Behaviour support in out-of-home care

Summary: This document is designed to inform the behaviour support practice of DCJ staff working in out-of-home care. It may be used as a guide by non-government out-of-home care service providers to develop their own behaviour support policy.

Document approval

The behaviour support in out-of-home care guidelines have been endorsed and approved by:

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Deputy Secretary

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1 Purpose

This document is designed to provide high level guidance for NSW Department of Communities and Justice (DCJ) staff and non-government service providers about behaviour support for children[1] in out-of-home care (OOHC). The document provides advice on appropriately supporting behaviour, behaviour support planning, prohibited and restrictive practices. It is not intended as a comprehensive resource for supporting the behaviour of children in OOHC. Please refer to links to additional resources provided.

This document provides guidance on developing a behaviour support policy to meet the requirements of DCJ, the Office of the Children's Guardian (OCG) and NSW legislation. It is the responsibility of service providers to develop a behaviour support policy for their organisation and provide behaviour support training for carers and staff that care for children.

1.1 Background and policy links

The *Children and Young Persons (Care and Protection) Act 1998* (Care Act) and the *Children and Young Persons (Care and Protection) Regulation 2012* (Care Regulation) provide the legislative framework for the provision of behaviour support and development of behaviour support policies in OOHC.

The Care Act provides the authorised carer of a child with the authority to correct and manage their behaviour. The Care Act and Care Regulation also provide limitations around that authority. The behaviour support provided in OOHC, as well as the policies and procedures underpinning this support, must also comply with the *United Nations Convention on the Rights of the Child* and relevant NSW legislation.

The OCG accredits 'designated agencies', under the Care Regulation, to provide OOHC (referred to as OOHC service providers in this document). Service providers are required to submit their behaviour support policy, psychotropic medication policy and procedure for use of physical restraint as part of their application for accreditation as a designated agency.

These guidelines provide advice for DCJ staff and service providers to fulfil their obligations under the legislation, *NSW Child Safe Standards for Permanent Care* and the *United Nations Convention on the Rights of the Child*.

For links to relevant legislation and human rights:

- Care Act
- Care Regulation
- United Nations Convention on the Rights of the Child

This document was developed in consultation with the following areas of DCJ:

- Aboriginal Outcomes, Child and Family

[1] Throughout this document 'child and/or young person' is shortened to 'child'; 'children and/or young people' is shortened to 'children'. The Care Act defines a child, as "a person who is under the age of 16 years" and young person as "a person who is aged 16 years or above but who is under the age of 18 years".

- Accreditation
- Cross Cluster Operations and Business Support
- Directors Community Services
- Disability Services
- Intensive Support Services
- Legal
- Office of the Senior Practitioner (Community Services)
- Psychological and Specialist Services

This document has been developed using the DCJ Behaviour Support Casework Practice Mandate, the OCG Guidelines for Designated Agencies for Developing a Behaviour Management Policy and relevant research.

2 Glossary

The table below is a list of terms, keywords and/or abbreviations used throughout this document.

Term	Definition
Aversives	A prohibited practice that involves applying something painful or unpleasant to a child's face or body, in order to stop a specific behaviour.
Behaviour(s) of concern	Behaviour that is of such intensity, frequency or duration that the physical safety or emotional wellbeing of the child, or others around them, is at significant risk (i.e. beyond what is usually expected for the child's developmental stage). Behaviours of concern may include psychological symptoms, including detachment and dissociation, or the absence of behaviours that are usually expected for a child's age. The behaviour may limit the person's access to their usual activities, services, experiences and places they would go. Behaviours of concern substantially interfere with the acceptance of a child by their community and disrupts their quality of life, and that of their family, peers and carers. The concerns involved often go beyond the impact and effect of the behaviour, but also to the challenge that family, carers and staff may experience in attempting to provide support in an ethical, appropriate and effective manner.
Behaviour support expert	For the purposes of this document, a behaviour support expert is a psychologist, occupational therapist, social worker or equivalent professional

	with specialist training and expertise in behaviour support. For example, DCJ Psychologists are considered to be behaviour support experts. The Psychological and Specialist Services ‘Positive Behaviour Support’ training is foundational and does not qualify a staff member as a behaviour support expert.
Behaviour support plan (BSP)	Also known as a behaviour management plan or behaviour intervention support plan in OOHC service settings, it is a structured planning tool designed to strengthen positive behaviours, improve quality of life and promote the personal interests of the child. It aims to build upon strengths within the child, whilst reducing and preventing behaviours of concern, and keeping the child safe, by equipping the carer or staff with appropriate strategies. It takes into account the causes and underlying functions of the presenting behaviour, including the effects of trauma.
Carer	For the purpose of this document ‘carer’ refers to foster carers, relative carers, kinship carers, prospective guardians and prospective adoptive parents. Carers are also known as ‘authorised carers’ as they must be authorised under section 137 of the Care Act to provide care to children.
Caseworker	Also known as a case manager, the staff member responsible for working with clients in OOHC. DCJ caseworkers may be responsible for working with non-government service providers. DCJ caseworkers report to the ‘Manager Casework’.
Chemical restraint	The intentional use of medication to restrain a child’s behaviour or movement where no medically diagnosed condition is being treated, where treatment is not necessary or where it amounts to overtreatment. The intended effect of the medication may be to sedate for convenience or disciplinary purposes. The medical practitioner may have ceased recommending the medication or it may have been prescribed by a registered medical practitioner but used contrary to instructions. This is a prohibited practice.
Intensive Therapeutic Care	The system of OOHC services that support children with identified high and complex needs who are either unable to be supported in foster, relative or kinship care or require specialised and intensive supports to maintain stability in their

	care arrangements (previously referred to as Residential Care).
Office of the Children's Guardian (OCG)	An independent, statutory authority committed to delivering better outcomes for children in OOHC. The OCG is a regulator – not a provider of care services.
Manager Casework (MCW)	See 'supervising case staff' definition below.
Out-of-home care (OOHC)	All types of OOHC services unless otherwise specified. OOHC is a pathway to a permanent home for a child, not a long term form of support. This is assisted by the use of short term and interim court orders rather than long term parental responsibility for a child to the Minister until they reach 18 years.
Overcorrection	A response to a child that is out of proportion to the original behaviour, e.g. requiring a child to clean an entire room because they have deliberately tipped a meal onto the floor.
Principal Officer	A legally defined position that refers to the person with overall responsibility for supervising a service providers arrangements for providing statutory or supported OOHC. For each DCJ district, the Principal Officer is the Director Community Services or Director Operations nominated to the position. For Sherwood House and Intensive Support Services the Principal Officer is the Secretary, DCJ. For more information see fact sheet 6 on the OCG website.
Prohibited practice	Practices that must not be used. They are unethical and may constitute a criminal offence or incur civil liability. See heading 4.8 for a list of prohibited practices.
Psychotropic medication	Psychotropic medication is any prescribed medication which affects cognition (such as perception and thinking), mood, level of arousal and behaviour.
Restrictive practice	Also known as restricted practices, refers to any practice or intervention that has the effect of restricting the rights or freedom of movement of a child, with the primary purpose of protecting the person or others from harm. Please note: detailed information about what constitutes a restrictive practice and appropriate

	uses can be found in the 'restrictive practice' section of this document.
Service provider	For the purpose of this document this term refers to non-government organisations that provide OOHC services for children.
Staff	For the purpose of this document this term refers to any OOHC staff that provide day-to-day care for a child.
Supervising case staff	The manager of caseworkers and/or OOHC staff. The DCJ terminology for this position is the 'Manager Casework' (MCW).
Supervisory responsibility	Legally defined by section 140 of the Care Act, refers to the responsibilities a designated agency (service provider) has in their supervision of a placement of a child in OOHC with an authorised carer.
Therapeutic Specialist	A clinical expert in trauma informed therapeutic care. The role plays a critical oversight and coordination function within Intensive Therapeutic Care and the broader OOHC service system. A Therapeutic Specialist is considered to be a behaviour support expert.
Trauma informed	Practice and interventions informed by an understanding of the psychological and physical impacts of trauma experiences on the developing child.

3 Scope and application

This document applies to DCJ staff and OOHC service providers.

It is to be used to inform the practice of DCJ caseworkers and DCJ staff who work with children in OOHC.

Non-government OOHC service providers may use this document as a resource when developing their own behaviour support policy.

4 Behaviour support in OOHC

Children in OOHC have the right to be kept safe, be supported and encouraged to develop positive behaviours. They have a right to feel cared for, and be treated with dignity. This can be achieved by equipping carers and staff with appropriate strategies to help children stay safe and achieve their personal goals.

These guidelines provide advice on positive support, preventing and addressing the behaviours of a child which may be harmful to themselves or others, and strategies that must not be used.

4.1 Positive behaviour strategies

DCJ mandates the use of appropriate positive strategies to support a child's behaviour, such as strength based approach, role modelling and effective discipline within a safe and caring relationship. The aim is to provide a respectful and sensitive environment in line with the NSW Framework for Therapeutic Care.

Children should be encouraged to develop and build appropriate social and emotional skills. They need to be empowered to achieve and maintain their individual lifestyle goals, and establish positive attachments with adults that care for them. Many children in OOHC have experienced trauma and need support to address that trauma. Children who have experienced trauma need to feel safe before they can behave appropriately.

4.1.1 Positive behaviour strategies and case planning

Carers and staff need to be equipped with strategies to promote appropriate behaviours, address the underlying reasons for concerning behaviours and keep the child safe. DCJ and other OOHC service providers can help carers and staff to develop these strategies through evidence-based training and support.

As part of case planning, caseworkers (and service providers) are to provide support to carers to help them to:

- develop positive parenting responses to influence a child's behaviour and model positive behaviour
- be supportive and respond to the child in a way that reduces rather than escalates behaviours of concern
- nurture the child and develop their talents

- keep the child safe.

Caseworkers are to inform carers that they:

- need to ask the child if they feel safe and what helps them feel safe
- need to help the child to feel safe as they may be feeling a high level of anxiety
- need to understand a child’s adverse experiences to gain an understanding on the impact this may have on their behaviour
- are responsible for encouraging a child to develop positive behaviours
- have responsibility for making day to day decisions to support and manage a child's behaviour, which includes using positive parenting methods
- cannot use prohibited practices for behaviour support (for more information see the ‘behaviour support planning’ and ‘prohibited practice’ sections below)
- can only use restrictive practices when authorised to do so as part of a BSP (for more information see the ‘restrictive practice’ section below).

Carers are to be made aware that if a child’s behaviour is concerning they should ask their caseworker for advice and support. In particular, medical/therapeutic intervention needs to be discussed with the case worker first.

Caseworkers should talk with the carer and the child about:

- the behaviour support techniques the carer can use
- the best way to support the carer and child.

Practice advice

Children in care may have been maltreated in the past, making it difficult for them to trust adults. They may feel very anxious for long periods of time, get upset more easily and find it difficult to calm down. When a child has an emotional outburst it can be very confronting. Carers and staff should try to stay calm, not take the behaviour personally and avoid getting into a power struggle. It is helpful for carers or staff to reflect on their own triggers and be ready with strategies to calm down, such as walking away and discussing the issue later.

Additional information and resources

DCJ provides advice and strategies to support positive behaviours and provide effective discipline on the ChildStory Caring website and have developed a series of videos on supporting children who've experienced trauma.

Further resources on positive behaviour support strategies and parenting:

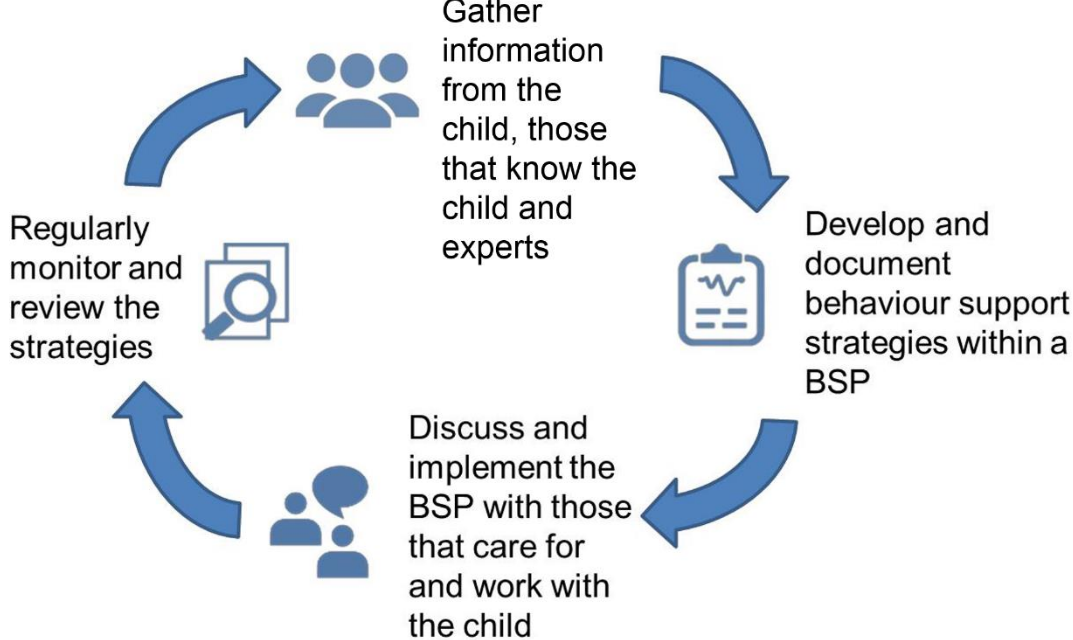
- Relationships Australia NSW
- The Raising Children Network
- Kids Matter
- Child Family Community Australia

4.1.2 Structured behaviour support planning

Carers and/or staff who care for a child need more structured support in situations where there are more complex or concerning behaviours and psychological symptoms. This support is provided through a collaborative process of planning, implementing and updating strategies to address any behavioural concerns and to build competencies. The process is documented within a BSP.

A BSP is required when:

- the child's behaviour is dangerous to themselves or others and/or is having a major impact on their daily functioning
- a medical practitioner or specialist prescribes the child psychotropic medication
- a behaviour support expert determines that physical restraint is required to keep the child safe
- approved restrictive practices are recommended.



For detailed information about when and how to develop a BSP, maintaining a BSP, use of psychotropic medication, restrictive practices and legal requirements around these practices see section five below.

4.2 Understanding the reasons for behaviour

Children in OOHC are likely to have experienced a range of adversity early in their life. It is important to remember and be sensitive to the factors that may have shaped their behaviour, such as:

- neglect
- exposure to drugs or alcohol before birth
- being exposed to violence, abuse and trauma early in life
- health and developmental issues (e.g. language and speech)
- inconsistent parenting
- not being taught a positive way of getting what they need
- learning that being disruptive gets attention
- trying to cope with grief, loss and separation
- repeated rejections by loved ones and feelings of abandonment
- lack of a stable home, family and school life due to moving in and out of care or placement breakdowns
- having to adjust to new environments with different rules and ways of doing things too often.

As a result children in care may react or behave in ways that carers and staff find confronting. Children may withdraw or not display behaviours expected for their age or development.

Behaviours that carers or staff find concerning usually serve a need for a child and can often be attributed to their traumatic experiences. Children should be supported to learn alternative ways of managing their behaviours and emotions that enhance the wellbeing and safety of themselves and those around them.

There can also be circumstances where some behaviours may not be related to early trauma and require additional interventions for successful management (e.g. conduct disorder). Relevant experts should be consulted when addressing these behaviours.

4.2.1 Influence of environment and context

Children have the best chance to thrive in settings that are engaging and supportive. The way that carers and staff interact with children, the activities they promote and the physical environment can impact on the child's development

Behaviours of concern should not automatically be viewed as an expression of defiance or abnormality, and their history and context should be considered. Children may need to learn how to manage their emotional responses and behaviours in a given setting or environment.

4.3 Children from Aboriginal communities

It is important to acknowledge the pain and suffering that separating Aboriginal and Torres Strait Islander children from their families and communities has caused, especially those from the Stolen Generations, and to their families and descendants.

For Aboriginal people, trauma has had an additional intergenerational impact due to past policies and practices. This has resulted in a cumulative effect over time and across generations so that inter-generational trauma is affecting Aboriginal people and communities and can be negatively affecting Aboriginal people's life opportunities.

Healing based support is required to address this trauma, promote cultural identity, connections and community participation. Healing is a central element of the NSW Government's OCHRE strategy for Opportunity, Choice, Healing, Responsibility and Empowerment. Behaviour support planning is expected to be consistent with this strategy.

Approaches to healing should be culturally embedded, and therefore must be led by Aboriginal people. A trauma informed and culturally embedded approach must be incorporated into all work with Aboriginal children, young people, family, kin, carers and community, including behaviour support. The behaviour support planning and policies of Non-Aboriginal agencies providing services to Aboriginal children must be underpinned by meaningful cultural planning.

4.3.1 Culturally aware behaviour support

The behaviour support provided for Aboriginal children is to be:

- culturally appropriate
- consistent with the child's cultural care plan

- actively involve the kin and family that care for the child, as well as the child's biological family whenever possible
- facilitated by Aboriginal staff and carers whenever possible, or when not possible, by culturally competent non-Aboriginal staff and carers.

4.3.2 Importance of kin and relatives

A meaningful connection to family and kin helps a child to develop a sense of belonging and identity, leading to greater resilience and lifelong wellbeing. Aboriginal children can be supported to develop these connections though behaviour support planning that actively involves their relatives and kin, and that is consistent with their cultural care planning.

The definition of 'family' within Aboriginal communities and culture is distinctly different from the Anglo-Australian nuclear family model. Aboriginal family structures are characterised by collective parenting models that involve both immediate and extended family members. The Elders of an Aboriginal community can also play a key role in teaching children respect and the customs of their community.

Practice advice

Members of a child's relative and kinship group can have a major influence on their behaviour. Family and kin should be given opportunities to contribute to the decision making for behaviour support planning and should be engaged throughout the process.

This means talking to the family and kin who care for the child and gaining their input when planning behaviour support. Caseworkers can also speak to the child's biological parents for advice about the child's behaviour and how they have successfully managed behaviours of concern in the past. When a BSP has been developed, talk to the family and kin about what it means, answer their questions and give them the support they need to implement the strategies.

Additional information and resources

Aboriginal Case Management Policy – for practitioners working with Aboriginal children, young people and families.

NSW Practice Framework – how DCJ works with children and families in NSW including the principles, values, mandates, approaches and systems that underpin our work.

DCJ 'Raising Them Strong' resource project – detailed guidance for Aboriginal carers

AbSec website – The Aboriginal Child, Family and Community Care State Secretariat (AbSec) is the peak NSW Aboriginal Organisation providing child protection and OOHC policy advice on issues affecting Aboriginal children, young people, families and carers.

4.4 Children from culturally and linguistically diverse backgrounds

There is no 'one size fits all' approach for working with children from culturally and linguistically diverse backgrounds (CALD).

Experiences will vary widely between children and every culture is unique. Children who have migrated are likely to have experienced disruption due to the process of change and adaptation to a new culture.

By definition, children of a refugee background will have experienced conflict and significant upheaval. If they are an unaccompanied humanitarian minor, this means they have come to Australia alone. Children of a refugee background may have complex psychological needs, such as post-traumatic stress, depression, anxiety and developmental delays.

They may have experienced:

- disease, hunger and starvation
- bereavement
- reduced social support or social exclusion
- disruption to schooling/routines
- prolonged periods of dislocation with uncertainty about the future
- separation from economic supports.

It is vital that all children in care are provided with opportunities to preserve their language, cultural and religious ties throughout their time in care. This is a requirement under the Care Act. A child is likely to benefit from having access to culturally appropriate activities and services, as well as mentors and role models who share the their language, culture and/or religion and that are looking out for their welfare.

4.4.1 Behaviour support strategies

It is important that behaviour support for children is culturally respectful and sensitive to their experiences, particularly if they are a refugee or migrant. Carers, caseworkers and staff should:

- use empathy, openness and patience
- use communication styles that are more easily understood by the child
- understand family and kinship connections and how this may foster a sense of security and belonging for the child in their adoptive country
- support the child's attachments with significant people
- allow time to adjust to life in Australia
- provide access to settlement supports, such as English teaching
- use services that provide culturally appropriate support whenever possible.

It is useful to be informed about the cultural and/or religious background of the child in order to understand behaviour and respond in a sensitive manner. At the same time it is important not to make assumptions about behaviour based on this information.

Practice advice

Children from a refugee background may initially be afraid of strangers and unwilling to open up. They are unlikely to provide details of any traumatic events they have experienced until a relationship of trust has been established. Professionals supporting the child generally need to invest a large amount of time engaging with the child and building confidence before any therapeutic work can begin.

Additional information and resources

Working with children from CALD backgrounds:

- NSW Heath Multicultural Health Communication
- NSW Health Transcultural Mental Health Centre
- Australian Institute of Family Studies

Working with children from refugee backgrounds:

- NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
- Raising Children

4.4.2 Using an interpreter

Carers, staff and services working with children, as well as their family and relatives may need to use an interpreter. It is not appropriate to use children, young people, family or friends as interpreters. Use a trained interpreter and if possible use an interpreter who is skilled in working with children with behavioural or mental health concerns.

There are additional considerations when choosing an interpreter when the child and their family are of a refugee background:

- If the interpreter belongs to the ethnic, political or religious group that persecuted the child and their family, this is likely to provoke anxiety and disrupt building trust.
- If the interpreter is from the same community the child, young person or their family may have fears that what they say will be spread among their community.

The child, young person or their family may have fears that the interpreter may inform the government of their home country about political criticism they make - putting friends and family at home in danger.

Further information about using interpreters can be found at:

- The Translating and Interpreting Service (**TIS** National) website which an interpreting service provided by the Australian Department of Home Affairs for people who do not speak English and for agencies and businesses that need to communicate with their non-English speaking clients.
- Raising Children website
- NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors website.

4.5 Children with disability in OOHC

Disability is any condition that affects a person's ability to perform daily activities or tasks and participate in the community. Some people may experience more than one disability and some conditions can lead to others. Disabilities can result from accidents, illness, or genetic disorders. A child's disability may be visible or not, may be permanent or temporary, and may have a minimal or a significant impact on their life.

It is important to remember children with a disability, like all children, have a right to express their views and be heard. Unfortunately, many children with a disability report that they are not listened to, ignored or undermined.

4.5.1 Being mindful of disability in your planning

Caseworkers should have a clear understanding of the child's disability itself and the behaviours and triggers when preparing and implementing a BSP. It is important not to make plans to eliminate a child's behaviour without having a clear understanding about what purpose that behaviour may serve. It may be helpful to ask yourself reflective questions such as:

- Could this behaviour be an indication that something is distressing the child?

- Are they trying to communicate something?
- Does it help to protect them or resist something they do not like?
- Is this a way of attempting to keep their dignity intact?

As when engaging with all children it is important to have empathy, openness and patience and use communication styles that are more easily understood by the child.

Behaviour support services provided through the NDIS

If you are an NDIS provider or practitioner providing behaviour support services to a child in OOHC that includes restrictive practices, you will need to ensure you are compliant with the NSW Restrictive Practices Authorisation Policy (RPA Policy) as well as meet requirements of the Care Act and Care Regulation.

Please refer to the *Addendum: Children who receive behaviour support services under the NDIS*.

Practice advice

Be mindful of the difference between behaviour management and abuse. Language can be used to minimise or excuse the abuse of children with disability. When children display behaviours that are challenging to others, abuse and neglect can end up being reframed as behaviour management.

Additional information and resources

Disability may be understood and supported differently across cultures. The resources below provide information on working with children and families in a culturally sensitive way.

- The National Ethnic Disability Alliance website provides key issues and information about advocacy for people with a disability from culturally and linguistically diverse backgrounds.
- The Raising them strong – Caring for kids with a disability booklet gives helpful information for kinship and foster carers who care for an Aboriginal child with a disability.
- The First Nations Disability Network Australia website has a range of helpful resources and contacts to support good Aboriginal practice with families who have a child with a disability

4.6 A trauma-informed approach

Children may have experienced one or multiple types of trauma. The causes can be physical, sexual, emotional or psychological abuse, exposure to domestic violence or neglect. It may be difficult to understand the specific source or event which causes the most distress.

The trauma may also occur within a child's broader cultural context, such as the ongoing effects of colonisation for Aboriginal and Torres Strait Islander families and communities, or the adverse experiences of a child and family with a refugee background.

Children need us to understand how their experiences effect their functioning, development; and how they relate to themselves, others, and the world.

Strategies for providing support where a child is experiencing trauma need to be tailored to the circumstances and in line with the NSW Framework for Therapeutic Care. Carers and staff working with the child should consider:

- maintaining routine and preparing for changes
- reassuring them about the future and providing hope
- helping them learn the language of feelings (some children cannot identify feelings)
- providing feedback and encouraging them to express emotions and asking about what they are thinking or feeling
- encouraging play in young children and enjoyable activities in older children/young people
- setting realistic goals for behaviour and trying to avoid overreacting to difficult behaviour during transition periods
- accessing services that can provide specialist culturally appropriate trauma and/or psychological services
- working collaboratively to provide support with the child's school or education provider.

Additional information and resources

- Video: Three core concepts in early development – from the Harvard Center on the Developing Child about early development including the impact of toxic stress on development.
- Video: How childhood trauma affects health across a lifetime – paediatrician Nadine Burke Harris explains the ACEs study and long term impacts of trauma.
- Helping Traumatized Children: A Brief Overview for Caregivers – developed by Dr Bruce Perry and The Child Trauma Academy it provides practical advice for carers, parents and professionals working with children who have experienced trauma.

4.7 Interaction with Youth Justice

Children in contact with the criminal justice system, particularly those who spend time in custody, have high levels of social disadvantage, with poor literacy skills, low educational attainment, a history of child abuse and neglect, fractured family networks, placement in OOHC, and parental incarceration. Associated with such disadvantage is also a higher prevalence of alcohol and illicit drug use, and poorer physical and mental health. Caseworkers and service providers should be reminded that detention is a last resort and it can have a significant impact on the child's risk of further contact with police and on their mental wellbeing.

If a child is in statutory OOHC and is also a client of Youth Justice, it is expected that there will be joint case planning between Youth Justice and Community Services within DCJ (or the service provider if applicable). This involves formal coordination and communication about the shared client's needs and the response to their identified needs, including their health management planning and behaviour support. To assist with this process and the safe management and support of the child, particularly if they are in custody, the behaviour management plan and psychological assessments should be shared with and developed in collaboration with Youth Justice.

For more information see the memorandum of understanding and accompanying guidelines between Youth Justice and Community Services which remains under DCJ.

4.8 Prohibited practices

Prohibited practices are **unethical** and **may constitute a criminal offence or incur civil liability**. They are also seen as a violation of a child's basic human rights and **must not be used.**

Caseworkers are to inform carers about what constitutes a prohibited practice. Service providers must ban prohibited practices in their behaviour support policy and inform staff and carers that they must not use these practices.

Any practice that interferes with a child's basic human rights, does not comply with the Care Act or Care Regulation or any other NSW or Commonwealth law is prohibited.

Prohibited practices may include the following:

- using physical force as punishment
- using any punishment that takes the form of immobilisation
- chemical restraint
- force feeding a child or depriving them of food
- using a punishment to intentionally humiliate or frighten a child
- denying access to basic needs or supports
- wrongful imprisonment (i.e. deprived of their liberty without legal authority)
- seclusion (i.e. placement of a child in a setting where they are confined in a room or area from which they cannot leave).

In addition DCJ policy also outlines the following practices that are prohibited:

- using psychotropic medication or physical restraint as the only behaviour support strategy for a child (for more information see the ‘psychotropic medication’ and ‘physical restraint’ guidance in section five below)
- punishment that involves withholding family or significant other contact, or that involves the threat to withhold contact
- unethical practices, such as taking away rewards that a child has earned or allowing a child to skip school as a reward
- using ‘aversives’ – applying something painful or unpleasant to a child’s face or body
- overcorrection – responding to a child in a way that is out of proportion to the original behaviour
- changing or making a threat to change a case plan or BSP in order to punish a child
- using a restrictive practice in a way that is contrary to these guidelines.

There are some limited circumstances where it may be appropriate for carers or staff to use restrictive practices for safety reasons. Restrictive practices refer to any practice or intervention that has the effect of restricting the rights or freedom of movement of a child, with the primary purpose of protecting the person or others from harm. For detailed information about when it is appropriate to use restrictive practices and the conditions around use, see the ‘restrictive practice’ guidance in section five below.

Secure care

In some limited circumstances DCJ can apply to the Supreme Court of NSW under the Court's parens patriae jurisdiction to detain a child in order to protect that child from imminent risk and danger arising from their behaviour through placement in a Therapeutic Care environment.

The orders are rare and are only considered under extreme circumstances for safety reasons. **Any other form of secure care or seclusion is illegal**.

For the Supreme Court order to be considered, a referral must be made by a Director Community Services to the Director, Intensive Support Services.

4.8.1 Response to use of a prohibited practice

If a prohibited practice is used supervising case staff are to assess the event and report it according to the DCJ reportable conduct policy for carers or employees, and the critical events casework practice mandate.

In the event that a critical event and/or reportable conduct matter occurs supervising care staff must ensure appropriate medical attention and support is provided to the child and others involved in the event. Guidance on responding to critical events is provided in the DCJ critical events casework practice mandate.

4.8.2 Use of police intervention

Police intervention must not form part of a behaviour support strategy or BSP. Police are not to be called for minor breaches of house rules or for minor incidents. For example, it is not appropriate to call police for a minor incident where no one is hurt and the victim wants no police action.

Staff and/or carers should call police to respond to incidents involving children where there is an immediate safety risk, in an emergency or when their behaviour will result in harm or serious injury to themselves or to others.

The NSW Ombudsman, in collaboration with DCJ, NSW Police, Legal Aid NSW and a range of service providers, have developed a joint protocol to reduce unnecessary police contact with children in OOHC, and the negative affect this contact may have. As a guide, the protocol aims to align Police involvement as it would be for a child living with their birth parents i.e. incidents are handled in-house with Police involvement as a last resort.

Residential Care (including Intensive Therapeutic Care) service providers are required to have procedures in place to adhere to the protocol. Annexure A of the protocol contains advice on appropriate delegation to contact police and guidance on developing collaborative relationships with specialist police at the local level.

Practice advice

There are opportunities for service providers to collaborate with police to work together to help keep a child safe and give support. Youth Liaison Officers and the Crime Unit Managers are located in every Police Local Area Command and are the best point of contact for such initiatives.

4.9 Duty of Care

Duty of care refers to the obligation of carers, staff and service providers to take care to avoid reasonably foreseeable physical or psychological injury to a child in their care.

Failures in duty of care may occur when an act causes injury or when appropriate action is not taken to prevent injury (omission), unless that act or omission is permissible under the law. For example, the use of physical restraint that causes injury may not be a failure of a duty of care, if it was considered reasonable in all of the circumstances.

Carers, staff and service providers should take reasonable measures to safeguard children from harm and avoid actions that cause harm. Staff and carers are not required to put themselves at immediate risk of serious injury or harm as part of this duty.

Principal Officers and managers are responsible for considering whether the use of a restrictive practice may lead to a reasonably foreseeable injury when they approve a BSP.

DCJ and service providers are also responsible for ensuring and actively promoting the safety, welfare and wellbeing of the children they care for under

the Care Act and the *NSW Child Safe Standards for Permanent Care* (Standard 3).

4.1 Avenues for complaint

Children are often not aware of their right to complain or the process to do so. As a caseworker, you have an obligation to ensure the children you work with know and understand their rights. You also have a responsibility to uphold these rights and comply with them in your work. To support this you must ensure that children have access to the Charter of Rights, the United Nations Convention on the Rights of the Child and where relevant the United Nations Declaration on the Rights of Indigenous Peoples.

All service providers must have a complaints process that protects and supports the child's right to make a complaint without fear of prejudice or punishment. The important thing is to let the child know that they can express disagreement at any time and that they will not be punished if they do.

It is DCJ policy that children can make a complaint in a range of ways. This includes in writing or verbally to their caseworker or someone else important to them. Children may choose to escalate their complaint to the Manager Casework or supervising case staff. If the child does not feel their complaint has been resolved they can contact DCJ Community Services Client Complaints. They can also contact the NSW Ombudsman who has a Youth Liaison Officer who can assist children to make complaints.

Additional information and resources

- Charter of Rights - People working with and caring for children and young people in OOHC are responsible for ensuring that children have access to the Charter or Rights.
- United Nations Convention on the Rights of the Child – The primary international treaty setting out the rights of children in addition to broader human rights set out in other international treaties.
- United Nations Declaration on the Rights of Indigenous Peoples – A non-binding treaty that provides a framework for recognising and upholding the survival, dignity and wellbeing of indigenous peoples around the world.

5 Behaviour support planning and restrictive practices

Behaviour support services provided through the NDIS

If you are an NDIS provider or practitioner providing behaviour support services to a child in OOHC that includes restrictive practices, you will need to ensure you are compliant with the RPA Policy as well as meet requirements of the Care Act and Care Regulation. Please also refer to the *Addendum: Children who receive behaviour support services under the NDIS*.

5.1 Developing and maintaining a BSP

Also known as a behaviour management plan or behaviour intervention support plan, the purpose of the BSP is to:

- strengthen positive behaviours, improve quality of life and promote the personal interests of the child
- reduce and prevent behaviours of concern by equipping the carer or staff with appropriate strategies
- keep the child safe
- understand the causes and underlying functions of the presenting behaviour, including the effects of trauma.

A BSP is required when:

- the child's behaviour is dangerous to themselves or others and/or is having a major impact on their daily functioning
- a medical practitioner or specialist prescribes the child psychotropic medication
- a behaviour support expert determines that physical restraint is required to keep the child safe (e.g. harness for transport)
- approved restrictive practices are used.

A BSP may also be required if a child has had an adverse change in behaviour, there are concerns about their behaviour and/or if those caring for the child require structured support to maintain their stable living arrangement. Caseworkers or staff should consult with their manager to decide if a BSP is needed in these circumstances.

Everyday safety procedures that are not designed to address behaviours of concern do not need to be included in a BSP. For example, practices such as keeping hot pans or boiling water out of reach of small children, engaging safety locks when transporting small children, or locking away prescription medications so that they are not accidentally consumed.

Legislative requirements

According to clause 26 of the Care Regulation a BSP must be developed and approved by the Principal Officer, following the prescription of a psychotropic drug to a child in care.

According to section 158 of the Care Act the use of physical restraint must be consistent with "*any behaviour management requirements of a care plan applying to the child*". This requirement can be addressed by detailing the use and conditions around physical restraint within an approved BSP and attaching it to the child's care plan.

5.1.1 Who develops a BSP?

5.1.1.1 Foster and family-based care

Caseworkers are able to develop BSPs in foster and family-based care, such as relative and kinship care. It is expected that all caseworkers who develop BSPs have training in behaviour support for OOHC. DCJ caseworkers who develop BSPs must have undertaken the 'Positive Behaviour Support' training developed by Psychological and Specialist Services.

A caseworker usually develops the BSP in consultation with a behaviour support expert the following circumstances:

- addresses a child's behaviours of concern that may threaten their safety or the safety of others
- includes the use of psychotropic medication to manage significant challenging behaviour
- includes the use of physical restraint
- includes a restrictive practice.

In these circumstances, at minimum, the BSP must be developed in consultation with and endorsed by a behaviour support expert.

A behaviour support expert is a psychologist, occupational therapist, social worker or equivalent professional with specialist training and expertise in behaviour support. For example, DCJ Psychologists are considered to be behaviour support experts. The Psychological and Specialist Services 'Positive Behaviour Support' training is foundational and does not qualify a staff member as a behaviour support expert.

If the young person is under Youth Justice supervision the Youth Justice Psychologist or Caseworker should be invited to be involved in the development of the BSP.

5.1.1.2 Residential care (including Intensive Therapeutic Care)

In these care settings a behaviour support expert from within the service provider develops BSPs. In Intensive Therapeutic Care, Therapeutic Specialists are considered to be behaviour support experts and can develop or provide input in the development of a child's BSP.

5.1.1.3 Existing BSP

The child may have an existing BSP developed by a different provider if a transfer of primary case management has recently taken place. The BSP should have been made available during the transfer process outlined in the Permanency Case Management Policy Rules and Practice Guidance 2019.

Once responsibility has been transferred it is recommended the BSP be reviewed in light of these guidelines or an service provider's behaviour support policy.

In circumstances when a provider's accreditation is suspended or cancelled, DCJ is responsible for giving the new provider with primary case management the following:

- the BSP from the previous provider
- or an updated BSP if it has expired (i.e. a period of over 12 months has elapsed since the plan was put in place).

5.1.2 Involving the child in behaviour support

The child is at the centre of behaviour support. The caseworker or behaviour support expert developing the BSP is to:

- discuss the BSP with the child during planning and implementation, and ask them about views about the planned actions
- consider the child's views
- let the child know what the plan means, why it is being developed and that they will be given support

Staff should be using the child-friendly BSP template to draw out the above information and guide conversations with the child. The template contains strengths-based questions for the child and is designed to show the child the plan is to support and benefit them.

The strategies included in a BSP are more likely to be effective if they are developed with the child with their consent and the child understands the benefits. Participation in the BSP process helps enable the child to take greater ownership over their behaviour. It also provides children with a way of understanding and influencing the process.

If the child does not support the plan it is advisable for the case worker to spend time understanding why they don't support the plan and develop strategies to address this. Also consider discussing the benefits of the plan and the alternatives. You should be aiming to achieve consent if possible. Where consent is not possible and the plan still needs to be implemented, record the child's views and the reason why the plan was implemented despite disagreement.

All children in OOHC have the right to make a complaint if they wish and must be provided with avenues to do so. Further information is included under the 'Avenues for Complaint' in section four above.

5.1.3 Developing a BSP

BSPs are usually a component of a child's case plan. There are exceptional cases where a BSP is developed as a stand-alone document in order to

support a child’s highly complex behaviour support needs and/or risk of harm to themselves or others.

Stand-alone BSPs are primarily required in Residential Care (including Intensive Therapeutic Care), and cases managed by Intensive Support Services; rather than family-based care, such as foster, relative or kinship care. Stand-alone BSPs are developed by a highly qualified and experienced clinical expert in trauma informed Therapeutic Care, for example, a Therapeutic Specialist, psychologist or equivalent.

The following people are to be consulted when developing a BSP:

- the child
- carers, parents and anyone else important to the child
- any interagency services involved, including appropriate contacts at the child’s school or early childhood education provider
- other qualified professionals as appropriate, such as psychologists, psychiatrists, occupational therapists and social workers.

The level of detail and input from other professionals needed matches the level of intervention and support that the child and those that care for the child need.

BSPs are to be based on an assessment that:

- is evidence based
- includes the child’s views
- highlights the child’s strengths and interests
- considers the child’s case history
- considers the child’s cultural, linguistic and religious background
- is appropriate to their age and developmental age (i.e. the age at which the child is functioning)
- identifies the triggers and function of behaviours of concern
- provides strategies for carers and/or staff aimed at preventing and managing behaviours of concern, as well as any consequences of the behaviour
- provides strategies to increase pro-social behaviours.

The environment and context of the child may be influencing their behaviour, including their relationships and family context. This should be considered as part of the BSP. Wherever possible, the child’s environment should be adjusted to support their behaviour and wellbeing.

All BSPs should be documented on individual files and each child should have their own individual BSP. If there are several children living together it may also be appropriate to develop an over-arching house plan.

Additional requirements apply for psychotropic medications and restraint. For further information see the ‘psychotropic medication’ and ‘restraint’ sections below.

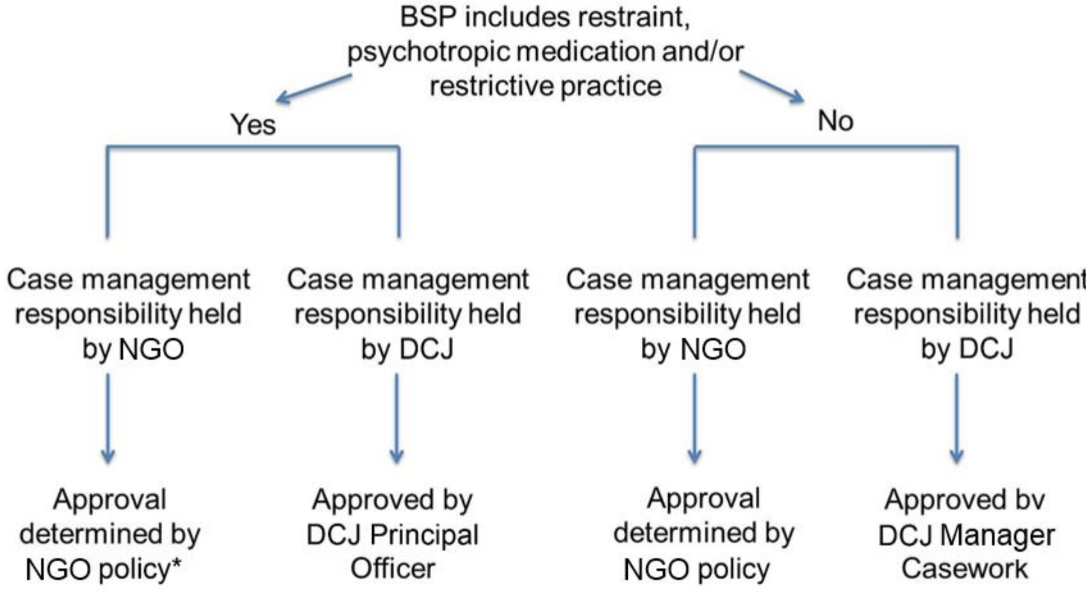
Practice advice

Teachers, learning and support teams, school counsellors and/or childcare workers who work with children play key roles in behaviour support and are likely to have useful information to share. Collaborating on a behaviour support strategy with the child's school or preschool can greatly improve the quality and effectiveness of the strategy. All children in OOHC are expected to have learning and support planning and their BSP is expected to complement and strengthen that planning. Caseworkers should share the BSP with the child's school or early education provider if appropriate.

Practice advice

Staff need to be self-aware and mindful of their own 'cultural lens' or biases, which are likely to influence their thinking – both consciously and unconsciously when developing a BSP. Section 4 of this document provides a useful starting point for better understanding the diversity of children in OOHC and how you might consider the best ways to meet their needs.

5.1.4 Approval of BSPs



When a BSP is developed by non-government service provider and case management responsibility is held by DCJ, DCJ must provide final approval for the BSP. Service providers may also include their own internal approval process.

If a child in Residential Care (including Intensive Therapeutic Care) is prescribed psychotropic medication and DCJ holds case management

responsibility, the DCJ Principal Officer must provide interim approval for administration of the medication while a BSP is being prepared as well as final approval for the BSP.

5.1.5 Implementing a BSP

It is important for a BSP to be implemented effectively in order for it to be a supportive document. Once completed the BSP is to be discussed (and if appropriate shared) with all relevant people, including:

- child
- carer and/or staff who care for the child
- kin and family, including biological family (when appropriate)
- child's school or early childhood education provider
- other qualified professionals or agency staff who work with the child (as appropriate).

Carers and staff working with the child are to be provided with training and support on how to implement the strategies in the BSP whenever it is needed. A behaviour support expert can also support the implementation of a BSP.

5.1.6 Monitoring and review of BSPs

Caseworkers are to visit the child and their carer to discuss progress within the first month of the BSP being in place. This allows the caseworker to identify whether the child or carer requires further support and decide whether changes are needed to the BSP. Caseworkers need to record details of the visit and reasons for any changes to the BSP, and attach it to the BSP.

BSPs are to be regularly reviewed, at least annually. It is recommended that a review of the BSP occurs when the case plan is being reviewed. This involves:

- checking with the child and carer or those who work with the child that the strategies contained in the BSP are working as intended
- updating the strategies to suit the circumstances
- adding information about any changes that have occurred.

For children in Intensive Therapeutic Care, monitoring and review of BSPs occurs in the context of Care Team Meetings, facilitated by the Therapeutic Specialist. The Care Team includes the caseworker, direct care staff, family, kin and significant others, and other practitioners providing support for the child.

Caseworkers should continue speaking to those who are important to the child to ensure the information they have is up to date and to share relevant information about the child with those who need to know.

Regular monitoring should eliminate the need for a major rework of a BSP and ensure it remains relevant to the child. Significant changes to the child's care environment, such a child's placement changing, are the type of events that should prompt a review to ensure a BSP remains fit for purpose.

BSPs that include psychotropic medication must be reviewed in line with the prescriber's recommendation or at least every three months (whenever is sooner). BSPs must be reviewed if there is a change in dosage or type of psychotropic medication.

BSPs that include restrictive practices (including physical restraint) must be reviewed in line with the behaviour support expert's recommendation or at least every three months (whenever is sooner).

Further advice on psychotropic medication, restrictive practice and physical restraint is included below.

5.2 Psychotropic medication

Psychotropic medication is any prescribed medication which affects cognition (such as perception and thinking), mood, level of arousal and behaviour. For advice about whether a medication is psychotropic or not, contact the prescribing medical practitioner or a behaviour support expert.

When psychotropic medication is prescribed for a child in statutory care a BSP must be developed which takes account of administration of the medication. This is to ensure these children receive comprehensive, holistic care, support and treatment. It is advisable you obtain a current supporting letter from the medical professional stating the psychotropic medication and dosage.

Under section 26 of the Care Regulation, there is a requirement to develop a BSP whenever a psychotropic medication is prescribed for a child in statutory OOHC, regardless of the condition it has been prescribed for.

Chemical restraint is a prohibited practice. It refers to the intentional use of medication to restrain a child's behaviour where no medically diagnosed condition is being treated, where treatment is not necessary or where it amounts to overtreatment. Part of the intended effect of the medication is to sedate for convenience or disciplinary purposes. The medical practitioner may have ceased recommending the medication or it has been prescribed by a registered medical practitioner but used contrary to instructions.

Psychotropic medication may be prescribed by a medical practitioner as part of a treatment plan for a child's:

- diagnosed mental illness
- psychiatric disorder
- psychiatric symptoms.

Decisions about the use of psychotropic medication are to be made by those who know the child best. This means that foster, relative and kinship carers can agree to the prescription of a psychotropic medication for a child in their care.

When a child is prescribed a psychotropic medication:

- the carer must immediately notify their caseworker
- the carer can consent to psychotropic medication prescribed by a medical practitioner and the medication can be used immediately
- a BSP must be developed which takes the administration of the medication into account.

When a child is prescribed a psychotropic medication and they are in Residential Care (including Intensive Therapeutic Care), the Principal Officer of the agency which holds case management responsibility authorises the administration of the medication.

Practice advice

Although it is not always possible, it is strongly encouraged that a caseworker is present when a medical practitioner prescribes psychotropic medication and for the same caseworker to attend subsequent appointments, if possible. This allows the caseworker to provide medical and relevant casework history about the child to the medical practitioner, advocate on the child's behalf and have continuity in their care.

Caseworkers and carers should ensure they understand why the medical practitioner has prescribed the psychotropic medication, how to use the medication and any side effects or interaction with other medications the child is administered. This information should be conveyed in an age appropriate way to the child. Caseworkers and carers should advocate for a medication review if the medication is not working as intended or if it causes an adverse reaction.

5.2.1 Who develops a BSP that includes use of psychotropic medication?

The BSP is usually developed by a caseworker in consultation with a behaviour support expert, particularly when there are significant, challenging or complex behaviours. At minimum it is developed by a caseworker (who has undertaken the Psychological and Specialist Services 'Positive Behaviour Support' training) in consultation with and endorsed by the behaviour support expert.

The person developing the BSP is to:

- seek specialist advice as appropriate and advice from those who know the child best
- incorporate any advice provided by the prescribing medical practitioner
- include a copy of the report, assessment or letter that informed the diagnosis and prescription in the child's records
- include the behavioural issues, diagnosis, type of medication, dosage and review requirements in the BSP
- make sure the carer and child understand the reason for prescribing the medication, conditions of the medication's use, dosage, potential side effects and interaction of the medication with other medications the child may be taking
- make sure the carer understands and follows the medical practitioner's instructions for administering the medication (i.e. dosage, time of day and interaction with other medications)
- discuss the BSP and the medication with the child and seek their views.

5.2.2 Who approves a BSP that includes use of psychotropic medication?

A BSP that includes the administration of a psychotropic drug is always required to be approved by the Principal Officer of the supervising designated agency.

If the BSP is developed by a non-government service provider and DCJ holds case management responsibility the DCJ Principal Officer must provide final approval for the BSP and ensure a DCJ authorisation form for use of restraint or psychotropic medication has been completed. Service providers may also have an internal approval process before the BSP is sent to DCJ.

If DCJ holds case management and the child is in Residential Care (including Intensive Therapeutic Care), the DCJ Principal Officer must also provide interim approval for the administration of the medication while the BSP is being prepared. Interim approval must not result in a delay to the child accessing medication and must be recorded. Interim approval may be provided verbally to ensure there is no delay to the child receiving their medication.

For interim administration of psychotropic medication while a BSP is being prepared, in Residential Care (including Intensive Therapeutic Care) where DCJ has primary case management responsibility, the DCJ Principal Officer must provide interim approval, as well as final approval for the BSP.

When case management is held by a service provider approval is determined by the behaviour support policy in place in the service.

5.2.3 Monitoring and review

BSPs that take account of the administration of psychotropic medication must be reviewed in line with the medical practitioner's recommendation or at least every three months (whenever is sooner). BSPs must be reviewed if there is a change in dosage or type of psychotropic medication.

As with other BSPs, the monitoring and review process should follow the guidance provided in section *5.1.6 Monitoring and review of BSPs*.

5.2.4 Health Management Plans

All children in statutory OOHC are required to have a Health Management Plan, which is a record of their health needs and the services required to address those needs. The Health Management Plan is developed in response to information gathered through assessment process, which includes psychosocial and mental health components. The need to develop a BSP may be identified through the health assessment process.

It is important that a child's behaviour support planning is consistent with their Health Management Plan. The prescribing medical practitioner is to be provided with a copy of the plan as it will help them to more effectively diagnose and treat the child. The prescribing medical practitioner also needs to be aware of other health conditions and/or other medications that have been prescribed for the child and any relevant history of the child. This will help the medical practitioner to understand possible reasons for symptoms and more effectively treat the child.

5.2.5 Young people who have been prescribed psychotropic medication

Although the legislation only refers to children, DCJ policy does not distinguish between children (aged up to 16) and young people (aged 16 -17) and the same requirements apply for both.

5.3 Restrictive practices

Restrictive practices, also known as restricted practices, involve some form of intervention on the child's freedom in order to protect them or others from harm. When a restrictive practice is used, it should only be employed as part of a formal behaviour intervention as set out in an approved BSP.

Some forms of restriction on a child's freedom or rights can constitute a criminal offence or incur civil liability and must not be used (for more information see the 'prohibited practice' in section four above). Restrictive practices must not be used for punishment or reasons of convenience.

Carers and staff have a duty of care to ensure the safety of children in their care. Restrictive practices may be required to keep a child safe by decreasing a particular behaviour. **Restrictive practices should only be used on a temporary basis along with a broader positive strategy to support behaviour.** The principle of using the least intrusive approach possible applies to any behaviour support strategy.

For information about who develops and approves a BSP that includes restrictive practices (including physical restraint), see section 5.1 'Developing and maintaining a BSP' above.

5.3.1 Responding to a crisis

Crisis management cannot be used to justify continued use of restrictive practice.

If a crisis occurs the caseworker or behaviour support expert should develop a BSP (or review it if one exists) and put in place strategies to prevent a crisis reoccurring. It is the agency with supervisory responsibility for the child (regardless of allocation of case management) to ensure processes are in place to prevent and stop recurring crises.

A crisis may constitute a critical event and/or reportable conduct incident. Service providers must have a policy and processes in place for critical events and reportable conduct. For more information on the topic see information about critical incidents on the DCJ website.

5.3.2 Physical restraint

Physical restraint is an action taken to restrict a child's movement. It does not include physical assistance or support for involuntary movement, physical assistance in activities of daily living (such as washing, dressing, or eating), functional support, or aid/safety devices used to prevent injury where the child does not resist.

Any use of physical restraint of a child must be in accordance with section 158 of the Care Act. According to section 158, only when a child is behaving in a way that they might seriously injure themselves or another person, the carer or staff caring for the child may:

- temporarily restrain the child, only to the extent necessary, to prevent them seriously injuring themselves or another person
- remove alcohol, illegal substances, a weapon or any object being used by the child in a dangerous manner
- remove any other objects or implements necessary to prevent the child from harming themselves or another person.

Section 158 of the Care Act applies to one-off use of physical restraint in a crisis or where the physical restraint is part of an approved BSP. **Any other use of restraint can constitute a criminal offence or incur civil liability**. For example, physically restraining a child because their behaviour is exasperating or to restrain longer or with more force than is necessary.

Inappropriate use of physical restraint may amount to a critical event and/or reportable conduct. Supervising case staff are to assess the event according to the DCJ critical events casework practice mandate and reportable conduct policy for carers or employees and determine whether it should be reported to the Child Protection Helpline, Police and/or the OCG.

All service providers are required to have a critical event and reportable conduct policy that their staff must follow.

5.3.2.1 Use of physical restraint in a crisis

If physical restraint has been used by a carer or staff in a crisis, the caseworker or service provider must:

- arrange medical help for the child where needed
- consult with a behaviour support expert
- talk with and support the child
- talk to and support the carer or staff to make sure they understand their responsibilities
- assess the event using the DCJ critical events casework practice mandate and report the event to police and/or other government agencies as necessary.

Each crisis situation is unique and is handled on a case by case basis. If a crisis occurs, carers and support staff should consider whether they are likely to seriously injure themselves, another person or the child by applying physical restraint and whether there are alternative approaches that have a lower risk of harm to those involved in the situation.

It may be appropriate to employ the following strategies depending on the circumstances:

- carers or staff removing themselves and others from immediate harm
- call emergencies services, such as Police or an Ambulance.

5.3.2.2 Use of physical restraint as a behaviour support strategy

Physical restraint must not be used as a child's only behaviour support strategy. If restraint is used as a recurring or regular means to prevent a child being hurt or causing harm it must be along with a strategy to reduce and stop the use of restraint.

If physical restraint is being considered as a behaviour support strategy the caseworker (or service provider) must:

- consult with a behaviour support expert (which includes therapeutic specialists) about the restraint strategy
- ensure the BSP is updated to include the restraint strategy (or developed if one does not exist), and is endorsed by a behaviour support expert (the behaviour support expert who determined the restraint strategy would usually update or develop the BSP)
- make sure the strategies have clearly documented outcomes
- talk to the child about why restraint was used, future strategies and gain consent if possible
- use only the restraint described in the child's approved BSP
- record the cause and behaviour leading to the restraint, duration, method, who made the restraint, consequences of restraint and any injury to those involved (each time it occurs)
- debrief with the carer or staff involved in the situation.

Those conducting restraint are to be appropriately trained and supported. It is expected that restraint would rarely be used in foster, relative or kinship care settings.

Monitoring and review: BSPs that include physical restraint must be reviewed in line with the behaviour support expert's recommendation or at least every three months (whenever is sooner).

Physical restraint does not include:

- physical assistance or support related to involuntary movement
- daily living routines
- function support
- aids or other safety devices used to prevent injury where the child does not resist.

⚠ Mental Health Act 2007

When a child is diagnosed with a mental illness, the care provided to them and any BSPs developed must comply with the Mental Health Act 2007.

There are guiding principles for care and treatment of people with a mental illness or mental disorder detailed in section 68, which include:

- people with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given
- any restriction on the liberty of patients and other people with a mental illness or mental disorder and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances
- people under the age of 18 years with a mental illness or mental disorder should receive developmentally appropriate services
- the cultural and spiritual beliefs and practices of people with a mental illness or mental disorder who are Aboriginal or Torres Strait Islander should be recognised.

5.3.3 Response cost

Response cost refers to a planned response to a specific behaviour that involves a child losing access to items/activities that they find rewarding as a consequence for the behaviour.

While it is not appropriate to deny a child certain activities that are needed for their personal development and wellbeing, it may be appropriate to deny certain privileges. Temporary loss of a desired activity that is easily accessible on other occasions, such as a daily TV program or the use of a computer, may be appropriate. However, denial of a highly valued and irreplaceable activity or privilege is unacceptable.

Response cost is a common discipline technique and as such would not normally be considered as a restrictive practice that requires formal approval (for example, fighting over a toy may result in the removal of the toy until the dispute is resolved). However, if this practice is used to target a particular behaviour of concern, it should be documented as part of a BSP.

Positive reinforcement (i.e. rewarding the child with a valued item/activity in response to good behaviour) is a far more effective practice than response cost.

5.3.4 Restricted access

Restricted access describes limiting a child's independent access to items, activities, experiences or places using physical barriers with the intention of influencing a particular behaviour to manage a safety or health risk. Restricted access imposes boundaries in an environment to ensure safety in a way that is appropriate to the child's developmental stage.

When restricted access is used to manage behaviour it must be as part of a formal BSP strategy in line with a behaviour support expert's recommendation. The least restrictive option needed to manage the risk should be used.

Examples of restricted access that need to form part of a BSP could include:

- locking the front door of a residence so that it cannot be opened from the inside, because a child will run out onto a road (the child should be able to exit using the back door if it is safe)
- locking away specific non-food items because a child has been trying to eat them
- putting a lock on a food cupboard or fridge at night when a child is known to binge eat (the child should have access to healthy alternative food options and water)
- limiting access to a mobile phone from a child if it is enabling a perpetrator of child abuse to contact and access the child.

A BSP is not required for appropriate everyday safety precautions that are not designed to target a specific behaviour of concern. Examples include:

- locking away household chemicals or prescribed medications to stop consumption or poisoning
- engaging child locks when transporting small children to stop them exiting the vehicle while it is moving.

Any implementation of restricted access must not involve seclusion, which can constitute a criminal offence or incur civil liability. Seclusion involves placing a child in a setting where they are confined in a room or area from which they cannot leave.

Containment is a form of restricted access where a person's access to events and/or conditions is prevented to help control behaviours of concern. It may involve the withdrawing of a person or others from a setting to assist the child in response to a crisis situation, where their capacity to manage or control themselves is diminished. The person is to be supported during the practice, which should stop when the person regains personal control.

Any implementation of containment must not involve seclusion, which can constitute a criminal offence or incur civil liability. Seclusion involves placing a child in a setting where they are confined in a room or area from which they cannot leave.

Containment is different to exclusionary time-out, which is described below.

5.3.5 Non-exclusionary time-out

Non-exclusionary time-out describes a response to specific behaviour in which carers withdraw their attention or interaction with a child for a period of time so that they do not reinforce the behaviour. Non-exclusionary time-out is a common discipline technique and does not normally require formal approval. However, if this practice is used to target particular behaviours of concern, it should be documented as part of the child's BSP.

Non-exclusionary time-out does not involve confinement or using force to remove a child. Non-exclusionary time-out is normally considered legal, unless it is intended to or causes humiliation for a child.

5.3.6 Exclusionary time-out

Exclusionary time-out (not involving seclusion) involves removing a child from a situation to stop access to reinforcement of a specific behaviour of concern. It may only be used as a temporary measure to restrict a child who might otherwise seriously injure themselves or another person. Other use of exclusionary time-out may be illegal and amount to criminal assault or wrongful imprisonment.

The approved use of exclusionary time-out would form part of an overall planned response aimed at changing or eliminating specific behaviours of concern. There should be specific safeguards for the use of this strategy when the person is physically removed from one setting to another (e.g. a room or corridor) on their own.

6 Developing a behaviour support policy

6.1 Behaviour support policy requirements

Non-government service providers are required to develop a behaviour support policy (also known as a behaviour management policy) as a condition of accreditation with the OCG. Service providers may use the information contained within these guidelines when developing their own behaviour support policy.

Service providers are required to submit their behaviour support policy, psychotropic medication policy and procedure for use of physical restraint to the OCG as part of the application for accreditation. They should include details about consent, reporting, analysis and supervision of staff, and the support and counselling to be provided to children if physical restraint has been used.

The OCG has developed a guidance tool which service providers can use to review their own behaviour support policy and procedures and determine components that may require further consideration, clarification or amendment. The guidance tool is used by the OCG when reviewing a service provider's behaviour support policy. The guidance tool can be accessed at the OCG website (factsheet eight).

6.2 Key considerations for a behaviour support policy

The safety, welfare and wellbeing of the child are the central considerations of any BSP or policy. The behaviour support policy of a service provider should address a range of interactions, from everyday behaviour support to formal behavioural interventions.

While the principles of behaviour support remain the same between family based and Intensive Therapeutic Care/Residential Care, the procedures and strategies in place should be tailored to the type of service being delivered. For example, in Intensive Therapeutic Care children are likely to receive care from multiple staff members and there may be more children in the household as compared to family based care. It is expected that systems are in place for Intensive Therapeutic Care settings to address interactions between children living in the house, coordination between multiple staff members and other risks common to Intensive Therapeutic Care.

It is recommended that the behaviour support policy clearly explain the service provider's position on relevant issues, such as:

- providing information, training, supervision and strategies to authorised carers and support staff in managing the behaviour of the children in their care, by suitably qualified people
- providing information to carers to assist them to identify when a BSP is required
- circumstances under which a service provider may formally intervene by developing a BSP
- who is able to develop a BSP
- providing any assistance that may be needed in implementing BSPs
- regular clinical review and audit of BSPs

- management of critical events
- consequences for carers or staff who use inappropriate behaviour support techniques.

As part of transparency and ensuring the behaviour support is working effectively, service providers should:

- collate individual reports on the use of restrictive practices and review them regularly to identify systemic issues such as environmental problems, program deficits and carer/staff training needs
- conduct regular and systematic reviews of all BSPs, supported by data collection
- provide information about their behaviour support policy and practices in their Annual Report.

To provide children with a voice about their care and to enable them to feel genuinely involved in their behaviour support, service providers should consider providing opportunities to meaningfully involve children in the development of their behaviour support policy, rules and systems.

Service providers must also have a critical event and reportable conduct policy that is consistent with their behaviour support policy. The policy should detail how appropriate medical attention and support will be provided to the child and others if a critical event and/or reportable conduct matter occurs.

Critical events may need to be reported to one or more agencies, including Police, Child Protection Helpline, NSW Ombudsman (covered by reportable conduct policy) and/or the OCG. Service providers may also be required to report the event to their DCJ contract manager. Further information about critical events and reporting can be found on the DCJ website.

6.3 Behaviour support training

Staff engaged by service providers are required to follow the behaviour support policy of the organisation. This can only be achieved if service providers provide ongoing training, support and supervision by suitably qualified professionals with expertise in behaviour support. This will promote a better quality of service for children, as well as address the occupational health and safety needs of carers and staff.

Service providers have a responsibility to provide ongoing training in a range of behaviour support skills and strategies. It is necessary to provide explicit and up-to-date behaviour support training for staff so that behaviour support strategies are applied appropriately and effectively. It is expected that training is developed and delivered by a suitably qualified professional with OOHC specific expertise. Within their behaviour support policy, service providers should outline their processes for training to help staff and carers comply with the legislation.

7 Appendix: BSP Checklist

The BSP Checklist is a practice support tool designed to assist practitioners in the development, implementation and review of a BSP.

Developing a plan

Have those who are supporting or working with the child or young person, and those that know them best, been involved in the development of the plan? *Check all that apply:*

- ☐ Child or young person
- ☐ Carer
- ☐ Biological parent(s) and kin
- ☐ School Learning and Support Team/teacher/early childhood education staff
- ☐ School counsellor
- ☐ Medical professional
- ☐ Behaviour support expert (psychologist or equivalent)
- ☐ NDIS coordinator/providers
- ☐ Other services working with the child

Note: consider who is appropriate to contact when developing the plan.

- ☐ Has any advice received and relevant correspondence been recorded?
- ☐ Has the child or young person consented to the plan? If not, does the plan provide details of why they have not consented?
- ☐ Does the child or young person understand why the behaviour support strategies have been developed? Have their views been considered?
- ☐ Does the plan provide strategies that will help the child or young person to develop competencies and personal skills?
- ☐ Does the plan consider possible reasons why one or more behaviours of concern are occurring (*i.e. environment, personal skills, any medical conditions, history of the child or young person?)*
- ☐ Does the plan consider prevention strategies (*i.e. what will stop behaviours of concern escalating? What are the triggers for a behaviour? Are there opportunities for broader skill development?*)
- ☐ Does the plan consider the expected outcome of the strategies? (*i.e. what does the plan aim to achieve for the child and those that support them?*)

If the plan contains restrictive practices:

- ☐ Is there a reason for use of a restrictive practice documented in the plan?
- ☐ What less restrictive options have been trialled and what was the outcome?
- ☐ Has clear information been provided in the plan about appropriate use and limits around use? Will this information be communicated to those using the restrictive practice?
- ☐ Does the plan contain a strategy to reduce/eliminate the use of restrictive practices?

If the plan contains psychotropic medication(s):

- ☐ Has the child or young person consented to the psychotropic medication? If not, does the plan provide details of why they have not consented?
- ☐ Does the child or young person understand why the psychotropic medication has been prescribed? Have their views been considered?
- ☐ Has clear information been provided in the plan about appropriate use and limits around use? Will this information be communicated to those using the restrictive practice?
- ☐ Has there been a discussion with the carer about the medication (or anyone providing medication to the child)? (I.e. what has the carer noted about the medication and its effects, both positive and negative? What are the carer's views about medication?)
- ☐ Does the child take the medication?
- ☐ Does the carer or anyone else administering the medication know how to do this correctly? (I.e. instructions around use, what time of day to take the medication, dosage, interaction with other medication)

Note for BSPs that contain restrictive practices/psychotropic medication:

- Restrictive practices should only be used on a temporary basis along with a broader positive strategy to support behaviour.
- It is expected that the BSP will be developed in coordination with a behaviour support expert.
- Behaviour support plans that include restrictive practices (including physical restraint) and/or psychotropic medications must be reviewed whenever there is a change in medication type or dosage, or at least every three months (whenever is sooner).

Implementing a plan

Have the strategies in the plan been discussed with those responsible for implementing them and anyone else who should know?

Please note: it is essential to discuss the plan with the child or young person and the carer.

Check all that apply:

- ☐ Child or young person
- ☐ Carer
- ☐ Birth parent(s) and kin
- ☐ School Learning and Support Team/teacher/early childhood education staff
- ☐ School counsellor
- ☐ Medical professional
- ☐ Behaviour support expert (psychologist or equivalent)
- ☐ NDIS coordinator/providers
- ☐ Other services working with the child
- ☐ Has the plan been shared with those who need to know? (I.e. if appropriate: the carer, the child's school, other services or agencies working with the child?)
- ☐ Do the people and services involved in the plan understand what task they are carrying out and the timeframe?
- ☐ Has any advice received and relevant correspondence been recorded?

Reviewing a plan

Have those who are supporting or working with the child or young person, and those that know them best, been involved in the review of the plan?

Check all that apply:

- ☐ Child or young person
- ☐ Carer
- ☐ Birth parent(s) and kin
- ☐ School Learning and Support Team/teacher/early childhood education staff
- ☐ School counsellor
- ☐ Medical professional
- ☐ Behaviour support expert (psychologist or equivalent)
- ☐ NDIS coordinator/providers
- ☐ Other services working with the child
- ☐ Has any advice received and relevant correspondence been recorded?
- ☐ Is the information contained in the plan up to date? Include review comments to show what has changed since the plan was last updated.
- ☐ Are the strategies working as intended? What is not working for the child or young person and those that care for them? Consider whether the behaviour support strategies are to be refined or changed to support the child's needs.
- ☐ Do the review comments specify proposed changes or refinements to the strategies contained in the plan?
- ☐ Have any changes or new behaviour support strategies been discussed with the child or young person? Have the views of the child or young person been taken into account?
- ☐ Does the child or young person consent to the changes? If not, do the review comments provide details of why they have not consented?

Refer to the implementation checklist above for advice on implementing any updated strategies and tasks associated with the BSP review.

If the plan contains restrictive practices:

- ☐ Has the use of restrictive practice(s) decreased or stopped? *Provide details in the review comments. If restrictive practices are still being used describe reasons for continued use.*

☐ Can use of restrictive practices decrease or stop? Do the strategies to reduce or stop use of restrictive practices need to be updated to ensure they work for the child or young person? *i.e. consider prevention strategies to stop behaviours of concern escalating. What supports can be put in place to positively address the needs of the child or young person?*

If the plan contains psychotropic medication(s):

☐ If there are changes to the psychotropic medication, has the child or young person consented to those changes? If not, does the plan provide details of why they have not consented?

☐ Does the child or young person understand why the psychotropic medication has changed?

☐ Does the child take the medication?

☐ Does the carer (or anyone else administering the medication) understand the changes to the medication and how to administer it?

(i.e. instructions around use, what time of day to take the medication, dosage, interaction with other medication)

Note for BSPs that contain restrictive practices/psychotropic medication:

- Restrictive practices should only be used on a temporary basis along with a broader positive strategy to support behaviour.
- It is expected that a caseworker will develop these BSPs in close coordination with a behaviour support expert. A referral might result from consultation.
- Behaviour support plans that include restrictive practices (including physical restraint) and/or psychotropic medications must be reviewed, whenever there is a change in medication type or dosage, or at least every three months (whenever is sooner). A behaviour support expert can be consulted.
- It is expected that a medical practitioner will regularly review psychotropic medication prescribed for a child or young person to ensure that is remains appropriate for them.

Addendum: Children who receive behaviour support services under the NDIS

Background

For children who are NDIS participants receiving behaviour support services under the NDIS, there are additional requirements under the *National Disability Insurance Scheme Act 2013* and its associated Rules, as well as the NSW Restrictive Practices Authorisation Policy (RPA Policy).

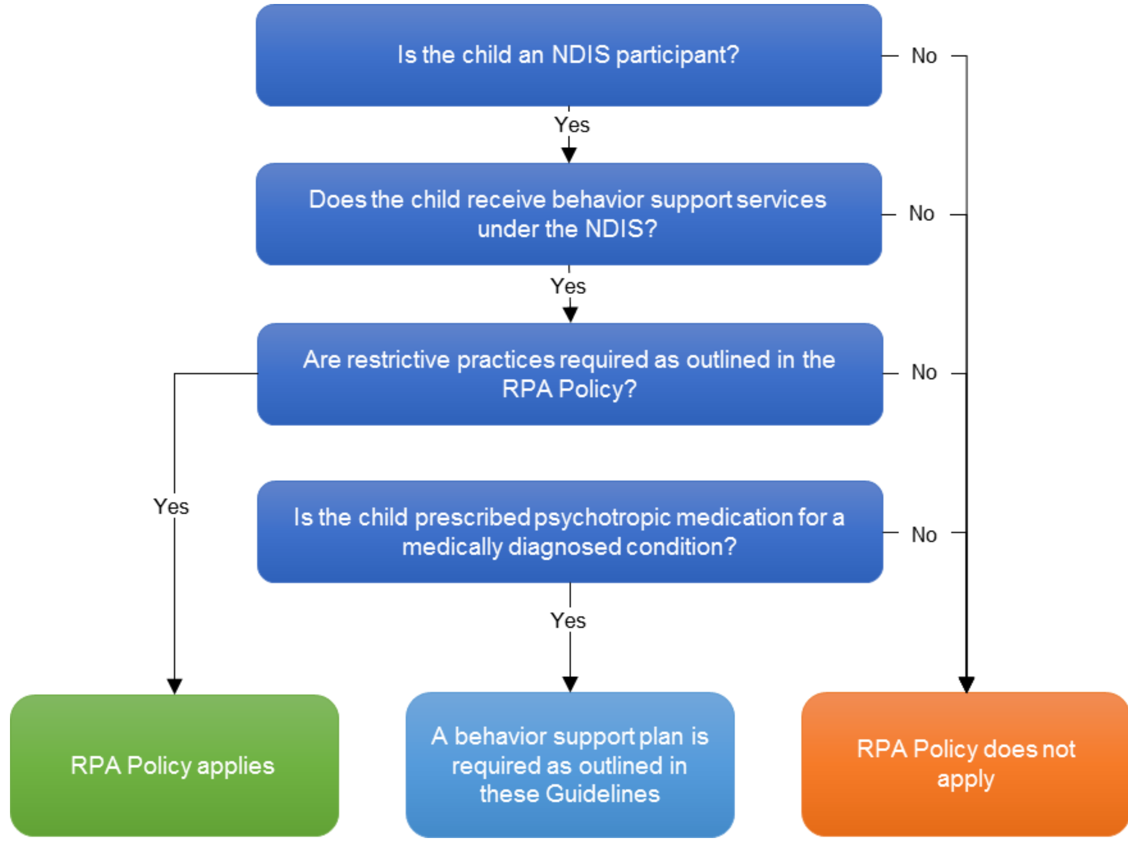
This regulatory framework applies to all NDIS registered providers and behaviour support practitioners operating in NSW.

The RPA Policy outlines the process and requirements for authorising the use of restrictive practices for behaviour support with an individual NDIS participant. It should be read in conjunction with the:

- NDIS Quality and Safeguarding Framework
- NDIS (Provider Registration and Practice Standards) Rules 2018
- NDIS (Restrictive Practices and Behaviour Support) Rules 2018
- Positive Behaviour Support Capability Framework

Application of the RPA Policy

The RPA Policy may need to be applied in place of, or in addition to, the advice in these guidelines depending on the answers to the questions below.



Care Act and Care Regulation requirements

Registered NDIS providers and practitioners must be mindful of relevant child protection legislation and associated regulations when developing and implementing behaviour support plans under the RPA policy.

While the RPA Policy and these guidelines share common principles around behaviour support plans and restrictive/prohibited practices, there are some differences. When navigating these differences, legislative requirements must take precedence over policy directives and/or guidelines.

The key legislative requirements are outlined in the table below.

Relevant legislation	Notes
Physical restraint	
Care Act, Section 158	Outlines the circumstances where physical restraint may be used and the extent, and limitations which apply under these circumstances.
Psychotropic drugs	
Care Regulation, Clause 26	Provides direction that must be followed when a medical practitioner prescribes administration of a psychotropic drug to a child. The authorised carer is to immediately notify the designated agency and a BSP must be prepared that takes into account administration of the psychotropic drug.
Prohibited practices	
Care Regulation, Clause 41	The following must not be used to correct or manage a child's behaviour: • any physical coercion or physical punishment (including corporal punishment), • any punishment that takes the form of immobilisation, force-feeding or depriving of food, • any punishment that is intended to humiliate or frighten a child or young person.

FAQ

What if a child takes psychotropic medication for a medically diagnosed condition and their behaviour support is funded through the NDIS?

The use of psychotropic medication requires that a BSP is developed in accordance with the guidelines. This still needs to occur despite the RPA Policy not considering this a restrictive practice. As outlined in the previous section 'Care Act and Care Regulation requirements', Clause 26 of the Care Regulation provides direction that must be followed when a medical practitioner prescribes administration of a psychotropic drug to a child.

What if a child with an existing behaviour support plan comes into statutory OOHC?

If a child has an existing BSP that was developed and authorised under the RPA Policy, the service provider should review the BSP to ensure it also fulfils the requirements within the guidelines.

What restrictive practices are permitted for a child with disability?

Children with disability in OOHC do not have a different restrictive/prohibited practices framework applied unless the child is receiving their behavior support through the NDIS. For these children, the definitions of restrictive/prohibited practices are outlined in the RPA Policy. However, there are still legislative requirements within the Care Act and Care Regulation which must also be complied with. These are listed in the previous section – 'Care Act and Care Regulation requirements'.

How are restrictive practices authorised now?

The authorisation process will depend on whether the child is an NDIS participant for the purposes of their behaviour support and what restrictive practice is being authorised. Refer to the section – 'Application of the RPA Policy' to help determine whether the RPA Policy applies.

Additional information and resources
Guidance documents, process information, and other useful resources on restrictive practices authorisation under the NDIS can be accessed at: https://www.facs.nsw.gov.au/providers/deliver-disability-services/restrictive-practices-authorisation-portal/rpa-resources/resources.