Behaviour Support Plan Toolkit

human services

Section 4

Useful assessment tools and forms

Useful assessment tools and forms

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1: What is a restrictive intervention?

This is any intervention that is used to restrict the rights or freedom of movement of a person with a disability. Restrictive interventions can be: chemical, mechanical, physical restraint, seclusion or other restrictive interventions. *(Refer to Part 7 of the Disability Act for further explanation on the use of restrictive interventions.)*

a) Chemical restraint (Disability Act, s. 3 (1)). The use, for the primary purpose of behavioural control of a person with a disability, of a chemical substance to control or subdue the person but does not include the use of a drug prescribed by a registered medical practitioner for the treatment, or to enable the treatment, of a mental illness or a physical illness or physical condition.

b) Mechanical restraint (Disability Act, s. 3 (1)). The use, for the primary purpose of the behaviour control of a person with a disability, of devices to prevent, restrict or subdue a person's movement. This includes the following.

- **Belt/ strap**

  An item of any material used to restrain any part of the body to a secure fixture. This does not include cuffs, which are reported as a separate category of mechanical restraint.
- **Gloves**

  Any material that is placed on the hand that covers all or part of the hand and/or finger(s).
- **Splint**

  A device that is applied or worn, in its original or a modified form, to a body joint (usually the elbow) that restricts movement of that joint in any way.
- **Restrictive clothing**

  An item of clothing that is applied in full or part, in its original or a modified form, or a specially designed device that is applied to or worn by a person that restricts their movement in any way, including to prevent the person accessing their incontinence/sanitary device or removing their clothing. This does not include gloves or helmets, which are reported as a separate category of mechanical restraint.
- **Cuff**

  A shackle or similar device with a closing mechanism that is applied to the wrist and/or ankle that is in turn attached to a secure fixture. This does not include belts/straps, which are reported as a separate category of mechanical restraint.
- **Helmet**

  Any type of headwear that is worn by the person to limit potential physical damage to themselves.
- **Wheelchairs**

  The application of brakes or the disengagement of the power source of a wheelchair to prohibit a person from independently mobilising. This also includes the placement of a person in a wheelchair who is ambulant in order to restrict their movement.
- **Bedrails**

  The raising of rails on one or both sides of a bed to prevent the person from getting out of bed.
- **Tables/ furniture**

  The deliberate placement of furniture in front of a person to prevent them from moving.

Mechanical restraint does not include the use of devices for the following reasons.

- *For therapeutic purposes.* 'Therapeutic' means the use of a device prescribed by a health practitioner for the treatment of a diagnosed medical condition. **If such a device is prescribed or suggested by a health practitioner for the purpose of controlling behaviour, this is still considered mechanical restraint.**
- *To enable the safe transportation of the person.* Safe transportation is considered necessary when a person does not remain seated with a seatbelt fastened during the time when they are a passenger in a moving vehicle being used for transportation. If such a device is being used, it must be removed immediately upon the vehicle arriving at its destination otherwise the device becomes restrictive. The use of devices that restrict or modify a person's behaviour that does not pose a risk to safe transportation is considered restrictive.
  (Disability Act, s. 3)

c) Seclusion (Disability Act, s.3 (1)). The sole confinement of a person with a disability at any hour of the day or night either:

- in any room in the premises where disability services are being provided of which the doors and windows cannot be opened by the person from the inside
- in any room in the premises where disability services are being provided of which the doors and windows are locked from outside
- to a part of any premises in which disability services are being provided, or
- outdoor areas such as back and front yards, verandas, the locking of a person in a vehicle and so on.

d) Other restrictive intervention. Section 58 of the Disability Act requires that a disability service provider must not unreasonably limit or interfere with a resident's access to his or her room or to the toilet, bathroom or other common areas in the premises that are available for the resident's use. If a person presents with behaviours of concern that necessitate limiting their access to these areas, these restrictions can only be used in accordance with a Behaviour Support Plan or treatment plan (for compulsory treatment) that has been submitted to the Senior Practitioner. The disability service provider must also implement strategies to minimise the impact on other residents.

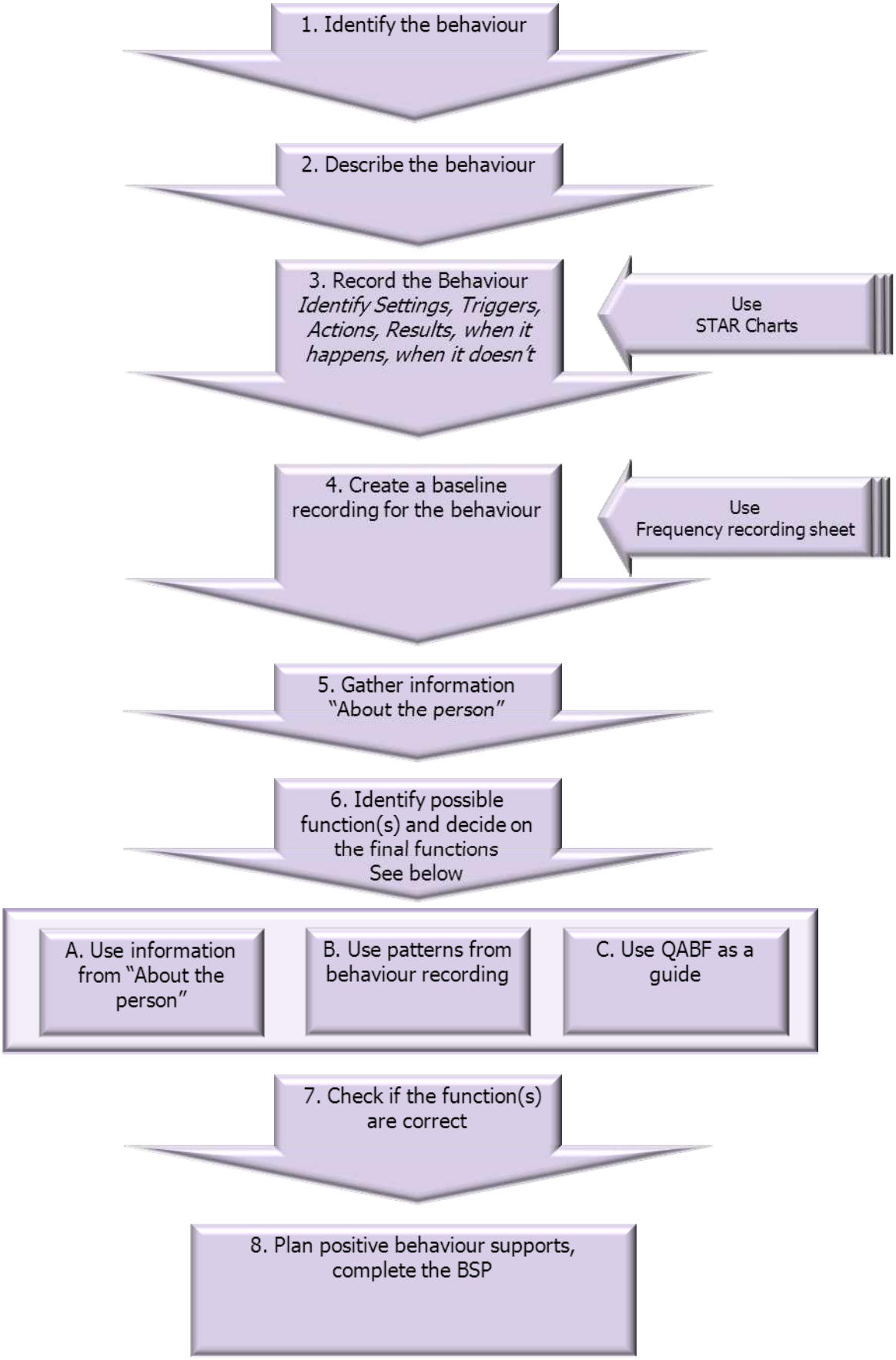
e) Physical restraint – planned emergency response

Behaviours that are known or can be predicted to occur in a potentially known situation, and where physical restraint is considered as a last resort, and as a planned response to be used in an emergency situation only, should be documented as a 'physical restraint – planned emergency response'. Physical restraint is not to be used as part of a person's routine behaviour support.

A physical restraint – planned emergency response for the person must be submitted.

- In developing a physical restraint – planned emergency response, disability service providers must consider all aspects outlined in Appendix 3: in the Senior Practitioner physical restraint direction paper – May 2011: Checklist on the use of physical restraints in an emergency and as a planned response.

2: Functional Behavioural Assessment Flowchart



3: Functional Behavioural Assessment - example

Those who support TJ decided to try to find the reasons for TJ's many behaviours of concern. They conducted a Functional Behavioural Assessment (FBA).

Steps 1 and 2. Identify and describe the behaviour of concern.

Staff looked at incident reports and found that TJ engaged in a number of behaviours. They chose to focus on the kicking as it caused physical harm, it resulted in the use of restrictive interventions, and it happened very often. They agreed on an initial description of this kicking behaviour. ***TJ can kick people in the legs with enough force to cause injury (bruising and swelling).***

Step 3. Record the behaviour.

Behaviour recording was completed for one week using STAR charts and a frequency recording sheet (see Section 4). ***It was found that TJ used the behaviour about eight times a day (frequency). The behaviour could last for up to 10 secs (duration) and each incident caused cause injury such as bruising and swelling (impact/intensity).***

Patterns that were noticed in the behaviour recording.

1. The kicking usually occurred when a staff member spoke to him and was calling him by names other than "TJ".
   - Therefore, trigger 1 for his behaviour was; People using names other than TJ and the setting event for this was; people not knowing his preferred name.
   - Trigger 2 for his behaviour was; People speaking to him, and the setting event for this trigger was; people not knowing his preferred ways to communicate.
2. Other important related issues; behaviour happened more often with staff member AP, when TJ was ill, it was a hot day, and there were a lot of people and noise in the house.

Step 4. Create a baseline recording of the behaviour.

Staff then wrote a full description of the behaviour with all information on its frequency, duration and impact. This was also used as a baseline recording of the behaviour i.e. what the behaviour was like before the BSP and its recommendations were implemented. ***TJ can kick people in the legs with enough force to cause injury (bruising and swelling). He does this about eight times a day. The behaviour can last for up to 10 secs. This has been happening since moving into his new home 3 months ago.***

Step 5. Gather information "About the person".

Staff used the "Planning guide" in Section 2 of the Toolkit to gather information about TJ by contacting those who knew him best and had supported him in the past, and looking through his client file especially for previous BSP's and other reports. Important information that was found included;

- What his intellectual disability was and how interactions and demands on him should suit his level of current ability; his communication level; his preferred way to communicate and the best way for staff to understand him and communicate successfully with him; past trauma and the need for professional support; health issues including frequent ear infections; sensory concerns e.g. sensitive to heat and loud noises; his likes and dreams for his life; and his dislikes (being called names other than TJ).

Information used to decide on triggers and setting events.

By talking to people who had supported TJ in the past it was found that TJ's preferred way to communicate was by writing, using cards or pictures. He never liked his Christian name and should only be called "TJ".
Staff were then able to complete the Behaviour, triggers and setting events sections of the Planning guide.

Steps 6: Identify possible functions and decide on the functions

Using the information gained through the behaviour recording along with the "About the person" assessment the staffing team came up with ideas about why the behaviour could be occurring, its function. They then used the QABF to try to put these ideas into sentences (see QABF Section 4).

Other functions they considered were "TJ engages in the behaviour to get attention" or "TJ engages in the behaviour to avoid having to do something", however they decided on the following specific functions;

Function 1: TJ kicks others to communicate his protest against being called any other name.
Function 2: TJ kicks others to protest against people communicating with spoken words rather than written or visual communication.

Importantly, the team not only described the basic function e.g. "TJ wanted to protest", but also WHY he needed to protest.

Step 7: Checking that the function(s) are correct.

Staff checked to see if these functions were correct by introducing some strategies that directly related to them.

- They informed all current and new staff of his preferred name and type of communication and each staff member were given cards, writing pads and pictures to use.
- They recorded the frequency of his behaviour and saw that it reduced significantly.

Step 8: Plan the positive behaviour supports, complete the plan, measure success

Staff completed the BSP and continued the behaviour recording to ensure the goals of the BSP were achieved. They compared the baseline behaviour recording (Step 4) to behaviour recording after the BSP had been implemented to see if change has occurred e.g. behaviour incidents reduced from 8 times per day with physical harm to others, to 2 times per day with no physical harm to others. PRN chemical restraint was stopped. A plan to review and reduce the routine chemical restraint was added to the updated BSP.

4: Behaviour Recording STAR Chart

NAME:_____ LOCATION :_____

DATE	TIME	DURA-TION	SETTING EVENTS •See instructions below	TRIGGER •What happened immediately before?	ACTION •What did the client do?	RESULT •What happened then? •How did you respond?	FUNCTION/ PURPOSE OF THE BEHAVIOUR?
12/2	4pm	Less 5 minutes	TJ, staff member AP and the other 3 residents were in the house, it was noisy, TJ has an ear infection.	TJ was pacing up and down the hallway holding his ears. Staff member AP called him "Tommy" instead of "TJ".	TJ kicked AP in the leg causing bruising and swelling.	TJ went to his room. AP left the hallway. CA used cards to find out that TJ had an earache and was being called Tommy.	• TJ kicks others to protest against being called Tommy because he only wants to be referred to as "TJ" • The ear infection is causing him pain

SETTING EVENTS	TRIGGERS	ACTIONS	RESULTS
The general conditions which may influence whether the behaviour will happen, some of which may have happened some time before the incident. • Factors external to the person: e.g. staff changes, level of structure, activity, noise and stress or tension • Factors internal to the individual: e.g. pain, hunger, stress, tension, depression, tiredness, frustration, medical factors (i.e. medical conditions, medication)	The events which occur immediately before which provide a "cue" for the behaviour. The person's own thoughts and emotions in response to the setting events may also serve as triggers.	The person's behaviour in response to the trigger.	The events which occur following the behaviour which may achieve an important result for the person: material items (food, preferred items), interaction, escape from undesirable or feared situations, the person's own emotions.
Atmosphere • tension • conflict • lack of purpose • high noise level State • lack of sleep • thirst • pain • hunger • depression • menstruation • illness Activities • uninteresting • lack of activities • waiting • too routine • lack of routine • too difficult • lack of structure • being hurried People • too many • lack of interaction • being refused an object/activity • was reprimanded • disappointing news	• demands • tasks • people • objects • sights • sounds • unexpected changes	• Write down exactly what the person did	**POSSIBLE FUNCTIONS:** Wanting something • recognition • maintenance of attention • access to objects • sensory feedback Escape or Avoidance • uninteresting activities • unending activities • too difficult tasks • feared objects, activities or people Protest • Expressing views about something

Record the behaviour for 2-3 weeks (less time might be needed if the behaviour occurs everyday, more time may be needed if it only occurs weekly). The team can also use the information from recent Incident Reports. At the end of the recording time calculate;

- Frequency (how often the behaviour occurred for the time period eg 3 weeks)
- Duration (how long the behaviour or the incident usually lasts for)
- Impact/Intensity (what was the result of the behaviour eg cut to face requiring medical care)
- Restrictive intervention use (e.g. how often was PRN restraint used in that time)
- Which functions emerged from the recording (see Appendix 3)

Example:
Behaviour description: TJ can kick people in the legs with enough force to cause injury (bruising and swelling). He does this about eight times a day. The behaviour can last for up to 10 secs. This has been happening since moving into his new home 3 months ago. RI use: PRN chemical restraint has been used 5 times in the last 3 weeks.
Function: TJ kicks others to protest against being called Tommy because he only wants to be referred to as "TJ"

5: Frequency recording sheet

Client Name:_____

This sheet can be used to record behaviour that occurs frequently. List each identified behaviour in a box across the top of the table. Put a tick in the relevant timeslot for every time the behaviour occurred. This recording sheet can be changed from hourly recording to daily or weekly recording.

Date:	Behaviour 1	Behaviour 2	Behaviour 3	Behaviour 4	Behaviour 5
7.00-8.00am					
8.00-9.00am					
9.00-10.00am					
10.00-11.00am					
11.00-12.00pm					
12.00-1.00pm					
1.00-2.00pm					
2.00-3.00pm					
3.00-4.00pm					
4.00-5.00pm					
5.00-6.00pm					
6.00-7.00pm					
7.00-8.00pm					
8.00-9.00pm					
9.00-10.00pm					

6: Questions about Behavioural Function (QABF)

The following questions may assist when deciding on the function or functions of a behaviour of concern. For more detail go to http://www.disabilityconsultants.org/.

Function: Attention

1. Engages in the behaviour to get attention.
2. Engages in the behaviour because he/she likes to be reprimanded.
3. Engages in the behaviour to draw attention to him/herself.
4. Engages in the behaviour to try to get a reaction from you.
5. Does he/she seem to be saying “come see me” or “look at me” when engaging in the behaviour?

Function: Escape

1. Engages in the behaviour to escape work or learning situations.
2. Engages in the behaviour when asked to do something (brush, teeth, work, etc.).
3. Engages in the behaviour when he/she wants to do something.
4. Engages in the behaviour to try to get people to leave him/her alone.
5. Does he/she seem to be saying “leave me alone” or “why are you asking me to do this” when engaging in the behaviour?

Function: Non-social

1. Engages in the behaviour as a form of “self-stimulation”.
2. Engages in the behaviour even if he/she thinks no one is in the room.
3. Engages in the behaviour because there is nothing else to do.
4. Engages in the behaviour in a highly repetitive manner, ignoring his/her surroundings.
5. Does he/she seem to enjoy the behaviour, even if no-one is around?

Function: Physical

1. Engages in the behaviour because he she is in pain.
2. Engages in the behaviour more frequently when he/she is ill.
3. Engages in the behaviour when there is something bothering him/her physically.
4. Engages in the behaviour because he/she is physically uncomfortable.
5. Does the behaviour seem to indicate to you that he/she is not feeling well?

Function: Tangible

1. Engages in the behaviour to get access to items such as preferred toys, food or beverages.
2. Engages in the behaviour when you take something away from him/her.
3. Engages in the behaviour when you have something he/she wants.
4. Engages in the behaviour when a peer has something he/she wants.
5. Does he/she seem to be saying “give me that (toy, item, food)” when engaging in the behaviour?

Reference:
Matson, J.L., Tureck, K., and Rieske, R. (2011). The Questions About Behavioural Function (QABF): Current status as a method functional assessment. *Research in Developmental Disabilities, 33,* 630-634.

7: Goal setting

Setting specific goals for a behaviour support plan will increase the chances of success. Goals should focus on increasing the replacement behaviour and quality of life, as well as providing supports that decrease the use the behaviour of concern.

A goal should include information on what the actual goal is, who is involved, the actions each person will take, how progress will be measured, who will measure it, and a date by which the goal will be achieved.

When teaching skills (especially replacement behaviours) additional information on what situations the skill will be taught or not taught (e.g. location, circumstances) and what the agreed level of success is (e.g. using his cards on 3 out of 4 opportunities).

Example replacement behaviour goal: TJ is being taught to use cards to communicate feeling unwell. CA and TJ will create cards; CA will teach, provide practice sessions and cue TJ and staff in the use of the cards. When TJ needs to communicate feeling unwell, he will give the correct card to staff without kicking, for ¾ of the time for three consecutive weeks within three months".

8: Action Plan

Client Name:		**Date:**	
Staff/ people involved:		**Next meeting date:**	

Goal	Actions needed to achieve goal	By When?	People responsible	Progress so far	Goal achieved? Further actions to achieve goal

9: BSP QEII review and feedback Form

Senior Practitioner Behaviour Support Plan Quality Review

	Quality components of Behaviour Support Plans	Evaluation Guidelines and examples	Score
1	Describe the behaviour/s of concern *eg Harm to others*	What the behaviour looks like, its frequency, duration, impact (harm caused). *TJ can kick people in the legs with force causing injury. He does this about eight times a day. The behaviour can last for 10 secs.*	2 1 0
2	What triggers the behaviour/s of concern *eg Communication*	Can be immediate or immediate past environmental factors. Include physical or social setting, specific activities, interaction, changes, degree of participation or choice. *1. Staff calling him or names instead of "TJ".* *2. Staff speaking to him rather than writing (his preferred way to communicate).*	2 1 0
3	Setting events for the behaviour of concern	What is in, or missing, in the environment that causes the trigger and behaviour to occur? *Staff being unaware or forgetting to say "TJ". Staff using verbal instead of written language.*	2 1 0
4	Function/s of all behaviours of concern E.g. *Protest*	What is the person trying to communicate with the behaviour? This must be logically related to the triggers and setting events identified. *Eg, TJ kicks others to protest against being called other names and/or the use of verbal instead of written communication.*	2 1 0
5	Environmental supports that addresses the triggers and setting events	What changes need to be made to address the triggers and setting events (eg. system, communication, materials, interactions etc). 1. *All staff will be told to use his preferred name, TJ. 2. Where possible, staff will communicate with TJ in written form at all times.* Other factors may also need to be considered. Eg, Health, choice, routine, engagement.	2 1 0
6	Replacement behaviour that meets the same function as behaviour of concern	Must specify replacement behaviour(s) that serve the same function as the behaviour of concern and must be easily performed. *Eg, TJ will be taught to use cards to protest against use of other names and verbal language. The cards will also inform staff of his preferred name/written communication.*	2 0
7	What strategies, tools or materials will be used to teach the replacement behaviour	Teaching strategies including at least one detail about how this will be done (eg. Materials, strategy, skill steps are described). *Staff CA and TJ will create cards, CA will teach TJ and staff how to use and respond (as in 6 above) and what reinforcers will be used and when (see 8 below).*	2 1 0
8	How the person will be encouraged to use the replacement behaviour	The reinforcer for the replacement behaviour must be: specifically stated, be effective, given frequently, *E.g., Every time TJ uses his cards properly, staff will immediately give him "thumbs up", and give a token for 5 mins extra time on the computer, and immediately perform the preferred action written on the card.*	2 1 0
9	What to do when the behaviour of concern occurs and how to de-escalate the situation	Interventions must be legal, ethical, safe and the least restrictive. *E.g., Ensure safety by stepping back 2m from TJ, prompt him to use the replacement behaviour, attempt to meet his need, re-direct him if this doesn't work, offer relaxation, debrief with him when he is calm, incident will be discussed with other staff at end of shift, changes made to strategies if necessary.*	2 1 0
10	Behavioural Goals	How much and by when will the replacement behaviour increase and the behaviour of concern decrease *E.g., When TJ needs to protest he will give the correct card to staff without kicking, 3/4 of the time for three consecutive weeks within three months. The goal is to reduce kicking within two months.*	2 1 0
11	Team Coordination	List of all people involved in the development of the BSP, their role/relationship and specific tasks are described in the BSP. *Eg., TJ, Staff CA, TM, DL and parents FT and RT created BSP. CA responsible for card making, teaching and recording, TM and DL to arrange fortnightly meetings to be attended by all.*	2 1 0
12	Communication and review of behavioural goals	How will the team monitor replacement and other behavioural changes? *E.g., CA will make daily recordings of behaviour and card use, to be kept on file and reviewed by CA, TM and parents every two weeks, decisions on changes to strategies to be decided by all if agreed progress towards behavioural goal is not occurring or a critical incident occurs.*	2 1 0

Scoring

The BSP QEII has a total achievable score of 24, with a total of 2 for each of the 12 components, where:

2 means the component has been addressed in the BSP completely.

1 means the component has been partially addressed in the BSP.

0 means the component has not been addressed correctly or not included in the BSP.

Please note that there is no partial scoring for replacement behaviours. That is, the replacement behaviour/s must serve the same function as the behaviour of concern to score 2.

More information on the BSP QEII can be found at http://www.pent.ca.gov/beh/qe/bspscoringrubric.pdf

10: What the Disability Act asks for in a BSP review and feedback form

Senior Practitioner-Disability What the Disability Act 2006 asks for in a Behaviour Support Plan		
Disability Act Section	Description of requirements that the Disability Act 2006 states need to be contained in the Behaviour Support Plan (BSP)	Evidenced?
1. Section 133	***Is the person with the disability identified?*** ☐ The person's name; and ☐ Date of birth should be recorded. Optional additional information: The person's profile within RIDS should also contain any other identifying information, such as gender, details of the person's disability or a CRIS number if appropriate.	Required by RIDs before system will allow e-BSP entry.
2. Section 142 (1) (a)	***Is there a planned review within 12 months?*** ☐ Is the BSP authorised for no more than 12 months	RIDS will only allow a maximum of 365 days
3. Section 134	***Is the Disability Service Provider (DSP) identified and approved to use restrictive interventions?*** ☐ The name of the Disability Service Provider is identified	Required by RIDs before system will allow e-BSP entry.
4. Section 142 (3) (c) and (d) Section 52 (2) (k)	***Does the person access services from another disability service provider? If yes have the other disability service providers been consulted?*** ☐ The names of any other services that are providing support are identified ☐ Evidence that the other service provider has been consulted in the development of the plan (eg shared BSP, notes within the BSP)	
5. Section 143	***Is Independent Person identified in the Behaviour Support Plan?*** ☐ The name of the Independent person is identified ☐ The phone number of the Independent person is identified	
6. Section 141 (3) (a)	***Has the person with the disability been consulted?*** ☐ The person to whom this plan applies is identified as being consulted in the development of the plan	Required by RIDs before system will allow e-BSP entry.
7. Section 141 (3) (b)	***Does the person with the disability have a guardian? If yes, have they been consulted?*** ☐ The person to whom this plan applies has a guardian who is identified as having been consulted in the development of this plan	

8. Section 145 (1)	***Is the Behaviour Support Plan approved and signed by the Authorised Program Officer (APO)?*** ☐ The eBSP (electronic Behaviour Support plan) is identified on RIDS as 'authorised' either by the primary APO or by multiple APO's if the BSP s shared	Required by RIDs before system will allow e-BSP entry.
9. Section 52 (2)	***Planning should be individualised*** ☐ There is evidence that a larger planning process has been taken into account. (For example Person Centred Plan's, health plans, mental health plans or other relevant plans that may interact with the Behaviour Support Plan and how the person is best supported to increase their quality of life. These should be referred to and where appropriate attached). ☐ There is a description of how the team co ordinates implementation of the plan and communicates information related to implementation of the plan.	
10. Section 140 (a) (i) and (ii)	***Does the Behaviour Support Plan demonstrate:*** • ***That the restraint or seclusion is necessary to prevent a risk to the person or others; and*** • ***The risk is in the form of physical harm or property destruction which results in harm to the person or others?*** ☐ There is an operational description of the behaviour of concern - a description that is clear, specific and easily understood by others and is in accordance with section 140 (a) of the Act. (links to question 9) ☐ There is an identified frequency of the behaviour of concern. This can include known dates of when the behaviour last occurred ☐ There is an identified duration of the behaviour of concern ☐ There is an identified intensity of the behaviour of concern (the risk of or the actual harm to self or others is stated)	
11. Section 3	**Section 3 defines a Behaviour Support Plan as a plan that:** • **"specifies a range of strategies to be used in managing the person's behaviour including;** • **proactive strategies to build on the person's strengths and increase their life skills."** ☐ Description of what makes the behaviours of concern more likely to occur (eg triggers, setting events, unmet needs or skill deficits etc) (links to questions 9 and 10) ☐ Description of what works well in reducing the behaviours of concern (eg positive behaviour support addressing triggers, setting events, needs or skill building etc), (links to questions 9 and 10) ☐ There is evidence (for *all behaviours of concern* that are identified) that 2 or more environmental strategies are in place ○ Addressing personal factors – health, hunger, communication ○ Settings – light, noise, number of people? ○ Expectations that are placed on the person - are they reasonable? ○ Characteristics of others – consistency ○ Interactions – how often and does the person enjoy the interactions? ○ Opportunities to make choices ○ Nature of activities – what they like, how often they get the opportunity and what support do they need?	

	○ Predictability – of the environment, staffing, interactions, responses and activities ☐ There is an identified behavioural goal for at least one behaviour of concern (links to question 9) ☐ A replacement behaviour for at least one behaviour of concern is identified(links to question 9) ☐ There is evidence that a Replacement Behaviour is planned to be taught during the period of the BSP. ☐ The replacement behaviour/skill is linked to a behaviour and a behavioural goal; ☐ The specific strategies are named; ☐ The replacement behaviour meets the same need (or function) that that behaviour of concern serves for the person; ☐ Be reinforced with something positive; ☐ Be achievable for the person; and ☐ Detail of how staff will carry this out.	
12. Section 140 (b) Section 141 (2) (c)	***Does the Behaviour Support Plan demonstrate that the use of restraint or seclusion is the option which is the least restrictive of the person as is possible in the circumstances?*** For routine and PRN chemical/mechanical/seclusion or other restraint – ☐ Description of what was tried before the service arrived at the point where *this restriction at this level* is deemed the least restrictive option for the person? (links to questions 9 and 10) Do the de escalation strategies contain: ☐ A clear explanation of what the person's presentation looks like (when they initially show they are becoming upset, when they escalate and when they return to a calm state); ☐ Along with clear description of staff response matched to the person's presentation; and ☐ The responses are from least (initial response) to most restrictive (restrictive intervention)? (links to questions 10 and 15) ☐ Do the responses (de-escalation) to warning signs of behaviours of concern contain at least two strategies before the restriction is used : ○ Prompt the person to use the replacement behaviour ○ Relaxation ○ Problem solving or attempt to meet the person's need ○ Active listening – encourage communication ○ Change the environment ○ Position self safely ○ Inject humour ○ Withdraw interaction for brief planned period of time	
13. Section 147 (3)	***Is the person being reported on RIDS (Restrictive Intervention Data System)?*** ☐ Do the RIDS reports match what is in the current authorised BSP? ○ Are there any emergency reports ○ Are there any identified gaps in reporting	

14. Section 140 (c) and (d)	***Does the Behaviour Support Plan state what the proposed restraint or seclusion is?*** There needs to be a detailed description of what the restraint is. ☐ Chemical restraint: Is the medication prescribed to change a person's behaviour in the absence of a diagnosis appropriate to the medication? The name of the medication, dose, how it is administered and when it is to be used needs to be articulated. ☐ PRN medication will also need to include what the maximum dose in a 24 hour period can be, and should indicate what level of use would trigger a review by the doctor. ☐ Mechanical restraint: What is being used and how? ☐ Seclusion: Where is the person being secluded and for how long should be articulated. ☐ "Other": Locked doors e.g. limiting or interfering with access to other people, the client's room, toilet, bathroom or other common areas or the community, supervision at specific times to prevent or manage behaviours of concern. ☐ Physical Restraint: **Cannot be approved in a Behaviour Support Plan by the APO.** Use of Physical restraint needs a separate plan that is approved by the Senior Practitioner – Disability, Office of Professional Practice. Please see the Senior Practitioner Physical Restraint Direction Paper – May 2011 for details.	
15. Section 141 (2) (a)	***Does the Behaviour Support Plan state the circumstances in which the proposed form of restraint or seclusion is to be used?*** ☐ Do *all restrictive interventions* have a logical link to a behaviour of concern? ☐ Do *all restrictive interventions* have a clear description of the circumstances in which the restraint will be used? (what is happening, when it happens and how it is applied) (links with questions 10 and 12) ☐ Do routine medications include drug, dose, time/frequency, and route? ☐ Do PRN chemical restraints include what the person's presentation looks like in order for the medication to be offered, the dose, the maximum amount in a 24 hours period can be and how often per 24 hours the person can have the PRN. ☐ Do mechanical restraints state what is being used, how it is applied, for how long and in what circumstances it will be applied and removed? ☐ Does seclusion state where and for how long the person is secluded, as well as what the person's presentation looks like for seclusion to be initiated, how often they will be checked, how their dignity is maintained (see section 140 (d) Disability Act 2006), and what the person's presentation looks like in order for seclusion to be ceased? ☐ Do "other" restrictive interventions have a clear description of what is happening, when and how? Note: physical restraint cannot be articulated within a BSP	
16. Section 141 (2) (b)	***Does the Behaviour Support Plan explain how the use of restraint or seclusion will benefit the person?*** ☐ There is a description of how *the person* benefits from the use of the restraint. ☐ For chemical restraint, there is a description of what the prescriber expects to see as a benefit for the medication that the person is taking.	

11: Questions to ask the doctor

1. What else should we or the team be doing to help with behaviour?
2. What medicines might help with (client's name) behaviour problems?
3. How will the medication help (client's name)? What are the behaviours (target symptoms) that the medicine might help with?
4. How long will it take before I see an improvement? What would you expect an improvement to look like?
5. What is the recommended dose? Why are you prescribing a higher or lower dose?
6. How should the medication be taken and at what times of the day? Can you write instructions for me?
7. What happens if (client's name) takes too much medicine or misses a dose? Is there information about the medicine that I can take home to look at?
8. What are the side effects of this medication, what sort of things do I need to look out for?
9. How do I explain the medicine to (client's name)?
10. Are there blood tests or other tests that need to be done before the medicine can be started?
11. Are there blood tests or other tests that need to be done after the medication starts?
12. How will you monitor (client's name) response to the medication? What information do you need?
13. How will (client's name) progress be assessed - When and how will we decide if the medicine is helping the target symptoms?
14. What information do I need to bring to each appointment? How often will (client's name) need to come back to the clinic? Who will we see for follow-up visits?
15. How do I as a parent or carer contribute to the medical reviews?
16. How long will the medication be needed? What factors may lead to a decision to stop the medication?
17. Are there any other medications, vitamins, supplements or food which should be avoided or affect this medication?
18. What should I do if a problem develops, for example: (client's name) becomes unwell, if doses are missed or if I see side effects? Who do I contact if (client's name) has problems or I have worries?

(Einfeld, 1990; Gratsa, Holt & Hardy, 2004; Hellings et al., 2010; Schall, 2002; Tsai, 2000)

12: Questions to ask the doctor about prescribing Risperidone to people with ASD

1. The length of the appointment should be as long as necessary
2. Comprehensive assessment of the challenging behaviour – will Risperidone actually be useful?
3. Avoid use in already overweight individuals
4. Get the opinions of everyone involved in supporting the person
5. Liaise between all medical practitioners
6. Non-pharmacological interventions first - functional behaviour assessment
7. Behaviour intervention at the same time
8. Target the specific behaviour
9. Start from the lowest possible dose and keep the dose as low as possible
10. Time-limit the prescription, don't change the dose frequently and don't abruptly stop taking the medication
11. Use one medication at a time (if possible)
12. Discuss medication with the family/guardian
13. Inform the person and family/carer if the use of the drug is off-label
14. Medication is not the only intervention implemented
15. Specify the expected outcomes
16. Outline the risks
17. Monitoring of side-effects
18. How will the medication be evaluated - not just sedation
19. Have a written treatment plan
20. When behaviours have been reduced to an acceptable level or absent for a reasonable period of time then an attempt should be made to reduce the dose

(ADA et al., 2004; Arnold et al., 2000; Baburaj & El Tahir, 2011; Baldwin & Kosky, 2007; Deb et al., 2009; Einfeld, 1990; Haw & Stubbs, 2007; Hazell, 2005; Hellings et al., 2010; Marshall, 2004; Matson et al., 2011; McCracken, 2005; McDougle, 2005; McKean & Monasterio, 2012; Panagiotopoulos et al., 2010; Raghavan & Patel, 2010; Santosh & Baird, 2001; Scahill, 2008; Schall, 2002; Simpson, 2005; Sovner & DesNoyers Hurley, 2006; Tsai, 2000; Unwin & Deb, 2010; Weeden et al. 2010; Williamson & Martin, 2012)

13: Example Behaviour Support Plan

Persons Details

Name of person	TJ Holgate	Service Setting	Market St, Castletown
Start Date	21/02/2013	End Date	20/02/2014
BSP Type	Normal	APO	Simon Forrester
Independent Person	Ray and Julia Holgate	Author	Jan Arnold (House Supervisor)

About the person

History	• TJ is 19 years old. He has a great sense of humour, he likes being busy and once he starts something he likes to finish it and do it well. He has a great memory and will remember dates, times, and people easily. He prefers writing to communicate and asks lots of questions. He loves footy and barracks for Hawthorn. • He has a mild intellectual disability and autism. • Until the age of 17, TJ lived at home with both parents, but he physically injured his mother on several occasions by kicking her. • His parents tried many different strategies to stop him from kicking, including prescription of medication. His parents' health suffered and they decided to move him into supported accommodation. When TJ first came to live at his current home, he was on 3mg of Risperidone per day and was having PRN Zyprexa on average once per week. This has since been slowly reduced. • He goes to Flinders Disability Services every day on the services bus which he hates because it's noisy and takes an hour. When he gets home, good to let him have time alone to cool off.
Health	• TJ is in good health most of the time but he can get ear infections about once a month. **He gets ear infections (will bang his ear or rub it)** please refer to Health Plan dated 27/2/2013 for details on how to manage ear infections. • He can be exhausted after his day placement especially after the bus journey and if it's been a hot day, best way to get him going the next day is to give him a cup of tea in the morning. • Mental health: It is reported that TJ was traumatised at school where he was punished by being locked in a "time out area". • He is sensitive to heat. **Have cool drinks ready on a hot day.**

Communication	A communication assessment (23 April 2012) showed that:
	• TJ can speak well but:
	  ○ He uses a notepad because he prefers written language than spoken, he finds the sounds of people's voices irritating;
	  ○ It takes time for TJ to understand information;
	  ○ He has difficulty changing attention from one topic or activity to another.

Likes/Dislikes	**Likes:** • **He only wants to be called TJ.** • **Listening to music is his favourite activity.**

	• He likes to be occupied; he prefers to do things on his own. • He loves praise especially the "thumbs up" sign. • He likes to know when everything is happening, and to be able to choose. • He likes to visit his family • **Structure and predictability are important to TJ. If plans need to change let him know in writing through use of the daily planners**. **Dislikes**: • **He really hates to be called his Christian name.** • **Hot days.** • He doesn't like noise especially high pitched voices. • To sit still for long or waiting. (depending on the day he can sit or wait for up to 10 minutes before needing to move) • Most things that make him unhappy are any changes to his routine or what had been agreed to in his daily plan • Dogs barking or children shrieking in the park • The bus to day placement.
Sensory	• Will seek to avoid the sounds of voices. • **Needs his iPod for car or bus travel or when in close confines with others.** • TJ would benefit from a sensory assessment. An appointment has been made and the plan will be updated once the assessment is completed and the report received.
Dreams and aspirations	• TJ wants to have friends, and be able to visit family more • TJ uses a computer at day placement and wants his own iPad. (currently has to share the house IPad) • TJ would like to learn to catch the train to his day placement • TJ would like to have more money of his own and a job. • TJ would like to move into his own flat with a support worker who had their own space (see attached PCP, March 2013).

Behaviour of concern	Harm to others
Behaviour Description	TJ can kick people in the legs with enough force to cause bruising and swelling. Can happen about eight times a day. The behaviour can last for up to 10 secs. This behaviour was noted by his parents to have occurred at home and at school and has continued since moving into his new home 3 months ago.

Triggers and Setting Events:	
Communication	Behaviour: Kicking • Trigger 1: Staff calling him by his Christian name instead of "TJ". • Setting event 1. Staff being unaware or forgetting to say "TJ". • Trigger 2: Staff only using verbal communication to him rather than predominately writing or visual communication (his preferred way to communicate). • Setting event 2. Staff using verbal instead of written language.
Physical environment	• Trigger: When the house is very noisy. TJ doesn't like noise. • Setting event: Most incidents occurred around 3pm to 4pm when all residents are returning home from their day placements and there is increased noise.
Routine	• Trigger: Sudden changes to his routine or what had been agreed to in his daily plan, e.g., change of staff, staff not doing as he requests or an unavoidable time delay make him very unhappy.
Other	• Setting event: TJ is more likely to kick others when he has an ear infection.
Functions:	
Protest, Avoidance or Escape	Function 1: • TJ kicks others to communicate his protest against being called his Christian name. He only wants to be referred to as "TJ". Function 2: • TJ kicks others to protest against when people don't communicate with written and/or visual communication.

Positive behaviour support	
Address triggers and setting events	**Behaviour: Kicking** • Trigger 1 and setting events: **His name is TJ. Do not use any other name.** Trigger 2 and setting events: • **Staff to communicate with TJ in written or visual form.** Other: • Staff will monitor TJ's health to avoid recurring ear infections. (see health plan 27/2/2013) • On hot days provide cool drink and suggest a shower.
Replacement behaviour and skill teaching	**Replacement behaviours** • TJ is being taught by CA to use cards to communicate. **These cards will also be used by TJ inform staff of his preferred name/ preference for written or visual communication and to protest if his preferred name or way of communicating are not used.** • **Every time TJ uses his cards, give him "thumbs up", and get him what wants**. Skill teaching • To take a shower after returning from day placement to help calm him is now part of his daily routine. • Waiting: Staff praise TJ when he has had to wait for a short time for something without getting upset. • Independence: See travel training in PCP.
Communication	• **Communication cards, I PAD and notepads are used instead of words.** • It takes time for TJ to understand information – when you have asked a question or given him some information count to 20 slowly in your head then prompt TJ to see if he has understood, or needs more time to plan his response and repeat information if necessary. • **Give him time to understand any communication.** • **Staff should also carry a spare notepad in case one is lost.** • Speak gently, softly and in a low tone around and to TJ as he responds better to this and *only* in conjunction with his preferred communication methods. • He has difficulty changing attention from one thing (activity, conversation or setting) to another – always gain TJ's attention via gesture, and gently speaking his name (TJ). • Give TJ time to finish what he is doing. • Give him warning or prompts that the activity, conversation or setting will change and provide him a time frame (eg 5 minutes). • Direct his attention to his planner so that he is aware of what's happening next. **TJ NEEDS TO KNOW WHAT'S HAPPENING AT ALL TIMES: DAILY PLANNER-STAFF ROSTER** • Make sure daily planner is updated every day • Make sure TJ has his smaller daily planner he carries with him.

	• A "Who's on" staff roster is put on the wall in the house with pictures and names of the staff for that day. **Always let TJ know of any changes to staff before the day if possible**. Use change and sorry cards if needed.
Physical and Mental wellbeing	FEELING ANXIOUS: • Suggest he listen to his music - have music available and ensure that his IPod is charged (sensory calming activity) • Waiting to see a psychologist who does internet counselling TIREDNESS AFTER DAY PLACEMENT: • Offer TJ a cool drink that he can make himself in the kitchen • Having a shower immediately on return from day placement works well (sensory calming activity) ROUTINE CHEMICAL and PRN USE SIDE-EFFECTS: • Observe TJ for side-effects of use including drowsiness, dizziness etc.
Goals and objectives	
Replacement behaviour and behaviour reduction	• Goal for increasing the replacement behaviour: When TJ wants to communicate or protest; he will give the correct card to staff without kicking, for ¾ of the time for three consecutive weeks within three months. • Goal for decreasing the behaviour of kicking: Reduce kicking within two months from eight times a day to 2 times a day.
Other goals	• Counselling: That counselling is arranged for TJ within the next two months. • Other: That ear infections are monitored regularly
De-escalation	
Assess safety	• Check everyone is safe. • Check in with TJ after returning from day placement • If he is unhappy (either by showing you his "unhappy" card or by his facial expression – glaring, frowning and eyebrows drawn together, or his body language – moving quickly without seeming to settle, muscle tension evident across shoulders and arms, fists may clench), ensure safety by keeping everyone 2 metres from TJ if possible. • If TJ has used his "unhappy" card, give him a "thumbs up". Use gesture to ask TJ to follow you away from the others. Ensure you stay out of kicking range.
Prompt the replacement behaviour	• Offer him the card that says: **"Are you ok TJ?** **"Use your cards to tell me what's wrong?"** **Each staff should have one of these cards on them at all times.**
Other	**If TJ uses his cards,**

	• Get him what he wants as soon as possible and reward him with a thumbs up sign • If TJ is showing signs of being unhappy or is agitated (eg yelling) because of a staff issue (daily planner not updated/ "who's on" board not completed), say sorry and ask TJ for help with finding out what's happening. • Then suggest something relaxing (shower/music/computer) as TJ can stay upset for a while after the problem has been solved. • Make sure to check in with him regularly for the rest of the shift and let new staff when they arrive. **If TJ indicates "No", that he either would not like to talk to you about it or use his cards.** • Ask him (by offering the choice through cards) if he would like a shower ("would you like a shower?"), a cold drink ("would you like a cold drink?") TJ will usually take you up on one of these offers as it is part of his usual routine • If TJ does not take you up on one of the options presented to him, encourage TJ to go to his room and listen to music until he calms down (no longer glaring, open relaxed body language, able to smile and engage). Do this by using the "bedroom and music" card or by pointing to his room. Check in on him in 10 minutes to see if he is feeling less upset and if he would like to complete his usual routine. **If TJ attempts to Kick** • Hold up your hand palm out to signal "stop". Remove yourself and any others from TJ's reach and give him some space. Check on him at 5 minute intervals. If TJ has not calmed after 20 minutes, offer him PRN Olanzapine 5mg. Continue to monitor until PRN takes effect (usually in 20minutes time – TJ will appear calmer and slightly drowsy). • Offer him a cool drink and the chance to go lie down and listen to some music. **If the behaviour occurs outside the home:** When he's in the park • Follow "assess safety", "prompt replacement behaviour" and "If TJ uses his cards" above. (substitute IPod for shower when out in the community) • If this is not working encourage TJ to sit in the bus on his own until he calms using the "bus" card or pointing. Check in on him in 10 minutes to see if he is feeling less upset and if he would like to rejoin the activity. • If he doesn't want to do this, move everyone away from him and give him space. • Follow "if TJ attempts to kick" above should he attempt to kick while in the community. **Use of PRN Chemical Restraint** • If TJ has kicked someone and will continue to kick them and they cannot escape or; • If all the above steps have been tried and it is certain TJ will kick someone follow the **PRN Chemical Restraint Guidelines dated 21/2/13** (see attached). • If the PRN is needed to be used more than twice within a 7 day period, the BSP should be reviewed and an appointment made with the GP for a medical review and a review of the PRN.
Post incident	• Check if staff, TJ or other residents have been injured or upset and require further professional support such as the Employee Assistance

debriefing	Program or a referral to the Critical Incident Response Management Team for group support. • Inform the other staff. • When he is calm, use the cards to ask him to discuss the incident, privately. • Discuss with other staff/manager if immediate changes to strategies and the BSP are necessary. • Discuss incident for next team meeting.		
Restrictive Interventions: Section 140 (c) and (d)	**Administration Type:**		
Routine	**Chemicals**	Risperidone 1mg,tablet orally at night. *The prescribing doctor indicates that this medication is to address 'anxiety' (as indicated by incidents of behaviours of concern and distress over changes which leads to behaviours of concern) The benefit for TJ is intended that he will be more able to engage with others and more able to achieve his goals of living independently if he is not engaging in behaviours of concern.* *A review with a potential planned further reduction will commence in two months time when TJ has had more time to learn to use the card system developed with him, the PBS strategies are being implemented consistently and there has been a noted decrease in frequency, intensity or duration of behaviours of concern.*	
PRN	**Chemicals**	Zyprexa, 5mg, Oral, Max dose 20mg in a 24 hour period, if used more than twice per week a review is indicated. *Used to sedate TJ This is only used in an attempt to prevent certain physical harm to others when all other least restrictive strategies have been followed so that TJ and others are not put in a position where they may be hurt. The benefit for TJ is intended that he will be more able to maintain relationships with others and more able to achieve his goals of living independently if he is not engaging in behaviours of concern.* *PRN Chemical restraint has not been needed since the BSP has been implemented. Its need will be reviewed in 2 months, if it has not been needed discussion will be held with the doctor regarding it being removed from his treatment.*	

Who has been involved in preparation of the Plan and what are their responsibilities?

Name	Agency	Role	Relationship
TJ Holgate			
Ray and Julia Holgate	Family		Parents
Nick Holgate	Family		Brother
Clare Adams	Southern Cross Services Inc.	Key worker	House Staff
Jan Arnold	Southern Cross Services Inc.	House supervisor	House Staff
Bruce Apway	Flinders Disability Services	Staff member	Staff member

Team co-ordination and review	List how the team will co-ordinate all the tasks and responsibilities and review the behaviour support plan. For more information see Good practice and guiding principles and Section 4 of the Toolkit.
Team co-ordination	Replacement behaviour: CA responsible for card making, teaching TJ and other staff and recording. Counselling and ear infections: Jan to arrange for referral to GP re counsellor and ear infections by 3/3/2013. All staff to follow Health Plan regarding observing TJ for signs of earache. Communication: Jan responsible for providing notebooks and card making items. Daily planners/staff roster: to be kept up to date by staff on shift everyday. Daily support: Shower after day placement continues daily as long as TJ wants it. All staff responsible. BA from Flinders Disability services is his key worker for Day Placement and is responsible for monitoring, recording and communicating with CA, TJ's accommodation key worker. CA is responsible for coordinating the information flow between day placement, TJ's home, his parents and any medical professionals. House staff and BA meet monthly to discuss any issues, incidents and plans. TJ's parents are invited to attend these meetings. PCP goals are achieved as soon as possible especially those related to the behaviour: All staff, parents, Nick and Bruce from day placement responsible. • Travel training to commence by 15/3/2013.
Communication and review of goals	• CA will make daily recordings of behaviour and card use, • Card use reviewed by CA, JA and parents every three weeks, decisions on changes to strategies to be decided by all if progress towards quality of life goals (PCP), behavioural goals, or BSP implementation is not occurring or a critical incident occurs. • TJ's health (ear infections), management of triggers or setting events, skills teaching, effectiveness of de-escalation strategies, behaviour, discussed at each team meeting.