Key Benefits of Positive Behaviour Support | Bloom Healthcare

Canonical:
https://bloom-healthcare.com.au/blog/understanding-positive-behaviour-support-for-adults-and-children/

Details:

Positive behaviour support (PBS) is the same discipline whether the person is four or forty-four. The assessment logic, the regulatory rules and the goal of a better everyday life do not change with age. What changes is who gives consent, who the plan has to work for, where it has to work, and which part of the NDIS pays for it. For a child, the plan is built around parents, early learning and school. For an adult, it is built around the person's own decisions, their home, their work or day program, and their paid support team. This page sets out those differences so you know what to expect before you start.

If you want to talk it through, call Bloom Healthcare on 1300 771 465 or use the referral form on this site. You do not need a GP referral for behaviour support under the NDIS, and NDIS participants can refer themselves.

The parts that are identical at every age

Four things hold no matter how old the person is.

Behaviour is treated as communication, not as a problem to be stopped. A functional behaviour assessment is defined by the NDIS Quality and Safeguards Commission as the process for determining and understanding the function or purpose behind a person's behaviour. That means collecting data, observing, and building an understanding of the events and circumstances that trigger and maintain a behaviour, then setting that understanding in the wider context of the person's life. A four-year-old who hits at pick-up time and a thirty-year-old who leaves the room when a support worker arrives are both telling you something. The method for working out what is the same.

The plan must be written by a practitioner the NDIS Commission considers suitable. An NDIS behaviour support practitioner is a person the Commission considers suitable to carry out behaviour support assessments, including functional behavioural assessments, and to develop behaviour support plans that may contain restrictive practices. Suitability is assessed against the Positive Behaviour Support Capability Framework through a self-assessment process. A specialist behaviour support provider must engage a suitable practitioner to write the plan, and this applies to plans that do not contain a restrictive practice as well.

The timeframes are the same. An interim behaviour support plan is developed within one month of the provider being engaged. A comprehensive plan, built on the functional behaviour assessment, is developed within six months of engagement. Engagement runs from the date of the service agreement, or from a date named inside it. These timeframes formally apply to plans containing regulated restrictive practices, but the Commission treats them as the guide for all behaviour support plans, consistent with the NDIS Practice Standards and the NDIS Code of Conduct.

Plans are reviewed, not filed away. A comprehensive plan containing regulated restrictive practices is reviewed if the person's situation changes, and at least every twelve months while it is in force. Checking regularly whether the strategies are actually working is good practice for every plan.

What is different when the person is a child

Consent, and who signs

For a child, parents or legal guardians hold decision-making authority and give consent for assessment and for the plan itself. The child's own voice is brought in wherever it is developmentally possible, through choice-making, pictures, or simply watching what the child moves towards and away from, but the legal signature belongs to the parent or guardian. Even inside that framework, the provider still has to consult the family and other relevant people while the plan is being developed. Consent is not a form at the start; it is an ongoing conversation.

The plan has to survive contact with school

A child's plan lives in at least three places: home, school or early learning, and the community. School is not an add-on. Strategies are designed with the classroom in mind, and the practitioner works directly with teachers and education support staff so that the same approach is used in the playground, at the desk and at home. If a strategy only works in one of those settings, it will not hold.

This is why a child's plan puts so much weight on building the capability of the adults around them. Parents, carers, teachers and education assistants are the people who will use the strategies dozens of times a week. The practitioner may be there once a fortnight. Capacity building for a child is therefore largely capacity building for the family and the school.

Children under 9 and the early childhood approach

Children under 9 with developmental delay or disability are supported through the NDIS early childhood approach rather than the standard pathway. The age limit was extended from under 7 to under 9 from 1 July 2023, phased in progressively over the following two years. Families work with an early childhood partner and a key worker who coordinates support, rather than with a local area coordinator. For children younger than 6 with developmental concerns, a formal diagnosis is not required to get early support.

Under this model, behaviour support usually arrives as part of a team rather than as a standalone service. The key worker coordinates, and a behaviour support practitioner is brought in when the behavioural need calls for that specific expertise, alongside occupational therapy, speech pathology, physiotherapy or psychology. Sessions happen where the child already spends time, so home, childcare, kindergarten and the local park do more work than a clinic room.

Extra safeguards where children are concerned

The NDIS Commission has published guidance specifically on regulated restrictive practices with children and young people with disability, including an Easy Read version and a practice guide. That separate guidance exists because children are recognised as needing additional protection. If anyone proposes a restrictive practice for a child, that specialised guidance is the reference point, and the ordinary authorisation rules below still apply in full.

What is different when the person is an adult

Capacity, guardianship and self-advocacy

An adult with decision-making capacity consents for themselves. That is the default and the starting assumption. Some adults have formal guardianship or supported decision-making arrangements in place, and those vary between people and between states, so the practitioner has to establish who holds which decision before assessment begins. Where an adult makes their own decisions,

self-advocacy stops being a nice extra and becomes a core skill the plan actively builds: saying what you need, saying what you do not want, and being heard.

A different set of settings and a different support team

Adult plans have to work in supported independent living or the person's own home, in employment or a day program, and in the community. Family may still be involved, and often is, but the people implementing the plan day to day are frequently paid support workers on a roster. That changes the training problem. A family of three learns a strategy once; a roster of support workers across three shifts needs the strategy written plainly, taught repeatedly, and checked. Consistency across a rotating team is the single biggest practical difference between adult and child plans.

Goals look different

Children's goals tend to be framed around development, participation in ordinary childhood activities, and readiness for what comes next. Adult goals sit around autonomy and quality of life: community participation, meaningful work or activity, independence in daily living, social connection, and personal aspirations the person names themselves. The measure of a good adult plan is not a quieter person. It is a person with more choices.

Funding: which part of an NDIS plan pays for this

Specialist behaviour support is a capacity-building support, funded under Improved Relationships . To use it, that funding has to be in the plan. It covers the functional behaviour assessment, development of the behaviour support plan, training and implementation support for the people around the person, and work to reduce or remove regulated restrictive practices.

For children under 9 in the early childhood approach, behaviour support is generally accessed through the early childhood partner and key worker arrangement rather than by the family sourcing it independently. For everyone from 9 upward, the participant, their support coordinator or their plan manager arranges it directly, and how it is claimed depends on whether the plan is self-managed, plan-managed or NDIA-managed.

How many hours sit in a plan varies with individual circumstances and is set by the NDIA, not by a provider. If Improved Relationships funding is not in the plan, or the amount does not match what the assessment shows is needed, that is a conversation for a plan reassessment. Bloom can supply the assessment and reporting that supports such a request, but cannot decide the amount. Fees and service terms are set out in the service agreement before any work starts.

Restrictive practices: the rules do not bend

Five categories of restrictive practice are regulated by the NDIS Commission: seclusion, chemical restraint, mechanical restraint, physical restraint and environmental restraint. Chemical restraint means medication used for the primary purpose of influencing behaviour, and it specifically excludes medication prescribed by a doctor to treat a diagnosed mental disorder, physical illness or physical condition.

Any regulated restrictive practice must be clearly written and stated, authorised by the relevant state or territory authorisation body, used as a last resort and for the shortest possible time, proportionate to the risk of harm, aimed at reducing that risk, and the least restrictive option available. It must sit inside a behaviour support plan written by a suitable practitioner. Authorised use is reported monthly to the NDIS Commission.

Authorisation processes differ between states and territories. Each jurisdiction has its own authorisation body, and the detail of their processes is a matter for them. If you need to know exactly what applies where you live, ask your practitioner or contact your state or territory authorisation body directly.

The point of naming a restrictive practice in a plan is to build the pathway out of it. Reduction and elimination are the objective, and the proactive strategies in the plan are what makes that possible.

How this differs from psychology, occupational therapy and speech pathology

People confuse these constantly, and the difference matters when you are choosing what to fund.

Psychology treats the person's mental health and internal experience. Occupational therapy works on doing daily activities, including sensory and environmental supports. Speech pathology builds communication and approaches the same problem from the language side. Positive behaviour support is the discipline that looks at the behaviour in its full context, works out what function it serves, and changes the environment and the skills so the behaviour is no longer needed. It is also the only one of the four that carries the regulatory responsibility for restrictive practices under the NDIS.

These are complementary, not competing. A child who hits when overwhelmed may need an occupational therapist for sensory strategies, a speech pathologist for a communication system, and a behaviour support practitioner to hold the whole picture together and write the plan. Bloom's practitioners work alongside occupational therapists , psychologists , speech pathologists and physiotherapists for exactly this reason.

Getting started

Bloom Healthcare delivers positive behaviour support across New South Wales, Queensland, South Australia, Tasmania, Victoria, Western Australia and the Australian Capital Territory. Services are mobile-first, so practitioners come to the home, school, day program or other community setting. Telehealth is available where travel is impractical or the person prefers it, which matters most for regional and remote areas.

To begin, use the referral form on this site, phone 1300 771 465, or email hello@bloom-healthcare.com.au. NDIS participants can refer themselves; families, support coordinators, GPs and schools can also refer.

Common questions about PBS for children and adults

Does my child need a diagnosis before behaviour support can start?

Not necessarily. For children younger than 6 with developmental concerns, a formal diagnosis is not required to access early support through the NDIS early childhood approach. What matters is that funding for the support is in place. Talk to your early childhood partner or call 1300 771 465.

At what age does a child move off the early childhood approach?

The early childhood approach covers children under 9. That was extended from under 7 from 1 July 2023 and phased in progressively over the following two years. From 9 onwards, support is arranged through the standard NDIS pathway with a local area coordinator.

Who has to agree to an adult's behaviour support plan?

The adult, if they have capacity to make that decision. Where a guardian or formal supported decision-making arrangement is in place, that arrangement determines who consents. Either way, the practitioner must consult the person, and their family or guardian and other relevant people, while developing the plan.

How long before we have an actual plan?

An interim plan is developed within one month of the provider being engaged, and a comprehensive plan within six months. Engagement dates from the service agreement or a date specified in it.

How often is a plan reviewed?

A comprehensive plan with regulated restrictive practices is reviewed whenever the person's circumstances change, and at least every 12 months. Reviewing more often is good practice for any plan, because the point is to check that the strategies are still working.

Can a behaviour support plan be used at school?

Yes, and for a school-aged child it usually has to be. Strategies are designed with the classroom in mind and teachers and education support staff are trained to use them consistently. School staff being part of the support network is normal, not exceptional.

What if a support worker or a school suggests restraint?

Any regulated restrictive practice must be authorised by your state or territory authorisation body, written into a behaviour support plan by a suitable practitioner, used as a last resort and for the shortest time possible, and reported monthly to the NDIS Commission. If restraint is being used without those things in place, that is not compliant. Raise it with the provider, and with the NDIS Commission if it continues.

Is PBS only for aggression or self-injury?

No. Behaviour support is equally about building communication, coping and daily living skills, and about changing environments so distress does not build in the first place. People access it to develop skills and increase participation, not only in response to a crisis.

Which NDIS funding category do I need?

Improved Relationships, within capacity building. If it is not in your plan, or the amount does not reflect what you need, raise it at your plan reassessment. Bloom can provide assessment and reporting to support that request.

Can you deliver this in a regional area?

Yes. Practitioners travel to homes, schools and community settings, and telehealth is available where distance makes regular visits impractical. Coverage and travel arrangements for your address can be confirmed on 1300 771 465.

Who can refer?

Anyone. NDIS participants can refer themselves, and families, support coordinators, plan managers, GPs, schools and other allied health professionals can refer as well. Use the referral form on this site or call 1300 771 465.

What is Positive Behaviour Support (PBS)?

Positive Behaviour Support (PBS) is a proactive, person-centered approach designed to improve quality of life by addressing the root causes of challenging behaviours. It is grounded in evidence-based practices and empowers individuals to live more fulfilling lives by focusing on their strengths, preferences, and goals.

What fields does PBS draw its principles from?

PBS integrates principles from psychology, education, and social work to develop holistic, person-centered strategies.

What are the underlying principles of PBS?

The underlying principles of PBS include being person-centered (focused on understanding the individual's needs, preferences, and goals), evidence-based (grounded in research and proven methodologies), proactive and preventative (emphasizing preventing challenging behaviours rather than reacting to them), and empowering (aiming to build skills that promote independence and self-determination).

How does PBS view challenging behaviour?

Rather than viewing challenging behaviour as simply a problem to be controlled, PBS recognizes that all behaviour serves a purpose and can be reduced if the underlying need is understood.

What factors can contribute to challenging behaviours according to the article?

Challenging behaviours can stem from biological factors (such as pain or discomfort leading to behaviours that communicate distress), psychological factors (such as anxiety or stress used as a coping mechanism), and social factors (such as lack of social interaction or communication skills, where challenging behaviour becomes a form of communication).

Who is this article about, and who can benefit from PBS?

The article addresses Positive Behaviour Support for both adults and children, noting that PBS is widely applicable, though the page content is limited on specifics of who benefits beyond indicating it applies broadly to adults and children.

Who publishes this article and what organization is behind it?

The article is published by Bloom Healthcare, a boutique disability and aged care allied health provider that focuses on evidence-based practice and client-centred care delivered by qualified health practitioners across Australia.

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