Therapy
PECS	Picture exchange communication system
PRISMA	Preferred Reporting Items for Systematic reviews and Meta-Analyses
PRT	Pivotal response treatment
RoB 2.0	Cochrane Risk of bias 2
ROBINS-I	Risk Of Bias In Non-randomized Studies
TAU	Treatment as usual

Tau^2	Tau-squared
TEACCH	Treatment and Education of Autistic and Related Communication Handicapped Children
UK	United Kingdom
US	United States

Glossary

Term	Definition
Autism spectrum disorder	Autism spectrum disorder (also referred to as "autism") is the collective term for a group of neurodevelopmental conditions affecting the brain's growth and development. Autism is a life-long condition which can impact, to varying degrees, all areas of a person's life, including social communication and social interaction. The behavioural features of autism are often present before a person is three years of age but in others they may not be recognised until their school years or later in life. The developmental challenges, signs and/or symptoms can vary widely in nature and degree between individuals, and in the same individual over time – that is why the term "spectrum" is used. We know that people prefer different terms to describe autism. We have used children on the autism spectrum (person-first language) to be consistent with how we refer to other target populations.
Behaviourally based intervention	We define behaviourally based interventions as interventions for children on the autism spectrum which are underpinned by behavioural principles. These interventions span several intervention categories defined within the Autism CRC umbrella review (external) of non-pharmacological interventions for children on the autism spectrum. These categories include behavioural interventions (for example, applied behaviour analysis [ABA]), naturalistic developmental behavioural interventions (NDBIs), technology-based interventions, developmental interventions, TEACCH, and other (uncategorised) intervention types. Behaviourally based interventions are typically delivered by trained clinicians but may also involve training parents or caregivers in behavioural principles to facilitate parent-delivered intervention.
Clinician	Throughout the report, we use the term 'clinician' to refer qualified or trained individuals who deliver interventions. These are typically the providers of the intervention.
Dose	To ensure results reflect current practice in the Australian context, dose was defined as clinician-delivered hours of intervention as this is the main delivery method funded through the NDIS. Dose was measured in two ways: 1. total clinician-delivered hours of the intervention, and 2. monthly clinician-delivered hours of intervention (i.e., dose intensity).

Term	Definition
Meta-analysis	A meta-analysis uses statistics to combine the results from these studies to find out how much of an effect the intervention has on selected outcomes (which we call the effect size) and what factors can predict the size of the reported effects.
Parent	For clarity of writing, throughout this report we use the term 'parent' to refer to any individual who has parenting responsibilities for a child.
Systematic review	A systematic review summarises the evidence from research studies focused on the same topic.

Summary

This report summarises findings from a systematic review and meta-analysis of research studies investigating the benefits of behaviourally based interventions in children (less than 7 years old) on the autism spectrum. A systematic review is a method for collecting evidence from studies of a particular topic. A meta-analysis involves synthesising this evidence statistically to arrive at quantifiable conclusions. Using this method, the benefits of behaviourally based interventions were investigated and how effects are related to the amount of intervention provided by clinicians (dose-response) was explored. An analysis of other intervention design factors and how these may relate to outcomes is also reported.

The project was conducted to assist the NDIA in developing evidence-based policy and practice guidance regarding the determination of reasonable and necessary supports for participants with autism under the age of 7. The Agency will consider this research evidence, alongside other important factors individual to each child and their circumstances, in determining what behaviourally based interventions are funded to help the child and family achieve their goals, aligned with the decision making criteria of the NDIS Act.

Key conclusions

Behaviourally based interventions are efficacious for key outcomes in children on the autism spectrum compared with children who undergo treatment as usual or non-behavioural interventions, but the pooled effect sizes are small (about 30% of a standard deviation) and vary considerably across studies.

Even for equivalent hours of clinician-delivered intervention, there is evidence for added benefit of behaviourally based intervention above that of treatment as usual (i.e., standard care or community-based intervention) or non-behaviourally based intervention.

With dose relationships varying based on the outcomes of the intervention, decisions regarding the amount of intervention provided should take into account the specific goals of the participant and the planned outcomes of the intervention.

- For goals related to the autism characteristics (i.e., socialisation, social affect, challenging behaviours, restricted repetitive behaviours, etc) or cognition and language, benefit of behaviourally based interventions can be seen at low total doses and dose intensities. There seems to be very little added benefit of increased hours and intensity of intervention for cognition and language, and no evidence for added benefit with increased dose in the case of autism characteristics, which means that many participants may benefit from less intervention hours.
- If the intervention is specifically intended to target adaptive functioning, there may be no benefit of behaviourally based interventions below approximately 800 total hours or an intensity of 65 hours per month. With such high dose requirements, intervention approaches other than behaviourally based interventions may be more feasible and cost-effective, unless supported by evidence for the specific intervention requested.

Importantly, just focusing on dose by itself is a weak predictor of outcomes of behaviourally based intervention in children on the autism spectrum and should only be considered as one factor in a treatment decision to ensure alignment to the holistic goals of the child.

No differences were found for benefit of behaviourally based interventions by type of intervention, type of comparison group, primary intervention setting, person delivering the intervention, or age of the participant. With no differences found in the intervention and design factors investigated, it is likely that all factors investigated could be useful in the right context. This emphasizes the importance of tailoring the intervention design to the unique context and goals of the child and their family.

With no evidence to suggest that interventions by a parent are inferior to those delivered by clinicians, this warrants further investigation of parent-delivered interventions. This report did not assess factors which may contribute to the success of these interventions, such as parent training (duration, content, etc), support for parents throughout the intervention (type, amount), and fidelity.

To further the work presented here, other meta-analysis methods would allow for examining differences in individual circumstances as well as other participant-level (e.g., autism severity) and intervention-related factors to be explored in more detail.


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1. Background and NDIS context

Autism spectrum disorder, also referred to as “autism”, is the collective term for a group of neurodevelopmental conditions which affect brain growth and development. Characteristics of autism vary greatly in nature and degree, but may involve challenges with social interaction and communication, sensory issues, and restricted and repetitive behaviours, interests, or activities (American Psychiatric Association, 2013). Behavioural features of autism are often present before the age of 3 years old but may not be recognised until later in life.

Autism is the largest primary disability category in the NDIS, encompassing 34% of active participants. As of December 2022, 22,018 NDIS participants under the age of 6 had a primary disability of autism, representing approximately one-quarter of NDIS participants in this age group. Intervention during childhood represents an important opportunity to support early development and build on the child’s strengths. Through the NDIA’s early childhood approach, children under 7 years old can access NDIS funding for early intervention supports. The NDIA’s early childhood approach is based on the National Guidelines for Best Practice in Early Childhood Intervention (external), emphasising the central role of family as well as development in natural, everyday settings (Early Childhood Intervention Australia, 2016). These principles are promoted within the Autism CRC National Guideline (external) (Trembath et al., 2022) for supporting children on the autism spectrum and their families, where similar recommendations are made for approaches which are child and family-centred, individualised, and strengths-focused (Trembath et al., 2022).

A wide range of non-pharmacological interventions are available for children on the autism spectrum, all of which aim to assist early development and skill acquisition across domains (e.g., social affect, cognition, adaptive functioning). Behavioural principles underpin a considerable range of these interventions (see **Appendix 1** for list of interventions), which span several intervention categories defined within the Autism CRC umbrella review (external) of non-pharmacological interventions for children on the autism spectrum (Whitehouse & Eapen, 2020). These categories include behavioural interventions (for example, applied behaviour analysis [ABA]), naturalistic developmental behavioural interventions (NDBIs), technology-based interventions, developmental interventions, TEACCH, and other (uncategorised) intervention types.

Behaviourally based interventions are typically delivered by trained clinicians but may also involve training parents or caregivers in behavioural principles to facilitate parent-delivered intervention. It is estimated that at least 7,936 participants under the age of 7 with a primary disability of autism received some form of capacity building support (which may include behaviourally based interventions) funded through the NDIS early childhood services in 2021.

There is currently low to moderate evidence supporting the efficacy of behavioural interventions for core autism characteristics which includes communication, cognition, behaviour, school readiness and academic skills (Whitehouse & Eapen, 2020). While some evidence exists, there is limited and varied evidence which reports the effect of amount (“dose”) of behaviourally based interventions on outcomes. Additionally, results of dose response investigations vary by their focus and research methods. For example, one systematic review reported benefits of higher intensity (hours per week) of intervention for cognition and adaptive behaviour, but not language, and found no effect of total

intervention duration (Makrygianni & Reed, 2010). Another meta-analysis identified a potential linear association between hours of intervention and benefit to adaptive functioning and language outcomes (Virues-Ortega, 2010). Finally, a meta-analysis of individual participant data reported larger effect sizes for overall autism characteristics after 24 months of intervention compared to 12 months (Rodgers et al., 2020).

With limited understanding of the optimal dose of behaviourally based interventions for children on the autism spectrum, there are currently no evidence-based guides or best practice principles available, which has led to inconsistency in service provision and participants receiving varied hours of an intervention. Confusion associated with this can be distressing for parents, as it is unclear how many hours are necessary for their child to achieve the best outcomes. With such variable results and a general lack of investigation of contributing factors (i.e., setting, intervention characteristics, participant characteristics, etc) (Trembath et al., 2021), it is difficult to use existing evidence to guide NDIA policy and operations. Crucially, evidence regarding dose of interventions is only one variable which can inform an individualised decision about what is needed for a particular child within their unique environmental context and family circumstances. As such, it is important to have a body of evidence of what works, at what dose, for who, in what context and to what end, to reduce confusion, strengthen guidance, and ensure the best outcomes for participants are achieved. One of the national best practice principles for childhood intervention is that interventions and practice must be research-based, so creating a body of evidence to support NDIA policy and practice is an essential part of how the NDIA must discharge its decision making responsibilities regarding funding for reasonable and necessary supports under the NDIS Act.

2. What did we do?

A comprehensive systematic review and meta-analysis was undertaken to identify the overall efficacy of behaviourally based interventions for various outcomes in children on the autism spectrum and, importantly, how contributing factors impact these outcomes.

The objectives of the systematic review and meta-analysis were to:

- examine the evidence for the efficacy of behaviourally based interventions in children under 7 years on the autism spectrum on child (functional and developmental) and family outcomes; and
- investigate how effects are related to dose (amount) of intervention as well as other factors relating to study design, intervention, comparison group, and child characteristics.

2.1 Overview of methods used

Findings included in this report were identified through a systematic review and meta-analysis. A systematic review is a process to locate and summarise the results of all studies that ask a particular research question, usually by using different methods with a common underlying question (e.g., are behaviourally based interventions efficacious in improving adaptive functioning in children on the autism spectrum?). A meta-analysis is a statistical procedure that combines results from the studies identified in a systematic review to find a common estimate of effect between studies, as well as how effects might vary across settings and other factors (e.g., age, intervention type).

A full description of the study methods is available in **Appendix 1**.

2.1.1 Search and screening of articles

Five databases were searched to identify all published studies that examined the impact of a behaviourally based intervention on a range of outcomes in children under the age of 7 years on the autism spectrum. The search screening process is in **Appendix 1** and criterion for inclusion are outlined below by Population, Intervention, Comparison, and Outcome (i.e., PICO).

Population

Studies were eligible if they included children who:

- are 7-years old or younger at the beginning of the intervention,
- **AND** have a diagnosis of autism spectrum disorder (or have a high likelihood of autism spectrum disorder for children less than 3 years)

Intervention

Studies were eligible if they included behaviourally based interventions (typical interventions listed in **Appendix 1**).

Interventions may be delivered to children:

- face-to-face,
- **OR** via telehealth.

Interventions may be delivered to children by:

- qualified or trained individuals,
- parents,
- caregivers,
- teachers,
- **OR** a combination of these.

Interventions may be:

- one-to-one,
- **OR** in a small group format.

Comparison

Studies were eligible if they included a comparison group which comprised of children 7-years old or younger on the autism spectrum who:

- continued standard care or treatment as usual (i.e., community interventions),
- were on a waitlist,
- **OR** completed an alternate, non-behaviourally based intervention.

Studies without a comparison group (i.e., single arm studies) and case studies were excluded.

Outcomes

Studies were eligible if they reported outcomes that were measured both:

- before intervention has begun,
- **AND** following intervention.

Outcomes within the following five domains were eligible for inclusion:

1. **Autism characteristics**
    a. Global measures of autism characteristics and behaviours
    b. Emotional regulation
    c. Restricted repetitive behaviours/sensory
    d. Social affect (foundational social skills)
    e. Socialisation (application and competence in using social skills)
    f. Challenging behaviours
2. **Cognitive and language outcomes**
    a. Cognition (verbal and nonverbal cognitive abilities and motor skills)
    b. Language (receptive and expressive language and verbal communication)

3. **Functional outcomes**
    a. Adaptive behaviour (everyday functioning e.g., Vineland Adaptive Behaviour Scales)
    b. Education outcomes (e.g., education setting/level of support)
4. **Family outcomes**
    a. Caregiver or family wellbeing
    b. Quality of life (child, caregiver, overall family unit)
5. **Adverse effects**
    a. Child distress (e.g., anxiety/depression)
    b. Parent stress/burden (e.g., Parenting Stress Index)
    c. Reduced participation in mainstream settings (e.g., reduced participation in preschool)

For inclusion, each study must report **at least one** of these outcomes.

2.1.2 Combining effects from included studies

Intervention effects within each outcome domain (see **Section 4.1.1** for domain descriptions) were combined across studies using meta-analysis. The intervention effect was measured using standardised mean difference, calculated as Hedges' *g,* with 95% confidence interval (CI).

Hedges' *g* provides the difference (effect) between two groups in standard deviation units. This allows us to combine the intervention effects from the different outcome domains into a single analysis. A positive Hedges' *g* means that the intervention was beneficial over the comparison group.

The confidence interval estimated the precision of the estimate of effect. When the confidence interval includes the null (i.e., when the lower bound of the interval is below zero), the effect estimate is too imprecise to be considered statistically significant, meaning there is not enough information to determine whether the intervention is beneficial or not.

Each pooled estimate is provided along with a measure of statistical heterogeneity, denoted as tau-squared (Tau^2). This gives an estimation of the extent to which an effect estimate is inconsistent across studies.

2.1.3 Investigating a range of contributing factors to efficacy

To investigate variability in these combined efficacy estimates (i.e., heterogeneity), further analyses were conducted to explore the effect of dose as well as other study, intervention, and population-based factors. The factors examined within subgroup analyses were (1) person delivering intervention; (2) intervention type; (3) comparison group type; (4) age group; (5) primary intervention setting; and (6) study design.

These factors are critical as they are overarching characteristics of the study, intervention and participants which may impact the efficacy of the intervention. It is also useful to know what types of interventions work best, what settings are associated with best outcomes, whether there are better

outcomes when the intervention is delivered by certain individuals, and whether the behaviourally based interventions are more efficacious in certain age groups compared to usual alternatives.

The levels of each of these subgroups, in addition to descriptions and examples are described below.

Person delivering intervention

1. **Clinician** (i.e., clinician, facilitator, or provider)
2. **Clinician and parent**
3. **Parent** (i.e., parent or caregiver)
4. **Teacher** (i.e., early educator or teacher)

Intervention category

The six intervention categories are based on Autism CRC definitions (Whitehouse & Eapen, 2020).

1. **Behavioural**, for example:
    a. Early Intensive Behavioural Intervention (EIBI)
    b. Applied Behavioural Analysis (ABA)
    c. Discrete Trial Teaching (DTT)
    d. Picture exchange communication system (PECS)
2. **Naturalistic Developmental Behavioural Interventions (NDBIs)**, for example:
    a. Early Start Denver Model (ESDM)
    b. Pivotal response treatment (PRT)
    c. Joint Attention, Symbolic Play, Engagement, and Regulation (JASPER)
3. **Developmental**, for example:
    a. DIR Floortime
4. **Technology-based**, for example:
    a. GOLIAH
5. **TEACCH** (a discrete intervention)
6. **Other** interventions, for example:
    a. Autism 1-2-3
    b. Learning Experiences and Alternative Program for Preschoolers and their Parents (LEAP)
    c. Parent-Child Interaction Therapy (PCIT)

Comparison group

1. **Treatment as usual (TAU)**, for example:
    a. Waitlist controls
    b. Usual or routine care, often in the community (e.g., speech and language therapy).
    c. Regular or non-specific specialised school-based services.
    d. Public education or psychoeducation for parents.

2. **Eclectic** interventions (i.e., a specific early intervention program or intervention that is not behaviourally based and not part of routine or usual care)

Age group

1. **0-1 years** (up to but not including children 2 years old)
2. **2-4 years** (children from the age of 2, up to but not including children 5 years old)
3. **5-6 years** (children from the age of 5 years old)

Primary intervention setting

1. **Health** (i.e., interventions primarily delivered within clinical [e.g., psychology, university] specialist or private health settings)
2. **Community** (i.e., interventions primarily delivered in childcare centres, community or public agencies or service centres)
3. **Early education** (i.e., interventions primarily delivered in the child's preschool or school)
4. **Home** (i.e., interventions primarily delivered in child's home)

Study design

1. **Random** (i.e., randomised controlled trial)
2. **Non-random** (i.e., non-randomised controlled trial)
3. **Cohort study** (i.e., prospective comparison of intervention groups)

Investigating the effect of dose

To ensure results reflect current practice in the Australian context, dose was defined as **clinician-delivered hours** of intervention as this is the main delivery method funded through the NDIS. Specific parent-delivered interventions and interventions in early education settings (often delivered by teachers) were excluded from the dose analyses. It is important to note these studies were still included in the main efficacy analyses, as well as subgroup analyses investigating the effects of study, intervention and population characteristics.

Dose was measured in two ways:

3. **total** clinician-delivered hours of the intervention, and
4. **monthly** clinician-delivered hours of intervention (i.e., dose intensity).

It is worth noting that duration (weeks) of intervention was not accounted for or further explored within this report. Nevertheless, duration of intervention had a large association with both total hours of intervention ($r = 0.8$, $p < 0.001$) and monthly hours of intervention ($r = 0.8$, $p < 0.001$), and therefore its potential effect on the results is limited.

The effect of the dose of interventions was explored using three methods, listed here and further detailed below:

1. Relationship between dose and efficacy
2. Comparing efficacy for lower versus higher total and monthly dose
3. Relationship between dose and change from baseline to follow-up separately within the:
    a. Behaviourally based intervention group
    b. Comparison group

1. Relationship between dose and efficacy

Linear and non-linear models were used to explore the relationship between dose (**total** and **monthly** clinician-delivered hours) and efficacy (Hedges' *g*) of the intervention (see **Appendix 1** for description) across each of the outcome domains (where data permits).

As described previously, efficacy (Hedges' g) of the behaviourally based intervention (as compared to the comparative group) was calculated for each outcome domain reported in each study. For each outcome domain, the efficacy of each individual study was then plotted against the dose of intervention implemented within that study to visualise the dose relationship.

These relationships were then significance tested to assess the likelihood of a relationship between dose and efficacy. The model estimate (β) indicates the size of the relationship, with a positive model estimate indicating a positive relationship (as dose increases, so does efficacy) and a negative model estimate indicating a negative relationship (as dose increases, efficacy decreases). The model estimate (β) can be interpretated as the added benefit (in Hedges' *g*) associated with each additional hour of intervention. For example, if β=0.01, the effect size is estimated to increase by *g*=0.1 (i.e., 10% standard deviation difference) for every 10 additional hours.

2. Comparing efficacy for lower versus higher total and monthly dose

The dose analyses were corroborated by investigating differences in the efficacy of lower versus higher total dose as well as lower versus higher dose intensity (monthly hours), with lower and higher defined in both cases based on a median split. Lower and higher intervention doses were also directly compared within each outcome domain.

3. Relationship between dose and change from baseline to follow-up separately within the intervention group and the comparison group

This analysis involved the calculation of an effect size (Hedges' g) separately for the *behaviourally based intervention group* and the *comparison group* in each study. The resulting effect size is the change between two time-points: baseline (pre-intervention) and follow-up. A positive Hedges' *g* means that the group improved from baseline to follow-up on that outcome domain.

The effect size for the change in the *behaviourally based intervention group* represents the overall effect of the intervention, which includes the specific effect of intervention components as well as non-specific factors such as repeated measures and expectations ('placebo effect'). Conversely, the effect size for the change in the *comparison group* represents only the non-specific factors, such as those associated with treatment as usual in the community. Thus, if the effect size within the

intervention group is larger than that of the comparison group, the intervention offers a benefit beyond what would be expected from treatment as usual.

As was described for the dose response analyses (*1. Relationship between dose and efficacy*, above), linear and non-linear models were then used to explore the relationship between dose (total and monthly clinician-delivered hours) and change from baseline to follow-up (Hedges' *g*). These relationships were explored for each outcome domain (as outlined in **Section 4.1.1**), for both the intervention and comparison groups separately. Dose in the comparison groups was again recorded as clinician-delivered hours of intervention, and may include services such as occupational therapy, speech therapy, etc. This analysis allows an assessment of the difference in effect of behaviourally based intervention and treatment as usual, both with the same clinician-delivered hours.

3. What did we find?

The following section reports the key findings from the analysis. A more detailed description of results is available in **Appendix 2**.

3.1 Summary of studies

Overall, 98 studies were included, representing a total of 4,553 participants. These studies were conducted across 21 countries, predominantly the US (45 studies), followed by the UK (7 studies), Norway (6 studies), Australia (4 studies), Canada (4 studies), and Italy (4 studies), among others. Half of included studies were randomised controlled trials (50%), with the remainder non-randomly allocating participants to intervention or comparison groups (e.g., by caregiver preference or using existing groups), or using existing cohorts of participants. The age of study participants ranged from 9 months to 7.1 years with an overall mean of 3.8 years, and 84% of study participants were male. Further characteristics of the included studies are shown in **Appendix 2**.

Across the 98 studies, 1,560 outcome measures which met the criteria outlined in **Section 4.1.1** were reported, with an average of 16 outcome measures reported per study. The number of studies that reported outcomes within each domain varied: 81 studies reported autism characteristic outcomes; 47 reported adaptive functioning outcomes; 64 reported cognition and language outcomes; 20 reported family outcomes; and 27 reported adverse effect outcomes.

3.2 Characteristics of behavioural interventions

Interventions vary on several characteristics (subgroups) which include content, person delivering the intervention, and primary setting (see **Section 4.1.3**). The differences these characteristics have on outcomes following a behaviourally based intervention is explored in the following sections. To summarise the distribution of identified studies across these characteristics, **Table 1** shows the number of studies which fall under each category by outcome domain as well as the average dose of intervention across subgroup categories.

Table 1a. Number of studies and dose amount by person delivering intervention.

Notes: Number of studies is reported in total and across all five outcomes domains by subgroup level. Total and monthly clinician-delivered are across all studies which report that data within each subgroup level. NA = not applicable.

Subgroup level	Total	Autism characteristics	Adaptive functioning	Cognition and language	Family outcomes	Adverse effects	Total clinician-delivered hours: Median (Range)	Monthly clinician-delivered hours: Median (Range)
Clinician	**31**	25	14	20	2	3	96 (10 – 3616)	26 (3 – 152)
Clinician and parent	**25**	18	17	20	2	7	178 (7 – 5088)	32 (2 – 158)
Parent	**33**	31	13	18	16	16	NA	NA
Teacher	**10**	8	4	7	0	1	NA	NA

Table 1b. Number of studies and dose amount by intervention category.

Notes: Number of studies is reported in total and across all five outcomes domains by subgroup level. Total and monthly clinician-delivered are across all studies which report that data within each subgroup level. NA = not applicable.

Subgroup level	Total	Autism characteristics	Adaptive functioning	Cognition and language	Family outcomes	Adverse effects	Total clinician-delivered hours: Median (Range)	Monthly clinician-delivered hours: Median (Range)
Behavioural	**44**	30	27	28	11	12	1328 (10 – 5088)	103 (4 – 157)
Naturalistic Developmental Behavioural Interventions (NDBI)	**33**	31	11	23	6	9	156 (7 – 1912)	30 (2 – 80)
Developmental	**13**	13	5	7	2	2	20 (10 – 1040)	11 (3 – 43)
Technology-based	**3**	2	2	3	0	1	18 (18 – 18)	4 (4 – 4)
TEACCH	**4**	4	3	3	1	1	18 (18 – 18)	7 (7 – 7)
Other	**3**	3	1	2	0	2	NA	NA

Table 1c. Number of studies and dose amount by comparison group.

Notes: Number of studies is reported in total and across all five outcomes domains by subgroup level. Total and monthly clinician-delivered are across all studies which report that data within each subgroup level. NA = not applicable.

Subgroup level	Total	Autism characteristics	Adaptive functioning	Cognition and language	Family outcomes	Adverse effects	Total clinician-delivered hours: Median (Range)	Monthly clinician-delivered hours: Median (Range)
Treatment as usual	**78**	69	33	46	1	4	156 (7 – 5088)	31 (2 – 158)
Eclectic	**23**	15	13	16	18	22	172 (10 – 1820)	29 (4 – 158)

Table 1d. Number of studies and dose amount by age group.

Notes: Number of studies is reported in total and across all five outcomes domains by subgroup level. Total and monthly clinician-delivered are across all studies which report that data within each subgroup level. NA = not applicable.

Subgroup level	Total	Autism characteristics	Adaptive functioning	Cognition and language	Family outcomes	Adverse effects	Total clinician-delivered hours: Median (Range)	Monthly clinician-delivered hours: Median (Range)
0-1 years	**7**	7	3	6	2	2	876 (52 – 1912)	66 (4 – 80)
2-4 years	**73**	61	36	49	14	19	176 (10 – 5088)	39 (4 – 158)
5-6 years	**16**	13	7	7	4	6	12 (7 – 18)	4 (2 – 7)

Table 1e. Number of studies and dose amount by primary intervention setting.

Notes: Number of studies is reported in total and across all five outcomes domains by subgroup level. Total and monthly clinician-delivered are across all studies which report that data within each subgroup level. NA = not applicable.

Subgroup level	Total	Autism characteristics	Adaptive functioning	Cognition and language	Family outcomes	Adverse effects	Total clinician-delivered hours: Median (Range)	Monthly clinician-delivered hours: Median (Range)
Health	**38**	35	12	21	11	13	32 (10 – 1820)	17 (3 – 152)
Community	**10**	9	7	6	1	1	792 (10 – 5088)	66 (5 – 158)
Early education	**26**	17	16	20	0	3	NA	NA
Home	**28**	25	14	18	9	11	692 (7 – 2662)	48 (2 – 116)

Table 1f. Number of studies and dose amount by study design.

Notes: Number of studies is reported in total and across all five outcomes domains by subgroup level. Total and monthly clinician-delivered are across all studies which report that data within each subgroup level. NA = not applicable.

Subgroup level	Total	Autism characteristics	Adaptive functioning	Cognition and language	Family outcomes	Adverse effects	Total clinician-delivered hours: Median (Range)	Monthly clinician-delivered hours: Median (Range)
Randomised controlled trial	**49**	45	16	28	13	13	52 (10 – 1912)	13 (3 – 80)
Non-randomised controlled trial	**31**	23	16	20	6	12	156 (7 – 5088)	26 (2 – 158)
Prospective cohort study	**18**	13	15	16	1	2	1330 (80 – 3616)	94 (13 – 152)

3.2.1 Clinician-delivered dose of intervention

A total of 34 studies reported clinician-delivered dose. Due to limited evidence for family outcomes and adverse effects, dose-response analyses were not included for these outcome domains.

Total clinician-delivered dose (**Figure 1**) varied greatly across studies, ranging from 7 to 5088 hours (median = 137 hours). Monthly clinician-delivered hours (**Figure 2**) also had a wide range, from 2 to 158 hours per month (median = 27 hours).

Both total ($r = 0.8$, $p < 0.001$) and monthly ($r = 0.8$, $p < 0.001$) clinician-delivered hours were significantly associated with total duration (weeks) of the intervention, meaning that longer intervention durations typically meant more total and monthly clinician-delivered hours of intervention. Because of this association, the unique effect of duration is unlikely to be substantial and duration was not explored further within the analyses relating to dose.

The clinician-delivered dose of an intervention varied across subgroups. Average clinician-delivered dose and range by subgroup is shown in **Table 1**.

Figure 1. Total clinician-delivered hours of intervention within included studies

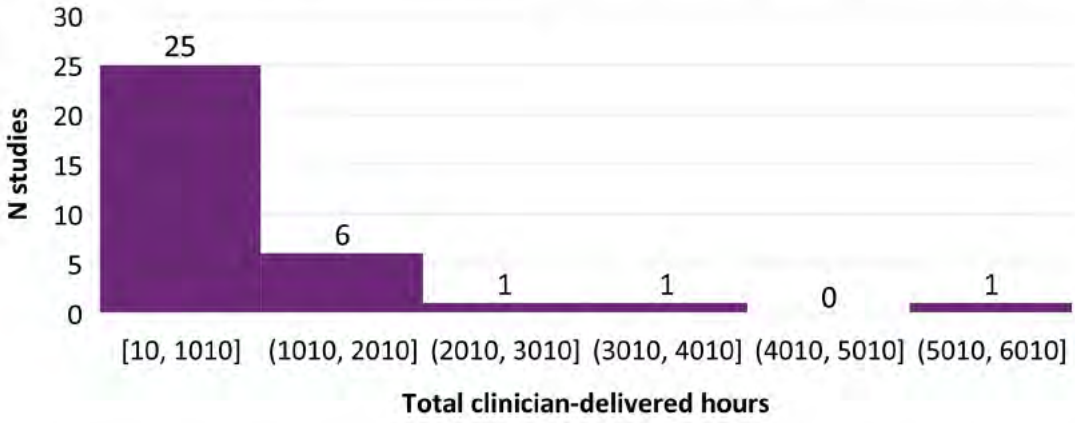
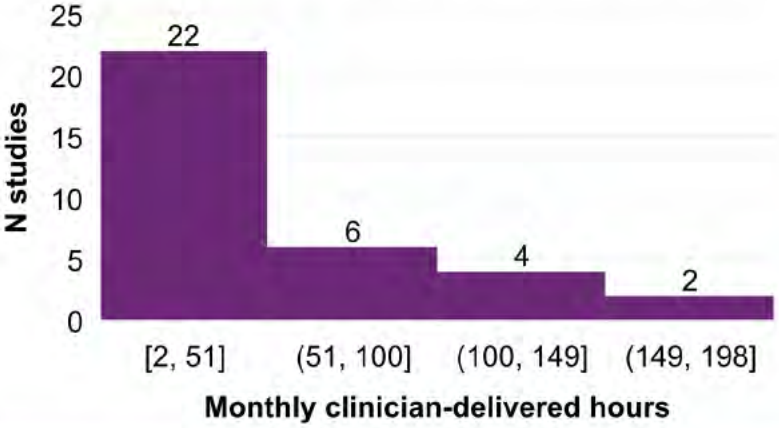


Figure 2. Monthly clinician-delivered hours of intervention within included studies



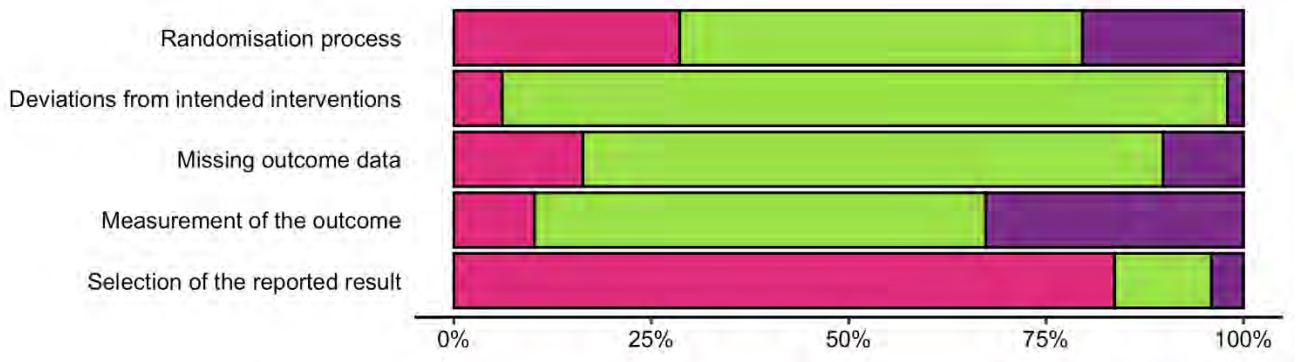
3.3 Quality of the evidence used within this report

3.3.1 Randomised controlled trials

Risk of bias was evaluated for the 49 randomised controlled trials included in this report. Of the overall assessments, 28 were deemed to have a high risk of bias, 20 had some concerns, and one was deemed low risk. Assessments of risk of bias within individual bias domains are summarised in **Figure 3** (see **Table B2** for individual domain assessments by study). The high proportion of unclear risk in the selection of the reported result was due to few studies providing a pre-specified analysis plan. A considerable number of studies (>25%) had high risk of bias in the measurement of outcomes due to the lack of blinding for outcome assessors. Approximately 25% of studies did not specify the use of a randomisation process which was concealed prior to enrollment and assignment to intervention, resulting in a high risk of bias for randomisation process. Relatively low risk of bias due to deviations from intended interventions and missing outcome data were identified.

Figure 3. Risk of bias across outcome domains in randomised controlled trials.

Note: Purple indicates high risk assessment. Green indicates low risk assessment. Pink indicates risk assessment of some concerns.

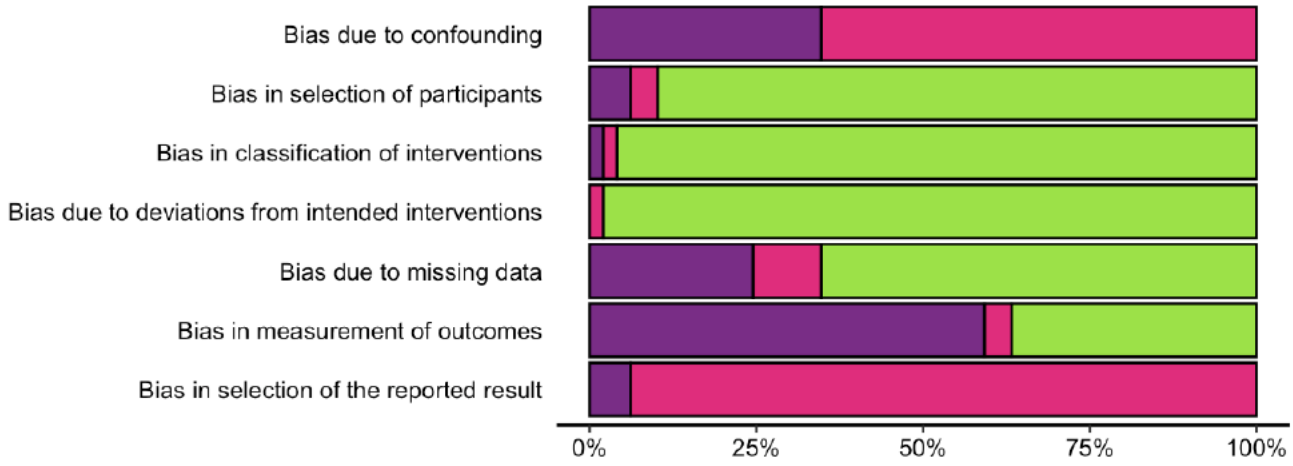


3.3.2 Non-randomised study designs

Risk of bias was assessed separately for the 49 studies which employed non-randomised study designs. Overall assessments deemed 38 to have serious risk of bias, and 11 to have a moderate risk of bias. Assessments of risk of bias within individual bias domains are summarised in **Figure 4** (see **Table B3** for individual domain assessments by study). Moderate or serious risk of bias due to confounding were seen across studies because of a lack of measurement or control of important cofounders (e.g., age, autism severity, IQ) within analyses. Moderate or serious risk of bias due to missing data were seen in >25% of studies due to the presence of substantial missing data (>10%) which was often unequal between groups. Greater than 50% of studies showed evidence of bias in the measurement of outcomes because assessors were unblinded. Predominantly moderate risk of bias in the selection of the reported result was shown due to the general absence of pre-specified analysis plans.

Figure 4. Risk of bias across outcome domains in non-randomised study designs.

Note: Purple indicates serious risk assessment. Green indicates low risk assessment. Pink indicates moderate risk assessment.



3.4 Overall results across outcome measures

Overall results across measures: a summary of findings

When considering the combined evidence across **all outcome measures** there was a **small benefit** of behaviourally based interventions when compared to treatment as usual, waitlist, or non-behaviourally based, "eclectic" interventions (the comparison groups). This small benefit was found, regardless of the dose intensity (**monthly** clinician-delivered hours) of the intervention.

A dose relationship was found, with increased **total** clinician-delivered hours associated with better outcomes following behaviourally based interventions than the comparative group.

- However, the associated real-world impact is arguably inconsequential. Every additional 100 hours of behaviourally based intervention a child receives translates to less than a 1% increase in standard deviation for the effect estimate.

3.4.1 Efficacy

Overall, there is evidence to support behaviourally based intervention in children less than 7 years old on the autism spectrum. Benefit of behaviourally based interventions when compared with treatment as usual, waitlist or a non-behaviourally based, "eclectic" intervention was shown across reported outcomes within the 98 studies but with a small effect size (Hedges' g = 0.32, 95%CI 0.26 – 0.38, Prediction Interval = -0.33 – 0.98, $tau^2 = 0.11$).

There was some evidence that effect sizes were larger in smaller studies, which can be indicative of over-estimation of treatment effect for this outcome. After estimating the bias, the effect estimate was reduced from 0.32 (95%CI 0.24 to 0.39) to 0.23 (95%CI 0.17 to 0.29). This estimated effect size which accounts for this bias is reported in **Appendix 2**.

3.4.2 Relationship between dose and efficacy

Across the 34 studies the linear models show a statistically significant relationship between increasing **total** clinician-delivered hours of a behaviourally based intervention and better outcomes (see **Figure 5**). However, while the linear dose response trend for increasing **total** hours of intervention was statistically significant, the associated real-world impact is arguably inconsequential, because every increase of 100 total hours of intervention translates to less than a 1% increase in standard deviation for the effect estimate.

There was no significant relationship between **monthly** clinician-delivered hours of behaviourally based intervention and effect estimate (Model estimates can be found in **Table B10**). The non-linear modelling demonstrated similar results (see **Figure 5**), with only slightly improved model fit.

Figure 5a. Linear model of monthly clinician-delivered dose by effect size (Hedges' g) for all outcomes.

Note: Hedges' g > 0 = better outcomes in the intervention group compared to the comparison group. Hedges' g < 0 = better outcomes in the comparison group compared to the intervention group.

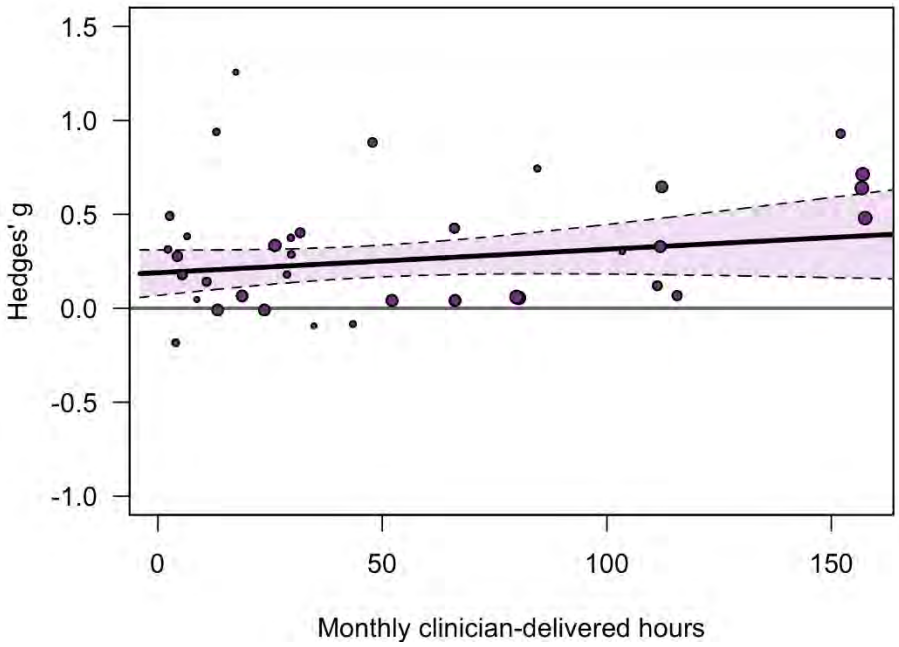


Figure 5b. Linear model of total clinician-delivered dose by effect size (Hedges' g) for all outcomes.

Note: Hedges' g > 0 = better outcomes in the intervention group compared to the comparison group. Hedges' g < 0 = better outcomes in the comparison group compared to the intervention group.

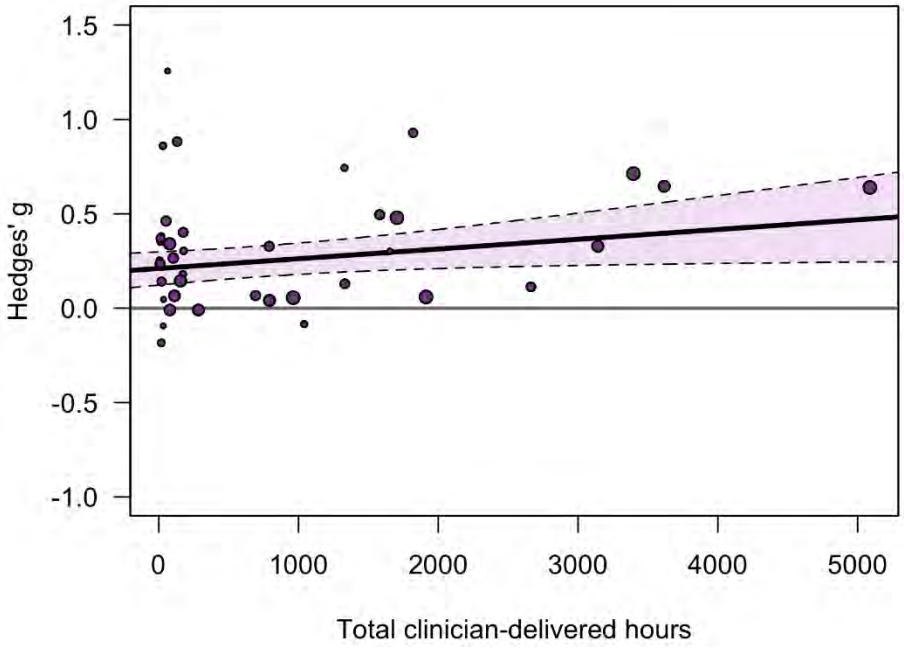


Figure 5c. Non-linear model of monthly clinician-delivered dose by effect size (Hedges' g) for all outcomes.

Note: Hedges' g > 0 = better outcomes in the intervention group compared to the comparison group. Hedges' g < 0 = better outcomes in the comparison group compared to the intervention group.

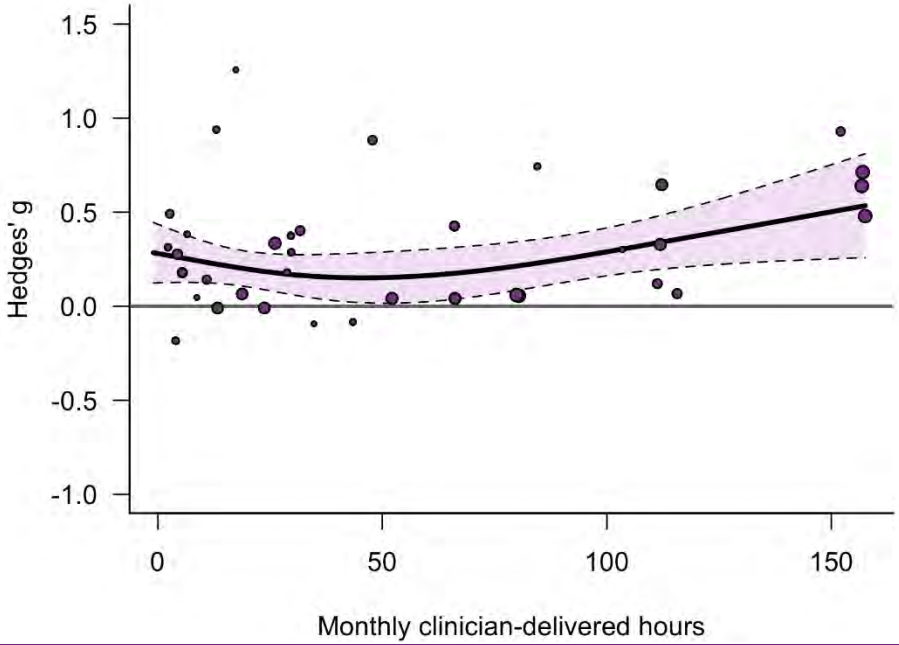
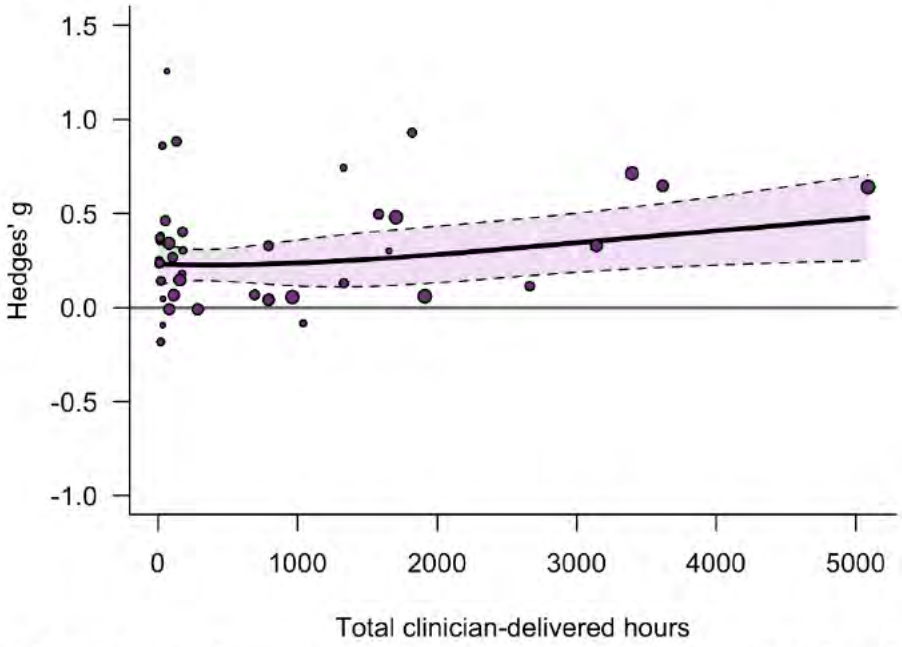


Figure 5d. Non-linear model of total clinician-delivered dose by effect size (Hedges' g) for all outcomes.

Note: Hedges' g > 0 = better outcomes in the intervention group compared to the comparison group. Hedges' g < 0 = better outcomes in the comparison group compared to the intervention group.



3.4.3 Comparing efficacy for lower versus higher total and monthly dose

The relationship between dose (both **total** and **monthly** hours of intervention) and efficacy was compared with lower and higher clinician-delivered hours (based on a median split of the data). No difference in efficacy was shown between lower and higher total and monthly doses of intervention, with small benefit shown at both dose levels (see **Figure 6** and **Table 2**).

Table 2. Results of analyses comparing lower and higher total and monthly doses for all outcome measures.

	Monthly clinician-delivered hours	Total clinician-delivered hours
Median hours	29.7 monthly hours	156 total hours
Lower dose: Less than median hours	**N studies:** 19 studies **Hedges' g (95% CI):** 0.27 (0.13-0.42)	**N studies:** 18 studies **Hedges' g (95% CI):** 0.30 (0.14-0.46)
Higher dose: Greater than median hours	**N studies:** 16 studies **Hedges' g (95% CI):** 0.29 (0.12-0.45)	**N studies:** 18 studies **Hedges' g (95% CI):** 0.27 (0.12-0.41)

Figure 6a. Linear dose relationship for lower versus higher monthly clinician hours (based on median) for all outcome measures.

Note: The green shaded area indicates less than the median number of monthly clinician-delivered hours, and the pink shaded area indicates higher than the median number of monthly clinician-delivered hours for this outcome.

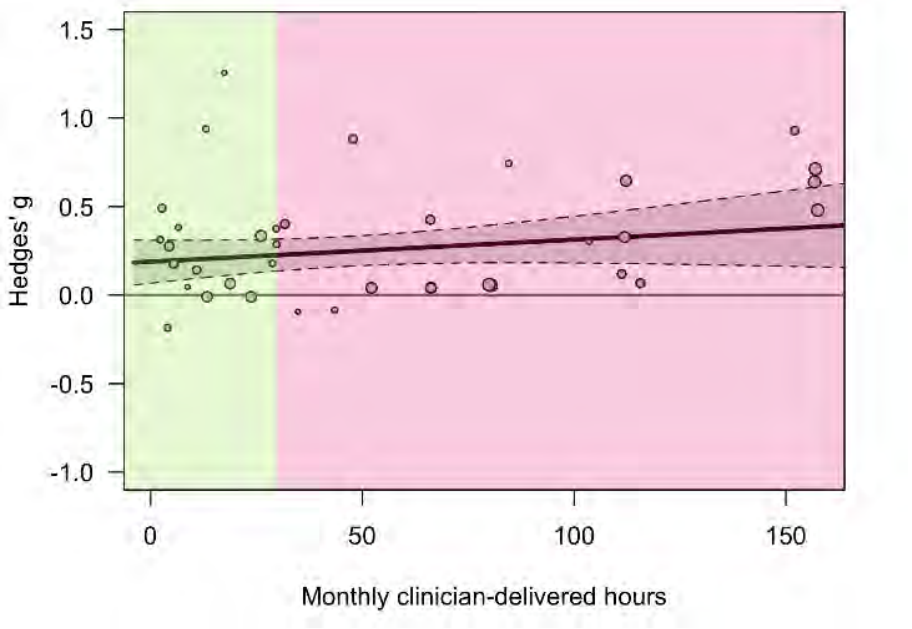
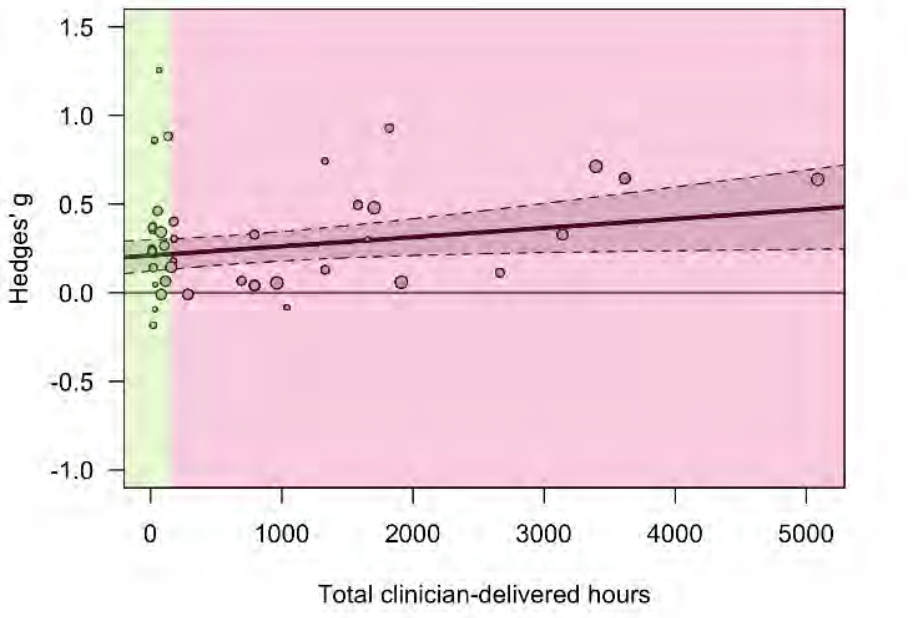


Figure 6b. Linear dose relationship for lower versus higher total clinician hours (based on median) for all outcome measures.

Note: The green shaded area indicates less than the median number of total clinician-delivered hours, and the pink shaded area indicates higher than the total number of monthly clinician-delivered hours for this outcome.



3.4.4 Relationship between dose and change from baseline to follow-up separately within the intervention group and the comparison group

When investigating change in outcomes over time from baseline to follow-up within the intervention group (regardless of the comparison group), linear models show a statistically significant relationship, indicating that increasing **total** and **monthly** clinician-delivered hours of an intervention translates to improved outcomes (see **Figure 7**). Model results and graphs of individual models with 95% confidence intervals can be found in **Table B11** and **Figure B14**. This means that, without controlling for the comparison group, increasing dose translates to better outcomes in the intervention group.

This relationship between dose (**total** and **monthly**) and change in outcomes over time from baseline to follow-up was not replicated in the comparison group (see **Table B12** for model results). Non-linear models can be seen in **Figure 7**, with models with 95% confidence intervals shown in **Figure B18**. This demonstrates that increasing clinician hours of treatment as usual intervention (most comparison groups involved treatment as usual or standard care in the community) does not translate to better outcomes.

Figure 7a. Linear model of monthly clinician-delivered dose by effect size (Hedges' g) for change in all outcomes from pre- to post-intervention within intervention and comparison groups.

Note: Hedges' g > 0 = improvement in outcomes from baseline to follow-up in the specified group. Hedges' g > 0 = decrease in outcomes from baseline to follow-up in the specified group.

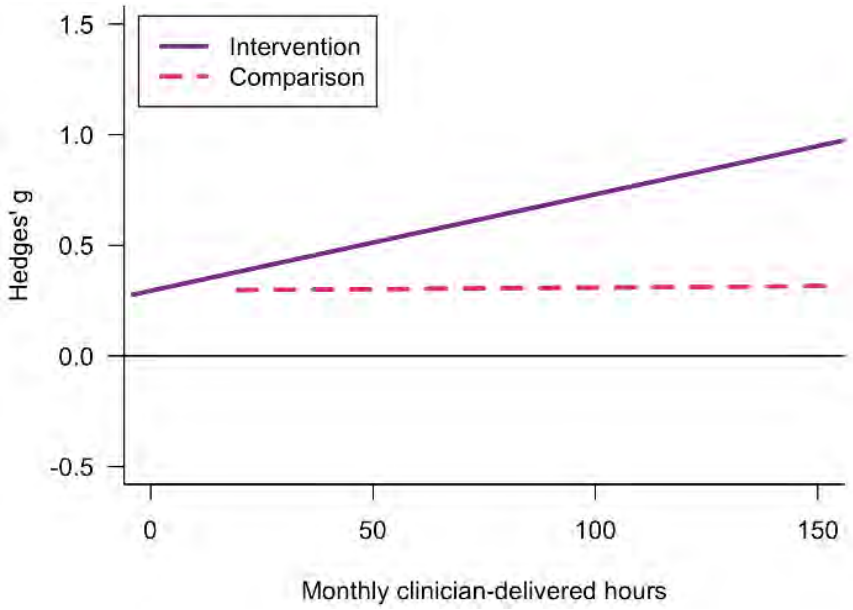


Figure 7b. Linear model of total clinician-delivered dose by effect size (Hedges' g) for change in all outcomes from pre- to post-intervention within intervention and comparison groups.

Note: Hedges' g > 0 = improvement in outcomes from baseline to follow-up in the specified group. Hedges' g > 0 = decrease in outcomes from baseline to follow-up in the specified group.

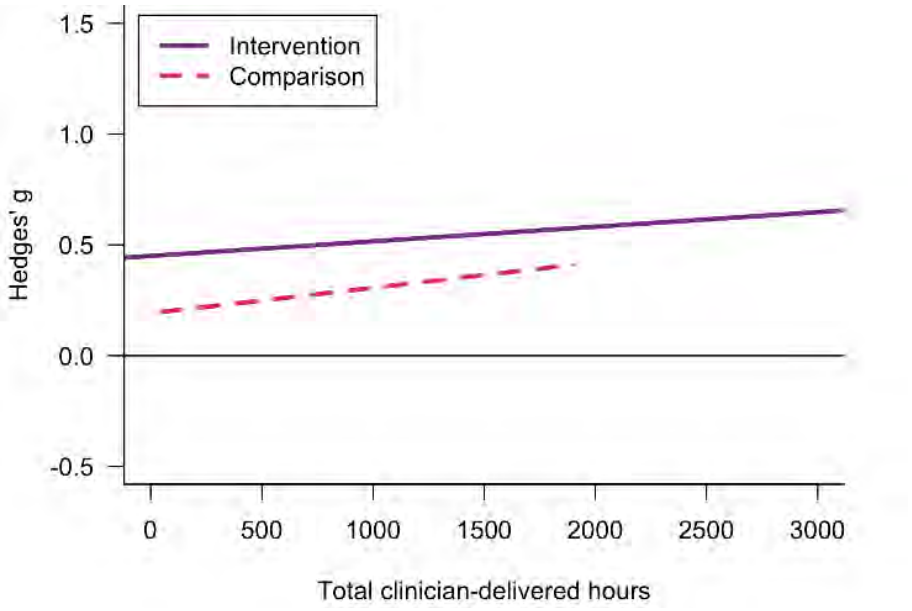


Figure 7c. Non-linear model of monthly clinician-delivered dose by effect size (Hedges' g) for change in all outcomes from pre- to post-intervention within intervention and comparison groups.

Note: Hedges' g > 0 = improvement in outcomes from baseline to follow-up in the specified group. Hedges' g > 0 = decrease in outcomes from baseline to follow-up in the specified group.

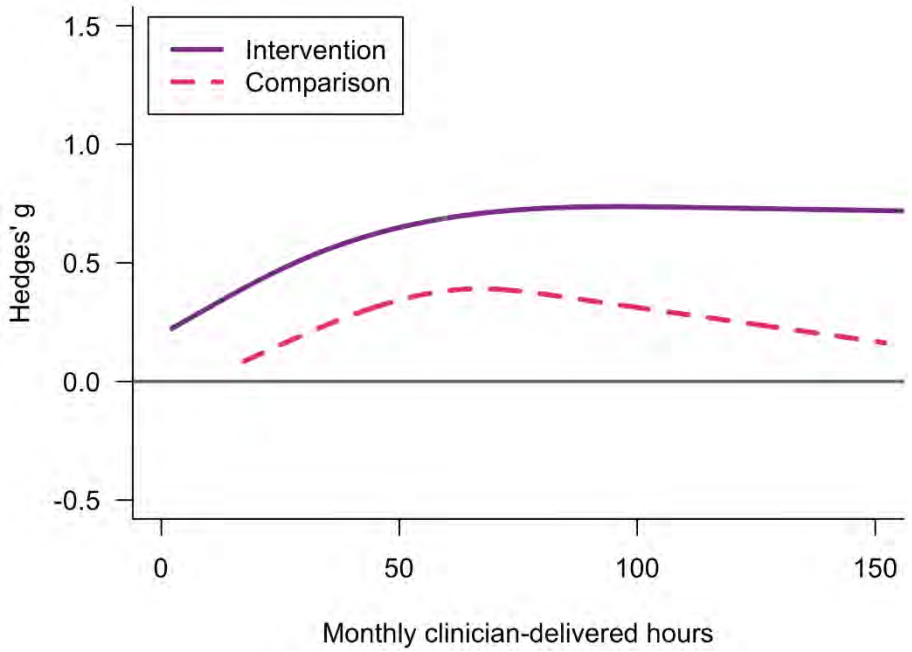
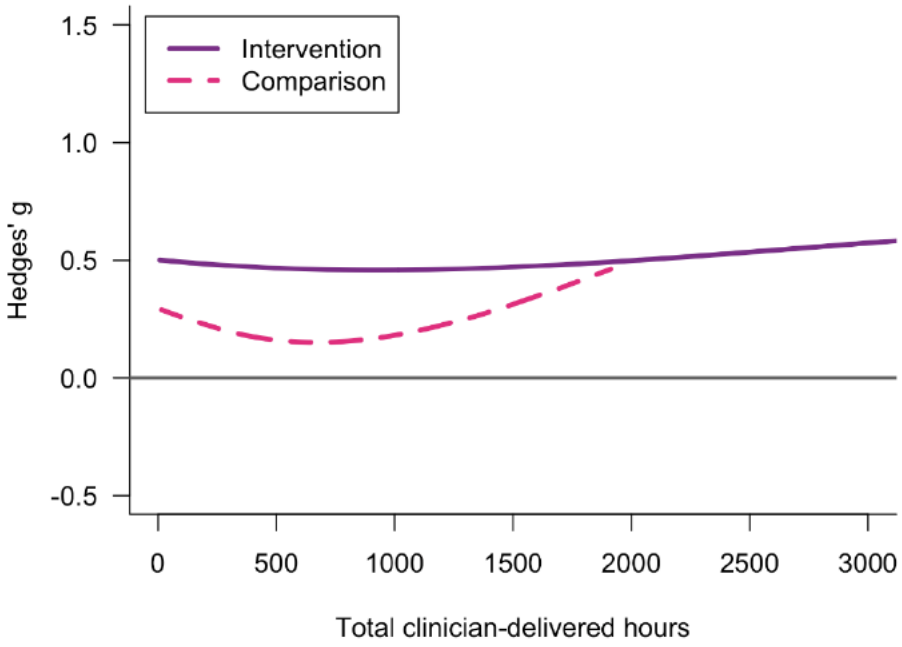


Figure 7d. Non-linear model of total clinician-delivered dose by effect size (Hedges' g) for change in all outcomes from pre- to post-intervention within intervention and comparison groups.

Note: Hedges' g > 0 = improvement in outcomes from baseline to follow-up in the specified group. Hedges' g > 0 = decrease in outcomes from baseline to follow-up in the specified group.



3.5 Efficacy within individual outcome domains

Efficacy within individual outcome domains: summary of findings

When the efficacy of the five outcome domains were investigated separately, evidence showed:

- There was a **small benefit** of behaviourally based interventions when compared to treatment as usual, waitlist, or non-behaviourally based, "eclectic" interventions on measures of autism characteristics, adaptive functioning, cognition and language, family outcomes and reductions in adverse effects (i.e., parent stress).
- There were large variances in effect estimates between studies (i.e., heterogeneity). This heterogeneity may be related to differences among studies, such as population, intervention, and study design factors. Analyses of some of these factors are provided in **Sections 6.6** and **6.7** below.

The efficacy of behaviourally based interventions was investigated across five outcome domains, which represent typical autism characteristics and behaviours, including autism characteristics, adaptive functioning, and cognition and language, as well as family outcomes and reductions in adverse effects (i.e., child and parent stress). These outcome domains are detailed in **Section 4.1.1**.

Small effect sizes for outcomes in all five outcome domains were identified (see **Figure 8** for individual estimates). However, they represent better performance in the behaviourally based intervention group when compared with the comparative group across all outcomes.

There was some evidence that effect sizes for the autism characteristics outcome domain were larger in smaller studies, which can be indicative of over-estimation of treatment effect for this outcome. After estimating the bias, the effect estimate was reduced from 0.32 (95%CI 0.24 to 0.39) to 0.22 (95%CI 0.15 to 0.29). This estimated effect size which accounts for this bias is reported in **Appendix 2**.

While pooled effect estimates for all five domains are statistically significant (confidence intervals do not include 0), there is large variability in the prediction intervals (i.e., the range of true effects across studies) (see **Figure 8**). This large variability indicates that some behaviourally based interventions may have no effect on investigated outcomes.

Figure 8. Forest plot of pooled effect sizes of overall efficacy for specific domains

Note: An accessible version of the data displayed in this figure is presented in Table 3 below. The prediction interval indicates the range of true effects across studies. Tau^2 is a measure of statistical heterogeneity, which gives an estimation of the extent to which an effect estimate is inconsistent across studies.

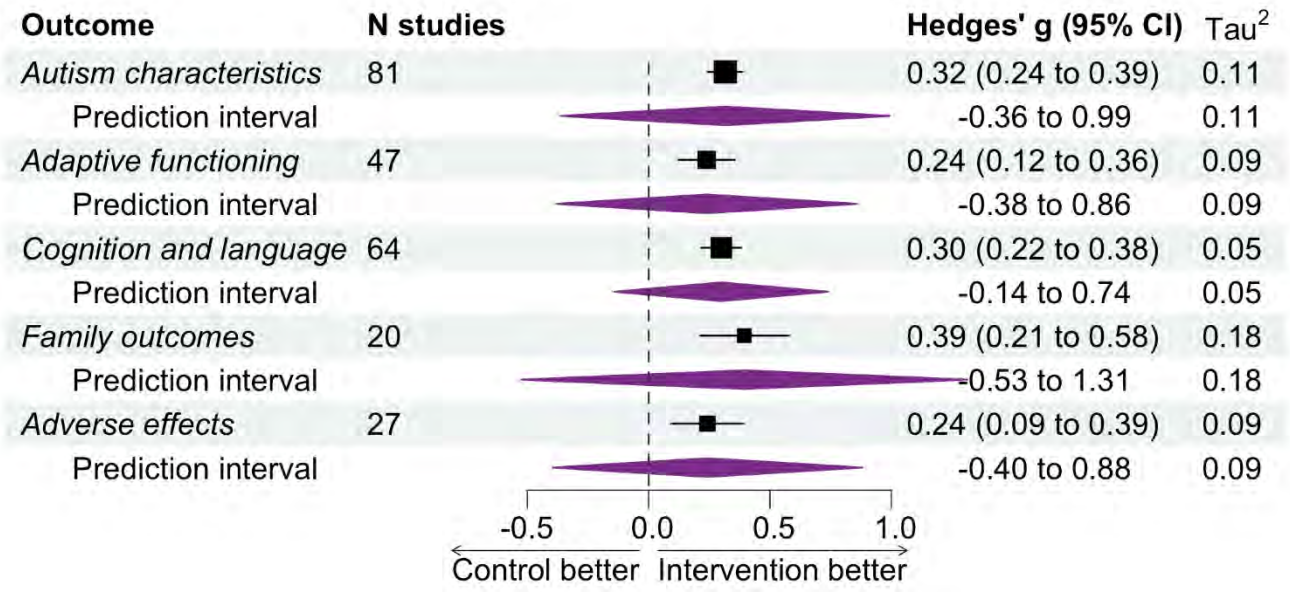


Table 3. Table version of forest plot of pooled effect sizes of overall efficacy for specific domains

Note: This table presents the information displayed in Figure 8 in an accessible format. The prediction interval indicates the range of true effects across studies. Tau^2 is a measure of statistical heterogeneity, which gives an estimation of the extent to which an effect estimate is inconsistent across studies.

Outcome	N studies	Hedges' g (96% CI)	Prediction interval	Tau^2
Autism characteristics	81	0.32 (0.24 to 0.39)	-0.36 to 0.99	0.11
Adaptive functioning	47	0.24 (0.12 to 0.36)	-0.38 to 0.86	0.09
Cognition and language	64	0.30 (0.22 to 0.38)	-0.14 to 0.74	0.05
Family outcomes	20	0.39 (0.21 to 0.58)	-0.53 to 1.31	0.18
Adverse effects	27	0.24 (0.09 to 0.39)	-0.40 to 0.88	0.09

It is important to explore this variability to find what factors are associated with best outcomes and what should be avoided. This was achieved by investigating changes in the effect across different factors (subgroups) and differences between these. In the following sections, the impact of dose, intervention (content, delivery, setting) and population (age) subgroups were investigated. These subgroups are detailed in **Section 4.1.3**.

3.6 Investigating the effect of dose

Investigating the effect of dose: summary of findings

Autism characteristics

No dose relationship was found between **total** or **monthly** clinician-delivered intervention hours and autism characteristic outcomes.

This means that there is no evidence for added benefit of increasing intervention hours or intensity for autism characteristic outcomes. Small benefits of behaviourally based interventions above that of the comparison group are consistently seen, regardless of the total or monthly clinician-delivered hours received.

Adaptive functioning

A dose relationship was found, with increased **total** and **monthly** clinician-delivered hours associated with better adaptive functioning outcomes following behaviourally based interventions.

The associated real-world impact of relatively smaller increases in intervention hours is minimal.

- Every increase in the total intervention dose by 100 hours translates to less than a 1% increase in standard deviation for the effect estimate.

- Every increase in the intervention dose intensity by 10 hours per month translates to an increase of only 3% of a standard deviation of the effect estimate.

Doses below approximately 65 hours per month or 800 total intervention hours may not produce the desired effect (inefficacious).

Increasing efficacy with increased total and monthly hours may be driven by decreasing outcomes with more clinician-delivered intervention hours in comparison group, rather than a specific benefit of behaviourally based interventions.

Cognition and language
A dose relationship was found, with increased **total** and **monthly** clinician-delivered hours associated with better cognition and language outcomes following behaviourally based interventions.

No evidence for a minimal required dose. Small, positive intervention effects are present even at lower total dose amounts and dose intensities, but slightly increasing with additional hours.

The associated real-world impact of relatively smaller increases in intervention hours is minimal.

- Every increase in the total intervention dose by 100 hours translates to less than a 1% increase in standard deviation for the effect estimate.
- Every increase in the intervention dose intensity by 10 hours per month translates to an increase of only 2% of a standard deviation of the effect estimate.

A relationship between increasing total clinician hours and improved outcomes was found for both the intervention and comparison groups, suggesting that the finding of better outcomes with increased hours is likely related to the amount of time spent with a clinician than the actual intervention taking place.

3.6.1 Autism characteristics

Relationship between dose and efficacy

The linear and non-linear models indicate no dose relationship between **total** or **monthly** clinician-delivered hours and efficacy of behaviourally based interventions for autism characteristics (see **Figure 9**). This shows that increasing the dose of an intervention (**total** or **monthly** clinician hours) does not change the efficacy of behaviourally based interventions for autism characteristics.

Linear model estimates are reported in **Table B10**.

Figure 9a. Linear model of monthly clinician-delivered dose by effect size (Hedges' g) for autism characteristics outcomes.

Note: Hedges' g > 0 = better outcomes in the intervention group compared to the comparison group. Hedges' g < 0 = better outcomes in the comparison group compared to the intervention group.

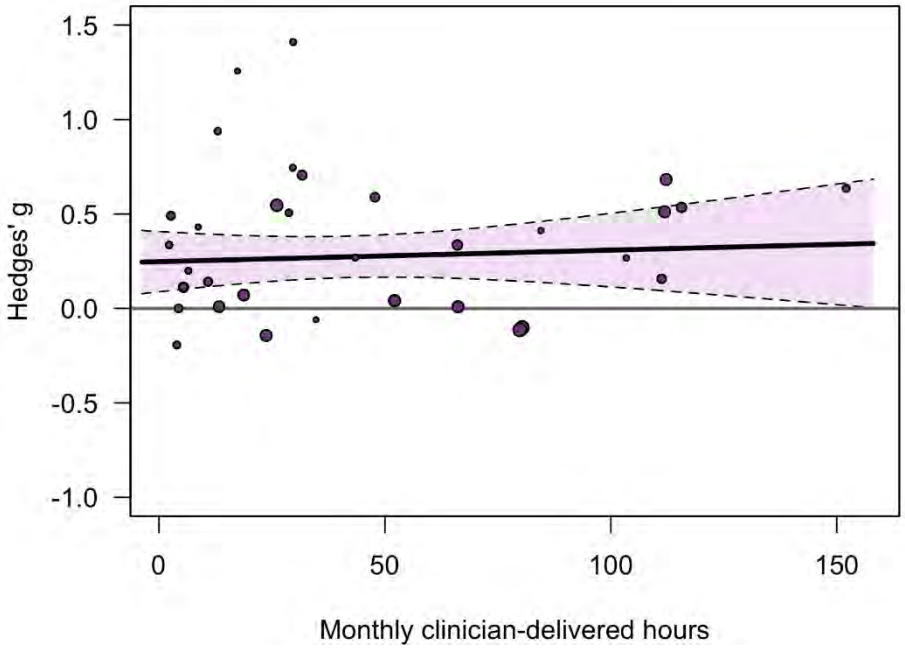


Figure 9b. Linear model of total clinician-delivered dose by effect size (Hedges' g) for autism characteristics outcomes.

Note: Hedges' g > 0 = better outcomes in the intervention group compared to the comparison group. Hedges' g < 0 = better outcomes in the comparison group compared to the intervention group.

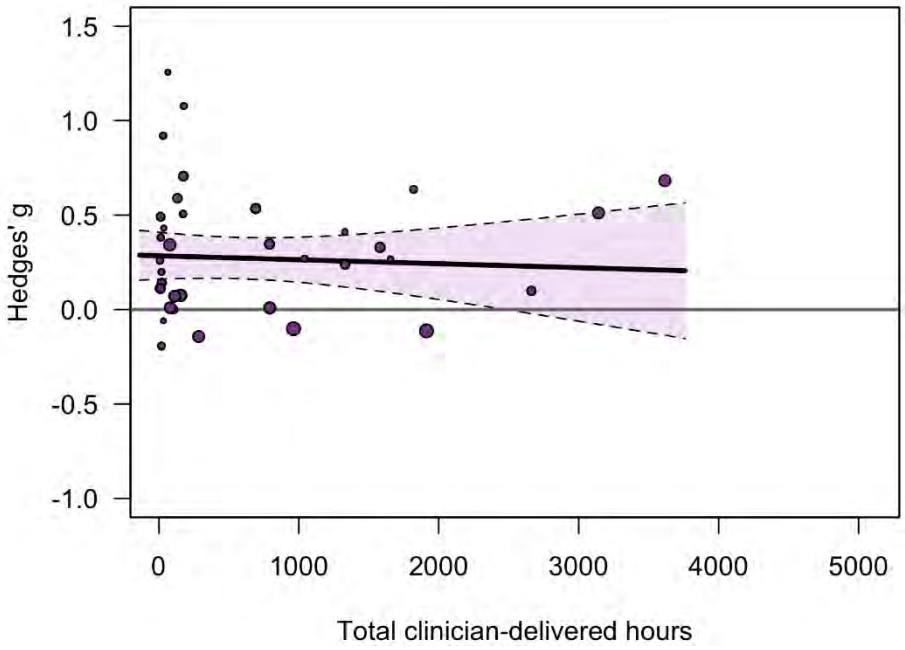


Figure 9c. Non-linear model of monthly clinician-delivered dose by effect size (Hedges' g) for autism characteristics outcomes.

Note: Hedges' g > 0 = better outcomes in the intervention group compared to the comparison group. Hedges' g < 0 = better outcomes in the comparison group compared to the intervention group.

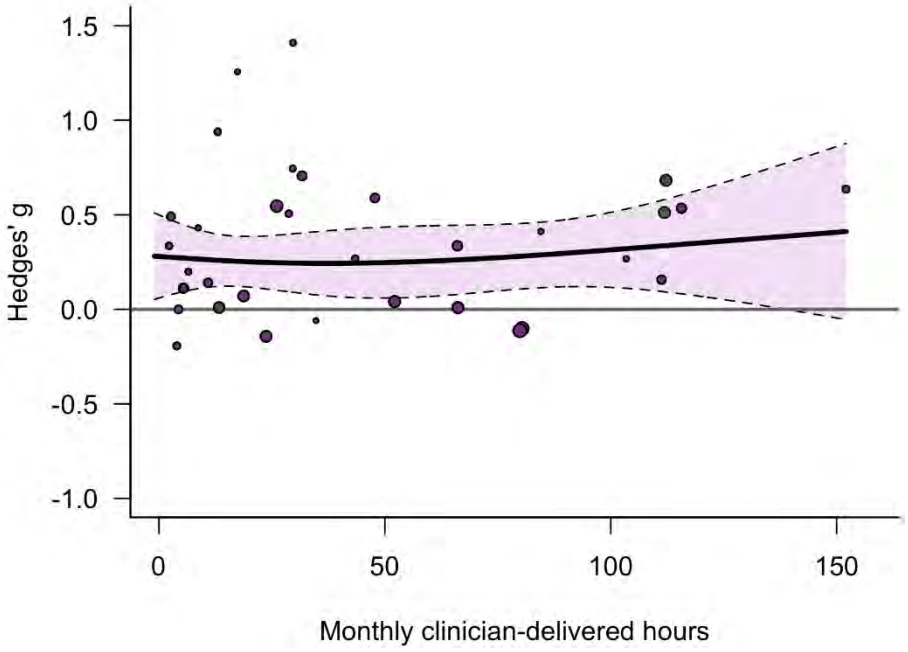
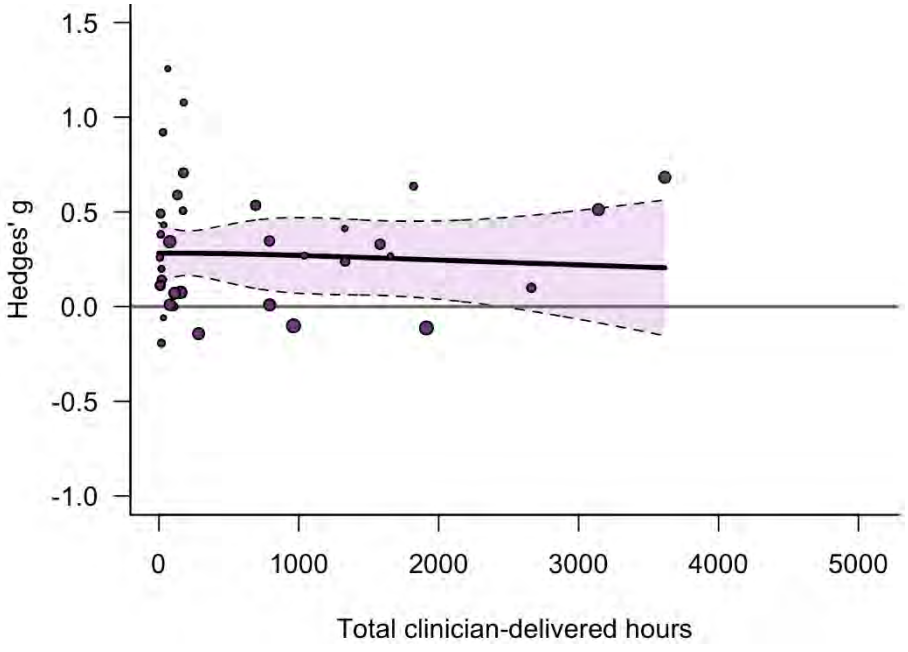


Figure 9d. Non-linear model of total clinician-delivered dose by effect size (Hedges' g) for autism characteristics outcomes.

Note: Hedges' g > 0 = better outcomes in the intervention group compared to the comparison group. Hedges' g < 0 = better outcomes in the comparison group compared to the intervention group.



Comparing efficacy for lower versus higher total and monthly dose

The results did not show a difference in efficacy between behaviourally based interventions delivered for less than the median dose versus more than the median dose, for both **total** and **monthly** clinician-delivered hours on autism characteristics (see **Figure 10** and **Table 4**). This confirms that efficacy of behaviourally based interventions on autism characteristics does not differ between lower and higher hours of intervention.

Table 4. Results of analyses comparing lower and higher total and monthly doses for autism characteristics.

	Monthly clinician-delivered hours	Total clinician-delivered hours
Median hours	29.66 monthly hours	156 total hours
Lower dose: Less than median hours	**N studies:** 156 total hours **Hedges' g (95% CI):** 0.28 (0.09-0.46)	**N studies:** 16 studies **Hedges' g (95% CI):** 0.27 (0.09-0.45)
Higher dose: Greater than median hours	**N studies:** 15 studies **Hedges' g (95% CI):** 0.30 (0.12-0.48)	**N studies:** 17 studies **Hedges' g (95% CI):** 0.30 (0.12-0.47)

Figure 10a. Linear dose relationship for lower versus higher monthly clinician hours (based on median) for autism characteristic outcomes.

Note: The green shaded area indicates less than the median number of monthly clinician-delivered hours, and the pink shaded area indicates higher than the median number of monthly clinician-delivered hours for this outcome.

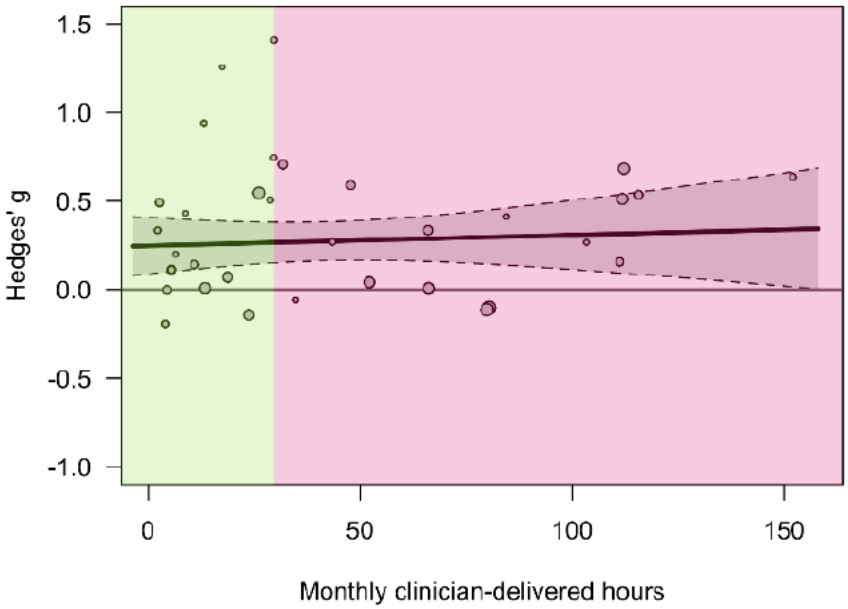
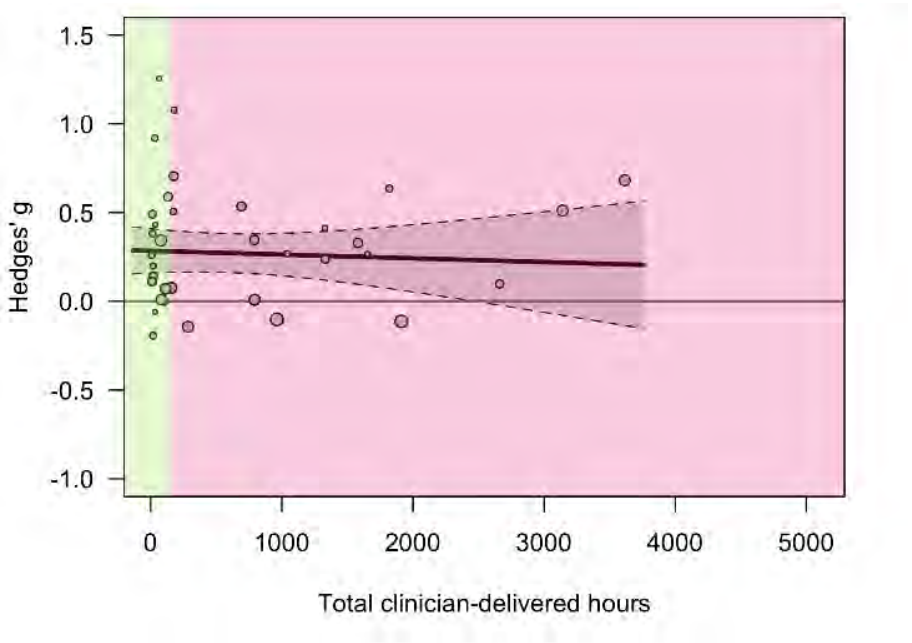


Figure 10b. Linear dose relationship for lower versus higher total clinician hours (based on median) for autism characteristic outcomes.

Note: The green shaded area indicates less than the median number of monthly clinician-delivered hours, and the pink shaded area indicates higher than the median number of monthly clinician-delivered hours for this outcome.



Relationship between dose and change from baseline to follow-up separately within the intervention group and the comparison group

The lack of relationship between dose and effect size was corroborated by analyses exploring the relationship between dose and change from baseline to follow-up separately in both the intervention and comparison groups (see **Figure 11**). Neither those who received behaviourally based interventions nor those who received some level of clinician contact hours in the comparative group (through treatment as usual, e.g., speech pathology) benefited from more intensive doses or higher total contact hours with a clinician (see **Tables B11 & B12** for model results).

The non-linear model suggested a gradual increase in effect with increasing monthly hours for the behaviourally based intervention group (**Figure 11**). However, confidence in this result is low due to a limited number of studies providing high intensity interventions. Individual linear and non-linear models with 95% confidence intervals are shown in **Figures B15 & B19**.

Figure 11a. Linear model of monthly clinician-delivered dose by effect size (Hedges' g) for change in autism characteristic outcomes from pre- to post-intervention within intervention and comparison groups.

Note: Hedges' g > 0 = improvement in outcomes from baseline to follow-up in the specified group. Hedges' g > 0 = decrease in outcomes from baseline to follow-up in the specified group.

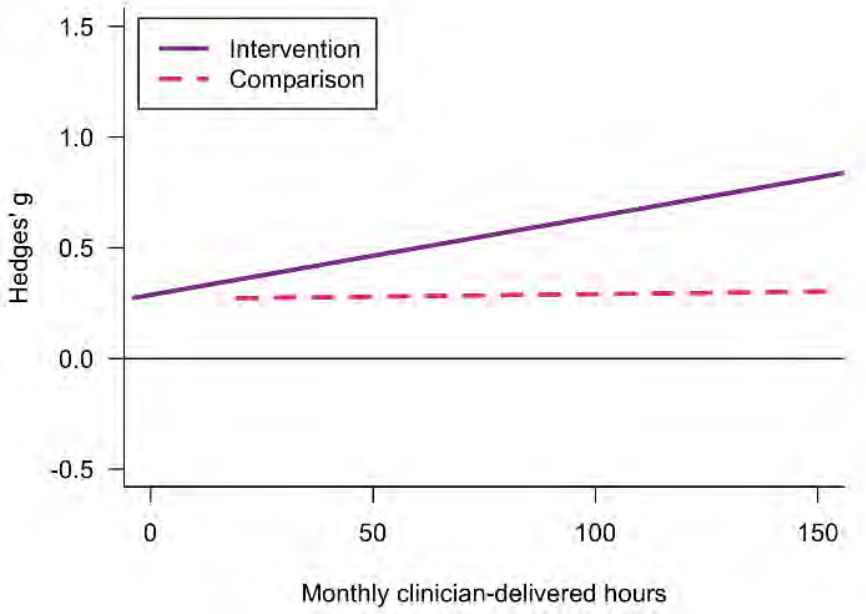


Figure 11b. Linear model of total clinician-delivered dose by effect size (Hedges' g) for change in autism characteristic outcomes from pre- to post-intervention within intervention and comparison groups.

Note: Hedges' g > 0 = improvement in outcomes from baseline to follow-up in the specified group. Hedges' g > 0 = decrease in outcomes from baseline to follow-up in the specified group.

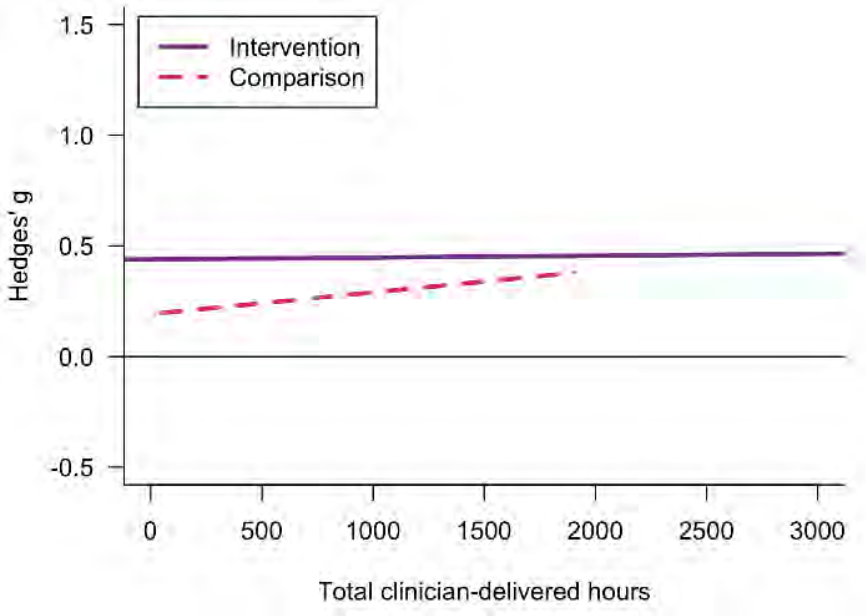


Figure 11c. Non-linear model of monthly clinician-delivered dose by effect size (Hedges' g) for change in autism characteristic outcomes from pre- to post-intervention within intervention and comparison groups.

Note: Hedges' g > 0 = improvement in outcomes from baseline to follow-up in the specified group. Hedges' g > 0 = decrease in outcomes from baseline to follow-up in the specified group.

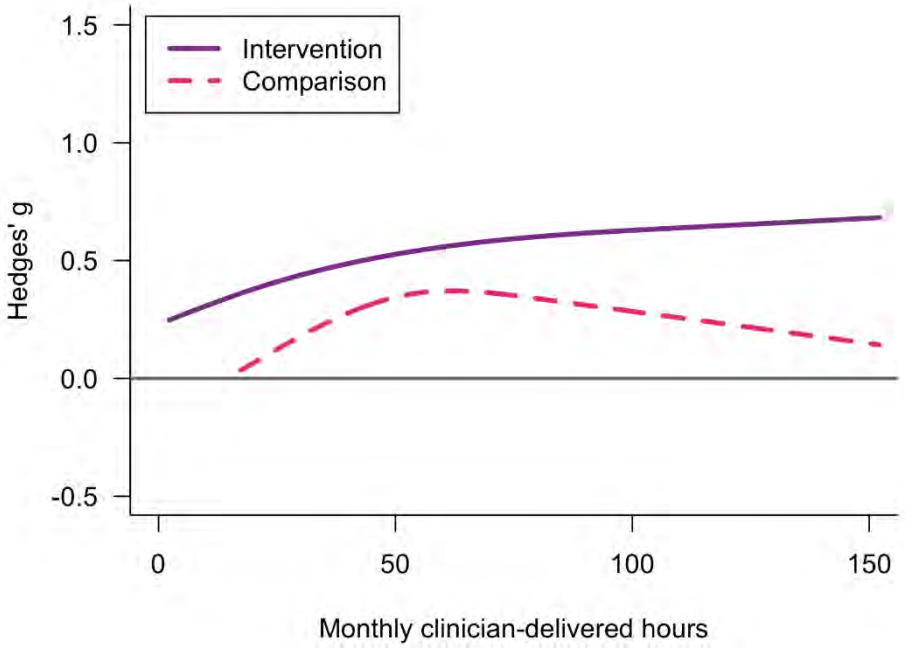
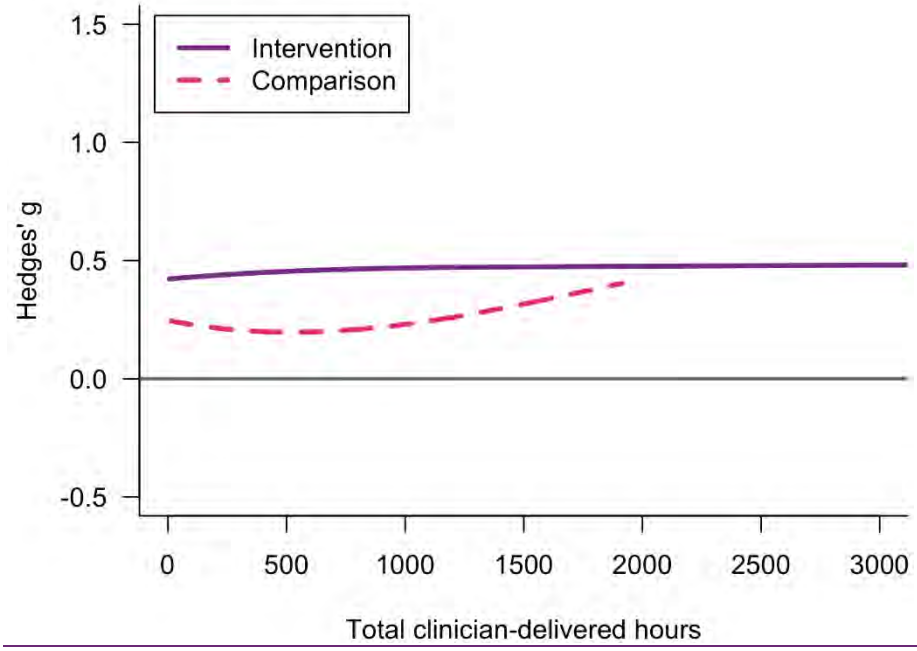


Figure 11d. Non-linear model of total clinician-delivered dose by effect size (Hedges' g) for change in autism characteristic outcomes from pre- to post-intervention within intervention and comparison groups.

Note: Hedges' g > 0 = improvement in outcomes from baseline to follow-up in the specified group. Hedges' g > 0 = decrease in outcomes from baseline to follow-up in the specified group.



3.6.2 Adaptive functioning

Relationship between dose and efficacy

The linear models show a statistically significant relationship between increasing **total** and **monthly** clinician-delivered hours of intervention and better adaptive functioning outcomes following behaviourally based intervention (see **Figure 12** and **Table B10** for model estimates). Non-linear modelling demonstrated similar results (see **Figure 12**), with only slightly improved model fit. A visual investigation of the non-linear model suggested that adaptive function may require large doses to achieve a clinically meaningful effect size, with negligible effects shown at lower doses.

Although the linear dose response trends were statistically significant, the associated real-world impact of relatively smaller increases in intervention hours is minimal. Every increase of the intervention dose by 10 hours per month translates to an increase of only 3% of a standard deviation of the effect estimate. Similarly, every increase of 100 total hours of intervention overall translates to less than a 1% increase in standard deviation for the effect estimate.

Figure 12a. Linear model of monthly clinician-delivered dose by effect size (Hedges' g) for adaptive functioning outcomes.

Note: Hedges' g > 0 = better outcomes in the intervention group compared to the comparison group. Hedges' g < 0 = better outcomes in the comparison group compared to the intervention group.

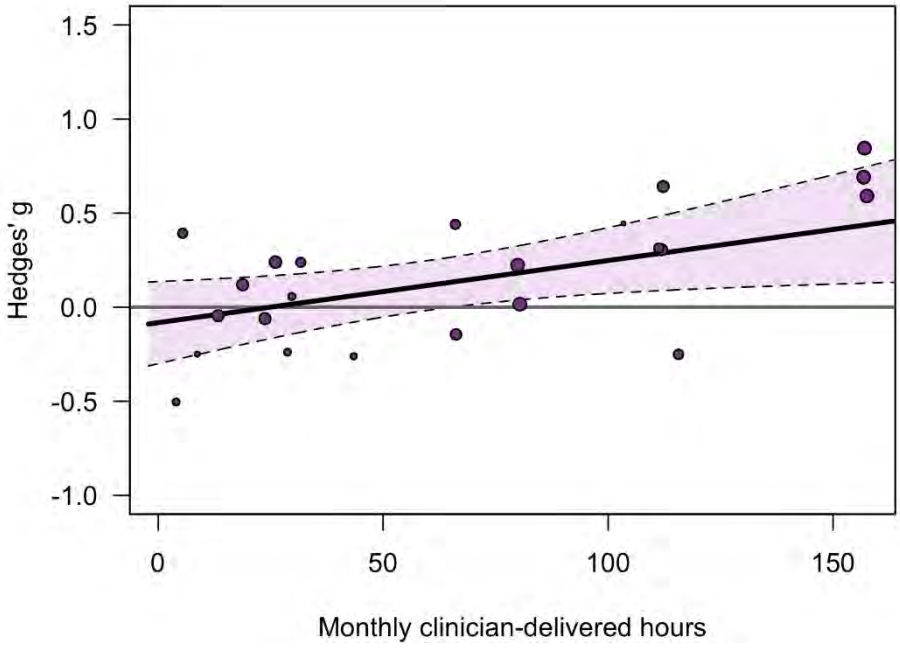


Figure 12b. Linear model of total clinician-delivered dose by effect size (Hedges' g) for adaptive functioning outcomes.

Note: Hedges' g > 0 = better outcomes in the intervention group compared to the comparison group. Hedges' g < 0 = better outcomes in the comparison group compared to the intervention group.

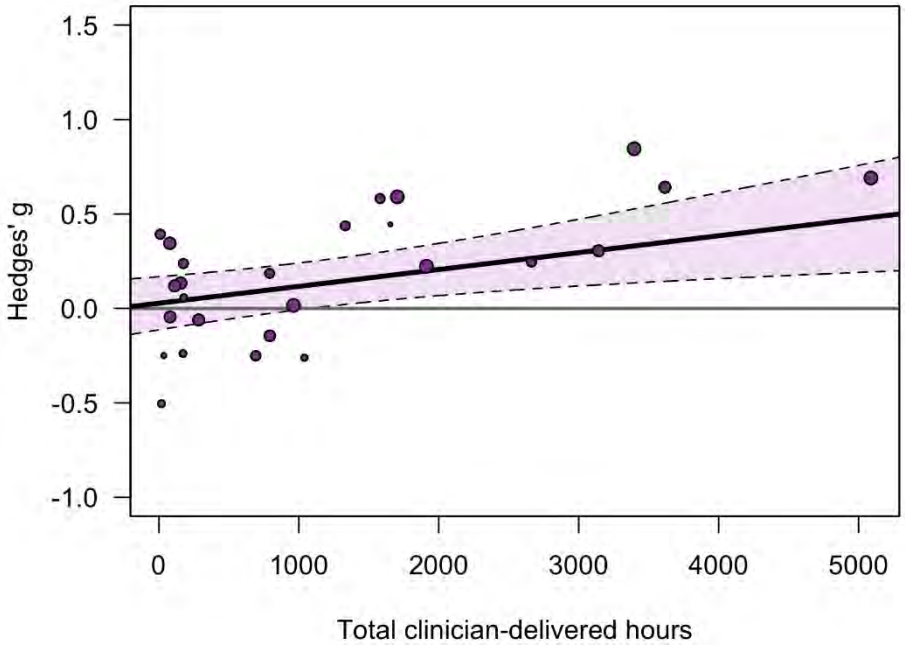


Figure 12c. Non-linear model of monthly clinician-delivered dose by effect size (Hedges' g) for adaptive functioning outcomes.

Note: Hedges' g > 0 = better outcomes in the intervention group compared to the comparison group. Hedges' g < 0 = better outcomes in the comparison group compared to the intervention group.

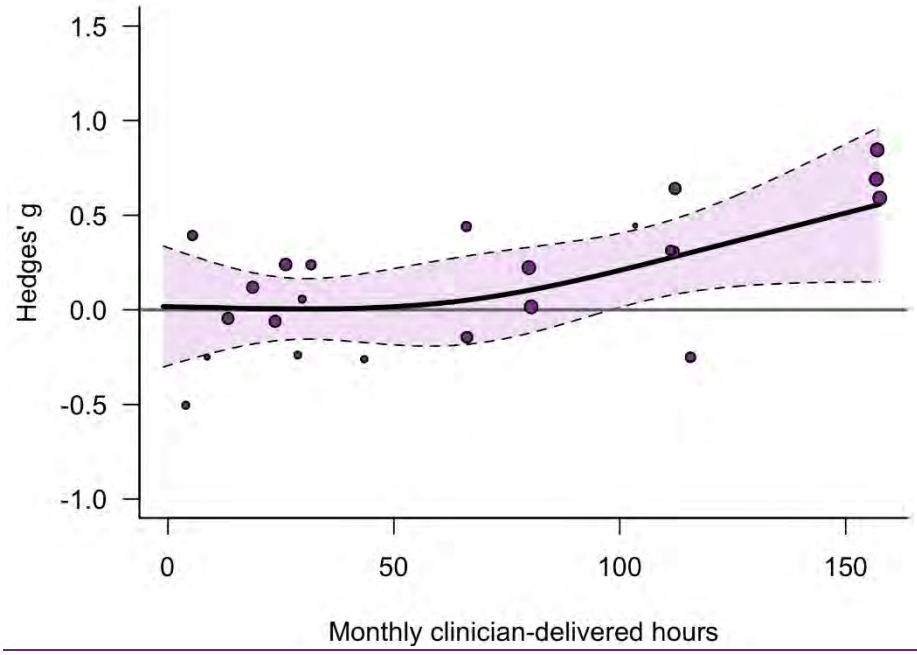
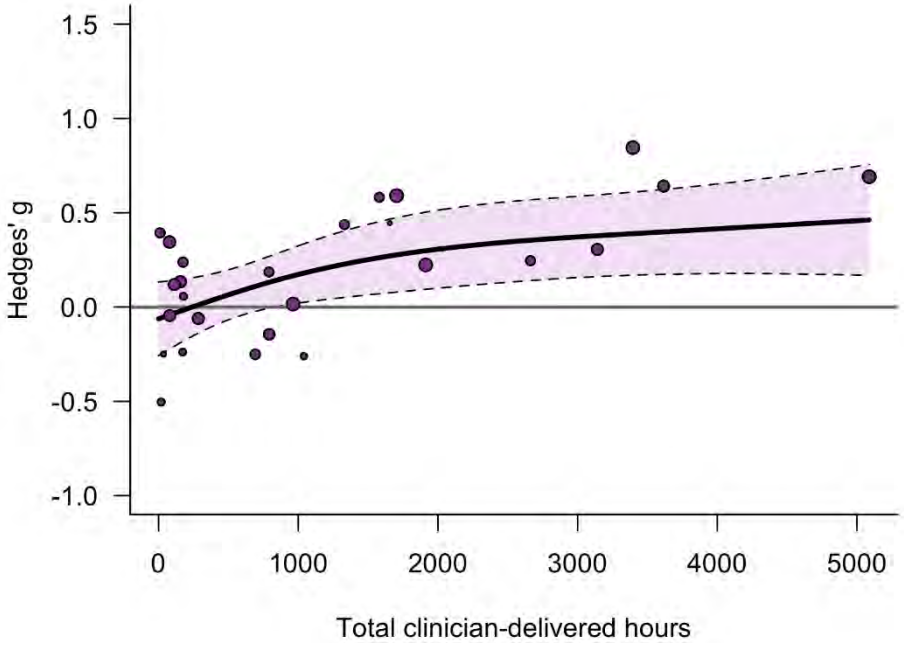


Figure 12d. Non-linear model of total clinician-delivered dose by effect size (Hedges' g) for adaptive functioning outcomes.

Note: Hedges' g > 0 = better outcomes in the intervention group compared to the comparison group. Hedges' g < 0 = better outcomes in the comparison group compared to the intervention group.



Comparing efficacy for lower versus higher total and monthly dose

A difference in effect sizes was found between studies that delivered less than the median dose and those that delivered doses higher than the median, both for total clinician-delivered hours as well as hours per month (see **Figure 13** for visual representation). Effect sizes were larger in studies that delivered doses at a higher versus lower dose, where a negligible effect size was found for the lower dose, and a small effect size for the higher dose. Practically, this suggests there are negligible effects below approximately 65 hours per month or 800 clinician hours overall.

However, there was not enough information (i.e., statistical power and precision) to detect a statistically significant difference between groups as only 10 and 8 studies, and 11 and 8 studies were available for analyses of both dose types. More detailed results can be found in **Table 5**.

Table 5. Results of analyses comparing lower and higher total and monthly doses for adaptive functioning.

	Monthly clinician-delivered hours	Total clinician-delivered hours
Median hours	66.04 monthly hours	791.20 total hours
Lower dose: Less than median hours	**N studies:** 10 studies **Hedges' g (95% CI):** 0.03 (-0.16-0.22)	**N studies:** 11 studies **Hedges' g (95% CI):** 0.03 (-0.15-0.21)
Higher dose: Greater than median hours	**N studies:** 8 studies **Hedges' g (95% CI):** 0.26 (-0.05-0.56)	**N studies:** 8 studies **Hedges' g (95% CI):** 0.30 (-0.03-0.62)

Figure 13a. Linear dose relationship for lower versus higher total and monthly clinician hours (based on median) for adaptive functioning outcomes.

Note: The green shaded area indicates less than the median number of monthly clinician-delivered hours, and the pink shaded area indicates higher than the median number of monthly clinician-delivered hours for this outcome.

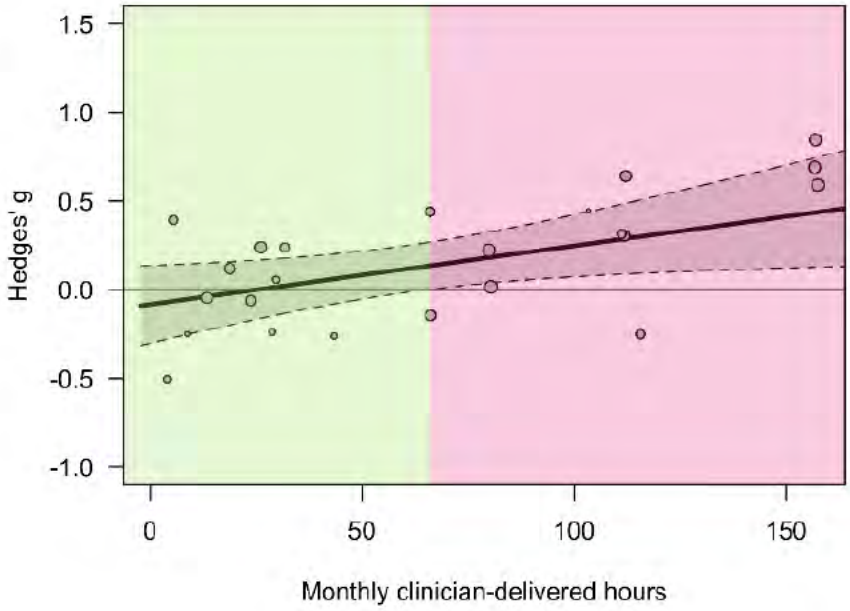
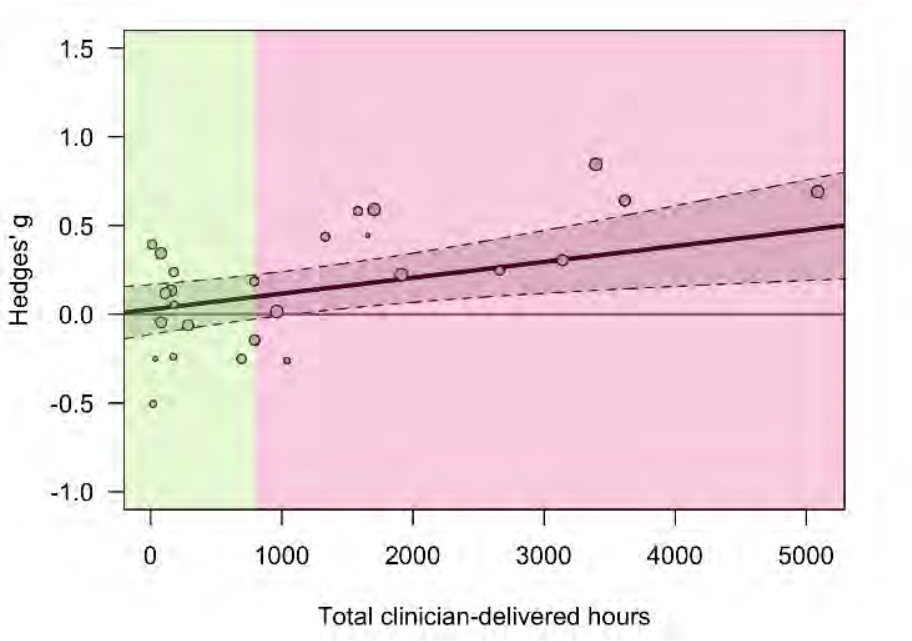


Figure 13b. Linear dose relationship for lower versus higher total and monthly clinician hours (based on median) for adaptive functioning outcomes.

Note: The green shaded area indicates less than the median number of monthly clinician-delivered hours, and the pink shaded area indicates higher than the median number of monthly clinician-delivered hours for this outcome.



Relationship between dose and change from baseline to follow-up separately within the intervention group and the comparison group

Analyses of the change from baseline to follow-up separately within the intervention and comparison groups provide some indication that the relationship between clinician time and effect size are specific to the intervention group. Linear models (see **Figure 14** and **Table B11**) revealed a statistically significant relationship (albeit small) between increasing **total** and **monthly** clinician-delivered hours of intervention and better adaptive functioning outcomes at follow-up for the behaviourally based intervention group, while no such relationship was observed between clinician hours and change in outcomes from baseline to follow-up within the comparison groups (see **Figure 14** and **Table B12**). Individual models with 95% confidence intervals are displayed in **Figures B16 & B20**.

Additionally, the non-linear models (**Figure 14**) indicate that improvements from baseline to follow-up within the behaviourally based intervention groups decrease after approximately 100 monthly hours. This may imply that the apparent increase in efficacy (comparing the intervention to the comparison group) with increasing dose (**Figure 14**) is driven by a decrease in effect within comparison groups rather than a specific benefit of more intervention hours for the behaviourally based intervention group. However, these results are based on a small number of studies and not all comparison group data are available, and therefore should be interpretated with caution.

Figure 14a. Linear model of monthly clinician-delivered dose by effect size (Hedges' g) for change in adaptive functioning outcomes from pre- to post-intervention in the intervention and comparison group.

Note: Hedges' g > 0 = improvement in outcomes from baseline to follow-up in the specified group. Hedges' g > 0 = decrease in outcomes from baseline to follow-up in the specified group.

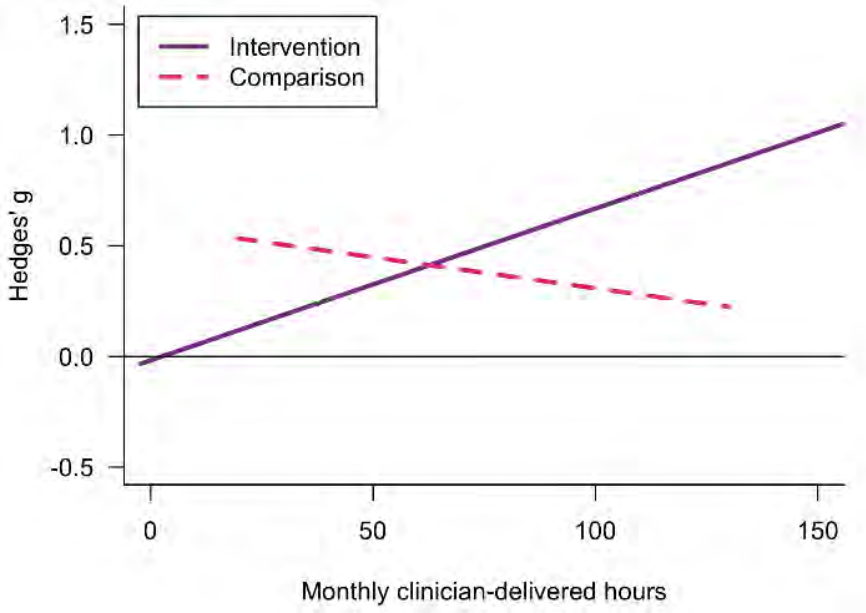


Figure 14b. Linear model of total clinician-delivered dose by effect size (Hedges' g) for change in adaptive functioning outcomes from pre- to post-intervention in the intervention and comparison group.

Note: Hedges' g > 0 = improvement in outcomes from baseline to follow-up in the specified group. Hedges' g > 0 = decrease in outcomes from baseline to follow-up in the specified group.

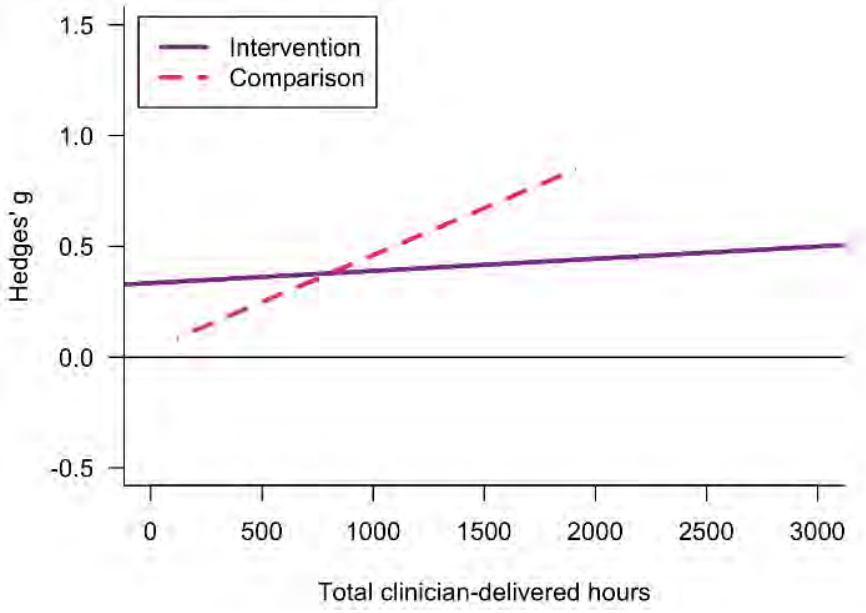


Figure 14c. Non-linear model of monthly clinician-delivered dose by effect size (Hedges' g) for change in adaptive functioning outcomes from pre- to post-intervention in the intervention and comparison group.

Note: Hedges' g > 0 = improvement in outcomes from baseline to follow-up in the specified group. Hedges' g > 0 = decrease in outcomes from baseline to follow-up in the specified group.

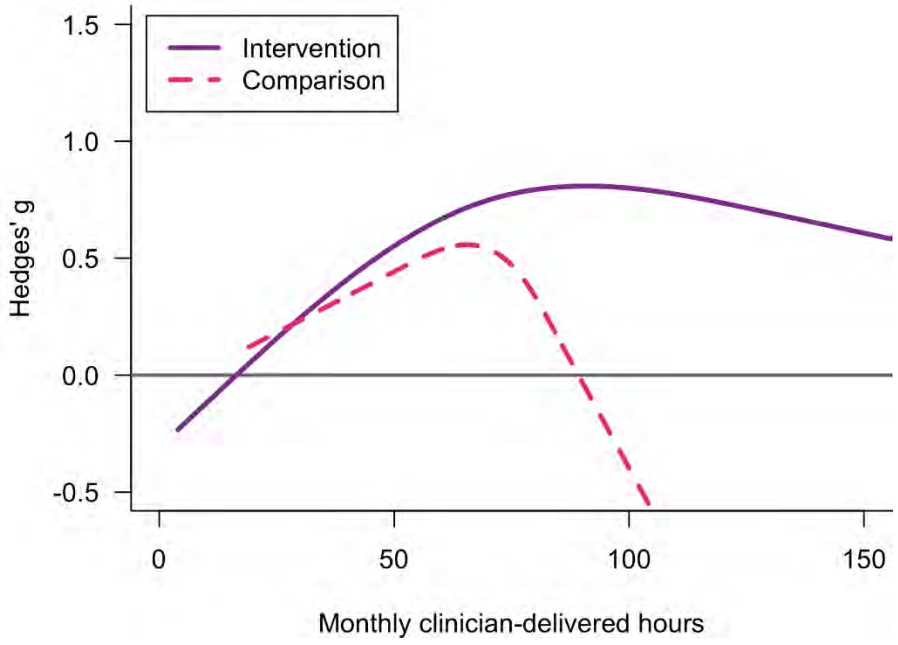
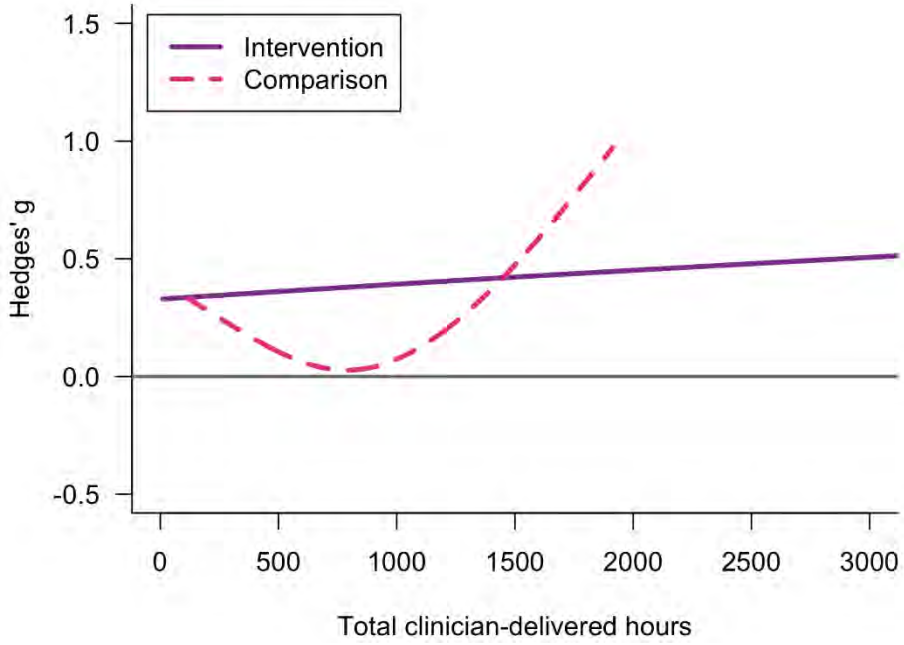


Figure 14d. Non-linear model of total clinician-delivered dose by effect size (Hedges' g) for change in adaptive functioning outcomes from pre- to post-intervention in the intervention and comparison group.

Note: Hedges' g > 0 = improvement in outcomes from baseline to follow-up in the specified group. Hedges' g > 0 = decrease in outcomes from baseline to follow-up in the specified group.



3.6.3 Cognition and language

Relationship between dose and efficacy

The linear models show a statistically significant relationship between increasing **total** and **monthly** clinician-delivered hours of intervention and better cognition and language outcomes following behaviourally based intervention as compared to a comparison group (see **Figure 15**). Linear model estimates are reported in **Table B10**. Non-linear modelling demonstrated similar results (see **Figure 15**), with only slightly improved model fit.

While the dose response trends for the linear models were statistically significant, similar to adaptive functioning outcomes, the associated real-world impact is of unclear clinical value. Every increase in dose of an additional 10 hours per month translates to an increase of 2% of a standard deviation of the effect estimate, and an increase in total dose of 100 additional intervention hours translates to less than a 1% increase. There is also less available evidence and thus less confidence (wider confidence intervals) in estimates for higher dose hours.

Figure 15a. Linear model of monthly clinician-delivered dose by effect size (Hedges' g) for cognition and language outcomes.

Note: Hedges' g > 0 = better outcomes in the intervention group compared to the comparison group. Hedges' g < 0 = better outcomes in the comparison group compared to the intervention group.

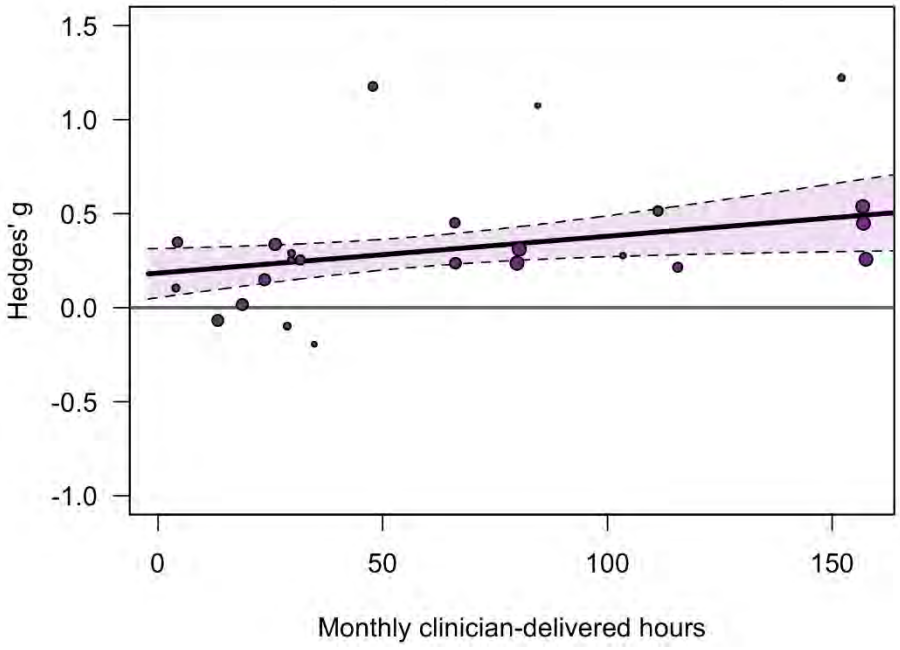


Figure 15b. Linear model of total clinician-delivered dose by effect size (Hedges' g) for cognition and language outcomes.

Note: Hedges' g > 0 = better outcomes in the intervention group compared to the comparison group. Hedges' g < 0 = better outcomes in the comparison group compared to the intervention group.

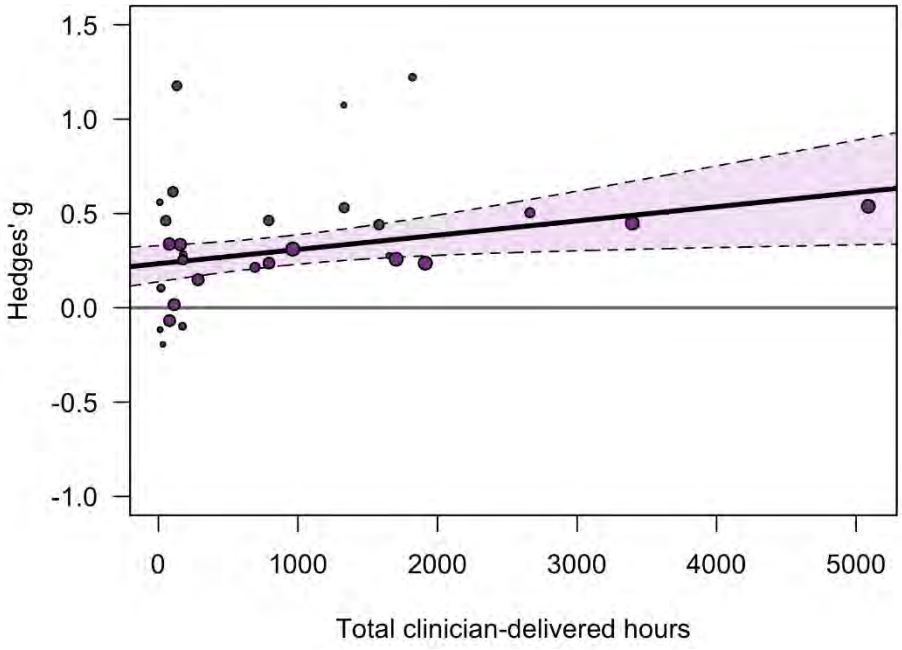


Figure 15c. Non-linear model of monthly clinician-delivered dose by effect size (Hedges' g) for cognition and language outcomes.

Note: Hedges' g > 0 = better outcomes in the intervention group compared to the comparison group. Hedges' g < 0 = better outcomes in the comparison group compared to the intervention group.

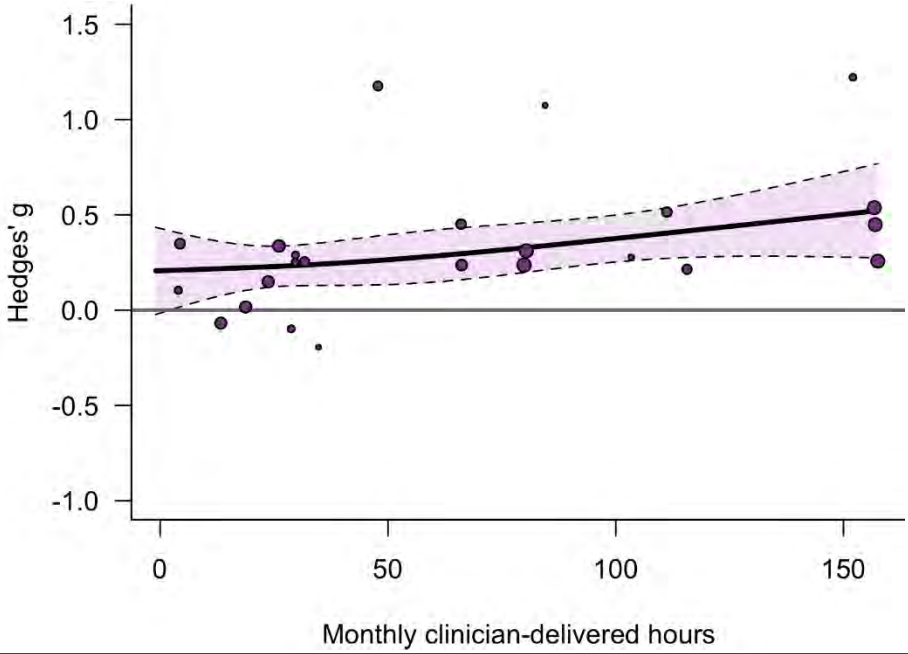
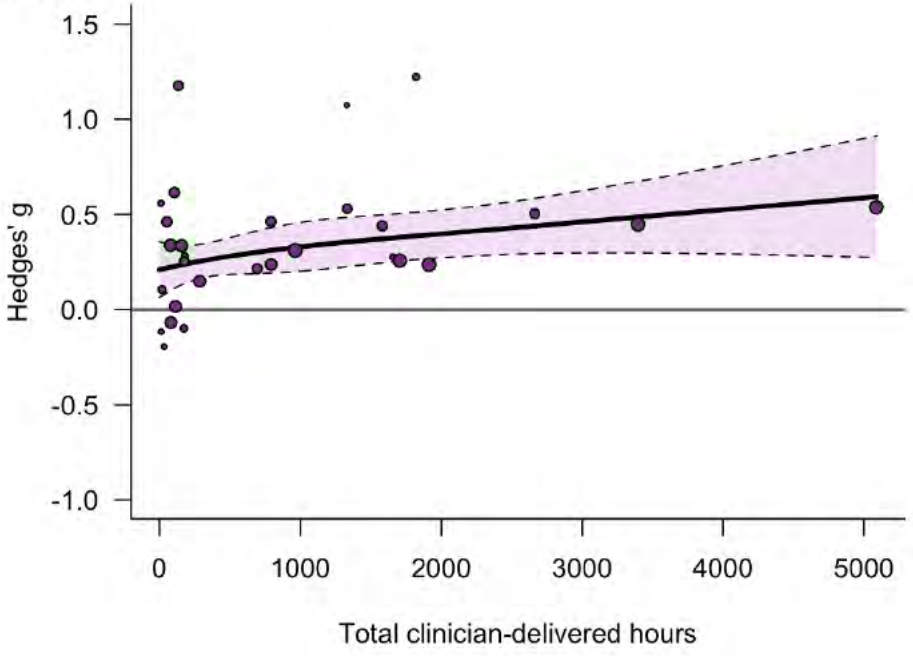


Figure 15d. Non-linear model of total clinician-delivered dose by effect size (Hedges' g) for cognition and language outcomes.

Note: Hedges' g > 0 = better outcomes in the intervention group compared to the comparison group. Hedges' g < 0 = better outcomes in the comparison group compared to the intervention group.



Comparing efficacy for lower versus higher total and monthly dose

The results did not show a difference in efficacy between the behaviourally based interventions delivered for less than the median dose of intervention versus more than the median dose of intervention, for both **total** and **monthly** clinician-delivered hours, on cognition and language outcomes (see **Figure 16** and **Table 6**). This confirms that efficacy of behaviourally based interventions on cognition and language outcomes does not differ between lower and higher **total** and **monthly** clinician-delivered intervention hours.

Table 6. Results of analyses comparing lower and higher total and monthly doses for cognition and language.

	Monthly clinician-delivered hours	Total clinician-delivered hours
Median hours	47.79 monthly hours	487.96 total hours
Lower dose: Less than median hours	**N studies:** 11 studies **Hedges' g (95% CI):** 0.20 (0.04-0.36)	**N studies:** 11 studies **Hedges' g (95% CI):** 0.21 (0.05-0.38)
Higher dose: Greater than median hours	**N studies:** 11 studies **Hedges' g (95% CI):** 0.40 (0.14-0.66)	**N studies:** 10 studies **Hedges' g (95% CI):** 0.39 (0.13-0.65)

Figure 16a. Linear dose relationship for lower versus higher monthly clinician hours (based on median) for cognition and language outcomes.

Note: The green shaded area indicates less than the median number of monthly clinician-delivered hours, and the pink shaded area indicates higher than the median number of monthly clinician-delivered hours for this outcome.

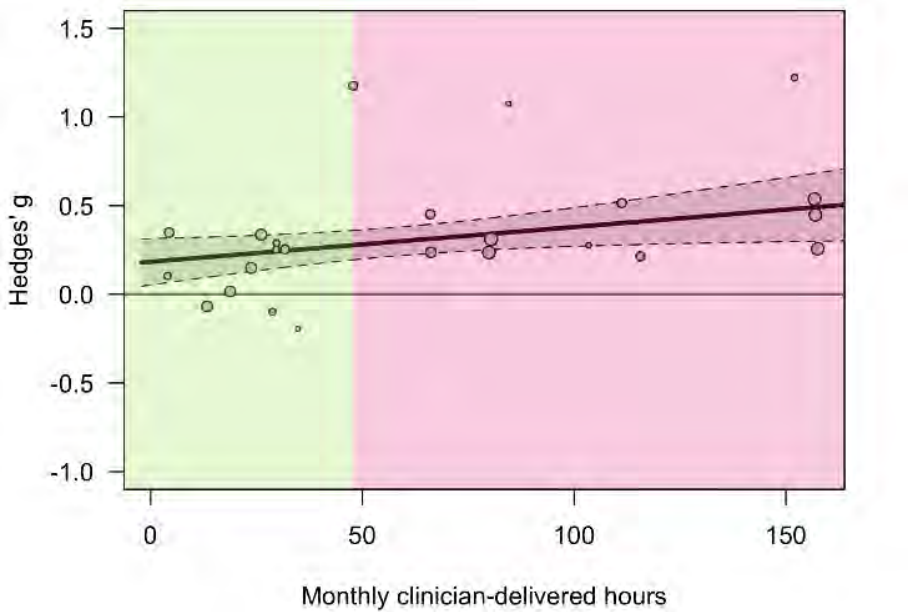
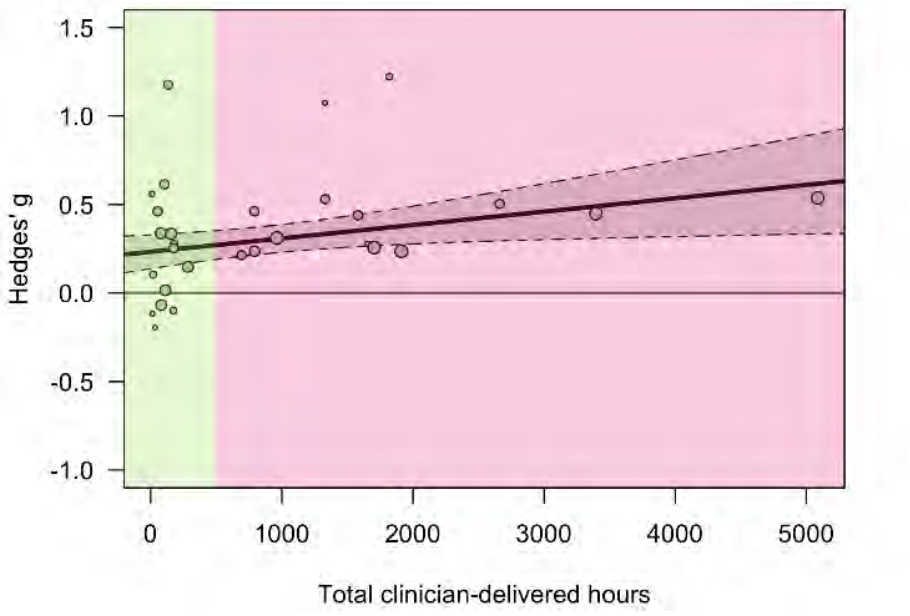


Figure 16b. Linear dose relationship for lower versus higher total clinician hours (based on median) for cognition and language outcomes.

Note: The green shaded area indicates less than the median number of monthly clinician-delivered hours, and the pink shaded area indicates higher than the median number of monthly clinician-delivered hours for this outcome.



Relationship between dose and change from baseline to follow-up separately within the intervention group and the comparison group

Analyses of change from baseline to follow-up separately within the intervention and comparison groups suggest that the relationship dose and effect size is not specific to the intervention. Linear models (see **Figure 17** and **Tables B11 & B12**) revealed statistically significant relationships between increasing **total** clinician hours and an improved outcomes from baseline to follow-up for both intervention and comparative groups, again with small coefficients (β = 0.0001 and 0.0002, respectively). Such relationships were not found for **monthly** clinician-delivered hours. This suggests that the slightly better outcomes with more hours are more likely to be related to amount of time spent with a clinician than the actual intervention taking place. The non-linear models (**Figure 17**) did not provide a clear indication of dose-response. Individual models with 95% confidence intervals can be seen in **Figures B17 & B21**.

Figure 17a. Linear model of monthly clinician-delivered dose by effect size (Hedges' g) for change in cognition and language outcomes from pre- to post-intervention in the intervention and comparison group.

Note: Hedges' g > 0 = improvement in outcomes from baseline to follow-up in the specified group. Hedges' g > 0 = decrease in outcomes from baseline to follow-up in the specified group.

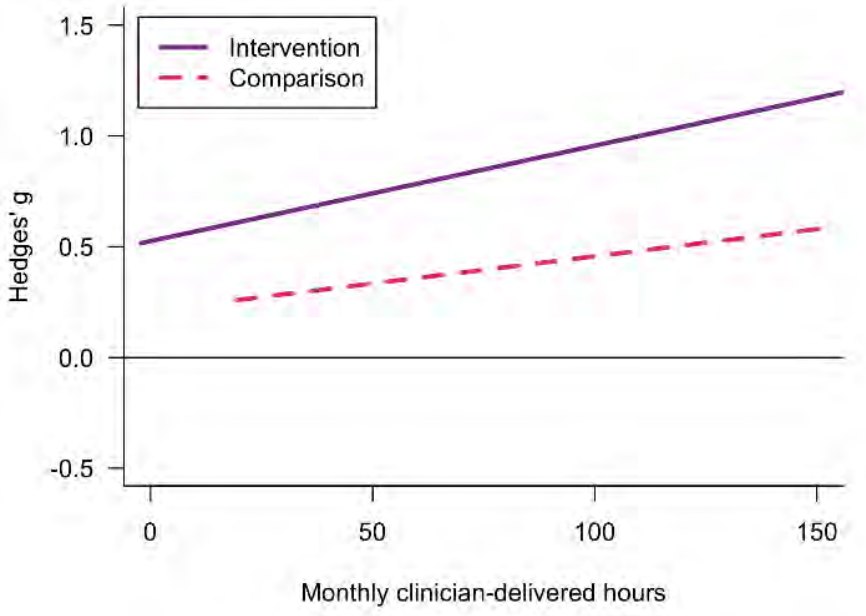


Figure 17b. Linear model of total clinician-delivered dose by effect size (Hedges' g) for change in cognition and language outcomes from pre- to post-intervention in the intervention and comparison group.

Note: Hedges' g > 0 = improvement in outcomes from baseline to follow-up in the specified group. Hedges' g > 0 = decrease in outcomes from baseline to follow-up in the specified group.

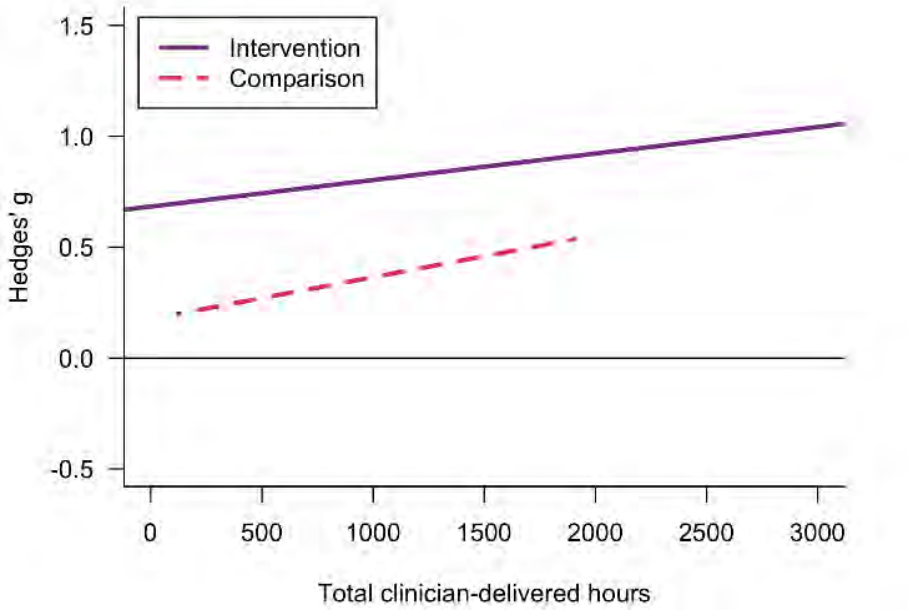
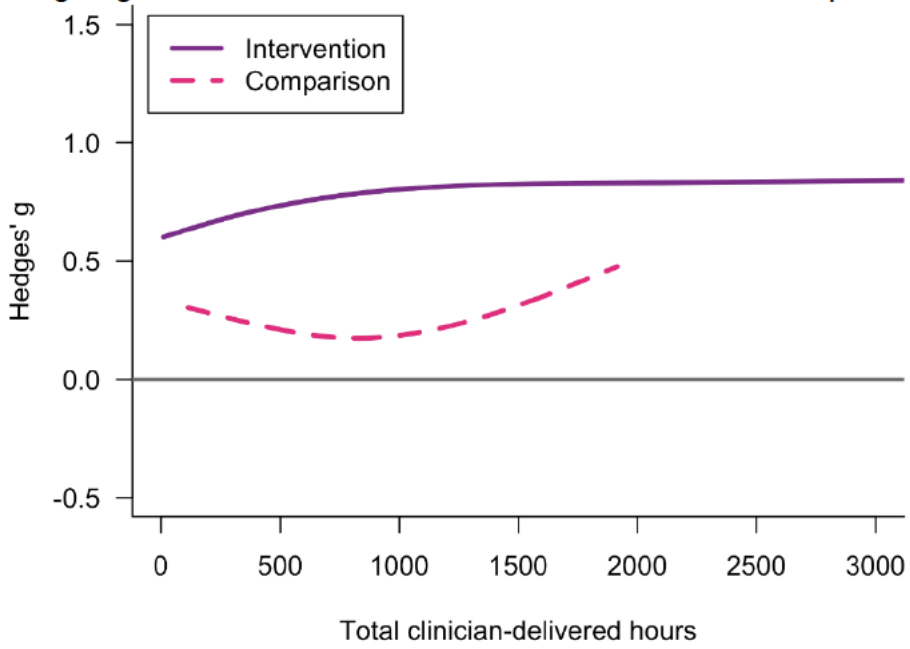


Figure 17c. Non-linear model of monthly clinician-delivered dose by effect size (Hedges' g) for change in cognition and language outcomes from pre- to post-intervention in the intervention and comparison group.

Note: Hedges' g > 0 = improvement in outcomes from baseline to follow-up in the specified group. Hedges' g > 0 = decrease in outcomes from baseline to follow-up in the specified group.

Figure 17d. Non-linear model of total clinician-delivered dose by effect size (Hedges' g) for change in cognition and language outcomes from pre- to post-intervention in the intervention and comparison group.

Note: Hedges' g > 0 = improvement in outcomes from baseline to follow-up in the specified group. Hedges' g > 0 = decrease in outcomes from baseline to follow-up in the specified group.



3.7 Investigating the effect of population, intervention, and study design factors on efficacy

Investigating the effect of population, intervention, and study design factors: summary of findings

No notable differences in the efficacy of behaviourally based interventions were identified based on any investigated factors which includes the person delivering the intervention, intervention category, comparison group, age of children, primary intervention setting, and study design.

There was no evidence to suggest that interventions delivered by a parent are inferior to those delivered by clinicians.

There was no evidence to suggest that the type of comparison group (i.e., treatment as usual or non-behaviourally based, "eclectic" intervention) biases the results.

There was no evidence to suggest that one choice of intervention characteristic is better than another. Interventions should be tailored to what is best for the child and their family's unique circumstances and needs.

3.7.1 Differences in effects within clinician, parent, or teacher-delivered interventions

The differences in effects when interventions were delivered either by a clinician, parent, or teacher was investigated using the evidence from the 98 studies (subgroup level data shown in **Table 1**). However, there was no evidence available for how teacher-delivered interventions effected family outcomes and adverse effects. Negligible effects were found in:

- teacher-delivered interventions for adaptive functioning outcomes;
- clinician-delivered interventions for family outcomes and adverse effects; and
- interventions which involved both clinician and parent-delivery on adverse effects.

Otherwise, consistent but small effects were identified for outcomes, regardless of the person delivering the behaviourally based intervention (see **Table 7** and **Figures B22-B26**).

Importantly, there were no significant differences in efficacy of intervention for any outcome depending on who delivered the intervention. While not significant, there was a difference in effect size in favour of parent-delivered interventions compared to clinician-delivered interventions for reductions in adverse effects (i.e., parent stress).

Table 7. Subgroup analysis of person delivering intervention for each outcome domain

Note: This table contains pooled effect estimates (Hedges' g) within each subgroup level for each of the five outcome domains. The colour of the text box indicates the direction of effect (worse outcomes for intervention versus comparison in pink; better outcomes for intervention versus comparison in green), with the opacity indicating the size of the effect (darker shade = stronger effect). Worse outcomes for the intervention versus comparison are also indicated by a negative effect size. Bold text and the presence of an asterisk (*) represents a significant effect estimate ($p < 0.05$). NA indicates insufficient data for analysis.

Subgroup level	Autism characteristics	Adaptive functioning	Cognition and language	Family outcomes	Adverse effects
Clinician	**0.33***	**0.32***	**0.41***	-0.07	-0.06
Clinician and parent	**0.30***	**0.26***	**0.32***	0.28	0.00
Parent delivered	**0.33***	**0.27***	**0.22***	**0.44***	**0.34***
Teacher delivered	**0.26***	-0.11	0.22	NA	NA

3.7.2 Differences in effects from each intervention category

Differences in effects relating to intervention categories (including behavioural, developmental, NDBI, technology-based, and TEACCH, as described in **Section 4.1.3**) were investigated. The number of studies which report data for each intervention category for each outcome domain are shown in **Table 1**. Results of this subgroup analysis are in **Table 8** and detailed in **Figures B22-B26**.

The evidence indicates no difference between intervention categories in efficacy across outcomes. Mostly small effect sizes in favour of behaviourally based interventions were seen, except where:

- a medium, positive effect size was observed for NDBI interventions on family outcomes;
- a negligible effect size was found for TEACCH and developmental interventions on cognition and language outcomes;
- a negligible effect size for technology-based and TEACCH interventions on autism characteristics; and
- a small, but negative effect of TEACCH on adaptive functioning outcomes was identified, although this was not significant.

Overall, the findings show that intervention content or the theoretical underpinnings of behaviourally based interventions do not effect the efficacy of the intervention on outcomes.

Table 8. Subgroup analysis of intervention category for each outcome domain

Note: This table contains pooled effect estimates (Hedges' g) within each subgroup level for each of the five outcome domains. The colour of the text box indicates the direction of effect (worse outcomes for intervention versus comparison in pink; better outcomes for intervention versus comparison in green), with the opacity indicating the size of the effect (darker shade = stronger effect). Worse outcomes for the intervention versus comparison are also indicated by a negative effect size. Bold text and the presence of an asterisk (*) represents a significant effect estimate ($p < 0.05$). NA indicates insufficient data for analysis.

Subgroup level	Autism characteristics	Adaptive functioning	Cognition and language	Family outcomes	Adverse effects
Behavioural	**0.37***	**0.32***	**0.41***	**0.35***	0.20
Developmental	**0.23***	0.36	0.06	0.21	0.33
NDBI	**0.35***	0.17	**0.29***	0.50	0.24
Other	0.27	NA	0.21	NA	0.44
TEACCH	0.05	-0.23	0.11	NA	NA
Technology-based	0.02	-0.01	0.25	NA	NA

3.7.3 Differences in effects by comparison group

Differences in effects relating to comparison group type (categories described in **Section 4.1.3**) were investigated. The number of studies which report data for each comparison group for each outcome domain are shown in **Table 1**. Results of this subgroup analysis are in **Table 9** and detailed in **Figures B22-B26**.

The evidence indicates there is no difference between the type of comparison group including treatment as usual and eclectic in efficacy across outcomes. Mostly small effect sizes are seen, except for a negligible, negative effect size for behaviourally based interventions when compared to eclectic interventions on the reduction of adverse effects. Overall, there is no evidence that the type of comparison group affects the efficacy of the intervention on outcomes.

Table 9. Subgroup analysis of comparison group for each outcome domain

Note: This table contains pooled effect estimates (Hedges' g) within each subgroup level for each of the five outcome domains. The colour of the text box indicates the direction of effect (worse outcomes for intervention versus comparison in pink; better outcomes for intervention versus comparison in green), with the opacity indicating the size of the effect (darker shade = stronger effect). Worse outcomes for the intervention versus comparison are also indicated by a negative effect size. Bold text and the presence of an asterisk (*) represents a significant effect estimate ($p < 0.05$). NA indicates insufficient data for analysis.

Subgroup level	Autism characteristics	Adaptive functioning	Cognition and language	Family outcomes	Adverse effects
Eclectic	**0.38***	0.17	**0.23***	0.69	-0.02
TAU	**0.31***	**0.27***	**0.34***	**0.35***	**0.32***

3.7.4 Differences in effects by age group

Differences in effects relating to age group (0-1 years, 2-4 years, 5-7 years) were investigated. The number of studies which report data within each age group for each outcome domain are shown in **Table 1**. Results of this subgroup analysis are in **Table 10** and detailed in **Figures B22-B26**.

The evidence shows no difference between age groups in efficacy across outcomes. Mostly small effect sizes are seen across age groups, except for:

- a medium effect size for 5-7 year-olds on cognitive outcomes;
- negligible effect sizes for 0-1 year-olds on autism characteristics and adaptive functioning outcomes; and
- a negligible effect size for 5-7 year-olds on adverse effects outcomes.

Overall, evidence indicates that age does not affect the efficacy of the intervention, although less studies currently report evidence for behavioural interventions for children aged less than 2 years old, and there is some indication of less benefit of intervention for autism characteristic and adaptive functioning outcomes in this age group.

Table 10. Subgroup analysis of age group for each outcome domain

Note: This table contains pooled effect estimates (Hedges' g) within each subgroup level for each of the five outcome domains. The colour of the text box indicates the direction of effect (worse outcomes for intervention versus comparison in pink; better outcomes for intervention versus comparison in green), with the opacity indicating the size of the effect (darker shade = stronger effect). Worse outcomes for the intervention versus comparison are also indicated by a negative effect size. Bold text and the presence of an asterisk (*) represents a significant effect estimate ($p < 0.05$). NA indicates insufficient data for analysis.

Subgroup level	Autism characteristics	Adaptive functioning	Cognition and language	Family outcomes	Adverse effects
0-1 years	0.15	0.12	**0.32***	0.4	0.24
2-4 years	**0.36***	**0.21***	**0.28***	**0.39***	**0.30***
5-6 years	**0.21***	0.42	**0.47***	**0.42***	0.06

3.7.5 Differences in effect by primary intervention setting

Differences in effects relating to primary setting of intervention (settings described in **Section 4.1.3**) were investigated. The number of studies that report data for each primary intervention setting and for each outcome domain are shown in **Table 1**. Results of this subgroup analysis are in **Table 11** and detailed in **Figures B22-B26**.

Available evidence shows no significant difference in the efficacy of behavioural interventions across settings for most outcomes. However, there was a significant difference between behaviourally based interventions primarily delivered in health and home-based settings in their efficacy for family outcomes. It is likely that health settings are more efficacious (medium effect size) compared to home settings (small effect size) for this outcome domain. Importantly, there is still evidence that interventions primarily delivered in the home are efficacious for family outcomes, the evidence just indicates that they are efficacious to a lesser degree than interventions delivered in health settings.

Table 11. Subgroup analysis of primary intervention setting for each outcome domain

Note: This table contains pooled effect estimates (Hedges' g) within each subgroup level for each of the five outcome domains. The colour of the text box indicates the direction of effect (worse outcomes for intervention versus comparison in pink; better outcomes for intervention versus comparison in green), with the opacity indicating the size of the effect (darker shade = stronger effect). Worse outcomes for the intervention versus comparison are also indicated by a negative effect size. Bold text and the presence of an asterisk (*) represents a significant effect estimate ($p < 0.05$). NA indicates insufficient data for analysis.

Subgroup level	Autism characteristics	Adaptive functioning	Cognition and language	Family outcomes	Adverse effects
Community	**0.28***	0.27	0.17	NA	NA
Early education	**0.37***	**0.31***	**0.37***	NA	0.41
Health	**0.31***	0.12	**0.29***	**0.53***	**0.27***
Home	**0.31***	**0.26***	**0.30***	**0.20***	0.16

3.7.6 Differences in effects by study design

Differences in effects relating to study design (study designs described in **Section 4.1.3**) were investigated. The number of studies which report data for each study design for each outcome domain are shown in **Table 1**. Results of this subgroup analysis are in **Table 12** and detailed in **Figures B22-B26**.

Available evidence shows no significant difference in the efficacy of behavioural interventions across study designs for most outcomes. However, there was a significant difference between cohort studies and randomised/non-randomised controlled trials on the reduction of adverse effects. It is likely that randomised and non-randomised controlled trials are more efficacious (small effect size) compared to cohort studies (small effect size), which demonstrate a significant increase in adverse effects (although with a small effect size).

Table 12. Subgroup analysis of study design for each outcome domain

Note: This table contains pooled effect estimates (Hedges' g) within each subgroup level for each of the five outcome domains. The colour of the text box indicates the direction of effect (worse outcomes for intervention versus comparison in pink; better outcomes for intervention versus comparison in green), with the opacity indicating the size of the effect (darker shade = stronger effect). Worse outcomes for the intervention versus comparison are also indicated by a negative effect size. Bold text and the presence of an asterisk (*) represents a significant effect estimate ($p < 0.05$). NA indicates insufficient data for analysis.

Subgroup level	Autism characteristics	Adaptive functioning	Cognition and language	Family outcomes	Adverse effects
Cohort	**0.26***	**0.27***	**0.33***	NA	**-0.27***
Non-random	**0.35***	0.20	**0.39***	0.50	**0.32***
Random	**0.32***	0.25	**0.22***	**0.39***	**0.25***

4. Limitations

To the best of our knowledge, this report is the largest systematic review and meta-analysis of behavioural interventions in children on the autism spectrum conducted (Whitehouse & Eapen, 2020). However, although 98 studies met eligibility criteria, approximately two thirds of these did not report quantifiable clinician-delivered hours of intervention. These studies were either parent- or teacher-delivered or did not report dose information at all. Therefore, the dose-response analyses in this report are based on a more limited evidence pool of 34 studies, which limits the precision (i.e., statistical power) of the analyses.

This report includes a statistical summary of best available evidence across the literature. In doing this, a high-level summary of over 4,500 children was made. Individual experiences and responses of children to these behaviourally based interventions will vary. It is beyond the scope of this investigation to evaluate philosophical or qualitative information around responses to behaviourally based interventions.

The quality and accuracy of reported dose information varied across studies. Often only the planned dose was reported rather than actual dose delivered. As actual dose delivered is commonly less than what was planned, the dose estimates reported here are likely an overestimation of what was delivered. Additionally, assessments of the potential risk of bias within included studies suggested a high, or serious, overall risk.

All children, even those in the comparison group, likely received some level of intervention. Studies varied in how comprehensively they reported details of alternative or standard-care intervention in the comparison group. Because of this, it was difficult to categorise and investigate the effects compared to different comparison groups. We acknowledge that the comparison group definitions used here (TAU and eclectic) are arbitrary, and there is potentially overlap across these groups.

Any behaviourally based interventions for children on the autism spectrum were included. While all-inclusive and comprehensive, this means that included interventions vary in their evidence for efficacy, with some based on stronger evidence. Additionally, fidelity was not adjusted for within analyses. The inclusion of all interventions, including those with less evidence and lower fidelity, may have resulted in an underestimation of the effect size.

Finally, the impact of important participant characteristics, such as autism severity, on the efficacy of behaviourally based interventions were unable to be assessed in this report. This was due to limited evidence and the lack of uniformity in the measures used to quantify autism severity within included studies.

5. What did we learn?

5.1 What benefits are likely?

Overall, there is evidence for benefit, of a small effect size (extent of benefit), of behaviourally based interventions for children less than 7 years old on the autism spectrum for key clinical outcome domains. Better outcomes following behaviourally based interventions than those in comparative groups were identified for all five investigated outcome domains: autism characteristics (e.g., socialisation, challenging behaviours), adaptive functioning, cognition and language, family outcomes, and in the reduction of adverse effects (i.e., child and parent stress/burden). Although, of note, the extent of the benefit (effect size) was smaller and more varied than reported in previous systematic reviews (Whitehouse & Eapen, 2020).

Importantly, while small in effect size, the benefit of behaviourally based interventions was found when compared against children undergoing both usual care and other “eclectic” intervention types. Importantly, larger improvements were consistently seen for children who underwent a behaviourally based intervention compared to children who experienced equivalent clinician-delivered hours (total and monthly) of treatment as usual or alternative, “eclectic” interventions. Due to limited data, this comparison of change following intervention by dose of intervention was only possible for autism characteristics, adaptive functioning and cognition and language outcomes.

The small effect size and variability identified across outcomes means that benefit of behaviourally based interventions cannot be guaranteed across all interventions, settings, and participants. This indicates that multiple factors must be considered when making treatment decisions for a child on the autism spectrum and decisions pertaining to a child’s goals and family values should reflect their individual needs. This report has explored factors including dose, primary setting, the person delivering the intervention and child characteristics (e.g., age). The impact of these on the efficacy of behaviourally based interventions is discussed in the sections which follow. Of note, some important factors to consider (e.g., autism severity) were unable to be investigated here.

5.2 Is more intervention better?

To answer the question of whether more clinician-delivered hours of intervention lead to better outcomes depends on the child’s outcome/s of interest (i.e., autism characteristics, adaptive functioning, cognition and language).

Evidence shows that there is no benefit in increasing clinician hours (total or intensity) for autism characteristic outcomes (e.g., global autism measures, social affect, socialisation, challenging behaviours, etc). For this outcome, small benefits of behaviourally based interventions are consistently seen, regardless of dose. This means that lower dose intensities and total doses may be sufficient to see maximum benefit for autism characteristics, and increased benefit is unlikely to occur with alterations of dose of the intervention.

Contrastingly, evidence indicates that increasing both total clinician hours as well as the intervention intensity is associated with improved adaptive functioning and cognition and language outcomes. However, incremental increases (e.g., from 10 to 20 monthly hours) show little added value, so decisions about the amount of intervention received should be made upon a child's progress towards their overall goals and what is most beneficial to the child, rather than dose alone. Improvements in cognition and language outcomes were shown at all dose levels, even low total clinician hours and dose intensities. This was not the case for adaptive functioning, where there is little evidence for benefit of behaviourally based interventions when delivered for less than approximately 800 hours, or 65 hours per month.

The results of the dose analyses warrant further validation due to the relatively small number of clinician-led studies reporting outcomes, especially at higher doses. The small number of studies meant there was large variability in estimates and lower confidence in the results, particularly for higher doses. Even if a dose relationship is found with more evidence, the potential benefit of increasing hours identified here was found to be minimal, translating to negligible real-world impact.

5.3 Who is best placed to deliver interventions?

Parent-delivered behaviourally based interventions (typically following parent training and ongoing support from providers) may be as useful as clinician-delivered designs, with no difference found between these designs on benefit of the intervention. Support for the benefit of parent-delivered interventions echoes the recent Autism CRC report (external), "Interventions for children on the autism spectrum", where the important and beneficial role of parents or caregivers in delivering early interventions is highlighted (Whitehouse & Eapen, 2020), as well the National Guidelines for Best Practice in Early Childhood Intervention (external) (Early Childhood Intervention Australia, 2016), which emphasize the importance of family-centred supports and the involvement of family in the intervention process.

5.4 What other intervention design, implementation or participant factors impact outcomes?

The current evidence does not indicate that the benefits of behaviourally based interventions differ based on the age group of children receiving the intervention, primary intervention setting (i.e., home or health setting), intervention category, type of comparison group (i.e., TAU or 'eclectic'), or study design.

5.5 Considerations for practice

Behaviourally based interventions can be efficacious for children on the autism spectrum under 7 years. However, effects will vary depending on individual and intervention-specific factors. Importantly, no particular benefit of specific intervention characteristics was found (e.g., intervention category, primary intervention setting, person delivering the intervention). This implies that all factors may be useful in the right context and behaviourally based interventions can, and should be,

individualised and take into consideration the needs, preferences, and individual circumstances of the child and their family.

In clinician-led behaviourally based interventions, the number and intensity of clinician contact hours cannot, on its own, account for the variability in the effects found. This means that intervention planning decisions should consider dose, but not in the absence of considerations relating to the child's goals, context, and family circumstances.

The specific goals of the participant and the planned outcomes of the intervention are of particular importance. Evidence presented here shows a benefit of more total hours as well as more intense intervention (more monthly hours of clinician-delivered intervention) for adaptive functioning and cognition and language outcomes. No impact of dose was found for autism characteristic outcomes. This difference in the effect of dose based on outcomes measured indicates that the justification for increased dose intensity should be based upon the needs and the goals of the participant.

Evidence suggests that higher doses of behaviourally based intervention may be required to see benefit for adaptive functioning outcomes. It may be the case that if the goals which have prompted the child to seek intervention relate to adaptive functioning, at least 65 hours per month of intervention would achieve greatest benefit, and lower doses may be futile. It is important to note that this is an estimated amount and results will vary, based upon a child's overall goals and other intervention-related factors. With such high doses required to see benefit for adaptive functioning, this may suggest that behaviourally based interventions may be less efficient (in terms of contact hours) for some outcomes. Thus, if treatment goal is adaptive functioning, participants may want to consider alternative approaches.

Additionally, the potential added benefits of incrementally increasing total and monthly dose across outcomes were shown to be minimal and unlikely to be clinically meaningful. Decisions to increase intervention intensity must be considered within the child's context and dose should only be considered as one factor within treatment decisions as it is not always related to better outcomes. Importantly, decisions regarding the amount and duration of intervention should be made in consideration of concerns around the impact of intensive therapies on a child's development (as highlighted within Recommendation 56 of the Autism CRC National Guideline (external) (Trembath et al., 2022)). For example, time spent in health and clinical settings may come at the cost of time for learning and development in more naturalistic settings that are family centred, which is beneficial to child development.

5.6 Potential areas and considerations for follow-up work

All analyses reported here are at group-level (grouped by characteristics within and between studies). To further this work, it is important to adjust for differences in individual circumstances. An analysis of individual participant data from the literature, clinical partners (e.g., from the Autism Specific Early Learning and Care Centres, ASELCCs (Masi et al., 2021)) or other NDIS providers will allow for factors relating to the interaction between dose and individual or intervention design factors to be explored in more detail.

The robust evidence for efficacy of parent-led interventions warrants further investigation into the factors underlying efficacious interventions. Potential questions may include, among others:

(1) what interventions or intervention components can be delivered effectively by parents,
(2) how to balance clinician- and parent-time, and
(3) how parents could be better supported to deliver interventions.

This can be achieved using network meta-analysis, which can investigate the components of interventions and synthetically compare intervention approaches head-to-head.

There is limited available information on enduring change over time following the conclusion of these interventions. Future research must include longer-term follow-ups in the children who receive these interventions in order to address this gap.

Importantly, research in this area is of poor quality. High risk of bias was identified in two thirds of studies included in this report. Improving the quality of studies in this field is vital. Common points for consideration in future study designs to improve study quality include ensuring the blinding of outcome assessors, concealing randomisation prior to assignment to intervention (for randomised designs), measuring or controlling for important confounders (e.g., age, autism severity, IQ), and using appropriate statistical methods for missing data.

6. References

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders - 5th Edition*. American Psychiatric Association.

Early Childhood Intervention Australia. (2016). *National guidelines: Best practice in early childhood intervention*. https://www.ecia.org.au/documents/item/1419

Makrygianni, M. K., & Reed, P. (2010). A meta-analytic review of the effectiveness of behavioural early intervention programs for children with Autistic Spectrum Disorders. *Research in Autism Spectrum Disorders*, *4*(4), 577-593. https://doi.org/https://doi.org/10.1016/j.rasd.2010.01.014

Masi, A., Dissanayake, C., Alach, T., Cameron, K., Fordyce, K., Frost, G., . . . Eapen, V. (2021). Clinical outcomes and associated predictors of early intervention in autism spectrum disorder: a study protocol. *BMJ Open*, *11*(8), e047290. https://doi.org/10.1136/bmjopen-2020-047290

Rodgers, M., Marshall, D., Simmonds, M., Le Couteur, A., Biswas, M., Wright, K., . . . Hodgson, R. (2020). Interventions based on early intensive applied behaviour analysis for autistic children: a systematic review and cost-effectiveness analysis. *Health Technology Assessment*, *24*(35), 1-306. https://doi.org/10.3310/hta24350

Trembath, D., Varcin, K., Waddington, H., Sulek, R., Pillar, S., Allen, G., . . . Whitehouse, A. (2022). *National guideline for supporting the learning, participation, and wellbeing of autistic children and their families in Australia*. Autism CRC. https://www.autismcrc.com.au/access/supporting-children

Trembath, D., Waddington, H., Sulek, R., Varcin, K., Bent, C., Ashburner, J., . . . Whitehouse, A. (2021). An evidence-based framework for determining the optimal amount of intervention for autistic children. *Lancet Child Adolesc Health*, *5*(12), 896-904. https://doi.org/10.1016/s2352-4642(21)00285-6

Virues-Ortega, J. (2010). Applied behavior analytic intervention for autism in early childhood: meta-analysis, meta-regression and dose-response meta-analysis of multiple outcomes. *Clinical Psychology Review*, *30*(4), 387-399. https://doi.org/10.1016/j.cpr.2010.01.008

Whitehouse, A., Varcin, K., Waddington, H., Sulek, R., Bent, C., Ashburner, J.,, & Eapen, V., Goodall, E., Hudry, K., Roberts, J., Silove, N., Trembath, D. (2020). *Interventions for children on the autism spectrum: A synthesis of research evidence*. A. CRC. https://www.autismcrc.com.au/interventions-evidence

Appendix A: Detailed study methodology

This systematic review adheres to guidelines from the 2020 update of the Preferred Reporting Items for Systematic reviews and Meta-Analyses statement (PRISMA 2020 (Page et al., 2021)).

A1. Study objectives

The review sought to synthesise the available evidence for the efficacy of behavioural interventions in children, aged 7-years or younger on the autism spectrum.

The following objectives were examined in the current systematic review and meta-analysis:

1. What is the evidence for the general efficacy and effectiveness of behavioural interventions?
    a. What effect sizes should be expected on common composite and domain-specific assessments of autism characteristics, functional or community outcomes?
    b. What adverse effect are reported and how common are they?
    c. How do effect sizes vary across outcome measures and domains?
    d. To what extent are any observed effects confounded by common sources of bias within and between studies?
2. How do effect sizes vary across settings?
    a. To what extent do effect sizes vary across studies (i.e., heterogeneity in true effects)?
    b. What common population, intervention and study design factors are possible moderators of heterogeneity?
3. How are effects associated with behavioural interventions related to intervention dose?
    a. What effects should be expected across different intensities (i.e., hours per week) and durations of interventions?
    b. How do intensity and duration interact across different delivery formats?
    c. What are the shapes of the dose-response curves for different outcomes?
    d. Are such dose-response relationships moderated or confounded by other design factors?
    e. How do the outcomes of each intervention compare to other behavioural interventions at different levels of intensity?

A2. Electronic search strategy

A single search of MEDLINE, EMBASE, CENTRAL and PsycINFO via OVID was conducted on 15 November 2021 for studies examining the effects of behavioural interventions (based on ABA principles) in children aged 7-years or less on the autism spectrum on at least one outcome involving autism characteristics, adaptive functioning, cognition and language, family outcomes, or adverse effects. The Medline search strategy is shown below.

The Ovid MEDLINE search strategy (including ALL from 1946 to November 15, 2021) was:

1. exp Autism/ or exp Autistic Disorder/
2. exp Autism Spectrum Disorder/ or exp Asperger Syndrome/
3. (autis$ or Asperger$ or Kanner$ or ASD or ASC or AAC).ti,ab,kw.
4. exp child development disorders, pervasive/
5. exp Developmental Disabilities/
6. Pervasive development$ disorder$.ti,ab,kw.
7. 1 or 2 or 3 or 4 or 5 or 6
8. exp Applied Behavior Analysis/
9. exp Behavior Therapy/
10. early intervention therap$.ti,ab.
11. (high intensity adj2 (analys$ or behavior$ or behaviour$ or intervention$ or model$ or program$ or therap$ or treat$)).ti,ab.
12. (low intensity adj2 (analys$ or behavior$ or behaviour$ or intervention$ or model$ or program$ or therap$ or treat$)).ti,ab.
13. (intensive behavior$ adj2 (analys$ or intervention$ or model$ or program$ or therap$ or treat$)).ti,ab.
14. (intensive behaviour$ adj2 (analys$ or intervention$ or model$ or program$ or therap$ or treat $)).ti,ab.
15. (early behavior$ adj2 (analys$ or intervention$ or model$ or program$ or therap$ or treat$)).ti,ab.
16. (early behaviour$ adj2 (analys$ or intervention$ or model$ or program$ or therap$ or treat$)).ti,ab.
17. (comprehensive behavior$ adj2 (analys$ or intervention$ or model$ or program$ or therap$ or treat$)).ti,ab.
18. (comprehensive behaviour$ adj2 (analys$ or intervention$ or model$ or program$ or therap$ or treat$)).ti,ab.
19. (applied behavior$ adj2 (analy$ or intervention$ or model$ or program$ or therap$ or treat$)).ti,ab.
20. (applied behaviour$ adj2 (analy$ or intervention$ or model$ or program$ or therap$ or treat$)).ti,ab.
21. (ABA$ adj2 (analys$ or intervention$ or model$ or program$ or therap$ or treat$)).ti,ab.
22. (IBI or EIBI or ABA).ti,ab.
23. Lovaas$.mp.
24. discrete trial train$.ti,ab.
25. Picture exchange communication system$.ti,ab.
26. functional communication training$.ti,ab.
27. (intens$ adj2 (analys$ or behav$ or intervention$ or program$ or therap$ or treat$)).ti,ab,kw.
28. (behavio?r$ adj2 (analy$ or intervention$ or model$ or program$ or therap$ or treat$)).ti,ab,kw.
29. (behav$ adj2 (analy$ or intervention$ or model$ or program$ or therap$ or treat$)).ti,ab,kw.
30. Comprehensive application of behav* analysis to school*.mp.
31. (Comprehensive application of behav* analysis to school* or CABAS).ti,ab,kw.

32. PECS.ti,ab,kw.
33. Direct instruction$.ti,ab,kw.
34. "treatment and education of autistic and communication related handicapped children".mp.
35. TEACCH.mp.
36. (Early Start Denver Model or ESDM).mp.
37. (Naturalistic Developmental behav* or NDBI*).mp.
38. (joint attention adj (training or skills or learning or intervention or program or therap$)).mp.
39. (Joint Attention Symbolic Play or JASPER).mp.
40. (Pivotal response adj1 (training or skills or learning or intervention or program or therap*)).mp.
41. reciprocal imitation.mp.
42. positive behav$ support.mp.
43. (developmental individual difference relationship based or DIR or floortime or floor time or interactive play).mp.
44. (developmental individual difference relationship or floortime or floor time or interactive play).mp.
45. (autism adj communication therapy).mp.
46. language training.mp.
47. Functional Communication Training.mp.
48. 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45 or 46 or 47
49. 7 and 48

The search was not limited by time, location, or language. Articles written in a language other than English were translated. Additional articles were identified by scanning the reference lists of existing reviews. One reviewer (Nicole Hill) conducted the initial search. Screening of title and abstracts and the review of full texts was conducted by five reviewers (Nicole Hill, Ivana Randjelovic, Amit Lampit, Erica Ghezzi, Matthew McQueen). Each article was screened by two of the five reviewers. Discrepancies were resolved by Amit Lampit who also contacted corresponding authors for additional information when required.

A3. Study selection and eligibility criteria

A3.1 Types of studies

Eligible studies included in the meta-analysis were randomised or non-randomised. Eligible studies must have been published in peer-reviewed journals or included in previous systematic reviews, but data extracted from those studies may have been unpublished (e.g., obtained from study authors).

A3.2 Types of participants

Studies were eligible if they included children (mean age ≤7 years at baseline) with a diagnosis of autism spectrum disorder or reported as at high likelihood for autism spectrum disorder if too young for formal diagnosis (less than 3 years old). Autism spectrum disorder comorbid with other conditions (including established or evident intellectual disability) will be eligible.

A3.3 Types of interventions

Behavioural interventions included those which:

- Used behaviourally based teaching strategies as the core components
- Used a comprehensive approach, to increase social engagement and learning while targeting a range of behaviours, skills (i.e., social, interpersonal, and daily living skills) and developmental domains (i.e., language, social communication, cognition, adaptive functioning, play development)
- Delivered face to face or using telehealth by qualified or trained individuals, on a one-to-one or small group basis to children directly, or via parents, caregivers, teachers, or combinations thereof
- Delivered at centre, home, school, or the community, or across multiple settings

Above criteria were based on Rodgers et al. (2020) and the Autism CRC (Whitehouse & Eapen, 2020). Studies of eligible interventions combined with other approaches were included if ≥50% of intervention time met above criteria.

Examples of typical interventions which meet the above criteria include:

- Early Intensive Behavioral Treatment (University of California/Lovaas Model)
- Intensive ABA
- Non-intensive ABA
- Comprehensive Application of Behaviour Analysis to Schooling (CABAS)
- Verbal behavior
- Discrete trial training
- Direct Instruction
- Picture Exchange Communication System (PECS)
- Treatment and Education of Autistic and Communication related handicapped CHildren (TEACCH)
- Early Start Denver Model (ESDM)
- Comprehensive intensive early intervention
- Naturalistic Developmental Behavioural Interventions (NDBIs)
- Early Social Interaction Project
- Joint attention and imitation skill-building
- Joint Attention, Symbolic Play, Engagement, and Regulation (JASPER)
- Learning Experiences Alternative Program (LEAP)
- Pivotal Response Training (PRT, also called Pivotal Response Treatment)
- Reciprocal Imitation Training
- Positive Behaviour Support
- Developmental Individual-Difference Relationship-Based (DIR) / Floortime
- Paediatric Autism and Communication Therapy (PACT)
- Language training
- Functional Communication Training

Eligibility of behavioural interventions were determined in consultation with Megan Clark, Postdoctoral Research Fellow and Provisional Psychologist at the Olga Tennison Autism Research Centre of La Trobe University.

There will be no limitation on intervention dose or intensity (hours per week, total number of hours, overall duration). All eligible intervention arms in multi-arm studies will be included.

A3.4 Types of comparators

Studies had to report data for at least one comparison group which was also comprised of children less than 7 years on the autism spectrum. Eligible comparisons include passive/waitlist control, treatment as usual (TAU), alternative community-based interventions (e.g., eclectic treatments) or non-evidence supported treatments.

A3.5 Types of outcome measures

Outcomes assessed at two time points (before and after the intervention) were eligible. Eligible outcomes included any measure which came under the following five categories:

Autism characteristics: Describes specific characteristics of autism, as well as global autism characteristic measures. Includes characteristics such as emotion regulation, restricted repetitive behaviours, sensory problems, social affect, socialisation, challenging behaviours.

Cognition and language: Describes the child's cognitive and language abilities. Includes measures of IQ, developmental age, motor skills, as well as receptive and expressive language.

Adaptive functioning: Describes measures of the child's everyday functioning. Includes functional behaviours such as toileting, helping with chores, answering the phone.

Family outcomes: Describes wellbeing or quality of life of the child, caregiver, or overall family unit, as well as parent sense of competency.

Adverse effects: Describes adverse effects of the intervention. Includes child distress (e.g., anxiety/depression) as well as parent stress or burden. These effects were coded so that higher scores indicated better outcomes (i.e., reduction in adverse effects).

A4. Data collection and coding

Coding of outcome measures was conducted by Erica Ghezzi who double-checked all data for accuracy. Data was coded into an excel spreadsheet for analysis in R. Data from studies were usually entered as means and standard deviations for pre-post measures for the intervention and comparison group, but if this was unavailable, any data from which an effect size for the difference between intervention and comparison groups in change from pre- to post-measures could be calculated was entered.

If a study included multiple follow-up timepoints **during** the intervention (e.g., after 1 year of intervention AND after 2 years of intervention), both were collected as they represent different dose amounts for the dose analysis. If a study had multiple follow-up points (with no further intervention delivered), data from the first time-point, immediately after completion of the intervention (maximum dose) was collected.

In addition to the primary outcome measures, information on the study design and characteristics were extracted for each eligible article which included, author, publication year, country, study design, intervention description, comparison group description, participant characteristics (e.g., age, gender), intervention settings, intervention dose (duration and frequency), mode of delivery (e.g., parent or clinical supervised).

A5. Assessing the quality of the evidence

Risk of bias was assessed using the Cochrane RoB 2.0 (Sterne et al., 2019) for included studies which were randomised controlled trials, and the ROBINS-I (Sterne et al., 2016) tool for included studies which employed non-randomised designs (e.g., non-randomised controlled trials, cohort studies).

Risk of bias was assessed for each reported outcome domain (e.g., autism characteristics, adaptive functioning, etc) within each included manuscript. Risk assessments were then summarised at the study level by taking the highest risk assessment for each risk of bias domain. Overall assessments were made as per the respective risk of bias tool's guidelines.

A6. Data analysis

All analyses were conducted using the R packages `metafor` and `robumeta`.

A6.1 Combining effects from included studies

The primary outcome was standardised mean difference (calculated as Hedges' g) of difference between intervention and comparison groups in change from pre- to post-intervention. Precision of the Hedges' g was calculated for each outcome measure by the 95% confidence interval (CI). A positive Hedges' g implies better therapeutic effects over time in the intervention group compared to the comparison group. By convention, Hedges' g values of 0.2, 0.5 and 0.8 are considered small, moderate or large effect sizes, respectively.

When studies provided multiple effect sizes or subgroups, all eligible effect sizes and subgroups were pooled using robust variance estimation models. Heterogeneity across studies was quantified using the tau^2 statistic.

Small-study effect ('publication bias') was assessed by visually inspecting funnel plots of effect sizes versus standard error. Where there were at least 10 studies in analyses, the small-study effect was formally tested using Egger's test. If evidence was found for this effect (if $p < 0.1$), the trim and fill method was used to create an adjusted effect estimate.

A6.2 Dose response analyses

Relationship between dose and efficacy

Linear models

The relationship between dose and effect size was modelled using multivariate linear meta-regression. When studies provided multiple effect sizes for the same dose of intervention, all eligible effect sizes and subgroups were pooled using robust variance estimation models, and then a linear regression was run.

These models were run separately for the two measures of dose (**total** clinician-delivered hours, and **monthly** clinician-delivered hours) for each of the three outcome domains which reported sufficient data for dose analyses (autism characteristics, adaptive functioning, cognition and language).

The model statistics were recorded, and the model significance was tested using the p-value ($p < 0.05$ represents a statistically significant lineal model). The model was then plotted, including the 95% confidence interval, which represents the precision of the model.

Non-linear models

The same relationships (effect size and dose for relevant outcome domains) were then explored using non-linear meta-regression models. This involved the same process, except now the relationship was not assumed to be linear.

For each analysis of dose and effect size by outcome domain, three types of non-linear models were investigated: cubic polynomial, restricted cubic spline, and thin plate spline. Across outcomes, the restricted cubic spline model was shown to have the best fit, and so this method was used for all non-linear models within this report. These models were fitted with three knots at the 10^{th}, 50^{th} and 90^{th} percentiles of dose.

Once again, model statistics were recorded, and the model significance was tested using the p-value ($p < 0.05$ represents a statistically significant lineal model). Plots of non-linear models included the 95% confidence interval to represent model precision.

Comparing efficacy for lower versus higher total and monthly dose

This analysis involved pooling the effect sizes (Hedges' g), as was done the main analysis described above, but now within subgroups. In this case, the subgroups were lower and higher dose, split by the median dose across studies with available data within each outcome domain (autism characteristics, adaptive functioning, and cognition and language). Separate analyses were conducted for the two definitions of dose: total clinician-delivered hours and monthly clinician-delivered hours (dose intensity).

Differences in effect size between lower versus higher dose levels were assessed for each dose type and outcome domain using a Wald-type test. If statistically significant ($p < 0.05$), this indicates that there is a difference in efficacy of the intervention between levels of the subgroup. In this case, it would mean there is a difference in efficacy for that outcome domain between lower and higher dose levels (per the definition of the specified analysis).

These analyses supplement and corroborate the previous dose analysis (Relationship between dose and efficacy). While the previous analyses investigated the relationship of dose and efficacy by investigating dose as a continuous variable, these analyses treat dose as a dichotomous variable (lower versus higher, defined based on a median split).

Relationship between dose and change from baseline to follow-up separately within the intervention group and the comparison group

The linear and non-linear model analysis is identical to the *Relationship between dose and efficacy* analysis described above. However, different data is input for the effect size (Hedges' g) and the interpretation differs.

In this case, Hedges' g represents the change between two time-points: baseline (pre-intervention) and follow-up. This effect size was calculated separately for the behaviourally based intervention group and the comparison group. As such, linear and non-linear models of dose by effect size were conducted separately for behavioural intervention and comparison groups.

Dose once again was defined as clinician-delivered hours (total and monthly). Studies were only included in the analyses if dose was reported. For the comparison group, the study had to report clinician-delivered hours of alternative intervention (including those in the community, occupational therapy, speech pathology, etc).

To compare the difference from baseline to follow-up across dose (total and monthly clinician-delivered hours) between behaviourally based intervention and comparison groups, plots were created. These plots included the linear and non-linear models (without 95% confidence intervals) for behaviourally based intervention and comparison groups on the same plot. This was to allow for comparison of effect sizes between the two groups for the same dose amount.

It is important to note that, while plotted in this way, different studies contributed to each analysis (less studies in the comparison group analyses). Additionally, even if studies contributed to both, the dose amount between the behaviourally based intervention group and the comparison group is not necessarily equal.

A6.3 Subgroup analyses

Heterogeneity (variance between studies) was further investigated through subgroup analyses. These involved pooling the effect sizes (Hedges' g), as was done the main analysis described above (beneath the *Data Analysis* header), but now within subgroups. Subgroup analyses assess whether there were any differences in efficacy of behaviourally based interventions based on differences in study design, intervention characteristics, and population characteristics.

All seven subgroups (low versus high dose [outlined in the previous section], person delivering, intervention category, comparison group, age group, primary intervention setting, and study design) were assessed for each of the five outcome domains. Each subgroup level that two or more studies reported data for a particular outcome domain was included in analyses.

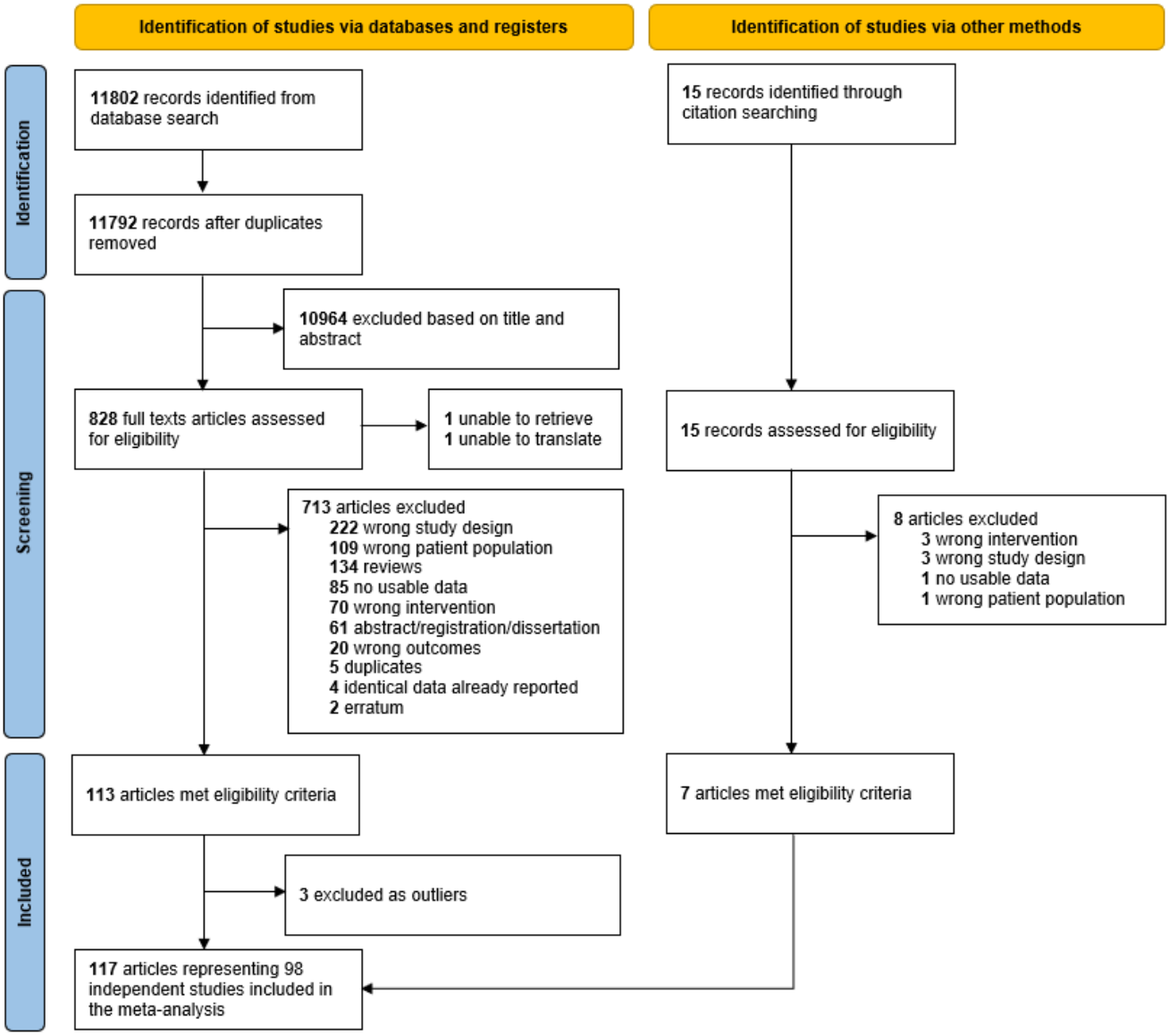
Pooled effect sizes (Hedges' g) and confidence intervals were estimated for each subgroup level individually. Differences in effect size between subgroup levels was then assessed using a Wald-type test. If statistically significant ($p < 0.05$), this indicates that there is a difference in efficacy of the intervention between levels of the subgroup.

Appendix B: Results

B1. Study selection

The initial search identified 11802 records, of which 10 were duplicates. A total of 11792 records were screened based on title an abstract (**Figure B1**). The full-text of 816 records were assessed, of which 113 records met the eligibility criteria. Of 15 articles identified through citation searching, 7 met eligibility criteria. After removing three articles as outliers, 117 records were included in analyses. A total of 35 records reported data from the same overarching study as at least one other record. These 35 records were combined within studies, to form 14 independent studies. The final dataset included 98 independent studies (14 of which included multiple records).

Figure B1. Summary of study selection



B2. Characteristics of included studies

A total of 117 records representing 98 studies were included in the meta-analysis. Details of all included records are shown in **Table B1**. All studies included interventions based on behaviourally based principles, but the characteristics of the interventions varied largely across studies (see **Section 4.1.2** of the main report). The intensity and duration of behaviourally based behavioural interventions ranged between 2.2 to 157.53 clinician-delivered hours per month, delivered over 4 to 141 weeks.

Table B1: Description of included studies

Note: NDBI = Naturalistic Developmental Behavioural Intervention; TAU = treatment as usual; NR = not reported.

Study	Article author (year)	Country	Study design	N	Boys (%)	Age (mths)	Outcome domains reported	Intervention category	Control group	Primary setting	Person delivering
1	Argumedes et al. (2021)	Canada	Random	23	78	51.6	Autism characteristics	Behavioural	TAU	Home	Parent delivered
2	Azarbehi (2012)	Canada	Cohort	20	85	41	Autism characteristics, adaptive functioning, cognition	Behavioural	TAU	Home	Clinician
3	Iadarola, Levato, et al. (2018)	USA	Random	180	87.78	50.4	Autism characteristics, family outcomes, adverse effects	Behavioural	Eclectic	Home	Parent delivered
3	Bearss et al. (2015)	USA	Random	180	87.78	56.4	Autism characteristics	Behavioural	Eclectic	Health	Parent delivered
3	Scahill et al. (2016)	USA	Random	180	87.78	56.4	Adaptive functioning	Behavioural	Eclectic	Health	Parent delivered
4	Bentenuto et al. (2020)	Italy	Non-random	37	NR	41.6	Autism characteristics, cognition	NDBI	TAU	Health	Clinician
5	Bernard-Opitz et al. (2004)	Singapore	Non-random	8	NR	38.75	Autism characteristics	Behavioural	Eclectic	Health	Clinician and parent
6	Blackman et al. (2020)	USA	Non-random	12	66.67	48.48	Autism characteristics, family outcomes, adverse effects	Behavioural	TAU	Health	Parent delivered
7	Bordini et al. (2020)	Brazil	Random	66	80.3	57.6	Autism characteristics, adaptive functioning, cognition	Behavioural	TAU	Health	Parent delivered

Study	Article author (year)	Country	Study design	N	Boys (%)	Age (mths)	Outcome domains reported	Intervention category	Control group	Primary setting	Person delivering
8	Boyd et al. (2014)	USA	Cohort	113	83.19	48.24	Autism characteristics, adaptive functioning, cognition	Other	TAU	Early education	Teacher delivered
8	Coman (2014)	USA	Cohort	144	85.42	48.36	Autism characteristics, adaptive functioning, cognition	TEACCH	TAU	Early education	Teacher delivered
9	Cariveau et al. (2019)	USA	Random	10	NR	34.84	Autism characteristics, cognition	Behavioural	TAU	Health	Clinician
10	Carr and Felce (2007)	UK	Non-random	10	NR	69.6	Autism characteristics, cognition	Behavioural	TAU	Early education	Clinician
11	Chang et al. (2016)	USA	Random	66	89	50.26	Autism characteristics, cognition	NDBI	TAU	Early education	Teacher delivered
12	Charman et al. (2021)	England	Random	62	80.6	80.04	Autism characteristics, family outcomes, adverse effects	Behavioural	TAU	Home	Parent delivered
13	Chiang et al. (2016)	Taiwan	Non-random	34	NR	37.6	Autism characteristics	Developmental	TAU	Health	Clinician
14	Cohen et al. (2006)	USA	Non-random	42	83.33	NR	Adaptive functioning, cognition	Behavioural	TAU	Home	Clinician
15	Coleman (2017)	USA	Random	19	81.5	45.4	Autism characteristics	Behavioural	Eclectic	Home	Parent delivered
16	Colombi et al. (2018)	Italy	Non-random	92	NR	34.22	Autism characteristics, adaptive functioning, cognition	NDBI	TAU	Health	Clinician
17	D'Elia et al. (2014)	Italy	Non-random	30	80	49.2	Autism characteristics, adaptive functioning, cognition, adverse effects	TEACCH	TAU	Early education	Clinician and parent
18	Dai et al. (2018)	Albania	Non-random	29	89.66	45.17	Family outcomes	Behavioural	TAU	Home	Parent delivered

Study	Article author (year)	Country	Study design	N	Boys (%)	Age (mths)	Outcome domains reported	Intervention category	Control group	Primary setting	Person delivering
19	Dawson et al. (2010)	USA	Random	48	NR	23.5	Autism characteristics, adaptive functioning, cognition	NDBI	TAU	Health	Clinician and parent
19	Estes et al. (2015)	USA	Random	48	76.92	23.5	Autism characteristics, adaptive functioning	NDBI	NA	Health	Clinician and parent
20	Dixon et al. (2019)	USA	Non-random	20	84.21	65.4	Cognition	Behavioural	TAU	Health	Clinician
21	Drew et al. (2002)	England	Random	24	79.17	22.5	Autism characteristics, cognition, adverse effects	Developmental	TAU	Home	Parent delivered
22	Duifhuis et al. (2017)	Netherlands	Non-random	47	83.33	69.48	Autism characteristics, adverse effects	NDBI	TAU	Home	Clinician and parent
23	Eikeseth et al. (2002)	Norway	Non-random	25	76	65.68	Adaptive functioning, cognition	Behavioural	Eclectic	Early education	Clinician and parent
24	Eikeseth et al. (2012)	Norway	Non-random	59	83.05	49.2	Adaptive functioning	Behavioural	Eclectic	Early education	Clinician
25	Eldevik et al. (2006)	Norway	Cohort	28	85.71	50.86	Autism characteristics, adaptive functioning, cognition	Behavioural	Eclectic	Early education	Clinician and parent
26	Eldevik et al. (2010)	Norway	Cohort	25	76	49.64	Adaptive functioning, cognition	Behavioural	Eclectic	Early education	Clinician
27	Eldevik et al. (2012)	Norway	Cohort	43	76.74	43.32	Adaptive functioning, cognition	Behavioural	Eclectic	Early education	Clinician
28	Elder (2012)	USA	Random	97	77	21	Autism characteristics, family outcomes	NDBI	TAU	Health	Parent delivered
28	Estes et al. (2014)	USA	Random	82	75.61	21.01	Adverse effects	NDBI	TAU	Health	Parent delivered

Study	Article author (year)	Country	Study design	N	Boys (%)	Age (mths)	Outcome domains reported	Intervention category	Control group	Primary setting	Person delivering
29	Fava et al. (2011)	Italy	Non-random	22	86.36	48.23	Autism characteristics, adaptive functioning, cognition, adverse effects	Behavioural	Eclectic	Home	Clinician and parent
30	Felzer-Kim and Hauck (2020)	USA	Random	14	71.43	53.86	Cognition	Behavioural	Eclectic	Health	Clinician
31	Feng et al. (2019)	China	Non-random	67	78.46	28.46	Autism characteristics	NDBI	TAU	Health	Clinician
32	Flanagan (2011)	Canada	Cohort	134	NR	35.2	Autism characteristics, adaptive functioning	Behavioural	TAU	Community	Clinician
33	Fox (2018)	USA	Random	10	70	32.8	Autism characteristics, cognition, family outcomes, adverse effects	NDBI	TAU	Health	Parent delivered
34	Frey et al. (2015)	USA	Random	34	NR	49.2	Autism characteristics, adaptive functioning	Behavioural	TAU	Early education	Clinician and parent
35	Furukawa et al. (2018)	Japan	Non-random	21	81	62.88	Autism characteristics, adverse effects	Other	TAU	Health	Parent delivered
36	Gengoux et al. (2019)	USA	Random	43	88.37	48.43	Autism characteristics, adaptive functioning, cognition	NDBI	TAU	Home	Clinician and parent
37	Gengoux et al. (2021)	USA	Random	44	95.45	60	Autism characteristics, adaptive functioning	Developmental	TAU	Health	Clinician
38	Ginn et al. (2017)	USA	Random	30	80	56.4	Autism characteristics, cognition, adverse effects	Other	TAU	Health	Parent delivered
39	Gomes et al. (2019)	Brazil	Cohort	33	87.5	59.3	Adaptive functioning, cognition	Behavioural	TAU	Home	Parent delivered

Study	Article author (year)	Country	Study design	N	Boys (%)	Age (mths)	Outcome domains reported	Intervention category	Control group	Primary setting	Person delivering
40	Goods et al. (2013)	USA	Random	15	NR	51.9	Autism characteristics, cognition	NDBI	TAU	Early education	Clinician
41	Grahame et al. (2015)	UK	Random	45	86.67	61.47	Autism characteristics, cognition, family outcomes	Behavioural	TAU	Health	Parent delivered
42	Grindle et al. (2012)	UK	Cohort	29	86.21	61.7	Adaptive functioning, cognition	Behavioural	TAU	Early education	Clinician and parent
43	Gulsrud et al. (2019)	USA	Random	20	65	49.36	Autism characteristics, cognition	NDBI	TAU	Early education	Clinician
44	Haglund et al. (2021)	Sweden	Non-random	94	81.91	51.6	Autism characteristics	NDBI	TAU	Early education	Clinician and parent
45	Hampton et al. (2020)	USA	Random	68	77.94	43	Autism characteristics, cognition	NDBI	TAU	Health	Clinician and parent
46	Haraguchi et al. (2020)	Japan	Non-random	61	85.25	46.75	Autism characteristics, adaptive functioning, cognition, adverse effects	Behavioural	TAU	Health	Clinician and parent
47	Hardan et al. (2015)	USA	Random	48	75	49.2	Autism characteristics, adaptive functioning, cognition	NDBI	TAU	Health	Parent delivered
48	Ho and Lin (2020)	Taiwan	Random	24	100	48.5	Autism characteristics, adaptive functioning, cognition	Developmental	TAU	Home	Parent delivered
49	Holzinger et al. (2019)	Austria	Non-random	13	100	43.32	Autism characteristics, adaptive functioning, cognition, family outcomes, adverse effects	NDBI	TAU	Home	Clinician

Study	Article author (year)	Country	Study design	N	Boys (%)	Age (mths)	Outcome domains reported	Intervention category	Control group	Primary setting	Person delivering
50	Howard et al. (2005)	USA	Non-random	45	84.44	32.17	Adaptive functioning, cognition	Behavioural	TAU	Early education	Clinician and parent
50	Howard et al. (2014)	USA	Non-random	45	NR	32.24	Adaptive functioning, cognition	Behavioural	TAU	Early education	Clinician and parent
51	Iadarola, Shih, et al. (2018)	USA	Random	150	87.33	85.14	Autism characteristics, adaptive functioning	Behavioural	TAU	Early education	Teacher delivered
52	Ingersoll (2010)	USA	Random	21	85.71	39.38	Autism characteristics	NDBI	TAU	Health	Clinician
52	Ingersoll (2012)	USA	Random	27	88.89	37.95	Autism characteristics	NDBI	TAU	Health	Clinician
53	Johnson et al. (2019)	USA	Random	42	95.24	61.2	Autism characteristics, adaptive functioning, family outcomes, adverse effects	Behavioural	TAU	Health	Parent delivered
54	Jouen et al. (2017)	France	Non-random	24	100	83.76	Autism characteristics, adaptive functioning, cognition, adverse effects	Technology-based	TAU	Health	Clinician and parent
55	Kaale et al. (2012)	Norway	Random	61	78.69	48.8	Autism characteristics	Developmental	TAU	Early education	Teacher delivered
55	Kaale et al. (2014)	Norway	Random	61	78.69	48.8	Autism characteristics, cognition	Developmental	TAU	Early education	Teacher delivered
56	Arora (2008)	USA	Random	36	NR	42.62	Autism characteristics	Developmental	TAU	Early education	Clinician
56	Kasari et al. (2006)	USA	Random	38	81.08	42.34	Autism characteristics	Developmental	TAU	Early education	Clinician

Study	Article author (year)	Country	Study design	N	Boys (%)	Age (mths)	Outcome domains reported	Intervention category	Control group	Primary setting	Person delivering
56	Kasari et al. (2008)	USA	Random	38	81.08	42.34	Autism characteristics, cognition	Developmental	TAU	Early education	Clinician
56	Lawton and Kasari (2012a)	USA	Random	36	78.12	41.36	Autism characteristics	Developmental	Eclectic	Early education	Clinician
57	Kasari et al. (2010)	USA	Random	38	76.32	30.83	Autism characteristics	Developmental	TAU	Health	Parent delivered
58	Kasari et al. (2015)	USA	Random	86	81	31.5	Autism characteristics, cognition, adverse effects	NDBI	Eclectic	Health	Parent delivered
58	Schlink et al. (2022)	USA	Random	86	81	31.5	Adverse effects	NDBI	Eclectic	Health	Parent delivered
58	Gulsrud et al. (2016)	USA	Random	86	81	31.5	Family outcomes	NDBI	Eclectic	Health	Parent delivered
58	Dimachkie (2021)	USA	Random	75	82.7	31.5	Autism characteristics	NDBI	Eclectic	Health	Parent delivered
59	Lawton and Kasari (2012b)	USA	Random	16	NR	44.69	Autism characteristics	NDBI	TAU	Early education	Teacher delivered
60	Leaf et al. (2017)	USA	Random	15	NR	56.4	Autism characteristics	Behavioural	TAU	Health	Clinician
61	Magiati et al. (2007)	UK	Cohort	44	NR	39.64	Autism characteristics, adaptive functioning, cognition	Behavioural	Eclectic	Home	Parent delivered
62	Manohar et al. (2019)	India	Random	50	88	41.4	Autism characteristics, family outcomes, adverse effects	NDBI	TAU	Home	Parent delivered
63	Matthews et al. (2018)	USA	Non-random	18	97.22	40.78	Autism characteristics, family outcomes, adverse effects	Behavioural	TAU	Health	Parent delivered

Study	Article author (year)	Country	Study design	N	Boys (%)	Age (mths)	Outcome domains reported	Intervention category	Control group	Primary setting	Person delivering
64	Nojiri and Yanagawa (2019)	Japan	Random	36	86.11	43.4	Autism characteristics, family outcomes	Behavioural	TAU	Health	Parent delivered
65	Nowell et al. (2019)	USA	Random	17	76.47	81.84	Autism characteristics, family outcomes	TEACCH	TAU	Health	Clinician and parent
66	Oosterling et al. (2010)	The Netherlands	Non-random	67	77.61	34.32	Autism characteristics, cognition, family outcomes	Developmental	TAU	Home	Parent delivered
67	Pajareya and Nopmaneejumruslers (2011)	Thailand	Random	32	87.5	54.05	Autism characteristics, adaptive functioning	Developmental	TAU	Home	Parent delivered
68	Peters-Scheffer et al. (2013)	The Netherlands	Cohort	40	90	62.52	Autism characteristics, adaptive functioning, cognition, adverse effects	Behavioural	TAU	Early education	Clinician
69	Reitzel et al. (2013)	Canada	Random	15	NR	58.5	Autism characteristics, adaptive functioning, family outcomes, adverse effects	Behavioural	TAU	Health	Clinician
70	Remington et al. (2007)	England	Cohort	44	NR	36.99	Autism characteristics, adaptive functioning, cognition, family outcomes, adverse effects	Behavioural	TAU	Home	Clinician and parent
70	Kovshoff et al. (2011)	England	Cohort	44	NR	36.99	Autism characteristics, adaptive functioning, cognition	Behavioural	TAU	Home	Clinician and parent
71	Rogers et al. (2006)	USA	Random	10	100	38.4	Cognition	NDBI	Eclectic	Health	Clinician and parent