**Positive behaviour support and managing high risk behaviour**

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# **Dedication**

This resource is written in memory of Max Guppy who passed away in 2021. Max was a respected psychologist in the disability sector in Brisbane. Max’s professional working background spanned the non-government disability sector, The Centre of Excellence for Clinical Innovation and Behaviour Support within Disability Services and short periods of time within Queensland Health. Max commenced working in the Department of Children, Youth Justice and Multicultural Affairs within Specialist Services team in 2019 prior to resigning in 2020 due to ill health.

Professionally Max’s areas of interest included structured Positive Behaviour Support and cognitive assessments for children and adults with physical disability who had complex communication needs. He co-authored articles on topics including IQ assessments and sleep in children with Cerebral Palsy and had professional connections with both Australian Catholic University and the Queensland University of Technology.

Values including child and family centred and strengths based practice and respecting an individual’s human rights were core to his work with children and adults with a disability and their families. Max was always generous in sharing his clinical knowledge to achieve outcomes for individuals and to create systems level change to better support children and young people who demonstrate challenging behaviour.

# **Introduction**

This resource has been developed to help the members of a child or young person’s safety and support network or care team\* plan how to support the behaviour of a child or young person in positive ways. It particularly helps the safety and support network members plan how to keep everyone safe when the child or young person demonstrates high risk behaviours.

*\*Throughout this resource safety and support network will be used to describe a safety and support network or care team.*

# **Legal considerations**

The Positive Behaviour Support and Managing high risk behaviour policies of the Department of Children, Youth Justice and Multicultural Affairs (the department) are in place to assist staff and carers and are informed by the:

* *Child Protection Act 1999*
* *Human Rights Act 2019*
* *Criminal Code Act 1899*

Organisations also need to consider the *Work Health and Safety Act 2011* in relation to their staff.

In Queensland, there is a distinction between use of emergency and planned actions to respond to behaviours that present immediate risk. There is currently no legal framework for the approval of the planned use of restrictive practices with children under the age of 18 and there are competing parts within different legislation that require careful consideration.

This includes carers taking positive steps to keep the child or young person safe (duty of care) and making decisions in the best interest of children. At times, carers may need to use emergency physical and other strategies to respond to a child’s behaviour that presents immediate risk of harm to self or others to keep everyone safe. These strategies may be considered a restrictive practice under the department’s policies or the *National Disability Insurance Scheme (NDIS) Positive Behaviour Support and Restrictive Practices Rules (2018)* but are assessed as necessary to ensure immediate safety.

Visually, the department’s policies and approach to managing high risk behaviours can be viewed in the following way.

**Human Rights**

**Positive behaviour support** includes *proactive and positive* strategies to help a child or young person’s behaviour. Safety and support network members work together in a child centred, strengths-based way to improve the child or young person’s quality of life and the use of *risk assessment and risk management* is important.

A **high-risk behaviour** may be a new behaviour that the child or young person has not used before. Carers will decide the best way to keep the child or young person safe (duty of care) at that time. Reflecting after these incidents can help determine ways to support the child or young person in the future if such behaviours re-present. At other times, the high risk behaviour is a known foreseeable risk and there is the need for strong safety planning that mitigates the risks the behaviours present and outlines the responsibilities and actions of all safety and support network members.

**PRACTICE PROMPT**

*The child or young person’s safety and support network is important. When safety and support network members keep the child’s needs central to decision making, clear information sharing can happen. There is shared problem solving, planning, decision making and reviewing of supports.*

*At times of crisis or high complexity, children and young people may require a more intensive response to ensure their safety. A high intensity response by the members of the safety and support network is a particular way of coordinating, planning, and working with the purpose of providing a very intensive, seamless, wraparound safety and support plan to identified children and young people for a time-limited period.*

*The practice guide* [*Safety and Support networks and high intensity responses practice resource*](https://cspm.csyw.qld.gov.au/resources/resource/Safety-and-support-networks-and-high-intensity-res/2cc29a70-6f5d-4982-908a-504d8e4ab805) *providers further information about safety and support networks.*

**ATTENTION**

*Where there is an immediate risk of harm to the child or others, there is a need for carers to take reasonable emergency actions to enact their duty of care to keep the child and/or others safe.*

*Without a legal framework for the approval of planned use of restrictive practices, risk assessment and risk management are important to keep everyone safe. The safety and support network can develop reasonable strategies to keep everyone safe. The strategies are continually reviewed by to ensure they are effective.*

# **What is challenging or high-risk behaviour?**

The words used to describe challenging or high-risk behaviour are different across sectors and states in Australia as well as around the world. Challenging behaviour is a term used in research. In practice other terms such as ‘behaviours of concern’, ‘behaviour that challenges’ or ‘behaviours of distress’ may be used.

A child or young person’s behaviour may be developmentally appropriate and seen in children of a similar age. Other times, the behaviour may be related to factors such as trauma, disability, mental health, drugs and alcohol, or the environment they are in.

Emerson (1995) defines challenging behaviour as ‘behaviour(s) of such *intensity, frequency, or duration* that the physical safety of the person or others is likely to be placed in serious *jeopardy*, or behaviour which is likely to seriously *limit* use of, or result in the person being *denied access* to, ordinary community facilities.

When Emerson developed this definition, the intent was not to label the person as the problem. It was to highlight that the behaviour was often a mismatch between the person and the environment they are in. As a result, the behaviour presents ‘challenges’ to those around the person about how to create an environment to better meet the person’s needs.

**TIP**

*Often challenging or high-risk behaviour is a way of communicating an unmet need for the child or young person. It is important for the safety and support network to understand the function of the behaviour for the child or young person.*

**IMPORTANT**

*Key parts of this definition of challenging behaviour include:*

* *describing the behaviour in terms of how often it happens (frequency), how severe is the behaviour (intensity) and how long it lasts (duration)*
* *the behaviour creates risk to the child or young person or others*
* *has a negative impact on the child or young person’s quality of life. This could include the impact it has on going to school or out in the community or the impact on relationships. It may also lead to the child or young person having contact with police and youth justice.*

*Additional considerations for high risk behaviour include behaviour that is:*

* *not typically seen in children or young people of a common age*
* *inappropriate to the context in which it occurs.*

Unfortunately, the term ‘challenging behaviour’ has often been used as a label to describe a child or young person, but it important to remember that children and young people are more than just their behaviours. When there is a focus on the child or young person’s challenging or high-risk behaviour, we may miss their strengths, interests and hopes for the future.

In this document, the term high risk behaviour is used but it is important to always think about the key parts of the definition for challenging behaviour.

# **Translating the policies into practice: on overview**

The following diagram presents a basic framework to support the translation of the department’s [Positive Behaviour Support](https://www.cyjma.qld.gov.au/resources/dcsyw/foster-kinship-care/positive-behaviour-support-604.pdf) and [Managing high risk behaviours](https://www.cyjma.qld.gov.au/resources/dcsyw/foster-kinship-care/managing-high-risk-behaviour-646.pdf) policies into practice. There are many existing processes to support children and young people that assists the embedding of the policy into practice in individual situations.

# **The Child**

It is always the department’s aim that children and young people are supported to meet their safety, belonging and wellbeing needs. Being child centred means placing the child at the centre of any decision and working to meet their needs. It involves considering the child or young person’s views, involving them in planning and giving them developmentally appropriate opportunities to grow and develop.

Moving through the diagram above allows the safety and support network to problem solve and make shared decisions about how to best support the child or young person’s behaviour. For all children and young people:

* Being child centred and respecting their human rights is central to planning and decision making.
* Positive behaviour support provides pro-active strategies to support a child or young person’s behaviour. Over time the child or young person has other strategies that they can use instead of the challenging or high risk behaviour.
* The safety and support network members use risk assessment and risk management to plan how to keep the child or others safe when they demonstrate high risk behaviour.

At times, a restrictive practice may be used to manage risk and cannot be immediately stopped. While the safety and support network must work together to reduce or eliminate the

use of planned restrictive practices (including the use of prohibited practices), there is an escalation process that can be used to plan the safe use of restrictive practices.

**TIP**

*Being child centred is key to positive behaviour support.*

Important considerations include:

**IMPORTANT**

*In this resource, child centred is used to describe a therapeutic approach and principle when working with children. When working with Aboriginal or Torres Strait children and young people, it is important to remember that the child or young person must also be supported in the context of their family and culture.*

* involving the child and young person in planning and decision making as much as possible
* a strong understanding of the child or young person’s strengths, likes and dislikes.
* the child or young person’s cultural needs both historical and current.

knowledge of the child or young person’s development, physical health, disability, emotional and behavioural difficulties including potential mental health difficulties

* a trauma-informed focus to support the child or young person. The impact of trauma on the child or young person is acknowledged and their trauma history, including themes and patterns over time, are understood. This is important to understand in the context of their behaviours. The safety and support network’s responses to high risk behaviour should not contribute to further trauma for the child or young person.

**PRACTICE PROMPT**

The [*CREATE*](https://create.org.au/wp-content/uploads/2020/12/CRE4299_CREATE_BestPracticeResource_A4_2020web.pdf) *Foundation has developed a practice guide to support child-centred participation and decision-making in out-of-home care settings.*

## Understanding the child or young person

Every child or young person has their own unique strengths and needs, likes and dislikes. When these are understood, the safety and support network is better able to change environments and access supports to meet the child and young person’s needs. The safety and support network can use this information to consider what is *important to* versus *important for* the child or young person to help planning and decision making.

## The child or young person’s cultural needs

A child or young person’s cultural needs are supported by their connection to family and community. Connection to family, community and culture is important to support healing. Many Aboriginal and/or Torres Strait Islander families have experienced inter-generational trauma. It is important to understand the layers of trauma experienced by child or young person and their family and what this means over time.

When working with children and young people who are Aboriginal and/or Torres Strait Islander it is important to understand:

* do they have ancestral ties to Aboriginal and/or Torres Strait Islander culture or another culture?
* which culture do they more strongly align their cultural beliefs with?
* is the child old enough to form their own sense of identity?

If we are not sure, it is important to understand who has the cultural authority to share this information on behalf of the child or young person and their family.

For children and young people where there is a non-indigenous family member, or they identify with another cultural group, it is important to acknowledge the additional complexities this can bring.

For Aboriginal and/or Torres Strait Islander children it is important to consider their behaviour in the context of inter-generational trauma and loss of connection with family, community and culture. Supporting connection to family, community and culture is an important part of an integrated positive behaviour support approach.

See Appendix 1 for more information’s regarding the needs of Aboriginal and Torres Strait Islander Children

# **Human rights**

Under the *Human Rights Act 2019,* the department must uphold a person’s human rights when making decisions and providing services. The *Human Rights Act 2019* acknowledges that human rights are not absolute - that is, they are allowed to be limited, but only after careful consideration and only in a way that is necessary, justifiable and proportionate. This means that departmental staff can act or make a decision that limits human rights, but only if it is reasonable and justifiable, or if they could not have acted differently or made a different decision because of another law, for example, the [*Child Protection Act 1999*](https://www.legislation.qld.gov.au/view/html/inforce/current/act-1999-010).

Restrictive practices by their nature significantly impinge on a person’s human rights. Restrictive practices do not facilitate long-term behaviour change and must not be the sole method used to manage a child or young person’s behaviour. Restrictive practices can present risk to the child or young person (for example, injury using the restrictive practice) or contribute to traumatisation. There is further information on restrictive practices in the ‘Managing risk’ section of this resource.

**TIP**

*The current evidence base identifies that restrictive practices should:*

* *only be used as a last resort when other less restrictive ways to support the child or young have been unsuccessful*
* *be the least restrictive option available*
* *only be used for its intended purpose*
* *be used for the shortest period necessary with the minimum level of force to effectively manage high risk behaviour*
* *be proportionate to the risk of harm presented by the behaviour.*

*These concepts align to the considerations detailed in the Human Rights Act 2018 to determine whether the limit is reasonable and justified.*

# **Positive behaviour support**

## What is positive behaviour support?

Positive behaviour support can be seen in the broadest sense as a continuum of strategies that start with positive parenting through to more structured positive behaviour support in situations where there is more complex or concerning behaviours or mental health difficulties.

Positive behaviour support:

* is child centred and respects the child or young person’s human rights.
* involves understanding why the child or young person demonstrates the behaviour (the function).
* uses this information to provide supports and change the environment to meet the child or young person’s needs
* teaches the child and young person to learn new skills so they do not need to use the challenging or high risk behaviour.

This helps improve their quality of life and helps to reduce their challenging or high-risk behaviour (Carr et al, 2002; Chan, French & Webber).

## Positive parenting strategies

**IMPORTANT**

*Being child centred is the first step of positive behaviour support. From this, the safety and support network members are able to:*

* *create environments, relationships and supports that will meet the child or young person’s needs and help them heal from trauma*
* *understand patterns to their behaviour and develop more targeted strategies to support the child or young person’s behaviour.*

*The child strengths and needs assessment is an important case work tool to support being child centred.*

For all children and young people, their behaviour is supported through strengths based, consistent responses and the use of appropriate discipline within safe and caring relationships. This is especially important for children and young people who have experienced trauma or experience neuro-developmental disability. This is consistent with the statement of standards where the child or young person will receive the positive guidance necessary to support their behaviour.

## Developmentally appropriate behaviour strategies

When a child or young person’s behaviour is considered in the context of typical development, the safety and support network can identify age and developmentally appropriate behaviour strategies.

For example, with toddlers and pre-schoolers the use of strategies such as role modelling positive behaviour, planning ahead for situations that can be difficult for the child, using distraction, the use of praise, and consistent household routines help support their behaviour.

As children enter school and move to adolescence, the use of clear rules, limits and boundaries can assist them learn independence, take responsibility, and begin problem solving. Strategies may include:

* continued role modelling of positive behaviour
* assisting the child or young person to discover their strengths to assist them to develop a positive self-image
* involving them in discussions about establishing rules and consequences when they break them
* talking to them about choices and their possible consequences. Help them understand that rights and responsibilities go together
* avoiding power struggles.

## Appropriate discipline

When appropriate discipline is used within a safe and caring relationship this can assist the child to feel safe and secure and in turn support the child and young person’s development, including social-emotional development. Appropriate discipline helps keep children and young people safe from danger while supporting their emotional self-regulation and responsibility.

Discipline can include:

* clearly explaining ground rules and ensuring that they match the child or young person’s age and developmental level
* recognising when children and young people are adhering to these rules
* ensuring that the rules are simple and there are reasonable limits for the child or young person, including, following through with the consequences, and being consistent with the rules and consequences when they are broken
* teaching the child or young person to help them identify more appropriate behaviours in the future.

## A note about punishment

Punishment should not be confused with discipline. Under the statement of standards techniques for managing the child or young person’s behaviour must not include corporal punishment or punishment that humiliates, frightens, or threatens the child or young person in a way that is likely to cause emotional harm.

When there is a focus on punishment, it does not teach the child or young person what they can do differently next time or support the development of their emotional self-regulation. It may quickly stop the behaviour, but the behaviour will re-emerge as we haven’t understood the function of the behaviour to develop more targeted supports. Punishment should also be considered in the context of the child or young person’s trauma experience.

## Positive parenting and case planning for positive behaviour support

For low and moderate risk behaviours positive parenting and effective discipline is key to positive behaviour support. This is combined with developmentally appropriate opportunities to develop skills to support children and young people identify alternatives to their challenging behaviour. Behavioural risk assessment is further described in the section ‘Managing high risk behaviour’.

**PRACTICE PROMPT**

*Ensuring that the child’s strengths and needs assessment is up to date and accurate assists with identifying additional supports to meet a child’s needs.*

*If children or young people are scoring primarily (a) or (b) in the child strengths and needs assessment across most domains especially behaviour, emotional well-being and cultural identity, this may indicate low or moderate risk behaviours. A focus on positive parenting and any additional supports to meet the child’s needs is often appropriate.*

## Low risk behaviours and case planning

For children and young people who demonstrate low risk behaviours the safety and support network can problem solve and identify positive parenting strategies that can be used to support the child or young person’s behaviour. This can be incorporated into, and monitored through, case planning and completion of the child strengths and needs assessment.

**TIP**

*If the child or young person is a NDIS participant, any disability related supports can be accessed through their NDIS plan.*

## Moderate risk behaviours

If children or young people demonstrate moderate risk behaviours the safety and support network not only identify appropriate positive parenting strategies but will identify additional supports that will be beneficial to meet the child or young person’s needs. Supports may include referral to allied health and therapeutic supports, for example, a speech pathologist to support communication, an occupational therapist to support sensory skills, or mental health supports. If the child or young person is a NDIS participant, any disability related supports can be accessed through their NDIS plan.

The safety and support network may identify the need for more structured positive behaviour support if there is a change in the frequency or severity of high-risk behaviour. This may be captured through an increase in critical incidents involving the child or young person.

If the child or young person is scoring predominately (c) or (d) across most domains in the child strengths and needs assessment, structured positive behaviour support should be considered. The behaviour risk assessment can be used to support decision making by the safety and support network.

## Understanding why the child or young person demonstrates the behaviour

There are many factors that may mean that a child or young person is more likely to demonstrate challenging or high-risk behaviour. These can include:

* trauma
* neurodevelopmental disability, for example, autism, foetal alcohol spectrum disorder
* communication difficulties
* sensory difficulties
* health issues
* experience of inconsistent parenting
* coping with grief, loss and separation.
* adjusting to new environments (schools or placements) and new rules in each environment.

It is important to understand these factors when assessing why the child or young person demonstrates the challenging or high risk behaviour, but they do not help to understand the function by themselves. A more comprehensive assessment is needed.

In the assessment process, the antecedent, behaviour, and consequence (ABC) approach helps to:

* identify what happens immediately before the behaviour (antecedent)
* the nature of the behaviour (behaviour)
* what happens immediately after the behaviour – what changes in the environment (consequence).

With this information the safety and support network can start to develop a view about why the child or young person is demonstrating the behaviour.

This information can be gained through interviews with both the child or young person and others, observations and recording information and behavioural data during incidents. In structured positive behaviour support this should be completed by a clinician or professional with the relevant capabilities.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **ANTECEDENT** | **BEHAVIOUR** | **CONSEQUENCE** |
| **What is this?** | What is happening for the child or young person before they demonstrate challenging or high risk behaviour? | The nature of the behaviour | What happens after the behaviour? What changes in the environment? |
| **What might the safety and support network consider** | * Who is around? * Timing of behaviours? * Where is the child or young person? * What is happening? Is the child or young person sick or tired? * What is the environment like? * Are there demands being placed on the child | * What does the behaviour look like? * How often does it happen? * How long does it happen? * How severe is the behaviour? | * What are the immediate and delayed reactions of everyone around the child? |

See Appendix 2 for more information regarding child and adolescent development.

See Appendix 3 for more information regarding positive behaviour support plans.

## Reflecting after crisis

Responding to crisis and critical incidents provides an opportunity for reflection and learning about the strategies used to manage the crisis. Using a structured focussed review process to reflect on the incident can support carers and the safety and support network to identify when a positive behaviour plan has not been followed, needs to be reviewed, or when there are alternative strategies that can be used to help keep the child or others safe.

This is not a punitive approach, but rather an opportunity to reflect and learn how to support the child or young person differently when demonstrating high risk behaviour. It should not replace any formal debriefing that is required after responding to crisis. A focus review may also include talking to the child or young person involved if this is appropriate.

This approach is separate to therapeutic work that may occur with the child or young person after an incident, for example, a life space interview.

A focussed review could occur with an individual carer or it may occur as part of a safety and support network meeting.

Some organisations may have their own tools and processes to support a focussed review.

# **Managing high risk behaviour**

A child or young person’s behaviour may present immediate risk of harm to themselves and others. Sometimes, the challenging or high risk behaviour occurs so regularly, that it may present a known foreseeable risk. Actions taken to ensure the immediate safety of the child or young person and others may be considered a restrictive practice under the department’s policies. In the absence of a legal framework for the approval of the use of restrictive practices with children under the age of 18, the use of risk assessment and management is important to keep everyone safe.

Safe Work Australia describes the risk management process as:

1. Identify hazards – what behaviour causes harm to the child, young person or others?
2. Assess the risk – how often does the harm occur? How serious is the harm?
3. Control risks – implement the most effective and least restrictive strategies to manage the risk that is reasonably practicable at the time.
4. Review hazards and control measures to ensure they are working as planned.

This basic process can be used when supporting children and young people who demonstrate challenging or high risk behaviour. It helps the safety and support network identify appropriate strategies to keep everyone safe.

## Restrictive practices

Restrictive practices are any intervention that impact on the rights or freedom of movement of the child or young person with the primary purpose of protecting the child or young person or others from harm.

**IMPORTANT**

*Restrictive practices:*

* *do not create long-term behaviour change*
* *can present risk and contribute to trauma to the child or young person and those using them.*

*The Managing high risk behaviour policy details the limited situations where the emergency use of restrictive practices can be used. The ongoing reliance on emergency use of restrictive practices without a positive behaviour support plan is not supported as a behaviour management technique. Restrictive practices should only be used on a temporary basis and be part of broader positive behaviour support approach to support the child or young person’s behaviour.*

*For children and young people who are NDIS participants, the NDIS Quality and Safeguards Commission has developed the* [*Regulated Restrictive Practices Guide*](https://www.ndiscommission.gov.au/document/2386)*.*

## Behaviour risk assessment

Sometimes there is a tendency for people around the child or young person to label all their behaviour as high risk. Without a strong framework to support this assessment, the safety and support network may incorrectly assess of the level of risk presented by a behaviour. For example, a high risk behaviour may be assessed as a low risk or a low risk behaviour may be assessed as a high risk.

When the assessed level of risk is not accurate the safety and support network will not be able to identify the most proportionate, reasonable, and least restrictive way to manage the risk presented by the behaviour.

The department has developed a behaviour risk assessment tool . Organisations may have their own behaviour risk assessment tools.

The behaviour risk assessment tool can be used by the safety and support network to guide discussions about assessing the level of risk presented by the behaviour. It helps the safety and support network to think about what is happening for the child or young person and then develop appropriate strategies to keep everyone safe.

**IMPORTANT**

*The behaviour risk assessment tool does not replace the need for other types of risk assessment, for example, forensic or suicide risk assessments. Information from all risk assessments is important for developing plans to keep the child or young person and others safe.*

## When to use the behaviour risk assessment tool

The behaviour risk assessment tool can be used at any time by the safety and support network when there are worries about the child or young person’s behaviour. The behaviour risk assessment assists the safety and support network identify the most appropriate strategies to minimise the risk with the behaviour.

The behaviour risk assessment is important to consider if:

* the child or young person is demonstrating the high risk behaviour regularly and it is agreed the behaviour is presenting a known foreseeable risk to the child or others
* there is a change in the frequency or severity of a child’s behaviour
* there is an increase in the critical incidents for a child or young person.

**PRACTICE PROMPT**

*The child strengths and needs assessment can help identify when a behaviour risk assessment may be required.*

*If the child or young person is scoring predominately (c) or (d) across most domains in the child strengths and needs assessment, use of the behaviour risk assessment tool is recommended. This will help the safety and support network identify and develop the most appropriate level of supports to manage the risk. The assessed risk will be useful in informing the development of a crisis management plan. Refer to the section ‘Development of crisis management plans’.*

## Who does the behaviour risk assessment?

It is important that the behaviour risk assessment is completed by members of the safety and support network. This allows:

* the contribution of those who work with the child or young person each day
* the knowledge of any allied health or specialist/therapeutic supports. This can include knowledge gained through specialist risk assessments. It also allows for the child or young person’s situation to be assessed holistically through a range of perspectives, for example, trauma, disability and mental health.
* a collective decision to be made about the agreed level of risk presented by each behaviour considering all the knowledge about the child or young person.

**ATTENTION**

*It should not be the responsibility of just one person to assess the level of risk presented by a child or young person’s behaviour.*

## How to use the behaviour risk assessment

The process of completing a behaviour risk assessment is outlined in the procedure Support a child in care, Meet a child health and wellbeing needs, Respond to the use of prohibited or restrictive practices for a child in the guardianship of the chief executive.

**TIP**

*During the discussion, the safety and support network may agree there is not enough information and behavioural data to assess the level of risk. When this happens, the safety and support network can agree the best way to gather this behavioural data. In the discussion, the safety and support network may have identified some strategies that can be immediately use, for example, a health assessment or removing general clutter in the house.*

## Managing foreseeable risk and crisis

Carers have a duty of care to ensure the safety of children and young people in their care. Where the child or young person demonstrates behaviour that presents immediate or known foreseeable risk of harm, carers must take reasonable steps to keep the child or young person or others safe.

Under the [Managing high risk behaviour](https://www.cyjma.qld.gov.au/resources/dcsyw/foster-kinship-care/managing-high-risk-behaviour-646.pdf) policy, the emergency use of restrictive practices can be used when:

* the child or young person is behaving in a way that poses immediate foreseeable risk of harm or actual risk of harm to themselves or others
* the practice is reasonable in all the circumstances of the behaviour
* where there is no less restrictive strategy available to respond to the child or young person’s high risk behaviour at that time.

Consideration must always be given to the best interests of the child.

In these situations, carers can use:

* emergency use of physical restraint not including specific high risk physical restraint techniques that have been identified as prohibited practices.
* emergency removal of items.

The emergency use of physical restraint must:

* be reasonable and necessary to prevent the child from harming themselves or other
* be the least restrictive option and be proportionate to the level of risk of the behaviour
* be applied for the shortest amount of time and be removed as soon as the risk of the behaviour has reduced
* only be used where the risk of not using the restraint outweighs the risk for using the restraint.
* must be ceased if the child says they cannot breathe, vomits, demonstrates signs of physical or psychological distress, starts to change colour or has a medical emergency such as a seizure or asthma attack.

When an emergency use of a physical restraint is ceased, the child or young person must be carefully monitored and supported to access any required medical attention. They should also be provided the opportunity to debrief about the incident when calm.

**PRACTICE PROMPT**

*The Managing high risk behaviour policy provides guiding principles on the emergency use of restrictive practices including emergency use of physical restraint and removal of items.*

If the child or young person is demonstrating the high risk behaviour frequently, a crisis management plan should be developed by the safety and support network to provide a more structured and planned way to manage the crisis.

Note: Crisis management plans can be recorded on the individual templates currently used by foster and kinship care service and care services.

## Incident reporting

If carers have used an emergency restrictive practice, they must report the use of the strategy in line with the [Managing high risk behaviour](https://www.cyjma.qld.gov.au/resources/dcsyw/foster-kinship-care/managing-high-risk-behaviour-646.pdf) policy.

Any use of a prohibited or restrictive practice that is not being managed within the informal and formal safeguarding processes may constitute a standards of care issue and the information will be assessed in accordance with Responding to concerns about the standards of care policy.

For NDIS funded and registered providers, the department’s incident reporting process does not replace any reporting requirements under the NDIS Quality and Safeguarding Framework.

## Prohibited practices

Prohibited practices are unlawful and unethical practices which can cause a high level of discomfort and trauma. Without a legal authorising framework many restrictive practices are prohibited practices under the Managing high risk behaviour policy. These include:

* specific high-risk physical restraint techniques. Evidence has demonstrated that these techniques can result in injury, trauma and death.
* seclusion
* containment
* environmental restraints – ongoing use of restricted access to items
* chemical restraint
* mechanical restraint
* corporal punishment
* aversive strategies
* unethical practices.

**FURTHER READING**

*The* [*Managing high risk behaviour*](https://www.cyjma.qld.gov.au/resources/dcsyw/foster-kinship-care/managing-high-risk-behaviour-646.pdf) *policy provides definitions of each of the restrictive and prohibited practices.*

Any incident that involves the use of a prohibited practice must be reported in line with the [Managing high risk behaviour](https://www.cyjma.qld.gov.au/resources/dcsyw/foster-kinship-care/managing-high-risk-behaviour-646.pdf) policy and the procedure Support a child in care, Meet a child health and wellbeing needs, Respond to the use of prohibited or restrictive practices for a child in the guardianship of the chief executive.

**IMPORTANT**

*High risk physical restraint techniques and seclusion must stop immediately as there are other less restrictive ways to keep children and young people safe at crisis.*

At times, the restrictive or prohibited practice may not be able to be ceased immediately due to the level of known foreseeable risk of the behaviour. This is because it may take time to introduce other less restrictive ways to support the child or young person’s behaviour. This may include chemical restraint or mechanical restraint.

The safety and support network must demonstrate that working collaboratively they have determined this through:

* a child centred approach that considers best interest of the child including their human rights
* development and implementation of structured positive behaviour support including additional supports such as allied health, mental health, and addiction services
* a behaviour risk assessment that demonstrates that the level of risk presented by the behaviour. This behaviour risk assessment supports that the response is proportionate, reasonable, and necessary at this time due to the level of known foreseeable risk of the behaviour.

In these situations, the safety and support network will use the escalation process, outlined in the procedure *Support a child in care, Meet a child health and wellbeing needs, Respond to the use of prohibited or restrictive practices for a child in the guardianship of the chief executive*. As part of the escalation process, the Director-General will note that those involved in caring for the child including members of the safety and support network are working outside of policy through the planned use of restrictive practices or use of a prohibited practice while additional strategies are introduced to reduce and eliminate the practice.

**IMPORTANT**

*This escalation process is not a formal authorisation process for the use of restrictive practices. It acknowledges the need to work outside of policy through the planned use of restrictive practices or use of prohibited practices for the short term due to the level of known foreseeable risk of the child or young person’s behaviour. During this time other strategies will be discussed, agreed to and used to manage the risk in the least restrictive way and reduce the use of the restrictive and prohibited practice.*

**FURTHER READING**

*The NDIS Quality and Safeguarding Commission have developed the following resources that are useful if the child or young person is a NDIS participant:*

* [*Regulated Restrictive Practices Guide*](https://www.ndiscommission.gov.au/document/2386) *– this includes information and examples of all types of restrictive practices. It explains when the contraceptive pill might be considered a chemical restraint.*
* [*Regulated restrictive practices with children and young people with disability: Practice guide*](https://www.ndiscommission.gov.au/document/2741)*.*

**PRACTICE PROMPT**

*There are certain actions including locking away sharps, chemicals, medications and car keys that carers must do to meet licencing requirements under the Child Protection Act 1999 and the Human Services Quality Framework.*

*These practices are age appropriate, in line with community standards, and are used for all children. The use of the strategy is not reliant on the child demonstrating high risk behaviour.*

When there are concerns about whether a child proofing strategy is a restrictive practice, it is important for the safety and support network to have collaborative discussions to understand the use of the strategy. If the strategy is identified as a restrictive practice and cannot be immediately stopped, the appropriate escalation process can be used while the safety and support network implement strategies to reduce and eliminate the practice.

**FURTHER READING**

*Child proofing strategies are typically not considered regulated restrictive practices under the NDIS rules. However, the continued use of these with older children and young people with a disability who are NDIS participants may constitute a regulated restrictive practice in some situations.*

*The NDIS Quality and Safeguards Commission has developed the document* [*Regulated restrictive practices with children and young people with disability: Practice Guide*](https://www.ndiscommission.gov.au/document/2741)*. The document provides some information on child proofing. It provides examples of common parenting strategies and whether they may be considered a regulated restrictive practice.*

## Development of crisis management plans

*Please note: Crisis management plans are referred to as a plan to manage crisis situations in the Child Safety Practice Manual.*

The child or young person may repeatedly demonstrate the high or extreme risk behaviour and it is determined that the behaviour presents known foreseeable risk. In these situations, a crisis management plan is needed to keep everyone safe.

## Development of crisis management plans

**TIP**

*A crisis management plan describes strategies to respond to high risk behaviour when it is occurring at crisis. Keeping everyone safe when the high risk behaviour occurs is important. When there are only strategies to manage high risk behaviour when it is occurring, it will not stop the behaviour occurring again. It may make it more likely to occur if we do not understand the function of the behaviour. Children and young people who demonstrate high and extreme risk behaviour must also have positive behaviour support plans. This provides the proactive and positive ways to support the child or young person’s behaviour.*

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The crisis management plan should:

* be informed by the level of risk assessed for each behaviour
* clearly identify the point at which there is known foreseeable risk of harm for the child or young person or others associated with the behaviour (crisis)
* describe a gradient of strategies to manage the risk presented by the behaviour
* consider any individual risk factors of the child or young person when identifying strategies to manage the risk.

Within the crisis management plan, it is important that practices are:

* individualised for the child or young person and their needs
* the least restrictive way to keep everyone safe
* proportionate to the level of risk presented by the behaviour
* reasonable in all the circumstances of the behaviour
* done for the shortest time.

Where possible, the child or young person should be involved in the development of the safety plan to the greatest extent possible. The crisis management plan should be shared with the child and young person so they know the strategies that everyone will use to keep them safe. Information should be provided in a way that the child or young person understands.

**TIP**

*Ideally, the safety and support network would develop a crisis management plan that works across contexts rather than having many plans that say similar things developed by different systems and supports in the child or young person’s life.*

**IMPORTANT**

*Crisis management plans based on the regular and unmonitored use of prohibited physical restraint techniques are not supported by the department.*

## Individual risk factors to consider in developing safety plans

In developing crisis management plans, the safety and support network should consider any individual risk factors for the child or young person when identifying strategies. This may influence the decision about whether a strategy is appropriate or not. The crisis management plan should include risk mitigation strategies in the event of an adverse outcome from the strategy. These risk factors are especially important to consider for Aboriginal and Torres Strait Islander children who have health inequalities and have experienced inter-generational trauma.

|  |  |  |
| --- | --- | --- |
| **Individual risk factor** | **Examples** | **Consideration** |
| Respiratory disorders | * Asthma * Structural problems with the chest wall, for example, scoliosis | * Some physical restraint techniques can impact on the chest wall. Many of these are prohibited practices under the Managing high risk behaviour policy. * Asthma attacks may be linked to severe emotional distress. * Breathing should be monitored during any use of an emergency physical restraint. |
| Cardiac disorders | * Structural heat difficulties * History of abnormal heart beats (arrythmia), for example, Long QT Syndrome, * High blood pressure | * A child or young person should be observed for any signs of cardiac issues after the use of an emergency physical restraint. |
| Musculoskeletal problems | * Hyperlaxity of joints, for example, Stickler syndrome and Ehlers-Danlos syndrome * Juvenile idiopathic arthritis * Juvenile osteoporosis | * Risk of dislocation * Risk of breaks * Some of these conditions cause pain in general for children. |
| Neurological problems | * Epilepsy * Muscular dystrophy * Cerebral palsy | * Emotional distress can lead to a seizure * Conditions such as muscular dystrophy can lead to muscular wasting and weakness that can impact on a child or young person’s respiration |
| Trauma | * History of physical/sexual abuse * History of neglect * Exposure to domestic and family violence * Anxiety * Post traumatic disorder | * Physical restraint may trigger memories of abuse * Seclusion may be traumatic for children exposed to neglect |
| General health and wellbeing | * Weight, including overweight * Drugs (prescribed or illicit) * Clotting disorders * Visual and hearing difficulties | * Obesity can be linked to chronic health issues. * Side effects of drugs, for example, cardiac arrthymia * Those with visual or hearing difficulties may experience increased stress from not understanding what is happening. |

(Perry et al, 2006)

## Suicidal behaviour

There are two important elements when considering safety planning for young people who express suicidal ideation or attempt suicide. That is both the development of the young person’s own personal safety plan (with support), and the development of a collaborative, cross-agency plan detailing a planned and coordinated response to suicidal behaviours. Again, in developing plans that are responsive and sensitive, it is important to partner with the young person, the safety and support network, and any mental health and other professionals (for example, foster carers, residential care workers, Police, Ambulance, Evolve). Relationships are key. Plans must be reviewed regularly.

## Use of police or ambulance intervention

**PRACTICE PROMPT**

*For more information refer to the procedure* *Support a child in care, Meet a child health and wellbeing needs,* [*Respond to suicidal behaviour*](https://cspm.csyw.qld.gov.au/procedures/support-a-child-in-care/meet-a-child-s-health-and-wellbeing-needs#Respond_to_suicidal_behaviour)*.*

*Refer to Working with a child with mental health issues in the practice kit* [*Mental Health*](https://cspm.csyw.qld.gov.au/practice-kits/mental-health/working-with-young-people)*.*

In Australia, data indicates that children in contact with statutory child protection services are over-represented in the youth justice system. There are many contributing factors to this. One factor for children and young people in residential care is the criminalisation of their challenging or high-risk behaviour also known as ‘care criminalisation’ (Baidawi et al, 2020). In these situations, children and young people in residential care may face police involvement for relatively low or medium risk behaviours that may not have resulted in police involvement in the young person had been living in their family home (Baidawi et al, 2020).

The use of police or ambulance services should not be used as a routine way to manage low or moderate risk behaviour demonstrated by a child or young person.

**FURTHER READING**

*In 2018, The Queensland Family and Child Commission released the Joint Agency Protocol to Reduce Preventable Police Call-outs to Residential Care Services (Joint Agency Protocol). All agencies, residential care providers and residential care workers involved in providing care to children and young people in residential care are responsible for implementing and monitoring the Joint Agency Protocol.*

*PeakCare has developed the* [*Practice Guidelines: Reducing Preventable Police Call-outs to Residential Care Services Guide 1 and 2*](https://www.cyjma.qld.gov.au/about-us/our-department/partners/child-family/resources-publications)*. These should be used by the safety and support network when developing Safety/Individual Crisis Management Plans.*

# **Appendix 1: Resources for Aboriginal and Torres Strait Islander children and young people**

*Resources for Aboriginal and Torres Strait Islander children and young people*

**PRACTICE PROMPT**

*The* [*Safe Care and Connection*](https://cspm.csyw.qld.gov.au/practice-kits/safe-care-and-connection) *practice kit provides information to assist with culturally capable practice when working with Aboriginal and/or Torres Strait Islander children, young people and families.*

*The* [*Cultural support plan*](https://cspm.csyw.qld.gov.au/practice-kits/safe-care-and-connection/cultural-support-plans/responding-1/developing-the-cultural-support-plan) *forms part of the child or young person’s case plan and is completed to support Aboriginal and/or Torres Strait Islander children and young people retain their connection to family, community and cultural supports, regardless of where they are living. More information about cultural support plans can be found in the Safe Care and Connection practice kit.*

*Families are given the opportunity to participate in case planning, which includes the development of the cultural support plan, including in a family-led decision making process (where possible led by an Aboriginal and/or Torres Strait Islander person).*

**FURTHER INFORMATION**

*There are a number of resources that can assist with considering how to best support Aboriginal and/or Torres Strait Islander children and young people:*

* [*Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*](https://www.telethonkids.org.au/our-research/early-environment/developmental-origins-of-child-health/expired-projects/working-together-second-edition/)
* [*The ‘Growing Up’ of Aboriginal and Torres Strait Island Children: A literature Review*](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1728989) *was commissioned as part of the Footprints in Time – the Longitudinal Study of Indigenous Children.*
* *The* [*Working with Aboriginal and Torres Strait Islander families and children toolkit*](https://emergingminds.com.au/resources/toolkits/working-with-aboriginal-and-torres-strait-islander-families-and-children/) *developed by Emerging Minds.*

*These resources provide general and overarching information, but it is important to talk to the most appropriate person in the child or young person’s family or community.*

**IMPORTANT**

*SNAICC is the national non-governmental peak body for Aboriginal and Torres Strait Islander children. They work to fulfil the rights of children particularly to ensure their safety, development and wellbeing. They achieve this through a number of activities including research and resource development. Relevant resources include:*

* [*The Early Years Learning Framework*](https://www.snaicc.org.au/wp-content/uploads/2015/12/02896.pdf)
* [*Cultural Care plans*](https://www.supportingcarers.snaicc.org.au/rights-of-the-child/cultural-care-plans/)
* [*Foster their Culture*](https://www.snaicc.org.au/foster-their-culture-caring-for-aboriginal-and-torres-strait-islander-children-in-out-of-home-care-2008/) *is a handbook for carers and state and territory foster carer associations and networks*
* [*Working and Walking together: Supporting Family Relationships Services to work with Aboriginal and Torre Strait Islander Families and Organisations*](https://www.snaicc.org.au/?attachment_id=13784)*.*

## Cultural considerations with parenting

Within Aboriginal and Torres Strait Islander culture, families live within a complex kinship system that defines how people relate to each other and determine the behaviour of an individual to each person. People had defined roles according to age and gender. Raising children is seen as the collective responsibility of all members of the community (SNAICC, 2011). These collective approaches help:

* keep children safe
* develop self-confidence
* support discipline and learning through positive role modelling, and
* support the child or young person to have range of support when they experience difficulties.

(Lohoar, Butera & Kennedy, 2014)

When working with Aboriginal and Torres Strait Islander families, it is important to understand who the child or young person identifies as a significant and important person in their life. This may not always just be parents but may include other family members. Supporting the connection between the child or young person and their family is important.

**FURTHER READING**

*For further information about cultural child rearing practices can be found in these resources:*

* [*Growing up our way – Aboriginal and Torres Strait Islander child rearing practices matrix*](https://www.snaicc.org.au/growing-up-our-way-aboriginal-and-torres-strait-islander-child-rearing-practices-matrix-2011-snaicc/)
* [*Strengths of Australian Aboriginal cultural practices in family life and child rearing*](https://emergingminds.com.au/resources/strengths-of-australian-aboriginal-cultural-practices-in-family-life-and-child-rearing/?gclid=EAIaIQobChMI7cHd78CW8gIVVZNmAh333gLoEAAYASAAEgKETPD_BwE)*.*

**IMPORTANT**

*Consider how to support the connection between parents, family, community and the child or young person’s carer within case planning*.

# **Appendix 2: Development from childhood to adolescence**

It is important to understand typical development throughout childhood and adolescence. In general, development happens in the same order in most children, but skills might develop at different ages or times. Understanding typical development helps with early identification of when children are not meeting their developmental milestones for example their communication. It also helps with early identification of social-emotional difficulties or mental health worries for a young person. During childhood and adolescence, the brain is continuing to develop. Getting help early when carers first have worries about a child or young person’s development is important.

The first two years of a baby’s life is an important and critical time for brain development. Throughout childhood, their development is influenced by the relational (attachment with key figures) and physical environment that they live in and the developmental opportunities that these provide. For babies, they learn through ‘serve and return’ interactions across the day when they are with a secure carer (Snow, 2020). These mutually rewarding interactions, for example, peek-a-boo provide opportunities for connection and regulation. As children become older play and early learning environments for example Kindy provide these opportunities to support sensory and motor development, social skills development, communication, and cognitive development (Snow, 2020).

**TIP**

*For children, it is important to consider how we can strengthen relationships, give opportunities to develop core skills and reduce sources of stress. These core principles help early learning and life-long physical and mental health*.

When children experience delays in early childhood, accessing supports including speech pathology and occupational therapy can assist carers to find out other strategies that they can use in everyday activities to help the child’s development.

**FURTHER READING**

*There are many resources that provide more information about typical development.*

*The* [*Raising Children’s Network*](https://raisingchildren.net.au/) *provides information about development across childhood and adolescence. It provides information about tips and strategies that carers can try to help children and adolescents to help their development.*

*Children’s Health Queensland have developed the* [*Red Flags Early Identification Guide for children aged birth to five years*](https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/red-flags.pdf) *and* [*Red flags school-aged guide*](https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qcycn/CYCHS-School-aged-Red-Flags-folding-guidelines.pdf)

*The Centre on the Developing Child at Harvard University have produced and developed resources on topics such as* [*Three core concepts in early*](https://developingchild.harvard.edu/resources/three-core-concepts-in-early-development/) *development – these videos explain how experiences and interactions influence brain development and the influence of toxic stress. These are expanded on in separate sections of the website.*

Adolescent development involves the transition from being a child to being an adult. It has social, personal, cultural, neurological, and physiological aspects. It begins in the early teens and continues into the late twenties. Neuroscience has shown that adolescence is a time of profound brain growth and change.

**TIP**

*Children who are under the age of 6 years do not need to have a diagnosis to access the National Disability Insurance Agency (NDIS) Early Childhood, Early Intervention (ECEI) approach. For more information on ECEI, refer to the procedure Support a child in care, Meet a child health and wellbeing needs,* [*Respond to a child’s disability needs*](https://cspm.csyw.qld.gov.au/procedures/support-a-child-in-care/meet-a-child-s-health-and-wellbeing-needs#Respond_to_a_child_s_disability_needs)*.*

**PRACTICE PROMPT**

*The* [*Transition to adulthood*](https://cspm.csyw.qld.gov.au/practice-kits/transition-to-adulthood/working-with-young-people) *practice kit has more information on the developmental stage of adolescence and supporting transition to adulthood planning with young people.*

*The Raising Children’s network has further information on* [*brain development in the teenage years*](https://raisingchildren.net.au/teens/development/understanding-your-teenager/brain-development-teens)*.*

Increasing opportunities for independence, for example, going out safely with friends without an adult is an important part of the young person’s transition to adulthood. Carers should consider how to assist the young person to gradually become more independent. This includes negotiating independence, establishing rules about independence, and developing skills to stay safe. During this period of adolescence, it is also important to give young people the dignity of risk to assist with developing their skills.

In addition to physical changes that occur in adolescence, there are many other changes such as relationships with carers, siblings, and friends. Romantic relationships and sexual development are another major developmental milestone for adolescents. Supporting young people to develop their skills to safely navigate these relationships is important.

**TIP**

*The Raising Children Network provides information on ‘*[*Going out independently: teenagers*](https://raisingchildren.net.au/teens/healthy-lifestyle/safety-first-aid/teenagers-going-out-independently)*’ as well as other tips on how to support development in adolescence in areas such as behaviour, relationships and mental health.*

*In this* [*video*](https://raisingchildren.net.au/teens/videos/teen-independence)*, parents and teenagers talk about increasing independence in adolescence.*

*In this* [*video,*](https://raisingchildren.net.au/teens/videos/risky-behaviour-video) *young people talk about what risky behaviour is and how they would work out whether a situation or action is risky.*

It is important to consider a child or young person’s behaviour in relation to their development. For example, in adolescence, young people will try to test boundaries or engage in risk taking behaviour. For children and young people with developmental delays or disabilities, it is useful to consider their behaviour not only in terms of chronological age but also developmentally. Carers may be quick to label behaviour that would typically be expected in a child or young person of a similar age or developmental level as ‘challenging behaviour’ without seeing it context of the child or young person’s delays.

## Neurodevelopmental disability

Many children and young children in contact with the child protection system may experience neurodevelopmental disabilities. ‘Neurodisability (sometimes termed neurodevelopmental disability/disorder) is an umbrella term for conditions with onset in childhood and adolescence that involve a compromise to the nervous system due to genetic, pre-birth or birth trauma, injury, or illness in childhood’ (Baidawi & Piquero, 2020). These disorders can include intellectual disability, specific learning disabilities, communication disorders, for example, Developmental Language Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder and Foetal Alcohol Spectrum Disorder.

The child or young person can have difficulties in areas including cognition, language, memory, attention, executive function, sensory and learning. These difficulties can contribute to problems at school including exclusion, getting a job, mental health, substance use and contact with the law (Bower et al, 2017; Snow, P, 2020). For many children, these difficulties may remain undiagnosed despite the significant and ongoing impact that it can have in adolescence and adulthood.

**ATTENTION**

*The impacts of adversity in childhood can compound and develop into broader difficulties in the teenage years and adulthood. This can include mental health difficulties, difficulties with friendships and learning. These difficulties can lead to what is known as the school-to-prison pipeline where these young children are an increased risk of contact with the youth justice system (Snow, 2020).*

*The difficulties that a child experiences in areas such as language, cognition and learning can impact on academic success and behavioural self-regulation during the early years of schooling which can increase as the young person moves into high school. These difficulties can contribute to early separation from school due to academic difficulties or repeated histories of suspensions or exclusions from school.*

Some genetic diagnoses are linked to predictable behavioural difficulties (behavioural phenotypes). Examples include:

* Children with Prader-Willi syndrome never feel full, so will often demonstrate high levels of food seeking behaviours. Mental health difficulties are common.
* Children with Smith-Magenis syndrome may have sleep difficulties and high rates of self-injurious behaviour.

While every child and young person with a disability is different, understanding their diagnosis, and common difficulties linked to that diagnosis is important to help identify appropriate supports.

**Practice Prompt**

*Refer to the procedure Support a child in care, Meet a child health and wellbeing needs,* [*Respond to a child’s disability needs*](https://cspm.csyw.qld.gov.au/procedures/support-a-child-in-care/meet-a-child-s-health-and-wellbeing-needs#Respond_to_a_child_s_disability_needs) *for more information about how to access supports including the National Disability Insurance Scheme.*

*The* [*Disability*](https://cspm.csyw.qld.gov.au/practice-kits/disability) *practice kit has further practical information about working with children and young people with a disability*.

## Health

Underlying health conditions can contribute to a child or young person’s behaviour or developmental delays. An example is if a child experiences hearing loss. If the child has a hearing loss, when they don’t follow an instruction, people may see this as the child being ‘non-compliant’. It might be that the child did not hear what was said to them. When there is a focus on the ‘behaviour’ the safety and support network may miss the underlying health cause that can be easily monitored and treated.

**Note**

*Aboriginal and Torres Strait Islander children experience high rates of middle ear infections which can impact on their ability to hear what is said to them. If this occurs during critical periods of time for language development, the persistent middle ear infections may contribute to communication delays. Those around the child or young person may say that they are ‘not listening’ when it is because they do not hear what is said to them and/or they may not understand what is said to them. Regular hearing assessments can be useful to support early identification of middle ear infections and support access to appropriate treatment as needed.*

Research demonstrates that children and young people with disabilities experience common health conditions such as epilepsy, constipation, reflux, poor dental hygiene all of which can be easily monitored and treated. These health conditions can contribute to challenging behaviour if the child or young person cannot tell you that they are unwell. Treating these health conditions is an important part of responding to a child’s challenging or high risk behaviour and the delivery of positive behaviour support.

**Practice Prompt**

*It is important to assist children and young people to access comprehensive health assessments to support early identification and treatment of health conditions. There are many processes and supports to assist this.*

*The* [*Child health passports*](https://cspm.csyw.qld.gov.au/resources/resource/Child-health-passports/da11f35c-fab0-494a-afd9-5854bd097451) *practice guide contains information that carers need to meet the day-to-day health needs of the child or young person. Refer to the procedure Support a child in care, , Meet a child health and wellbeing needs, Develop a child health passport for more information.*

*Navigate Your Health is a partnership between the department (Child Safety and Youth Justice) and Children’s Health Queensland Hospital and Health Service and is currently available in three regions (and 10 Child Safety Service Centres).*

*Navigate Your Health provides children and young people, subject to an interim or finalised child protection order granting custody or guardianship to the chief executive, with improved access to health checks, referrals and health care coordination support. The Navigate Your Health model is supported by dedicated Nurse Navigator positions, who take a lead role in supporting children and young people referred to the program. The Navigators work across Child Safety and Youth Justice Service Centres and in partnership with General Practices, Hospitals, Aboriginal Medical Services and other community health centres, as required.*

*The Navigate Your Health model is informed by the National Clinical Assessment Framework (NCAF) for children and young people in out of home care. The NCAF was developed to guide the improvement of the range and consistency of responses to meeting the health needs of children and young people in care across Australia.*

Health conditions are also important to understand in the context of strategies that may be used to support a child or young person’s behaviour. Health conditions can influence a child or young person’s individual risk of injury during a physical restraint. Health considerations (Perry et al) to be mindful of when undertaking crisis management planning can include:

* respiratory conditions such as asthma
* weight, particularly if overweight
* musculoskeletal problems, for example, scoliosis or lax joints (for example, Ehlers Danlos Syndrome)
* heart conditions, for example, structural changes in the heart or heart arrythmia
* epilepsy
* medications and potential side effects of medications.

There is more information about these considerations in the ‘Managing high risk behaviour’ section of this resource.

## Aboriginal and Torres Strait Islander Health

The then National Aboriginal and Islander Health organisation developed the following definition health from an Aboriginal and/or Torres Strait Islander perspective, “Aboriginal health does not mean the physical wellbeing of an individual, but refers to the social, emotional, and cultural wellbeing of the whole community. For Aboriginal people this is seen in terms of the whole-life-view” (Dudgeon, Milroy & Walker, 2014).

This holistic understanding of health and well-being involves the whole community throughout the entire life course. The Aboriginal and Torres Strait Islander concept of health includes mental and physical health, and cultural and spiritual health. Connection to community and country, water/sea, and sky is central to wellbeing.

Aboriginal and Torres Strait Islanders experience health inequalities that lead to poor health and shorter life expectancy. This can then impact on other areas of life including education, employment ad contact with the justice system. Health inequalities exist due to immediate social disadvantage experienced by many Aboriginal and Torres Strait Islander families as well as the impact of intergenerational trauma.

In rural and remote communities, families may have limited access to health workers and services. This creates additional challenges to meeting health needs.

**FURTHER INFORMATION**

[*Closing the Gap*](https://healthinfonet.ecu.edu.au/learn/health-system/closing-the-gap/) *is a strategy that aims to improve the life outcomes of Aboriginal and/or Torres Strait Islanders. It is a formal commitment made by all Australian governments to achieve health equality for Aboriginal and/or Torres Strait Islander people.*

**IMPORTANT**

*It is important to support the health and wellbeing of Aboriginal and/or Torres Strait Islander children and young people. This includes ensuring they access comprehensive physical and mental health assessments and supports, particularly from culturally appropriate services.*

*There are a number of Aboriginal Medical Services through Queensland that provide ongoing support and care for children and young people and their families. Contact these organisations for more information about the supports that they can offer.*

An understanding of culture is important to guide assessment and supports of physical and mental health for Aboriginal and/or Torres Strait Islander children and young people (Dudgeon et al, 2014). It is important to consider whether the behaviours of the young person are culturally appropriate in the context they occur or whether they reflect signs of a mental health disorder (Dudgeon et al, 2014; Westerman, 2021). This then influences the supports offered to support healing and recovering which may include cultural and traditional healing methods, clinical therapeutic approaches or a combination of both (Dudgeon et al, 2014; Westerman, 2021).

**FURTHER INFORMATION**

*The* [*Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*](https://www.telethonkids.org.au/our-research/early-environment/developmental-origins-of-child-health/expired-projects/working-together-second-edition/) *resource provides more information on holistic models of care to support social and emotional well-being.*

## Social-emotional difficulties and mental health

Research tells us that children in care experience significantly poorer mental health outcomes than children who have never been in care. The experiences of children in care, both prior to and during their time in care can make them more vulnerable to the development of mental health difficulties or mental illness. The emergence and development of mental health difficulties and mental illness though is complex, and is affected by a combination of biological, psychological, and social factors.

These following links provide general information about mental illness difficulties young people may be experiencing:

* anxiety: [Youthbeyondblue](https://www.beyondblue.org.au/who-does-it-affect/young-people/mental-health-issues)
* depression: [Youthbeyondblue](https://www.beyondblue.org.au/who-does-it-affect/young-people/mental-health-issues)
* understanding the effect of cannabis on mental health: [headspace](https://www.headspace.org.au/young-people/understanding-cannabis-for-young-people/)
* understanding the effect of alcohol on mental health: [headspace](https://headspace.org.au/young-people/how-does-alcohol-affect-mental-health/)
* understanding post-traumatic stress disorder: [headspace](https://headspace.org.au/young-people/understanding-post-traumatic-stress-disorder/)
* understanding psychosis: [headspace](https://www.headspace.org.au/young-people/understanding-psychosis-for-young-people/)
* bullying and cyberbullying: [Youthbeyondblue](https://www.youthbeyondblue.com/understand-what's-going-on/bullying-and-cyberbullying)
* eating disorders and body image issues: [The Butterfly Foundation](https://thebutterflyfoundation.org.au/understand-eating-disorders/)

Of note, a significant minority of children in care will experience complex psychological and behavioural problems. For example, “in their 2005 study, Tarren-Sweeny and Hazell reported that children presented with complex disturbances, including conduct problems and defiance, attachment insecurity and disturbance, attention deficit/hyperactivity, trauma-related anxiety and inappropriate sexual behaviour. In their 2006 study using the same sample, a quarter of the children were found to display clinically significant eating problems” (Osborn & Bromfield, 2007).

As described by the Australian Childhood Foundation, trauma causes behaviours that challenge. “Trauma is the emotional, psychological and physiological reactions caused by the prolonged and overwhelming stress that accompanies experiences of abuse, neglect and family violence” (Bristow, Macnamara, & Mitchell, 2020, p. 8). These reactions can sometimes be referred to or thought of as mental health difficulties. Sometimes a child or young person can develop a mental illness that is related to their trauma, like a reactive attachment disorder, post-traumatic stress disorder, or an emerging personality disorder or vulnerabilities. Sometimes a child or young person will not be diagnosed with a mental illness, though they will have significant mental health concerns. See The dual continuum of mental health and mental illness section in the [Overview of mental health](https://cspm.csyw.qld.gov.au/practice-kits/mental-health/overview-of-mental-health-1) of the Mental health practice kit, for more information on this distinction.

For more information about Evolve, please refer to the procedure *Support a child in care, Meet a child health and wellbeing needs,* [*Refer a child to Evolve*](https://cspm.csyw.qld.gov.au/procedures/support-a-child-in-care/meet-a-child-s-health-and-wellbeing-needs#Respond_to_a_child_s_disability_needs).

## Self-harm

“Self-harm involves deliberately harming oneself physically by cutting, burning, hitting, scratching, biting, or consuming harmful substances. Self-harm might be used to try and control difficult and overwhelming feelings or to gain relief from emotional pain. It may also be used to express anger, to feel ‘something’ or to communicate a need for help” (Project Air). Other definitions of self-harm are broader, and refer to sets of behaviour that have pain or self-injury as the intended outcome like self-maiming, risk-taking and substance abuse (Cameron, McPherson, Gatwiri, Macnamara, & Parmenter, 2020, p. 3).

**PRACTICE PROMPT**

*Evolve Therapeutic Services (Evolve) is a collaborative partnership between the department (Child Safety) and Queensland Health. Evolve’s multidisciplinary clinical teams provide specialist intensive therapeutic interventions for children in care with severe and complex mental health support needs.*

It is important to develop and create self-harm risk management plans, alongside and in partnership with the child or young person, that include monitoring and checking for safety. It is equally important to note that the immediate aim or response is not necessarily to stop a child or young person from self-harming, though this may be the longer-term goal through focus on relieving underlying distress. In developing a plan that is responsive and sensitive, it is important to partner with the child or young person, the care team or safety and support network, and any mental health and other professionals who are involved.

**PRACTICE PROMPT**

*The Ed-LinQ Program was established to improve linkages and service integration between the education sector, primary care, community and mental health sectors. Ed-LinQ works with schools and service providers to facilitate early access to mental health advice. More information about the program and resources can be found on the* [*Ed-LinQ website*](https://www.childrens.health.qld.gov.au/service-statewide-ed-linq-program/)*.*

**ATTENTION**

*A young person may use self-harm to manage their distress without ideas of suicide. However, self-harm is a risk factor for suicide.*

## Suicide

Suicide is the act of deliberately killing oneself (WHO, 2014). The term ‘suicidal behaviour’ can encompass a broad variety of concepts, including suicidal ideation and thoughts, suicidal plans and attempts, and suicidal death.

Children with a history of child protection involvement or a care experience are at an increased risk of suicide. These young people can be up to four times more likely to die by suicide than those with no child welfare involvement (Trew, Russell, Higgins, & Stewart, 2020, p. 9).

**FURTHER READING**

*For further information regarding self-harm and suicide, see:*

* [*Practice Guide: Responding to behaviours that challenge*](https://cetc.org.au/app/uploads/2021/03/CETC-Practice-Guide-Behaviours-the-Challenge.pdf)
* [*Research Brief: Preventing self-harm among young people in out-of-home care*](https://cetc.org.au/app/uploads/2020/12/Research-briefing-Preventing-self-harm-among-young-people-in-out-of-home-care-Nov-2020.pdf)
* [*Understanding and Supporting Young People Who Self-Harm in Residential Care*](https://cetc.org.au/blog/understanding-and-supporting-young-people-who-self-harm-in-residential-care/)*.*

## Trauma informed support

The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies 4 assumptions with regards to trauma informed care including:

* Realisation of the widespread impact of trauma and paths to recovery
* Recognises the signs and symptoms of trauma in individuals
* Responds by fully integrating knowledge about trauma into supports
* Resist re-traumatisation – actively resists re-traumatisation when providing supports to individuals.

These concepts extend not only to the child or young person, but those who are supporting them on a day to day basis. When a trauma-informed lens is used, the behaviour can be seen in the context of the trauma the child or young person has experienced (recognise). The safety and support network can use the knowledge of the child or young person’s trauma history to ensure that strategies to manage their high risk behaviour do not cause further trauma (resist re-traumatisation).

**IMPORTANT**

*When working with Aboriginal and/or Torres Strait Islander children, young people and their families it is important to recognise the impact of intergenerational trauma and provide support in a way that does not re-traumatise or cause further trauma.*

## Trauma informed care environments

In Queensland, Peak Care has developed the Hope and Healing Framework for working with children and young people living in residential care. This describes the foundation for caring and working with children and young people living in care.

Many of the fundamentals of working with children and young people in this document are consistent with aspects identified in being child centred.

**FURTHER READING**

*More information about the* [*Hope and Healing Framework*](https://peakcare.org.au/hopehealing/introduction/) *including information about training can be found on the PeakCare website.*

*The Queensland Foster and Kinship Care website has a number of useful links in their* [*General resource*](https://www.qfkc.com.au/resources/general-resources) *section. Please see the section ‘Sarah McMurtie’s articles, tips and ideas to support carers, parents, caseworkers and teachers’*

## Understanding the child or young person’s trauma history

Trauma can be the result of a single frightening or unsettling event. For children and young people involved with the department, it is more likely that they will have experienced complex trauma established throughout their early childhood. This is often the result of ongoing exposure to physical and emotional abuse and neglect. Exposure to domestic and family violence, parental drug use, parental mental health, and generally not receiving the basic support to grow physically and emotionally strong can result in a young person who has grown to be afraid and untrusting of the world around them. The result is a young person who is unable to express distress in a way which is easily understood by people who are trying to care for them. The obstacles to these young people being able to form trusting relationships on which to move confidently into the future can include:

* Poor self-regulation.
* Negative thinking with a lack of ability to conceptualise a positive future.
* Hypervigilance.
* Lack of modelling during childhood of respectful, mutual relationships, and how to negotiate complexities of these relationships.

Exploring the themes and patterns around a young person’s trauma history will assist in establishing the types of negative experiences the child or young person has had, and at what developmental stage these experiences have occurred, as the effects of ongoing trauma experiences are cumulative. Children who have experienced harm through abuse and neglect have missed out on the opportunity to develop an early template or model that shows them they can trust and rely on adults to care and nurture, and have instead developed an understanding of the world which is centred on a need to stay on high alert to people and situations which pose a risk to their safety and wellbeing. Sustained or frequent activation of the internal systems, such as continual production of adrenaline and cortisol in response to stress, results in serious developmental consequences, some of which can last beyond when the threat is no longer there. For children and young people, high and sustained levels of these hormonal system responses impact on the development of regions of the brain linked to learning, memory and the development of self-regulation.

Research has shown that a child or young person who has reliable, safe, and engaging relationships both at home and in [out-of-home] care can buffer the effects of multiple stressors that may exist in his or her life *(*[*Excessive Stress Disrupts the Architecture of the Developing Brain*](https://46y5eh11fhgw3ve3ytpwxt9r-wpengine.netdna-ssl.com/wp-content/uploads/2005/05/Stress_Disrupts_Architecture_Developing_Brain-1.pdf)*)*

The importance of holding the impacts of trauma in mind whilst case planning for a child or young person, including developing responses to externalising and internalising trauma behaviours, is an important step. Trauma and its impact on a child’s behaviour, sits alongside other considerations such as developmental stage, intellectual or other impairments, as well as individual child circumstance. Responses should be continually reviewed for relevance and how supports best lead to a child being able to form positive relationships with others and walk a similar path into adulthood as their peers, despite being impacted by trauma in their early childhood. Refer to [Trauma-Informed practice with Young People in Foster Care](https://assets.aecf.org/m/resourcedoc/jcyoi-IssueBrief5TraumaInformedPractice-2012.pdf#page=4) for more information.

When the child or young person’s trauma history is understood, the safety and support network can start to consider whether strategies to manage their child or young person’s high risk behaviour may trigger painful memories or retraumatise the child or young person (SAMSHA, 2014). Some examples include:

* For a child or young person who experienced physical or sexual abuse, how might they experience physical restraint?
* For a child or young person who has been neglected or abandoned how might they experience time out or seclusion?

# **Appendix 3: Positive behaviour support plans**

## What is in a positive behaviour support plan?

A positive behaviour support plan should include an assessment to understand why the child or young person demonstrates the challenging or high-risk behaviour. It will also consider other factors including physical health, mental health, likes and dislikes, communication and sensory needs and trauma history.

Understanding the function helps to develop effective strategies to support the child or young person. Within the positive behaviour support plan there should be a gradient of strategies to assist the child or young person when they are calm, early in an escalation, and at the point of crisis. Teaching new skills is an important part of a positive behaviour support plan.

It is important that the child or young person is involved in the development and implementation of a positive behaviour support plan.

## Time intensity model

Kaplan & Wheeler created the time intensity model which details the 5 stages of physical aggression. These include:

1. Baseline
2. Trigger
3. Escalation
4. Crisis
5. Remorse and Recovery.

A strong positive behaviour support plan will develop a gradient of approaches to support the child or young person through these stages.

## Primary strategies

Primary strategies are those that can always be used with all children and young people. These are the strategies that:

* used when the child or young person is calm.
* help create environments and relationships that meet the child or young person’s needs to minimise triggers
* support skill development.

A useful framework to help the safety and support network is capable environments. These are environments that have been created to support children and young people effectively by providing the best settings for positive interactions and opportunities. It is a holistic approach that supports the child or young person’s quality of life.

Features of capable environments include:

* Skilled support
* Positive interactions
* Communication
* Meaningful activity
* Predictable routines
* Choices
* Relationships
* New skills
* personal and health needs (physical and mental health)
* Physical environments

**FURTHER INFORMATION**

*This short video by Redstone PBS talks more about* [*Capable Environments*](https://www.youtube.com/watch?v=zGavAZ-xAI8)*.*

When the safety and support network use this framework, they can identify ways to change the environment (physical and relational) to meet the child or young person’s needs. It also ensures that the child or young person’s communication, sensory, physical and mental health needs are identified and met.

An important part of positive behaviour support plans is skill development. This includes short term skills such teaching a child or young person another way to communicate the function of the behaviour. It will also include medium and longer term goals. This includes learning to wait, emotional regulation or learning how to do an activity by themselves.

The best time for children and young people to learn new skills is when they are calm. No one learns when they are at crisis as they are working in the lower part of their brains. Carer’s are not good teachers at the time of crisis for the same reason.

**TIP**

[*Dan Siegel’s*](https://www.youtube.com/watch?v=gm9CIJ74Oxw) *hand model explains why crisis is not a good time to try to teach new skills.*

*It is important that skills are achievable in the context of the child or young person’s current development. It is useful for the Safety and Support network to share the best ways and what support the child or young person needs to learn the new skill.*

## Secondary strategies

The aim of secondary strategies is to reduce the risk of the situation and prevent the behaviour escalating to crisis (Ridley & Leitch, 2020). They are used when there are early warning signs of high risk behaviour – in the early stages of the escalation phase. The strategies aim to remove or reduce the underlying cause of the behaviour including pain, distress, or frustration. Secondary interventions involve individualised de-escalation strategies.

Secondary strategies help to respond to behaviour when it presents low risk to the child or others. This is best for everyone.

**IMPORTANT**

*Sarah is a 7 year old girl. Since waking up, Sarah has been agitated. She has calling other children names and swearing at the carer and not participating in the morning routine. The carer notices that Sarah is pulling her ear. The carer knows this can be a sign that Sarah has an ear infection. If Sarah is in pain, she is more likely to demonstrate physical aggression to others. The carer asks Sarah if her ear hurts and Sarah says yes. The carer provides Sarah with some Panadol and arranges a doctor appointment.*

## Non-aversive reactive strategies

Effective primary and secondary strategies may not be enough to stop the challenging or high risk behaviour. The aim of non-aversive reactive strategies is to bring about safety for everyone at the point of crisis. They are used when the child is demonstrating the challenging or high risk behaviour. Non-aversive reactive strategies include individualised de-escalation strategies. These can include distraction, diversion or meeting the child’s needs.

Non-aversive reactive strategies should be used before a more restrictive strategy such as the emergency use of a restrictive practice.

**IMPORTANT**

*John is a 9 year old boy with Foetal Alcohol Spectrum Disorder (FASD). He has just moved into a new placement. John has been escalated all morning. His carers have been following strategies in his positive behaviour support plan. Despite this, John has started to demonstrate property damage and is kicking walls and leaving marks. The carers know that distraction can be useful when John is demonstrating challenging behaviour. They start to silly dance near him. John stops the property damage and after a short period of time joins the carers in dancing. John starts to return to baseline and eventually engages back into activities in the house.*

## Who can write a positive behaviour support plan?

When children and young people demonstrate mainly low and medium risk behaviours, the safety and support network can problem solve how to best support their behaviour.

**PRACTICE PROMPT**

*For children who demonstrate mainly low and medium risk behaviour case management tasks such as case planning and the child strengths and needs assessment can be used to monitor and review the child or young person’s behaviour.*

When a more structured positive behaviour support plan is required, this should be developed by a clinician or professional with the appropriate capabilities. Children and young people may need support from other professionals in areas like communication, sensory needs, emotional self-regulation. These professionals can include a speech pathologist, occupational therapist or a mental health clinician.

For children and young people who have NDIS plans, ensure that there is funding in the NDIS plan for a positive behaviour support plan. This should include funding for the development of the positive behaviour support plan and training to carers on how to implement the plan. If another allied health professional is required, make sure there is enough funding for these clinicians.

When children and young people have an NDIS plan, the plan should include funding for the development of the positive behaviour support plan and training to carers on how to implement the plan, if required. If another allied health professional is required, this can also be funded by the NDIS.

When a residential provider has funding as a therapeutic residential or employs their own clinicians, the positive behaviour support plan can be developed by the service.

For other children, funding might need to be sought through individual placement and support packages funding to engage a clinician to develop a positive behaviour support plan.

# **Appendix 4: Understanding safeguarding**

## Working together to manage risk (safeguarding)

For some children and young people, a practice is identified as a restrictive practice and it cannot be immediately stopped. The safety and support network must work together to understand the practice and work towards reduction and elimination.

If the practice cannot be immediately stopped, then an escalation process occurs to ensure there is appropriate noting that safety and support network is working outside of policy for a period of time to manage high risk behaviours. When this happens the safety and support network must still work to reduce and eliminate the practice/s.

## Collaborative discussions

When a strategy is identified as a potential restrictive practice the safety and support network must work together to understand the situation. The values of the Strengthening Families, Protecting Children Framework for Practice are the foundation of this work including:

* Family and community connection
* Participation
* Partnership
* Cultural integrity
* Strenghts and solutions
* Fairness
* Curiousity and learning.

Within the safety and support network the following key points need to be considered:

* What is the strategy and why is it being used? It is important for everyone to understand what the strategy is and why it is being used. For example, a car harness in a car could be used for postural support or in response to a child’s behaviour - the safety and support network must be clear why it has been recommended.
* How is the strategy understood in the context it is being used?
  + Is the strategy being used in the home, residential or community?
  + How old is the child? Some practices may be considered appropriate child proofing strategies or parenting response to keep the child safe.
  + How is the strategy understood in relevant departmental policies? This can include licencing.
  + When a plan is developed through the NDIS:
    - How is the strategy considered under the NDIS Quality and Safeguards Framework?
    - Are there any core funded supports that are using the strategy?
* What is the risk?
  + Does the safety and support network understand the risk of the behaviour? What does the information and behavioural data tell us?
  + What are the associated risks to be considered in the use of the strategy? This can include individual risk factors for the child or young person such as trauma history. What is the risk of the strategy that is being used?
* What is the plan to reduce and eliminate the practice?
  + As part of risk management, the safety and support network must always think about how to do things differently to reduce and eliminate the practice.
* How will the reduction and elimination be monitored?
  + During visits by the CSO?
  + In safety and support network meetings?
  + In case planning processes and through the completion of the child strengths and needs assessment?
  + How will this be captured in placement agreements?

In these discussions, the safety and support network may identify that further information is needed to answer these questions. This may involve bringing other supports into the safety and support network, for example, allied health provider such as an occuptational therapist.

**PRACTICE PROMPT**

*It is important to consider how to capture these discussions in case notes and within processes such as case plans, child’s strenghts and needs assessment and placement agreements.*

## Escalation and safeguarding

There may be times where a practice that is identified as a prohibited or restrictive practice cannot be stopped immediately. An example is that medication may take some time for a planned reduction to occur. In this situation the department has an escalation process where the Director-General notes that work with the child is occurring outside of the Positive Behaviour Support and Managing high risk behaviours policies.

**IMPORTANT**

*This process is not a formal authorisation process for the use of restrictive practices. It is a noting that based on the work of the safety and support network that the current risk assessment process shows that these strategies cannot be immediately ceased. The noting allows the use of structured positive behaviour support and ongoing risk assessment by the safety and support network to reduce and eliminate the strategy.*

## Monitoring and review

Once the Director-General has noted the use of prohibited or restrictive practices for a child or young person, the safety and support network will determine the appropriate monitoring and review process, as outlined in the procedure, Support a child in care, Respond to a child’s health and wellbeing, Respond to the use of prohibited or restrictive practices for a child in the guardianship of the chief executive.

## Standards of care

The statement of standards sets out the standards of care for children in care (*Child Protection Act 1999*, section 82(1)). They are based on reasonable and widely held community expectations about the quality of care children require.

While the formal safeguarding and escalation process allows the noting for the acting outside of Positive Behaviour Support and Managing high risk behaviour policies, the standards of care still apply. If information is received indicating worries about the quality of care provided to the child or young person, including how their behaviour is supported, the department still has a responsibility to take appropriate actions if it indicated that the standards of care may not have been met for a child or young person or if a child or young person has experienced harm.

**PRACTICE PROMPT**

*The procedure Provide and review care, Support and monitor care outlines how to respond to any standards of care concerns that arise.*

# **References**

Baidawi, S., & Piquero, A.R., (2020). Neurodisability among Children at the Nexus of the Child Welfare and Youth Justice System. 20, 803-819 *Journal of Youth and Adolescence.* [https://doi.org/10.1007/s10964-020-01234-w](https://doi.org/10.1007/s10964-020-01234-w%20)

Bower, C., Watkins, R., E., Mutch, R. C., Marriott, R., Freeman, J., Kippin, N. R., Safe, B., Carmela, P., Cheung, C. S. C., Shield, H., Tarrat, L., Springall, A., Taylor, J., Walker, N., Argiro, E., Leitao, S., Hamilton, S., Condon, C., Passmore, H., Giglia, R. (2017). Fetal alcohol spectrum disorder and youth justice: a prevalence study among young people sentenced to detention in Western Australia. *BMJ Open.* [doi: 10.1136/bmjopen-2017-019605](https://bmjopen.bmj.com/content/8/2/e019605.info)

Bristow, G., Macnamara, N., & Mithcell, J. (2020). Practice Guide: Responding to behaviours that challenge. Sydney: Centre for Excellece in Therapeutic Care. Retrieved from [CETC-Practice-Guide-Behaviours-the-Challenge.pdf](https://cetc.org.au/app/uploads/2021/03/CETC-Practice-Guide-Behaviours-the-Challenge.pdf)

Burke, N. J., Hellman, J. L., Scott, B. G., Weems, C. F., & Carrion, V. G. (2011). The impact of adverse childhood experiences on an urban pediatric population. *Child abuse & neglect*, *35*(6), 408–413. <https://doi.org/10.1016/j.chiabu.2011.02.006>

Carr, E. G., Dunlap, G., Horner, R. H., Koegel, R. L., Turnbull, A. P., Sailor, W., Anderson, J. L., Albin, R. W., Koegel, L. K., & Fox, L. (2002). Positive Behavior Support: Evolution of an Applied Science. *Journal of Positive Behavior Interventions*, *4*(1), 4–16. <https://doi.org/10.1177/109830070200400102>

Cameron, N., McPherson, L., Gatwiri, K., Macnamara, N., & Parmenter, N. (2020). Research Brief: Preventing self-harm among young people in out-of-home care. Sydney, NSW: Centre for Excellence in Therapeutic Care. Retrieved from [Research-briefing-Preventing-self-harm-among-young-people-in-out-of-home-care-Nov-2020.pdf (cetc.org.au)](https://cetc.org.au/app/uploads/2020/12/Research-briefing-Preventing-self-harm-among-young-people-in-out-of-home-care-Nov-2020.pdf)

Dew, A., Jones, A., Cumming, T., Horvat,.K., Dillon Savage, I., & Dowse, L. (2017). Understanding Behaviour Support Practice: Children and Young People (9-18 years) with Developmental Delay and Disability. UNSW Sydney. [Intellectual Disability Behaviour Support Program Resources | Arts, Design & Architecture - UNSW Sydney](https://www.arts.unsw.edu.au/our-research/research-centres-institutes/research-networks/intellectual-disability-behaviour-support-program/intellectual-disability-behaviour-support-program-resources)

Dudgeon, P., Milroy, H., & Walker, R. (Eds.). (2014). Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. (2nd ed.). Downloaded from [Working Together Second Edition (telethonkids.org.au)](https://www.telethonkids.org.au/our-research/early-environment/developmental-origins-of-child-health/expired-projects/working-together-second-edition/)

Felitti, V. J., Anda, R. F., Nordenburg, D., Williamson, D.F., Spits, A. M., Edwards, V., Koss, P. & Marks, J.S. (1998). Relationships of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine, 14 (4), 245-258.* <https://doi.org/10.1016/S0749-3797(98)00017-8>

Nunno, M., Holden, M.J., & Tollar, A. (2006). Learning from tragedy: A survey of child and adolescent restraint fatalities*. Child Abuse and Neglect, 30, 1333-1342*

Osborn, A., & Bromfield, L. (2007). Outcomes for children and young people in care. Australia: Child Family and Community Australia. Retrieved from [Outcomes for children and young people in care | Child Family Community Australia (aifs.gov.au)](https://aifs.gov.au/cfca/publications/outcomes-children-and-young-people-care)

Perry, D., White, G., Norman, G., Marston, G., & Auchoybur, R. (2006). Risk Assessment and the use of restrictive physical intervention in adults with a learning disability. *Learning disability Practice*, 9(6), 30-36.

Project Air. (n.d). Self -harm: How to respond. Wollongong: University of Wollongong. Retrieved from [uow225923.pdf](https://documents.uow.edu.au/content/groups/public/@web/@ihmri/documents/doc/uow225923.pdf)

Substance Abuse and Mental Health Services Administration. (2014). SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach. Rockville, MD: Substance Abuse and Mental Health Services Administration. Downloaded from [SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach](https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf)

Snow, P., McLean, E., & Frederico, M. (2020). The language, literacy and mental health profiles of adolescents in out-of-home care: An Australian sample. *Child Language Teaching and Therapy*, *36*(3), 151–163. <https://doi.org/10.1177/0265659020940360>

Trew, S., Russell, D., Higgins, D., & Steward, J. (2020). Effective interventions to reduce suicidal thoughts and behaviours among children in contact with child protection and out-of-home care systems – a rapid evidence review. Institute of Child Protection Studies, Australian Catholic University. <https://doi.org/10.26199/5f1771a5a6b9e>

Westerman, T. (2021). Culture-bound Syndromes in Aboriginal Australian populations, Clinical psychologist. [DOI: 10.1080/13284207.2020.1843967](https://indigenouspsychservices.com.au/wp-content/uploads/2021/03/Culture-bound-syndromes-in-Aboriginal-Australian-populations.pdf)