



Director of Forensic Disability

POLICY

Title: Positive Behaviour Support

1. Policy Statement

The Forensic Disability Service (FDS) should use a positive behaviour support model as both an ethos and practice in enhancing client quality of life, reducing behaviours of concern, and when using a regulated behaviour control. The FDS must support clients with the least restriction necessary.

2. Purpose

The purpose of this policy is to outline the relevant provisions of the Act, and support best practice in relation to promoting client quality of life and skill development and a safe and therapeutic environment for staff and clients. Overall, this policy seeks to ensure that:

- clients are supported using a positive behaviour support approach that involves fully understanding the person, their interests, preferences, quality of life, trauma experiences, and the function of the behaviour to inform strategies that support the client;
- in instances where a Senior Practitioner has determined that a Positive Behaviour Support Plan (PBSP) is necessary, the client is managed and supported in accordance with the PBSP;
- the reduction of risk occurs by understanding, planning, responding to, and reducing behaviours of concern;
- clients are supported with proactive strategies and to learn and use functionally equivalent replacement behaviour (FERB), new skills of daily living (e.g., social or coping skills) and ultimately increase quality of life while reducing behaviours of concern and use of any regulated behaviour control;
- evidence based interventions (non-aversive reactive strategies) are used to safely de-escalate and therapeutically support the person using behaviours of concern;
- risk of behaviours of concern and/or potentially critical situations are assessed systematically, including thorough analysis of behavioural data that allows for the review and proactive development of interventions;
- staff understand the systems and methods in place that reduce risk to the individual and others in a safe and least restrictive manner;
- all requirements for documentation and reporting are adhered to;
- the relationship and difference between positive behaviour support and the use of regulated behaviour controls are clearly outlined (refer to *Director of Forensic Disability Policy - Regulated Behaviour Control*);
- critical incident reporting processes are undertaken and maintained; and
- support is available to staff involved in incidents of behaviour of concern (including for example, employee assistance services, debriefing and/or post incident analysis).

3. Scope

This policy applies to the FDS. The Administrator, Senior Practitioner, Authorised Practitioner and other persons performing a function or exercising a power under the *Forensic Disability Act 2011* (the Act) must comply with this policy.

This policy must be implemented in a way that is consistent with the purpose and principles of the Act. Where appropriate, positive behaviour support should be considered in all client care, support, assessments and relevant plans under the Act.

4. Authorising Legislation

Section 91 of the Act.

5. Policy

FDS staff should use positive behaviour support as an overarching ethos and practice framework in the provision of care and support of clients to improve their quality of life, reduce behaviours of concern, reduce or eliminate regulated behaviour control, and to maximise the safety of themselves and others. Strong emphasis should be placed upon prevention and early intervention (proactive and antecedent strategies, and teaching skills). The positive behaviour support model sits within the Individual Development Plan (IDP); and is considered a '*relevant plan*' under the Act if a formal PBSP exists.

Behaviours of concern can be defined as '*behaviour of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit the use of, or result in the person being denied access to, ordinary community facilities*' (Emerson, 1995). The *behaviours of concern* terminology is used in this policy as it is more strengths-based than other language sometimes used, however it is inclusive of behaviours of physical harm or serious risk of physical harm (e.g., property damage).

Individuals with intellectual disability or cognitive impairment and offending behaviours sometimes present with challenging or dysregulated behaviour. This behaviour often occurs as a result of the interaction between personal and environmental factors. Positive behaviour support proposes that behaviours of concern represent an individual's best attempt to communicate their needs and exert influence and control over their life, and can be understood as learnt behaviour within the context of an individual's abilities and needs. This behaviour may develop and be maintained by the social and physical environment(s) within which the behaviour occurs (Gore et al, 2013).

People with intellectual disability who also have communication difficulties, autism, sensory processing difficulties and physical or mental health problems may be more likely to develop behaviours of concern (National Institute for Health and Care Excellence, 2015). Furthermore, clients at the FDS are likely to present with a risk profile that features increased dynamic risk factors such as impulsivity, poor emotional coping, antisocial attitudes, and poor compliance with supervision or treatment. These dynamic risk factors may contribute to a further likelihood of behaviours of concern.

Positive behaviour support has a strong evidence base and is a widely accepted approach to managing behaviours that may cause harm to the person, others and or property (Carr et al, 1999; Dunlap and Carr, 2007; Harvey et al, 2009; Hassiotis et al, 2009; LaVigna and Willis, 2012). Positive

behaviour support aims to expand an individual's behaviour repertoire with a primary focus on enhancing quality of life and a secondary focus on minimising behaviours of concern. This may occur through teaching the individual new skills or replacement behaviours, or making change to the environment and the system that supports them.

To ensure best practice the FDS should adopt a positive behaviour support approach to the support of all clients and keep abreast of the evidence-based literature and research for supporting individuals with intellectual or cognitive impairments (refer to Attachment 1 - key references on positive behaviour support).

In the event that staff are uncertain as to how to proceed in relation to a client, they should consult the Senior Practitioner and/or Principal Clinician. The Senior Practitioner has prepared the Individual Development Plan which outlines the provision of programs and services that best promote the care, support and rehabilitation of each individual client.

5.1 Policy and practice support

This policy should guide knowledge and practice of positive behaviour support across the FDS. It is the Senior Practitioner and Administrator's responsibility to oversee that the positive behaviour support approach is embedded into the governance and operations at FDS and is understood and applied by all staff.

The Director of Forensic Disability has developed an overarching risk assessment and management framework that considers some of the models appropriate to the FDS client group, including positive behaviour support and trauma informed care. These models are key elements of care and assessment and management of risk at the FDS.

5.2 Development of positive behaviour support knowledge, skills and abilities at the FDS

All staff must be trained in the ethos and practice of positive behaviour support as applied to the FDS client group. The development, training, and implementation of positive behaviour support across FDS should be led by the Senior Practitioner and/or Principal Clinician.

5.3 Positive behaviour support and other models

Positive behaviour support is a core tenet of the FDS Model of Care and fits well with other elements of care, support and rehabilitation at the FDS. It is a framework that does not operate independently from, or exclusive of other models. The model integrates easily with other evidence-based support models such as person-centred planning, active support, strength-based programs such as the Good Lives Model, and parts of the Risk, Need and Responsivity model. Similar to the other approaches used at FDS, positive behaviour support:

- is strength-based and person-centred;
- has a quality of life focus;
- promotes physical (e.g., environmental, health) and psychological safety (i.e., care-giving that aims for a sense of security and autonomy);
- removes or reduces triggers for behaviours of concern and recognises the potential for these behaviours to be a traumatic event;
- provides opportunity for teaching and practicing new skills (e.g., coping, social); and
- aligns with the trauma-informed care approach (refer to *Director of Forensic Disability Policy – Trauma Informed Care*);

6. Assessment

Positive behaviour support emphasises the importance of fully understanding the person. This may involve undertaking a range of assessments such as occupational, speech and language, quality of life and relevant health assessments.

An ethos of positive behaviour support should be adopted broadly for all FDS clients. Given the likelihood that clients at the FDS will present with behaviours of concern (of varying forms, intensity, duration and frequency), it is likely that most clients would benefit from having a current functional behaviour assessment and positive behaviour support plan. It is the responsibility of the Senior Practitioner to decide whether a formal PBSP is required for each client, to have oversight of each plan, and to include a summary in the client's individual development plan. Where a decision is made to have a formal PBSP, assessment and plan development must include the client and key stakeholders.

A multi-component PBSP should be informed by direct and indirect data collection, a comprehensive understanding of the person and a functional behaviour assessment. Without a thorough evidence-based functional behaviour assessment, staff can draw inaccurate conclusions regarding the reason/s for a behaviour and, as a result, use strategies which can lead to an increase in the behaviour (intensity, frequency and duration).

A functional behaviour assessment should involve four key steps:

1. identifying the behaviour (a clear description of exactly what occurs during a behaviour, including whether or not it causes damage or injury);
2. identifying what triggers the behaviour;
3. identifying what happens after the behaviour; and
4. based on all this information, identifying the function of the behaviour (i.e., the purpose or intent of the behaviour).

An evidence-based model should be used to identify the function/s of a client's behaviour. The EATS model is evidence-based and often used for this purpose:

- **escape or avoid** (interaction with others);
- **access** (interaction with others), even if the interaction is not positive;
- **tangible** (access to an item); and
- **sensory / automatic** (to access or avoid an internal state), e.g., avoiding pain or noise; or using movement to meet a sensory need. This function should be considered only where it is clear none of the other functions are applicable.

Escape or avoiding interactions with others is the most common function of behaviour for people with a disability, hence the importance of ensuring staff interact with clients in a way that meets their need.

A functional assessment of behaviour report should be on file with the formal PBSP to demonstrate how the function/s were developed from the data.

7. Positive Behaviour Support Plan

A PBSP must be informed by assessment and include:

- Setting Event Strategies;
- Antecedent Strategies;
- Teaching Skills (including a FERB); and
- Non-aversive Reactive Strategies.

Positive behaviour support is **not** a regulated behaviour control, punishment, or an aversive or coercive practice. A regulated behaviour control should only be included in a PBSP if it has been identified as the least restrictive method of managing behaviour, adheres to relevant legislation, is evidence based and all alternative options have been considered. Importantly, if a regulated behaviour control is considered the least restrictive means of managing a behaviour that may cause imminent physical harm to the person or others, it should be reflected in the PBSP, time limited and the PBSP updated to include strategies to reduce or eliminate its future use. The PBSP must therefore clearly outline the regulated behaviour control to be used and the strategy to reduce its use (refer to *Director of Forensic Disability Policy – Regulated Behaviour Control*).

Setting Event Strategies

Setting event strategies address the longer-term physical, social, and physiological events that increase the likelihood of a behaviour, rather than the immediate trigger for the behaviour. Setting events are also known as background factors as they provide the environment or situation (i.e., the setting) that increases the chance of a behaviour occurring.

Setting Event Strategies may include, but not be limited to, making positive changes to:

- interactions and meeting communication needs (e.g., regular and positive contact with family members and other important people in the person's life, developing prosocial communication, following speech language pathology recommendations such as allowing extra processing time for receptive communication; using communication supports, e.g. visual schedules/ devices);
- background factors that may contribute to a trauma response for an individual;
- routines and preferred activities including supporting the client to participate in activities that develop their skills;
- the environment (e.g., including the client in enhancing their environment, comfort, decorations, pictures etc, providing opportunities for choice and a more predictable life); and
- improve health care (e.g., medical reviews, pain management, mental health strategies, supporting healthy activities, and nutrition).

Antecedent strategies

Antecedents are the physical, social, and physiological events that occur immediately before a behaviour occurs. Antecedent strategies set out to address what was happening immediately prior to the behaviour.

Antecedent strategies may involve:

- identifying, reducing and/or eliminating triggers (e.g., trauma responses);
- providing choices to divert the client away from the behaviour of concern;
- considering the function of the behaviour and supporting the client to achieve the intended goal without having to engage in the behaviour of concern (for example, allowing the client to remove themselves from a stressful situation);
- increasing staff interaction and support; and/or
- providing access to desirable activities or items in lieu of the behaviour of concern.

Teaching Skills

Teaching clients new skills is considered one of the most effective means of positive behaviour support. Teaching skills can lead to enhanced quality of life, increased sense of achievement and competence as well as providing the client with more efficient and effective means of obtaining their desired goals. Ultimately, teaching skills should lead to clients' development of a FERB where the client uses new skills rather than the behaviour of concern. The FERB will become effective for the client when it becomes easier to use the new skill, it achieves the same function, it is based on the capacity of the individual, and gives the person what they want (e.g., staff positively reinforce the use of the new skill).

Common areas for skill development may include:

- Communication and social skills;
- Coping skills (e.g., arousal reduction, emotional self-regulation, distress tolerance); and
- General life skills such as cooking, housework, or using public transport.

Non-aversive Reactive Strategies

Non-aversive reactive strategies are actions and planned interventions in response to an identified behaviour of concern. They are not aimed at long-term behaviour change, but at stopping the behaviour with dignity and safety. Reactive strategies aim to bring immediate control over a situation so that risk is minimised or eradicated.

Non-aversive Reactive Strategies may include actions to stop and/or reduce behaviour with dignity and safety or reducing barriers to client accessing prosocial or diversionary activities during a behaviour.

8. Implementation

Implementation of a positive behaviour support approach should involve:

- training and on-the-job coaching and mentoring of staff to ensure they are familiar with the client, the client's positive behaviour support needs and competent in implementing the PBSP strategies (including accurate behaviour reporting and data collection);
- monitoring, documenting and reporting on the implementation of positive behaviour support strategies and incidents of behaviours of concern to support or dispute functions of behaviour, remove any unhelpful or incorrect assumptions staff or others may have about the client, and updating plans where necessary;
- reviewing, monitoring and modifying of PBSPs based on assessment including an analysis of the collected data and consultation with stakeholders; and

- completion of a task list within each PBSP/IDP that identifies the key tasks required (such as medical, communication or sensory assessment) during the life of the plan, including the person responsible for completing each task and the expected completion date.
- Risk management plans must be consistent and align with client's PBSP.

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Attachment 1: Reference List

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