NDIS Quality and Safeguards Commission

Behaviour Support Assessment, including Functional Behaviour Assessment

Practice Guide

External use

Version 1.0, April 2026

NDIS Quality and Safeguards Commission

PO Box 210, Penrith NSW 2751

Copyright

Attribution and suggested citation

Use of all or part of this document must include the following attribution:

A suggested citation: NDIS Quality and Safeguards Commission (2026). Behaviour Support Assessment, including Functional Behaviour Assessment: Practice Guide. Penrith, Australia: NDIS Quality and Safeguards Commission.

Using the Commonwealth Coat of Arms

Terms of use for the Coat of Arms are available at the Department of Prime Minister and Cabinet website.

Important notice

The information in this practice guide is for general guidance only. It does not constitute legal or other professional advice, and should not be relied on as a statement of a law in any jurisdiction. You should obtain professional advice if you have any specific concern.

The NDIS Quality and Safeguards Commission has made every reasonable effort to provide current and accurate information, but it does not make any guarantees regarding the accuracy, currency, or completeness of that information.

Parties wishing to re-publish or otherwise use the information in this policy must check this information for currency and accuracy prior to publication. This should be done prior to each publication edition, as NDIS Quality and Safeguards Commission guidance and relevant legislation may change. Any queries should be addressed to communications@ndiscommission.gov.au.

Acknowledgements

The *Behaviour Support Assessment, including Functional Behaviour Assessment: Practice Guide* was developed by the NDIS Quality and Safeguards Commission in consultation with:

- National Disability Insurance Agency (NDIA)
- Representatives from the following state and territory agencies through the Senior Practitioners' Leadership Group:
  - Community Services Directorate, Australian Capital Territory
  - Department of Communities and Justice, New South Wales
  - Department of Health, Northern Territory
  - Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships, Queensland
  - Department of Human Services, South Australia
  - Department of Premier and Cabinet, Tasmania
  - Department of Families, Fairness and Housing, Victoria
  - Department of Communities, Western Australia
- National Disability Services Community of Practice members

Table of contents

1. Background

The NDIS Quality and Safeguards Commission (NDIS Commission) is an independent agency that exists to uphold the rights of people with disability and promote their health, safety, and wellbeing. The NDIS Commission is focused on developing a nationally consistent approach to quality and safeguarding for people with disability who receive supports and services under the National Disability Insurance Scheme (NDIS). In fulfilling this role, the NDIS Commission is committed to promoting, protecting, and ensuring the full and equal enjoyment of all human rights and fundamental freedoms by people with disability and promoting respect for their inherent dignity (United Nations, 2006). This includes providing leadership in behaviour support and the reduction and elimination of restrictive practices.

Behaviour Support, also referred to as Positive Behaviour Support (PBS), is a human rights and values-led approach. It includes an ongoing process of assessment, intervention, and data-based decision making. Behaviour Support focuses on skill building, creating supportive contexts through ecological and systemic change and reducing the likelihood and impact of behaviours of concern. It relies on person-centred, proactive and evidence-informed strategies that are respectful of a person's dignity and aim to enhance the person's quality of life. Behaviour Support draws primarily on behavioural, educational, and social sciences, although other evidence-based strategies may be incorporated. It can be applied within a multi-tiered framework at the level of the individual and at the level of larger systems (Adapted from Kincaid et al., 2016 and Leif et al., 2023).

The NDIS Commission routinely evaluates the quality of behaviour support plans. Results published in the Behaviour Support Plan Quality Snapshot 2025 highlighted that the mean score has remained relatively stable but continues to sit in the 'underdeveloped' range. This means that while most behaviour support plans are above the minimum threshold required to effect some change, they do not clearly embody best practice. Behaviour support assessment, including functional behaviour assessment (FBA), is the foundation for determining the strategies in a behaviour support plan. High quality behaviour support plans rely on thorough, well-informed assessments to ensure strategies are evidence based, address the person with disability's needs and the function(s) of behaviour (i.e. why behaviour occurs).

2. Purpose of the guide

The purpose of this guide is to:

- outline the expectations of specialist behaviour support providers and their NDIS behaviour support practitioners when undertaking a behaviour support assessment, including FBA
- provide practice advice consistent with a positive behaviour support framework, contemporary evidence-informed practice, the NDIS Act and associated Rules
- improve the quality of FBAs and the comprehensive behaviour support plans (BSPs) informed by them.

3. Scope of the guide

This guide was developed for registered providers of specialist behaviour support and NDIS behaviour support practitioners supporting NDIS participants. It may also be of interest to anyone who supports a person with disability or provides NDIS supports and services. It provides guidance on behaviour support assessments, including functional behaviour assessments.

This guide is not intended to teach or outline in detail how to undertake a behaviour support assessment. We expect that NDIS practitioners are supported by Specialist Behaviour Support Providers to undertake ongoing professional development to remain current with evidence-informed practice and approaches to behaviour support. This includes developing capabilities relevant to undertaking a behaviour support assessment and functional behaviour assessment.

Practitioners and providers should review the Positive Behaviour Support Capability Framework in conjunction with this guide. The PBS Capability Framework also supports the NDIS Commissioner's function of promoting:

- continuous improvement among NDIS providers and practitioners
- the delivery of progressively higher standards of supports and services to people with disability.

4. What are providers required to do?

Specialist Behaviour Support providers must adhere to the conditions of their registration as outlined under the NDIS Act, Behaviour Support Rules and the Provider Registration and Practice Standards Rules. This includes:

- when developing a Comprehensive BSP for a person with disability, the specialist behaviour support provider must undertake a behaviour support assessment, including an FBA
- the Comprehensive BSP must include strategies that are evidence-based, person-centred and proactive and that address the person with disability's needs and the functions of the behaviour.

A Comprehensive BSP is a holistic document based on a behaviour support assessment (including an FBA). It contains proactive and evidence-informed strategies to improve a person's quality of life and support their progress towards positive change. It addresses the underlying function(s) of the person's behaviour of concern and where appropriate, identifies functionally equivalent replacement behaviours. A Comprehensive BSP outlines any environmental changes required, provides skill development opportunities, and includes response strategies to be followed when the behaviour(s) of concern occurs. The plan also identifies if, when and how any regulated restrictive practices are to be applied and includes fade-out strategies to promote their reduction and elimination over time.

5. Key points

- Upholding a person's human rights is both an ethical and a legal requirement. Human rights principles should guide all elements of PBS practice including the behaviour support assessment.
- The behaviour support assessment is the foundation for determining proposed strategies in the development and/or review of the person's comprehensive behaviour support plan and the reduction and elimination of regulated restrictive practices.
- Quality of life improvements are fundamental to the assessment process and are considered the primary goal of PBS, which involves learning what constitutes a good life for the person.
- Evidence-informed practice and data-based decision making is fundamental to the behaviour support assessment process.
- Behaviour support assessment should be comprehensive and holistic, including consideration of biological, psychological, social, and environmental factors that contribute to and/or maintain behaviour to support systemic change and the promotion of capable environments.
- Collaborative engagement with all key people in a person's life is essential in understanding a person, their needs and for determining proposed supports and strategies. A collaborative approach is more likely to lead to positive behaviour support strategies that are understood and implemented by all parties.
- Behaviour support assessments should be culturally responsive to ensure behaviour support plans are socially and culturally valid.
- Behaviour support assessments should carefully consider the aversive and or traumatic experiences the person and key people in their lives may have encountered (Gore, et al., 2022).
- Understanding the function of behaviour supports the design of function-based interventions to meet the needs of the person.
- Behaviour support assessments are dynamic and subject to change over time, as more information is obtained to confirm or challenge working hypotheses.
- Studies have shown high quality behaviour support plans are associated with a reduction in the use of restrictive practices (Webber, et al., 2012).

6. What is a behaviour support assessment and functional behaviour assessment?

Behaviour support assessment

Behaviour support assessment is a broad term that recognises the holistic and varied assessment considerations that go beyond functional assessment procedures. It is a human rights and values-led

approach that involves understanding human rights principles and actively promoting and protecting those rights. It includes person-centred approaches that consider the various dimensions of wellbeing and quality of life directed by the person's values and preferences. It should include a full biopsychosocial assessment to understand the broader context of the person's life, circumstances, and rights and how this supports a holistic formulation as to why behaviour occurs. The FBA is one component of a comprehensive behaviour assessment.

Functional behaviour assessment

When conducting a behaviour support assessment, this must include an FBA. Section 5 of the Behaviour Support Rules defines FBA as the process for determining and understanding the function or purpose behind a person's behaviour. This may involve the collection of data, observations, and information to develop an understanding of the relationship of events and circumstances that trigger and maintain behaviour.

This functional understanding of behaviour should then be placed in the broader context of the person's life and circumstances to inform holistic formulation about why the behaviour occurs. FBAs inform function-based interventions.

7. Who can undertake behaviour support assessment and functional behaviour assessment?

Registration requirements

In accordance with the Provider Registration and Practice Standards Rules, NDIS providers must be registered under section 73E of the NDIS Act to provide specialist behaviour support services to a participant if the person will as part of the provision of services:

a. undertake a behaviour support assessment (including an FBA) of the participant; or

b. develop a behaviour support plan for the participant.

NDIS practitioner suitability

Under section 17 of the Behaviour Support Rules, registered providers of specialist behaviour support must use NDIS behaviour support practitioners to provide specialist behaviour support services. This is a condition of their registration.

An 'NDIS behaviour support practitioner' is defined under section 5 of the Behaviour Support Rules, as 'a person the Commissioner considers suitable to undertake behaviour support assessments (including functional behavioural assessments) and to develop behaviour support plans that may contain the use of restrictive practices. The NDIS Behaviour Support Practitioner Application Guidelines describe the process used by the NDIS Commissioner to assess whether an applicant is

suitable or not suitable to be an 'NDIS behaviour support practitioner' as defined by the Behaviour Support Rules.

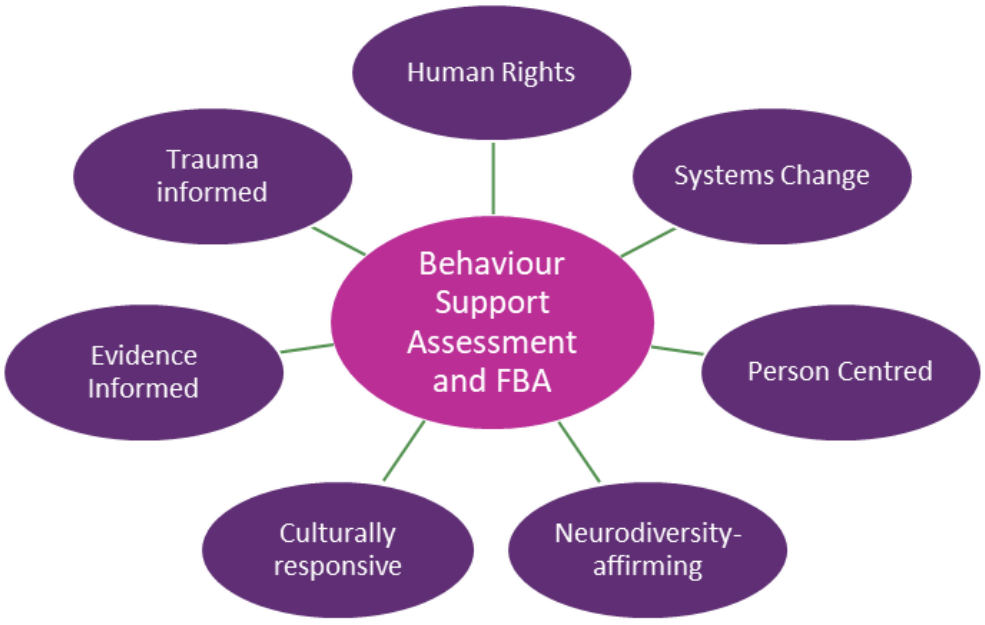
The PBS Capability Framework sets out the NDIS Commission's policy position on how the Behaviour Support Rules and Guidelines are implemented in practice. It is foundational in relation to the NDIS Commission's behaviour support function and forms the basis for consideration of suitability of behaviour support practitioners to deliver services under the NDIS. Until the NDIS Commission considers someone suitable to be an NDIS behaviour support practitioner, they cannot undertake behaviour support assessments (including functional behaviour assessments) or develop behaviour support plans in the delivery of NDIS-funded supports and services, even under supervision.

Under the NDIS Act, all activities associated with undertaking behaviour support assessment, including FBA, can **only** be completed by NDIS behaviour support practitioners. However, family members, support workers and others should play a role in the collection of raw data, providing information to the NDIS behaviour support practitioner and participating in discussions. This ensures there is a shared understanding of the needs of the person and why behaviour occurs (See: Working with the person and their support network).

8. Guiding principles

The PBS Capability Framework outlines the values and principles that underpin all practice elements of positive behaviour support. These are expected to be demonstrated by NDIS practitioners and providers in the delivery of specialist behaviour support. The following principles have been specifically highlighted in the context of undertaking a behaviour support assessment, including FBA (see *Figure 1*).

Figure 1: Reflects guiding principles when undertaking Behaviour Support Assessment and FBA



Human rights

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) serves as a significant treaty for ensuring people with disability enjoy the same human rights and fundamental freedoms as everyone else. A rights-based approach involves considering human rights principles and actively promoting and protecting those rights.

Positive behaviour support (PBS) is a human rights and values-led approach. It relies on person-centred, proactive and evidence-informed strategies that are respectful of a person's dignity, aim to enhance the person's quality of life, and reduce and eliminate the use of practices that may impact on their rights. Specialist behaviour support providers and NDIS practitioners have a legal and ethical responsibility to uphold the rights of the person. The behaviour support assessment must therefore be informed by a deep understanding of the person's rights, unique experiences, and broader life circumstances to inform holistic formulation about why behaviour occurs (Fisher, et al., 2024). It also involves understanding what a good life looks like to the person and ensuring their values and preferences are understood and prioritised to support quality of life improvements (Fisher, et al., 2024).

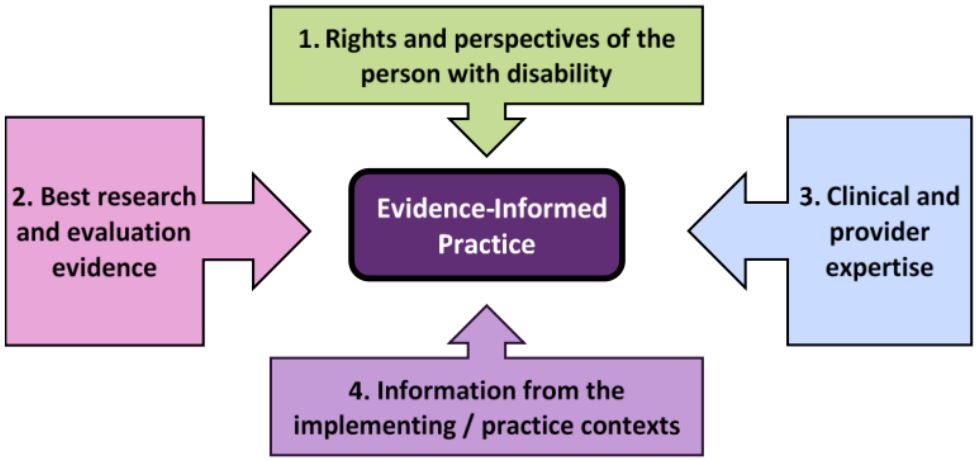
The assessment of any regulated restrictive practices being used is fundamental to upholding the rights of the person. Regulated restrictive practices involve seclusion, chemical restraint, mechanical restraint, physical restraint, and environmental restraint. These practices have "the effect of restricting the rights or freedom of movement of a person with disability" (Australian Government, 2013). The use of regulated restrictive practices (RRP) by registered NDIS providers is subject to conditions outlined under the Behaviour Support Rules. For example, RRPs must only be used as a last resort, be the least restrictive, reduce the risk of harm, be proportionate and be used for the shortest possible time. (See: The reduction and elimination of regulated restrictive practices)

Upholding the rights of the person involves assessing whether the use of RRPs is clinically justifiable and absolutely necessary. It also involves exploring and promoting the use of alternatives as a priority. Where an RRP is included in a behaviour support plan, it requires authorisation in line with state or territory requirements, and plans should be in place to reduce and eliminate the practice over time. In recognition of the person's rights to autonomy, decision making, and to accessible information, the person should be provided with information about the restrictive practices in a way that is easy for them to understand. This should include exploring their views and alternatives to the use of restrictive practices.

Evidence-informed practice

Specialist behaviour support providers must ensure each participant's quality of life is maintained and improved by person-centred, evidence-informed behaviour support plans that are responsive to their needs (Australian Government, 2018a). This Practice Standard is a condition of registration as a specialist behaviour support provider under the Provider Registration and Practice Standards Rules. Evidence-informed practice (see *Figure 2*) means integrating the rights and perspectives of the person with disability, with the best available research, with professional expertise and information from the implementing or practice contexts. This involves collecting and analysing information from a range of sources to ensure evidence-informed and data-driven decision making.

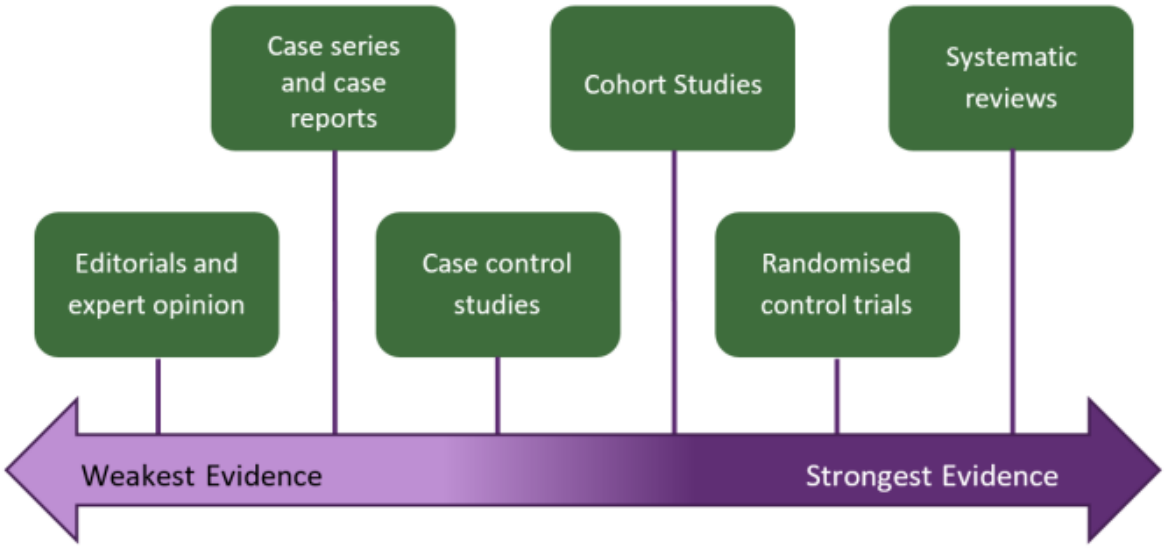
Figure 2: NDIS Commission's model of evidence-informed practice
(*Adapted from Sackett, et al., 1996 and Hoffman, et al., 2016* - Evidence informed practice)



Evidence-informed practice also involves understanding a person's lived experience and recognising them as an expert in their own life. Positive behaviour support provides a framework for collecting and analysing primary evidence about a person, their preferences and goals, and their unique circumstances to inform person-centred and data-driven decision making (McDonnell, et al., 2015 as cited in Fisher, et al., 2025).

The best available research should be considered when selecting assessments and making decisions about the effectiveness of interventions or strategies. Hierarchies of evidence rank study types based on the strength of their research method (see *Figure 3*). Well-designed systematic reviews and randomised controlled trials provide the strongest level of evidence. Expert opinion and anecdotal experience represent the weakest level of evidence. The age and reliability of the research should also be considered. This means using current and contemporary research and referring to reputable sources of information.

Figure 3: Hierarchy of research evidence (adapted from NSW Department of Communities and Justice (2020) – See Evidence informed practice)



NDIS practitioners should work collaboratively with other relevant specialists and/or professionals who have the expertise to meet the person's needs. Specialist behaviour support providers and NDIS practitioners are expected to work within their scope of knowledge, skills, and experience. This involves knowing when to refer on when additional expertise or assessment is required.

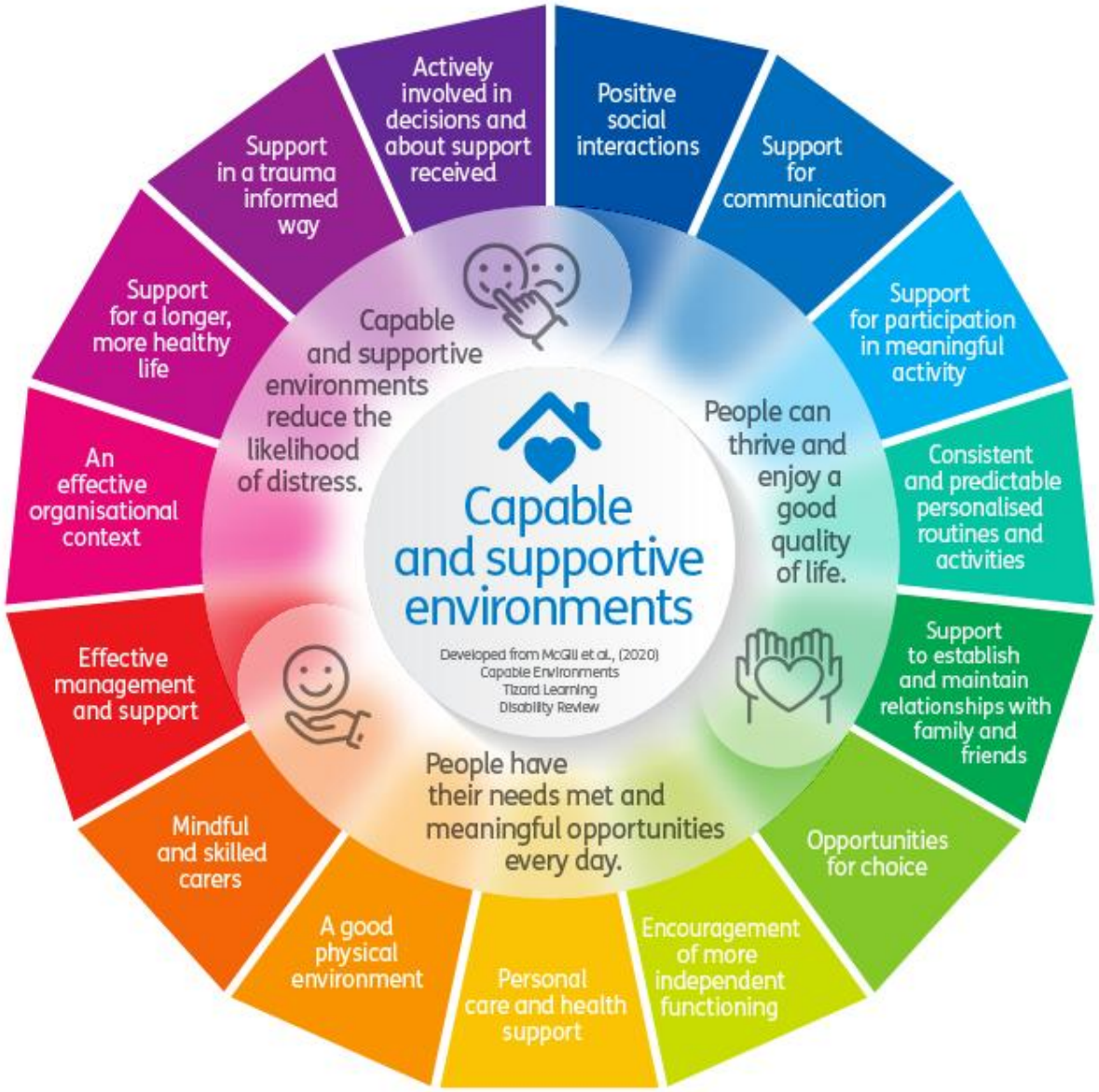
Evidence-informed practice means making data-driven decisions based on evidence collected and analysed. This should include collecting baseline data to evaluate the effectiveness of strategies over time and collaborating with the person, their support network and implementing providers. This ensures that the diverse views, experience, and knowledge of all relevant stakeholders is collected and considered throughout the assessment process. Being data driven also ensures decisions are based on evidence rather than personal biases or assumptions.

Systems change

All behaviour is related to the context or environment in which the behaviour occurs (Browning, et al., 2013). PBS includes creating supportive contexts through ecological and systemic change, rather than focusing solely on the individual. This requires a comprehensive and holistic assessment process to help others better understand the person and support improved quality of life outcomes. This should involve consideration of the person's developmental history and the broad range of biological, psychological, social, and environmental factors that may contribute to and/or maintain behaviour. Developing a shared understanding of these factors and the function of behaviour is an important part of achieving systemic change.

Growing evidence suggests that focusing on 'environments' is the key to meeting behaviour support needs and improving quality of life for people with disability (Jorgensen, et al., 2023). This supports the development of individualised multicomponent behaviour support plans that meet the needs of the person. McGill, et al. (2020) also describes the key elements of capable environments that are associated with a prevention of behaviours of concern and improved quality of life outcomes. These are described as environments in which people can thrive and are illustrated in the image below (see *Figure 4*). If the various factors contributing to a person's behaviours of concern are not addressed, even well-designed positive behaviour support may not be enough to achieve lasting behaviour change (Nankervis & Vassos, 2023).

Figure 4: BILD Capable Environments. (Note: From *BILD Capable Environments*, McGill et al, 2020, CC BY-NC-ND 4.0)



Systems changes relies on organisation-wide approaches, multidisciplinary input, working in partnership with key stakeholders, and education, training, and resources for implementers. It acknowledges that problems don't belong to any one person but exist between people and requires a holistic approach to assessment. NDIS practitioners play a key role in understanding behaviour in the context of whole systems, designing rights-based interventions and using influence to shape organisational practices, staff capabilities and service-wide approaches to support.

Person centred

Person centred practice is an approach underpinned by recognition of the fundamental human right to equality and self-determination, and the recognition and facilitation of what matters to that person. It is a holistic approach that prioritises wellbeing and quality of life directed by the person's needs and preferences in the context of the person's world (including environments and relationships), individual expression, values, and beliefs.

Person-centred assessment means ensuring the person remains at the centre of the assessment process. The positive behaviour support process involves supporting people to have good lives, so it is critical to determine what this means at an individual level (Gore, et al., 2022). The needs, aspirations and preferences of the person should be central to the goals, methods and individualised outcomes that are selected (Gore, McGill, &Hastings, 2021; Kincaid & Fox, 2002 as cited in Gore, et al., 2022). This includes ensuring that person-centred goal formation is part of the PBS process and guides the behaviour support assessment (Carr, 2007; Fox & Emerson, 2010; Gore, et al., 2021 as cited in Gore, et al., 2022).

Under the Behaviour Support Rules, the specialist behaviour support provider must take all reasonable steps to consult with the person and other relevant stakeholders when developing and reviewing a behaviour support plan. Adopting a person-centred approach means including the person and their support network in the assessment and data-gathering process. This should include working with the person and their support network to identify unmet needs, the function or purpose of the behaviour(s) and individualised, function-based strategies (Australian Government, 2018d). It also involves working with the person and other relevant stakeholders to verify the accuracy of information gathered, test the insights gleaned and establish the social validity or acceptability of strategies proposed.

Neurodiversity-affirming

A rights-based approach involves embracing and promoting human diversity. Neurodiversity-affirming practice involves focusing on supports and adjustments. It builds on a person's strengths and unique neurological processing style to support life improvement rather than changing (or 'fixing') a person to meet the expectations of others (Dallman, et al., 2022; Dwyer, 2022 as cited in Fisher et al, 2025). This means that features of a person's disability or differences in processing style should never be the target behaviours for change.

The theoretical foundations of PBS are built on concepts, principles and practices from applied behaviour analysis. However, only the principles and practices that are compatible with PBS core values should be used. That is, those that aim to support learning or address behaviours that are likely to cause harm or significantly reduce a person's quality of life (Gore, et al., 2022).

Supporting a neurodiversity-affirming approach to assessment should involve learning about the person's neurological processing style and educating others who may be supporting the person. It should also include evaluating and making changes to environments that may affect the person along with celebrating their strengths, rather than expecting the person to conform to any perceived societal norms.

Culturally responsive

All people with disability have the right to enjoy and benefit from their own culture, practise their own religion, and use their own language. Supports and services provided under the NDIS should be culturally inclusive and respectful of the person's diversity, values, and beliefs (Australian Government, 2018a). They should consider the culture, religion, beliefs, linguistic circumstances, gender, and identity of the person (Australian Government, 2013). In providing safe and culturally responsive behaviour support assessments, specialist behaviour support providers and NDIS practitioners should take steps to build cultural awareness and limit cultural bias.

The behaviour support assessment process should include learning about the person's lived environments and developing an understanding of the role and importance of culture, religion, and beliefs in the life of the person. It involves a collaborative approach with the person and their support network to inform assessment and the development of socially and culturally valid behaviour support plans. This involves taking the time to build rapport and trust with the person and their support network and adapting assessment processes and approaches within the context of the person's cultural environment. It may also include seeking expert advice from a cultural consultant to understand different cultural practices, beliefs, and values so that supports can be tailored to meet the diverse needs of individuals.

Trauma-informed practices

Behaviour support assessments should carefully consider the aversive and traumatic experiences that the person and key people in their lives may have encountered (Gore, et al., 2022). The data clearly shows people with disability in Australia are subjected to higher rates of interpersonal violence and abuse than people without disability.

More than half of all people with disability aged 18 to 64 years (55 per cent) have experienced physical or sexual violence since the age of 15. In comparison, around 38 per cent of adults aged 18 to 64 without disability experienced physical or sexual violence [Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. (2023). *Final Report Volume 3: Nature and extent of violence, abuse, neglect and exploitation*, p. 86]. Given the prevalence of potentially traumatic events experienced by people with disability and the impact such events may have on behaviour, using a trauma-informed approach during the assessment process with all participants is likely to be beneficial (Rajaraman, et al., 2022 as cited in Jessell, et al., 2025).

9. Consent and privacy

Specialist behaviour support providers and their NDIS practitioners must maintain confidentiality and protect the person's dignity and right to privacy (Australian Government, 2018a). The person should also understand and agree to what personal information will be collected as part of the behaviour assessment process and why (Australian Government, 2018d). This means explaining to the person what is going to happen and why, in a way that is easy for them to understand so they can make informed decisions. When a person has a legally appointed guardian, NDIS practitioners

should understand the powers/functions of the guardian as prescribed in the relevant guardianship order and act in accordance with the order.

Obtaining consent

Before starting the behaviour support assessment process, NDIS practitioners should get consent from the person and/or their guardian, to collect, use, disclose and hold personal information (including sensitive information) about the person. Consent refers to an individual (or, where applicable, Guardian's) informed, free and voluntary agreement to a proposed action. NDIS practitioners should also be mindful of only collecting information that is reasonably necessary and of direct relevance to the positive behaviour support process.

Protecting personal information

All reasonable steps must be taken to protect personal information from misuse, interference, loss or unauthorised access, in accordance with the Privacy Act 1988. This includes when using electronic or online methods of data collection throughout the assessment and/or implementation and monitoring phase of positive behaviour support (e.g. enabling password protection and access controls). These measures assist to protect against risks and ensure that personal information is only accessed by authorised persons.

Specialist behaviour support providers and NDIS practitioners should be familiar with the Australian Privacy Principles (OAIC). The Guide to securing personal information (OAIC) also outlines the reasonable steps entities are required to take under the Privacy Act 1988 to protect the personal information they hold from misuse, interference, loss, and from unauthorised access, modification or disclosure.

Use of artificial intelligence

Artificial intelligence (AI) is being increasingly used in behaviour support assessments and development of behaviour support plans under the NDIS.

The NDIS Commission does not endorse or approve the use of AI tools in behaviour support assessments or the development and review of behaviour support plans. This does not prevent NDIS providers using AI, so long as such use complies with providers' legal obligations. While the current legislative framework does not explicitly prohibit the use of AI, several risks are associated with the use of AI by providers. These include:

- disclosure of personal participant information to third parties
- processing or storage of personal information overseas and a lack of transparency regarding how data is stored, secured, or used once entered into an AI system
- inaccurate or misleading content or advice generated by AI, including content not developed in consultation with the participant and/or their support network

- automated decision-making without appropriate human oversight or the application of clinical judgement.

Unless mitigated, these risks may, in certain circumstances, lead to breaches of the Code of Conduct Rules, and other provider obligations. The NDIS Commission expects that, if a provider elects to use AI in behaviour support assessments or the development and review of behaviour support plans, all information is appropriately de-identified and that no personal information of participants is disclosed to AI systems. Any use should be consistent with Australia's AI Ethics Principles. Failure to do so may place NDIS providers in breach of their legal obligations, including under the NDIS Act 2013.

10. Risk appraisal and harm minimisation

While not specific to the FBA process, assessing the risks of harm to the person and/or others and developing an interim behaviour support plan to minimise the risk of harm is a key component of behaviour support. It focuses on safeguarding and risk mitigation while a functional behavioural assessment is undertaken, and a Comprehensive Behaviour Support Plan is developed.

The Provider Registration and Practice Standards Rules requires that each person with an immediate need for a behaviour support plan must receive an interim behaviour support plan that minimises the risk to that person and others. An interim behaviour support plan is a short document that contains general preventative and responsive strategies designed to keep the person with disability and others safe. It clearly describes the behaviours of concern and includes protocols to follow to minimise the risk of harm. It also identifies if, when, and how any regulated restrictive practices are to be applied.

Risk is the combination of the likelihood (chance) of an event occurring and the consequences (impact) if it does occur. The risk assessment should consider all identified risks to the person and/or others including the physical safety of the person and/or others, psychological wellbeing, and the impact on the person's quality of life. A risk assessment should also consider that risks can be static (relatively stable over time), or they can be dynamic (fluctuate based on conditions or factors). It should also consider risks associated with the use of any strategies, including the use of restrictive practices. Understanding risk is critical to informing clinical interventions and decision-making processes.

The risks should be evaluated in collaboration with the person and their support network, including implementing providers and other relevant stakeholders. There may also be a need to re-assess risk throughout the assessment process if there is a change in circumstances for the person (e.g. a new risk of harm presents).

It is important to remember the goal is not to eliminate all risks. Rather, consistent with the principle of dignity of risk, the person should be supported to take reasonable risks and be supported to make decisions even when they involve a degree of risk.

11. Working with the person and their support network

Including the person in the assessment and data-gathering process

All people with disability have a right to supported decision making, to have a say in matters that affect them and to be provided with accessible information they can understand. Consistent with international human rights standards, people who have little or no speech have the same communication rights as any other person (United Nations, 2006). Augmentative and Alternative Communication (AAC) is when a person uses something other than speech to communicate. AAC may include communication boards, speech-generating devices, tablets/apps, paper-based systems (books, pictures, words), key word sign, gestures, body language and facial expressions. The person may also use a combination of methods to communicate (Speech Pathology Australia, 2023).

This may require learning about the person's communication needs and preferences and/or seeking support from someone who knows the person well to interpret their communication and support their participation. Understanding the person's method of communication is fundamental to support their participation in the assessment and data-gathering process, which may involve the use of communication aids to support their participation. This should include (but is not limited to) the following:

- meeting the person (either in-person or via Tele PBS) and planning how they will be included in the assessment and data-gathering process. It also involves understanding from the person's perspective who they want to be involved (i.e. who is important to the person)
- facilitating and/or supporting the person's decision making throughout the assessment process by adopting supported decision-making frameworks. This may include the use of supported decision-making tools to support their participation (e.g. Deciding With Support and The Right Direction)
- ensuring the person's cultural and linguistic circumstances and identity is considered in the assessment process to deliver person-centred and socially valid outcomes. This may include the use of an interpreter or translation of documents. It may also include adapting methods of collecting data and information to suit the needs of the person and their family or support network (e.g. Let's Yarn Factsheet - Council for Intellectual Disability).

NDIS practitioners should consider their approach to engagement with the person in the assessment and data-gathering process. The Positive Behaviour Support Plan Quality Assessment (PBSP-QA; Vassos & Nankervis, 2025) defines informing, consultation and inclusion in *Table 1* (below).

Table 1: Definitions of informing, consultation and inclusion (Vassos & Nankervis, 2025, pp 10-11)

Informing	Consultation	Inclusion	
		Co-production	Co-creation
The practitioner engages in one-way communication with the person for the purposes of telling them about the plan development process and the plan content developed.	The practitioner seeks information from the person for the purposes of developing plan content. Plan content is then developed by the practitioner.	The practitioner engages the person to actively assist in developing plan content. The practitioner leads this collaborative process.	The person and practitioner, in equal partnership, make decisions about how the plan will be developed. The practitioner supports the person to remain in control of the plan development process and the content added to the plan.

Collaborating with the person's support network

Positive behaviour support is a collaborative process that relies on the engagement and contribution of key people in the person's life. Family members, support workers, NDIS providers and others all play an important role. This includes the collection of raw data, providing information and contributing to discussions with the NDIS practitioner to inform the development and review of an effective behaviour support plan. This should involve (but is not limited to) the following:

- including people who know the person well in the assessment and data-gathering process. This includes family, carers, guardian, NDIS providers, support workers and any other relevant person to ensure a collaborative approach to assessment (e.g. The Right Direction: What does my support network look like?)
- consulting with and working alongside specialists and/or professionals who have the qualifications and expertise to meet the person's needs and/or referring on, where additional expertise or assessment is required
- collaborating with other providers and mainstream services as required to ensure the interface between supports and services is considered, and strategies are integrated as practicable
- actively listening and adopting a posture of curiosity and neutrality so people can express their views and experiences in a safe and trusting environment throughout the assessment process
- developing a shared understanding of the needs of the person and how to meet those needs. This includes working in partnership with key people around the person to establish and test hypotheses about the function of behaviour.

The role of implementing providers

Implementing providers are providers that may use a regulated restrictive practice and/or implement behaviour support plans when delivering NDIS supports and services. A provider must be registered if, during the provision of the supports, there is, or is likely to be, an interim or ongoing need to use an RRP in relation to the participant. This includes completing an audit against Module 2A: Implementing behaviour support plans Provider Registration and Practice Standards Rules.

Implementing providers must adhere to their conditions of registration. This includes supporting the assessment and development of behaviour support plans and ensuring each participant's quality of life is maintained and improved by tailored, evidence-informed behaviour support plans that are responsive to the person's needs. This should include:

- supporting the person to contribute to the assessment. This may involve supporting and/or facilitating communication between the person and the NDIS Practitioner to ensure they are included in the assessment and data gathering process
- facilitating and enabling the NDIS practitioner to conduct information-gathering for the assessment. This may involve releasing support workers, team leaders and managers for discussions, interviews, or completion of other assessment tools
- identifying key stakeholders for the NDIS practitioner to ensure the effective monitoring and review of behaviour support plans. A key contact point for the NDIS practitioner can be an effective measure to support the flow of information and communication
- supporting the practitioner to conduct an initial risk assessment. This ensures a collaborative and informed approach to assessing risks across all relevant environments
- ensuring staff have the training and skills to effectively participate in data collection
- ensuring staff are supported to collect data and contribute to the development of a functional assessment
- supporting the person to arrange and attend medical reviews as required and coordinate and consult with the NDIS practitioner as required.

12. Identifying and defining target behaviour(s)

It is the role of the NDIS behaviour support practitioner to work with the NDIS participant and their support system to identify and define the behaviour(s) that will be the focus of the FBA and comprehensive behaviour support plan. This is sometimes referred to as the target behaviour(s). This should be informed by the risk assessment process and the views of key stakeholders. The target behaviour(s) should be the only behaviour(s) that is the focus of the FBA.

Prioritising target behaviour(s)

It may be necessary to prioritise which behaviours will be the focus of the FBA and comprehensive BSP. Behaviour support plans that attempt to do too much are less likely to be implemented due to their complexity (Nankervis & Vassos, 2023).

Behaviours of concern can be described as 'behaviour that is of such intensity, frequency, or duration that the physical safety of the person or others is likely to be placed in serious jeopardy. Behaviours of concern also include behaviour that is likely to seriously limit the use of, or result in, the person being denied access to services or ordinary community facilities' (Emerson, 1995). When deciding which behaviour(s) will be the focus of the FBA and comprehensive BSP, consideration should include (but is not limited to) the following:

- **The current impact of the behaviour(s) on the person's life:** the FBA and comprehensive BSP should focus only on behaviours that currently pose a risk of harm to the person and/or others. This respects the person's dignity and focuses on their current needs. Behaviour(s) that have occurred in the past should generally not be included as target behaviours. An exception to this may be where they are expected to re-occur or where the use of an authorised RRP is preventing the behaviour from occurring. However, we expect that all steps are taken to reduce and eliminate such practices if this is the case.
- **The likelihood and impact of the behaviour on the safety of the person and/or others:** this should be informed by the risk assessment process undertaken in collaboration with the person and their relevant support network. It should include an assessment of the likelihood and impact of the behaviour on the person (i.e. impact on the physical safety and/or psychological wellbeing of the person and/or others).
- **The impact of the behaviour on the person's quality of life:** this may include consideration of the negative impact of the behaviour in a range of areas associated with quality of life (e.g. emotional well-being, interpersonal relationships, self-determination, social/community inclusion, material wellbeing, personal development, rights, and physical well-being).
- **The behaviour is associated with the use of a restrictive practice:** the continued use of a restrictive practice in response to risk of harm signals that current supports are not effectively meeting the person's needs. This highlights the importance of prioritising proactive, positive alternatives that address underlying causes of behaviour to support the reduction and elimination of restrictive practices.

Observable and measurable

All target behaviour(s) should be described in observable and measurable terms (i.e. operational definition of behaviour) (see *Table 2*). This supports consistency in data collection and allows progress to be measured and monitored. Observable and measurable means:

- the description of the target behaviour is specific and objective. It is described in such a way that those supporting the person can easily identify when the target behaviour is or is not

occurring. Examples (what it does look like) and non-examples (what it does **not** look like) may also be used to increase understanding of the identified target behaviour

- non-observable internal states (what a person may be feeling or thinking) such as anxiety, anger, experience of pain or underlying symptoms of a mental health condition (e.g. delusions, hallucinations) should not be used to describe the target behaviour. These are considered setting events (i.e. factors that contribute to and/or maintain behaviour). The target behaviour may however include a description of observable signs that indicate what the person does when they are experiencing the internal state or mental health symptom
- if using general categories to define behaviour (i.e. physical aggression, self-harm), ensuring that these are subsequently defined in terms of what the behaviour looks like
- descriptions of behaviour are free from bias, judgement, and subjectivity. For example, descriptions such as "meltdowns" or "tantrums" should not be used to describe behaviour
- that data can be collected about the behaviour (i.e. when the behaviour occurs, how long the behaviour lasts and what happens as a result)
- there is agreement between relevant stakeholders on what the target behaviour is and how it is described.

Table 2: Examples of descriptions of behaviour

Observable and measurable	NOT observable and measurable
Physical aggression includes hitting others with an open or closed hand and throwing objects directly at others.	Lashes out and tries to hurt others.
Harm to self: • bites hand with such force that it leaves a red mark or breaks the skin and bleeds. • hits self in forehead with open or closed hand.	When distressed or bored _____ will self-harm, causing injury to self.
Slams bedroom door and yells at staff "no I don't want to" or "go away".	Non-compliant with requests of daily living activities.
Cries loudly, lays on ground and kicks legs.	Emotional meltdown when overwhelmed.

Baseline data

Baseline data should be collected to help understand the severity and impact of the behaviour and to track progress over time. This should include collecting data related to frequency (i.e. how often the behaviour occurs), duration (i.e. how long it lasts) and intensity of the target behaviour(s) (i.e.

severity of the behaviour). Baseline data should also be collected on quality-of-life measures and current use of regulated restrictive practices.

These baseline measures allow for comparisons to be made over time to:

- determine the effectiveness of positive behaviour support strategies after the BSP has been implemented
- inform the review of behaviour support plans and the reduction and elimination of restrictive practices
- support data-driven decision making.

13. Selecting assessment methods

The depth and scope of an assessment will vary in relation to an individual's needs, circumstances, and risks of harm. Assessment approaches should be individualised and used in partnership with key stakeholders with flexibility and sensitivity (Carr, et al., 2002 as cited in Gore, et al., 2022). This involves selecting assessment methods that suit the needs of the individual and their circumstances and supporting other key people involved in the assessment process to develop skills in assessment methods (Dunlap, et al., 2001; Dunlap & Fox, 2007; Willis, et al., 1993 as cited in Gore, et al., 2022).

The NDIS Commission does not specifically prescribe the assessment tools that should be used when undertaking a behaviour support assessment, including FBA. The nature and type of assessment tools used will vary based on the individual needs of the person and must be informed by the NDIS practitioner as part of their hypothesis-driven assessment process and clinical judgement. The assessment should however include the use of direct and indirect methods of assessment (see *Table 3* and *Table 4*) to gather information in collaboration with the person and their support network (Nankervis & Vassos, 2023).

Table 3: Descriptions and examples of indirect assessment methods

Assessment method	Description	Examples
Indirect assessment	Involves collecting information from others based on their recall of the behaviour and related events (Miltenberger, et al., 2016).	• Interviews and consultations • Standardised measures, e.g. Functional Analysis Screening Tool (FAST), Questions About Behavioural Function (QABF), Functional Assessment Interview (FAI), Contextual Assessment Scale (CAS), Individualised Behaviour Rating Scale (IBRST) • Reviewing other sources of information (e.g. records review, medical reports, communication assessments, sensory assessments)

Key considerations when selecting indirect assessment methods

- Use valid and reliable tools when collecting data and measuring participant outcomes (Davis, et al., 2018). Reliable and valid tools accurately measure what they are intended to measure and produce consistent results under the same conditions. This supports evidence-informed decision making.
- Select assessment tools that are fit for purpose. This involves understanding the tool's purpose, context and whether it is appropriate to the specific needs of the person (i.e. age group, population). This should include consideration of accessibility and cultural appropriateness and how the use of the tool will inform or contribute to positive outcomes for the person.
- Ensure that assessment tools are used only in accordance with the administration requirements as described (i.e. some tools may require specific qualifications or training to use them).
- Consider quality of life and wellbeing measures in addition to collecting data on behaviour. This ensures that data collection is holistic and comprehensive and focuses on goals and outcome measures that go beyond the reduction of behaviour (i.e. Be-well-checklist-final.pdf, the personal well-being checklist, WHOQOL - Measuring Quality of Life, The World Health Organization, QI-Disability).
- Consider other sources of information, including any previous behaviour support assessments and other assessments. We expect that any strategies included in the comprehensive behaviour support plan are informed by assessment findings (e.g. speech and language assessments, occupational therapy reports).
- The Compendium of resources includes a range of assessment tools that can be used for the purposes of behaviour support assessment.

Table 4: Descriptions and examples of direct assessment methods

Assessment method	Description	Examples
Direct assessment	Involves direct observation of the target behaviour in relevant environments and recording of naturally occurring environmental events that happen before (antecedents) and after (consequences) the behaviour (Miltenberger, et al., 2016).	• Antecedent – Behaviour – Consequence (ABC) Data Collection • Observations and recording of data (e.g. measures of frequency, intensity, duration of target behaviour) • Mapping data (e.g. scatterplots). • Collating written descriptions

Key considerations when selecting direct assessment methods

- Ensure data is collected in **all** relevant environmental contexts (e.g. person's home, community, relevant programs, or activities). Consideration should be given to the most effective and efficient way to collect data in each individual context.
- We encourage NDIS practitioners, where possible, to undertake direct observations in all relevant environments. Observations should seek to identify what is working well to support a person-centred and strengths-based approach.
- Assist and provide oversight to others who may be collecting data (i.e. families, support workers, providers). This may involve training, orientation, written guidance, examples, and ongoing support to ensure data is being collected consistently and with skill.

14. Using assessment methods to gather data

The information collected throughout the assessment process will vary from one person to another. It should be comprehensive and holistic to help others better understand the person and meet their needs. The information collected should be relevant only to the purpose and goals of the comprehensive behaviour support plan. It should reflect the person's wishes and respect their right to privacy. The assessment-data-gathering process should be done in collaboration with the person and their support network.

Current and reliable data is essential to informing the development of a comprehensive BSP. This ensures the FBA is valid, hypotheses about behaviour are evidence-based, and recommended strategies are appropriate, least-restrictive, and aligned with the person's current situation and needs.

Collecting data about the person and their environment

This should involve consideration of the broad range of biological, psychological, social, and environmental factors that may contribute to and/or maintain the risks of harm. It should also consider the person's strengths and protective factors and the various dimensions of wellbeing and quality of life directed by the person's values, preferences and rights, and how this supports a holistic formulation as to why behaviour occurs. The following table provides examples of content that may be relevant, noting assessment is individualised and the nature of information collected will vary from one person to another (see *Table 5*).

Table 5: Examples and descriptions of biological, psychological, social, and environmental factors

Assessment content	Examples
About the person	**Strengths, skills, and aspirations:** What are they good at? What do others admire about them? What are some of their skills and talents? What are their dreams and aspirations, goals, likes and dislikes, values, and preferences? How would the person describe themself? What do they want others to know? What new skills could the person learn to support their independence? What does the person want or need from others about how they are supported? **Communication needs, choice, and control:** What are their communication needs? How do they best understand information? How do they communicate information to other people? Do they use any devices or AAC systems? How does the person make decisions and choices? Is there an existing communication assessment or is there a need for re-assessment? **Sensory needs:** Are there any sensory needs such as sensations the person seeks, avoids, finds distressing or calming? Is there an existing sensory assessment or is there a need for reassessment? **Leisure, routines, and engagement:** What is important to know about the person's routine? How do they spend their time? (e.g. work, study, recreation, and other roles). Does the person have any specific needs related to predictability, change and navigating their routine? How is the person supported to participate in activities and is this meaningful to the person?
Background information	**Disability and health needs:** Confirmed diagnoses, physical and mental health needs including medications. Does the person experience pain or discomfort and how is this identified? Have medical factors been ruled out as causing or contributing to behaviour? When did the person last have a medical and/or medication review? When was the person's last dental review? Does the person have a psychosocial disability and are they accessing other evidence-based therapeutic interventions? For further information see: regular access to healthcare. **Relevant social history:** What is the person's developmental history including education? Is the person employed, or do they want to seek employment? Is the person actively supported to maintain or establish relationships with family and others in accordance with their wishes? Who are the key supports in the person's life? Who knows them well? What is the person's culture, religion, and spirituality; interests, hobbies, leisure; and significant life events relevant to understanding the

Assessment content	Examples
	person and their needs? Does the person have experience or background of trauma? **Living arrangements:** Does the person's living arrangements suit their needs? Does the person live with co-tenants and are they compatible? Did the person choose where they live with and with whom? What is the physical environment like, and does it meet the needs of the person?
Social and Physical Environment	**Interactions, approaches, and levels of engagement:** What do interactions with the person look like? Are these frequent and positive? Do staff and others know how to communicate with the person in a way they understand? Do people understand how the person communicates with others? What is the relationship like between the person and those providing support? **Skills, knowledge, attitudes, and the broader organisational context:** Do support workers have the necessary skills, knowledge, and resources to best support the person? Are they supported to engage in training and are they willing to adjust their support?

Collecting data about the target behaviour(s)

This should include consideration of setting events, triggers, maintaining consequences, early warning signs, and the frequency, duration, and intensity of **all** target behaviour(s). This is consistent with behavioural principles and quality markers of PBS and should be included in a behaviour support plan. These key terms have been defined below with supporting examples (see *Table 6*).

Table 6: Description of key terms and examples

Key term	Description	Examples
Setting events	The conditions or circumstances that occur at a distance from the behaviour (hours or days before) which increase the likelihood of the behaviour occurring.	Medication, routines, sleep cycles, diet, staffing patterns, physical health, number of people in the person's space, daily schedule.

Key term	Description	Examples
Triggers (also antecedent)	An event or observable condition that occurs immediately before the behaviour that directly triggers that behaviour. Note: triggers are 'observable' events. They are not internal states (i.e. anxiety, feeling out of control) or a reference to a person's disability or diagnosis.	Being asked to do something, being denied something, noise levels or certain sounds, particular places, sudden changes.
Maintaining consequences	The immediate response of others when the behaviour occurs that reinforces or maintains that behaviour (i.e. makes it more likely that it will occur again). Note: the 'maintaining consequence' is not the same as the 'function.' The maintaining consequence is what happens immediately after the behaviour (observable event), whereas the function is the purpose of behaviour.	Person is given item/activity, others leave the environment, support workers engage with the person.
Early warning signs	Descriptions of observable signs that the behaviour may occur. This may include an escalation cycle and/or specific examples to increase understanding of what early warning signs look like.	Pacing, raised voice, withdrawal, making specific statements.
Frequency	Information about how often the behaviour occurs.	Once a day, twice a week, or once every hour.
Duration	Information about how long the behaviour occurs.	30 seconds, 5-10 minutes, or one hour.
Intensity	Information about the severity of behaviour.	Damage (a hole in the wall), disruption (an activity was interrupted) or injury (bruising).

Information should also be collected on previously implemented strategies, including their effectiveness. This includes identifying what was trialled prior to the use of any regulated restrictive practices, such as routine chemical restraint.

15. Analysing data to determine the function of behaviour and formulation

All available information should be analysed and integrated into a cohesive understanding of the function(s) of behaviour. This should be used to develop a formulation. This will inform the prioritisation of supports and the design of function-based strategies and skills that have potential to reduce and eliminate the need for regulated restrictive practices.

The formulation should consider the broader factors that contribute to and maintain the behaviour to provide a shared, evidence-informed, and holistic understanding of why the behaviour occurs. It is crucial that strategies are consistent with the overarching goals for the person and the findings of functional behaviour assessment.

Identifying the function(s) of behaviour

Functions of behaviour are typically framed in terms of what the person is trying to get (seek out) or reject (avoid, escape) by using the behaviour. This involves systematically analysing the data to identify patterns related to:

- the events that happen immediately before the behaviour (antecedents/triggers)
- the events that increase the likelihood the behaviour will occur (setting events)
- the events that happen immediately after the behaviour (consequences or maintaining factors).

The hypothesised function(s) of each target behaviour or clusters of behaviour should be identified in a clear summary statement. The summary statement should include how the identified function(s) are related to the identified setting events and/or triggers and the identified consequences that are maintaining behaviour (see *Table 7*).

Multiple behaviours may serve the same function, and one behaviour may serve multiple functions. It is important to consider how best to achieve positive outcomes for the person, including which behaviours and functions will be the target of the comprehensive behaviour support plan.

Note, a person's diagnosis or disability or 'power' and 'control' should not be described as a function of behaviour.

Table 7: Examples of good and poor functional hypothesis statements

Good practice	Poor practice
When asked to complete a non-preferred task or activity (trigger), the person will engage in physical aggression including hitting, biting, and kicking others (behaviour). As a result, staff typically leave the immediate area (consequence). The hypothesised function of behaviour is to escape non-preferred tasks or activities (function).	The function of behaviour is to express feeling of being overwhelmed due to their diagnosis.
The person engages in self-harm behaviour by biting their hand and arm, resulting in red marks and broken skin (behaviour). This happens when they are left alone for longer than 20 mins or when staff are supporting others (triggers). It is more likely to occur when they are unwell or tired (setting events). Staff typically respond to the behaviour by redirecting the person to a preferred activity and engaging them in conversation (consequence). The hypothesised function of behaviour is to obtain social interaction and access preferred activities.	The function of behaviour is to gain control of their environment.

Formulation

The hypothesised function of behaviour (that is the reasons why it occurs) should be placed in the broader context of the person's life and circumstances to inform holistic formulation about why the behaviour occurs. Formulation should integrate the assessment information with clinical knowledge, theory, and practice. It should provide a shared, evidence-informed, and holistic understanding of the needs of the person and why the behaviour occurs to inform the choice and prioritisation of strategies.

Including a formulation statement helps the person's support network understand the reasoning behind the behaviour support strategies and why these strategies are considered the most effective and suited to the person (Nankervis & Vassos, 2023). Holistic formulation should consider predisposing, precipitating, perpetuating and protective factors (see *Table 8*) across biological, psychological, environmental, and social domains (Bolton, 2014).

Table 8: The 4P model of formulation and examples

Factors	Description	Examples
Predisposing factors	These are background factors, historical events and areas of vulnerability that increase the likelihood of the behaviour occurring.	History of childhood trauma, previous life experiences, poverty, brain injury, sleep difficulties, mental health conditions, high turnover of staff
Precipitating factors	These are stressors and onset events that directly precede or trigger the behaviour.	A difficult task, sudden loud noises, being told 'No', co-tenants returning home, change in routine, conflict or argument, crowded environment, temperature
Perpetuating factors	These are factors that reinforce, exacerbate, or maintain the behaviour.	Caregiver stress and burnout, access to treatment or services, chronic illness, environmental stressors, social isolation
Protective factors	These are individual and/or systemic strengths that may counteract the predisposing, precipitating and perpetuating factors.	Positive support system of family and friends, good health, stable home environment, social networks, existing skills

The holistic approach to formulation guides practitioners to consider the person's environment and life circumstances, not just the individual. This helps with understanding the person's behaviour and designing interventions that address the factors contributing to and maintaining it (Fisher, et al., 2024).

This guide promotes a biopsychosocial approach and the 4P framework for developing case formulation. However, the NDIS Commission recognises that a range of other methods and approaches can also support NDIS practitioners to develop and communicate clinical formulations (e.g. narrative, contingency/diagrammatic and systemic approaches). Regardless of the approach used, it is essential to provide an integrated and cohesive explanation about why behaviour occurs.

Intervention and planning

The findings of the behaviour support assessment, including FBA, inform the development of individualised, person-centred and function-based interventions. This includes ensuring that interventions are directed at environmental and systemic factors that contribute to and/or maintain the behaviour. This means:

- There should be a logical and clear relationship between the identified setting events and triggers and any proposed proactive and preventative strategies. This includes any changes within the environment of the person to reduce or remove the need for the regulated restrictive practice (e.g. setting event = poor sleep → routines to support good sleep hygiene).

- There should be a logical and clear relationship between the identified functions of behaviour and the proposed supports and strategies. This should include consideration of a functionally equivalent replacement behaviour (where relevant), alternative behaviours, and/or other new skills to teach the person.

16. The reduction and elimination of regulated restrictive practices

Section 9 of the NDIS Act 2013 defines a restrictive practice as "any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability". Under the Behaviour Support Rules, certain restrictive practices are subject to regulation and oversight by the NDIS Commission. These are referred to as regulated restrictive practices (RRPs) and include seclusion, chemical restraint, mechanical restraint, physical restraint and environmental restraint (for further information see: Regulated Restrictive Practices Guide).

The use of restrictive practices presents significant human rights limitations. Prior to recommending the introduction or continued use of RRPs, an assessment must be completed to carefully consider the clinical, ethical, and legal implications. This includes assessing whether the use of RRP is necessary as a last resort to keep people safe, and exploring and promoting alternatives to the use of RRPs in consultation with the person and their support network.

The NDIS Commission has released research on reducing restrictive practices. This includes an evidence summary of interventions for reducing inappropriate use of psychotropic medications in people with neurodevelopmental disabilities. This research provides evidence that medication reviews, workplace training, organisational guidelines and policies, and multi-component intervention strategies can decrease prescribing and administration of psychotropic medications in people with neurodevelopmental disabilities. NDIS practitioners play an important role in collaborating and consulting with prescribing medical practitioners to support the reduction and elimination of the inappropriate use of psychotropic medications, including chemical restraint.

Where an RRP is included in a behaviour support plan, there must be evidence that the use of the RRP meets the conditions in which an RRP can be used as outlined in section 21 of the Behaviour Support Rules. To demonstrate these requirements have been met, the information derived from the assessment of the RRP must be included in the comprehensive behaviour support plan. An overview of these requirements is outlined below (see *Table 9*) with examples of questions that may support the assessment of an identified RRP against the conditions in which an RRP must be used.

Table 9: Description of legislative requirements for the use of regulated restrictive practices and examples of potential questions to ask to inform assessment

Requirement	Potential questions to ask
Be clearly identified in a behaviour support plan	• Has assessment been undertaken in all relevant environments? • Are any RRPs included in the participant's existing BSP? • Are these practices clearly described or is what, how, when, where, who or why unclear? • Are there any strategies currently being used (outside of a BSP) that meet the criteria of an RRP? • Has the type of RRP been accurately identified?
The RRP must be used only as a last resort	• For existing RRPs in use, what was tried by the participant, their family or support network prior to resorting to the RRP? • What proactive strategies are being used before the RRP to meet the person's needs? Do these strategies have the potential to reduce or avert the need to use the RRP? • What evidence-based, person-centred and proactive strategies have been trialled and what were the outcomes?
The RRP must be least restrictive response	• On a continuum from most to least restrictive response, where does the RRP fall? • What other less restrictive options have been considered or trialled, including the effectiveness of such alternatives? • Are there any other less restrictive options that can be trialled that still ensures the safety of the person and others?
The RRP must reduce the risk of harm	• How does the RRP reduce the risk of harm to the person or others? • Does the use of the RRP increase the risk of harm to the person or others? • Does the use of the RRP introduce new risks that outweigh the risks of the behaviour?

Requirement	Potential questions to ask
The RRP must be proportionate to the potential negative consequence or risk of harm	• What is the risk of harm to the person or others if the RRP is not used? • What is the severity and likelihood of harm that is posed by the behaviour? • Is the level of restriction excessive based on the potential negative consequences of the risks of harm? • What are the short-term and long-term effects of the person's physical, psychological wellbeing and quality of life?
The RRP must be used for the shortest possible time	• What are the circumstances in which the RRP should be stopped? • What is the plan to fade out the RRP? • What are the indicators that the risk of harm is no longer present? • Can the circumstances in which the RRP is used be reviewed? That is, routine vs PRN use? • How long is the RRP being used/applied at any one time?
All reasonable steps to reduce and eliminate the use of RRP must be taken	• What strategies have the potential to reduce and eliminate RRP? How will the success of these strategies be monitored? • What are the goals and outcome measures for the person? • Who will collect and review data and how will this be communicated between stakeholders? • What is the plan to fade out the RRP and does the fade-out plan safeguard the rights, dignity, and wellbeing of the person? • How will the reduction of the RRP be monitored during the implementation of the behaviour support plan?

Some practices may be restrictive in nature but are not considered regulated restrictive practices under the NDIS. These do not require reporting to the NDIS Commission. These include, for example, practices used for safe transportation or age-appropriate parenting practices to safeguard a child or young person. See: Practice Guide on Safe Transportation, Regulated Restrictive Practices with Children and Young People with Disability Practice Guide.

Talking to the person about RRP

Specialist behaviour support providers must provide details to the person about the intent to include an RRP in a behaviour support plan in an appropriately accessible format. Conversations should include seeking the person's viewpoint on restrictive practice options or alternate strategies that may keep them or others safe. We have developed resources to support these conversations – Talking with participants about restrictive practices. These conversations should be documented within the behaviour support plan.

Practices that present high risk of harm

Some practices may be identified that present a high and unacceptable risk of harm to the person and should be ceased immediately. Behaviour support practitioners should consider the risks to the participant or others as well as any legal, ethical, or clinical considerations. They should also work collaboratively with the person and other stakeholders to identify alternative strategies. Where these practices are identified, the behaviour support assessment should include the rationale or assessment findings that support the position that the practice should not be used.

17. Reporting on outcomes of assessment

Communicating the outcomes of the assessment is an integral component of the PBS process. Best practice is that specialist behaviour support providers should produce a separate behaviour assessment report, which is a record of the FBA (as defined in the self-assessment resource guide for the PBS Capability framework).

This approach supports improved accessibility of the behaviour support plan to focus on the implementation of positive behaviour support strategies. Developing a separate behaviour assessment report also supports the person and their support network to understand the rationale underpinning the behaviour support strategies. It provides an opportunity to explain the outcomes of the assessment with the person and their support network and promotes collaboration.

The behaviour assessment report is a summary of the findings and should not include raw data. It should include (but is not limited to) the following:

Background information

1. Information about the person
2. Reason for referral
3. Date of the assessment report
4. Name of the NDIS behaviour support practitioner and Specialist Behaviour Support Provider who has undertaken the behaviour support assessment including FBA

Sources of information and assessment methods

5. Details and outcomes of indirect methods of assessment
6. Details and outcomes of direct methods of assessment.
7. Details of how the person was included in the assessment and data-gathering process
8. Details of how the person's support network (e.g. family, guardian, NDIS providers, support workers, specialists) were included in the assessment and data-gathering process.
9. Details of the other sources of information reviewed, including previous behaviour support assessments and/or other assessments.

Assessment findings

10. A clear description of the target behaviours (in observable and measurable terms)
11. Analysis of the triggers (events, times and situations that predict when the behaviour will and will not occur)
12. Analysis of the setting events (more distant factors that influence or contribute to the likelihood of the behaviour occurring)
13. Analysis of the consequences that maintain the behaviour (events that happen immediately after the behaviour and therefore reinforce the behaviour)
14. Analysis of the biopsychosocial and environmental factors that may contribute to and/or maintain behaviour
15. Analysis of the strengths and challenges faced by those implementing the plan
16. Summary of the history of the strategies that have been previously carried out and the success and/or failure of those strategies
17. A clear summary statement of the hypothesised function(s) of behaviour(s)
18. Formulation statement or summary that considers predisposing, precipitating, perpetuating and protective factors across biological, psychological, environmental, and social domains
19. Where relevant, proposed functionally equivalent behaviours or other skill development that addresses the function(s) of behaviour(s)
20. Summary statement outlining the strategies that will be developed in line with the findings of the behaviour support assessment
21. Any other recommendations identified throughout the assessment process, including where referrals to other professionals is required.

18. Frequency of assessment

Behaviour support assessment is not a one-time event but part of an ongoing process of assessment, intervention, monitoring, review, and data-based decision making. The needs and circumstances of the person and those who support them will change over time. Assessment should therefore be an open-ended and open-minded process of discovery (Gore, et al., 2022).

While an FBA must be completed to inform the development of a comprehensive behaviour support plan, there is no standard interval for re-assessment. The factors that trigger and maintain behaviour may also change over time, so assessment should be flexible and continuing, rather than fixed (NICE, 2015).

The behaviour support assessment is the foundation for determining proposed strategies in the development and/or review of the person's comprehensive behaviour support plan and the reduction and elimination of regulated restrictive practices. As such, the assessment should be revisited and where necessary updated and expanded every 12 months, or sooner if there is a change in circumstances. This should then inform the development and/or review of the person's comprehensive behaviour support plan.

What are the indicators that an assessment should occur?

The factors that may indicate that assessment should be revisited include (but are not limited to) the following:

- if new risks of harm to the person or others are identified and need to be prioritised
- where there is a change in the person's living arrangements or personal and/or environmental context that requires the behaviour support plan to be reviewed and amended
- when there has been no change in outcome measures such as quality of life, behaviours of concern, goal attainment, therapeutic-related measures and/or the reduction and elimination of restrictive practices. For example, if the behaviour support strategies are found to be ineffective, then this would indicate that further assessment is required. That is, has the function been accurately identified and have the person's needs been understood? Have the environmental strategies been developed and implemented effectively? Is there an error in the identification of the functionally equivalent replacement behaviour? Is the behaviour support plan being implemented as described?

At times, an NDIS participant may choose to stop receiving services from one specialist behaviour support provider and then engage a different one. When this occurs, the specialist behaviour support provider whose service are no longer required should ensure that all documentation is provided to the participant, including the behaviour support assessment report. **Information must only be shared with third parties (i.e. other providers) in accordance with the participant's (or their guardian's) express written consent.**

When assessment is revisited, the behaviour assessment report should be updated to reflect any new findings.

19. Key terms

The meaning of key terms and abbreviations in this policy are set out in the table below.

Term or abbreviation	Description
Behaviour support (also referred to as 'Positive behaviour support' or PBS)	A human-rights and values-led approach. It includes an ongoing process of assessment, intervention, and data-based decision making. PBS focuses on skill building, creating supportive contexts through ecological and systemic change, and reducing the likelihood and impact of behaviours of concern. It relies on person-centred, proactive and evidence-informed strategies that are respectful of a person's dignity and aim to enhance the person's quality of life. PBS draws primarily on behavioural, educational, and social sciences, although other evidence-based strategies may be incorporated. It can be applied within a multi-tiered framework at the level of the individual and at the level of larger systems (Adapted from Kincaid et al. 2016 and Leif et al. 2024).
Behaviour of concern	Behaviour that is of such intensity, frequency, or duration that the physical safety of the person or others is likely to be placed in serious jeopardy. Behaviours of concern also include behaviour that is likely to seriously limit the use of (or result in the person being denied access to) services or ordinary community facilities (NDIS Quality and Safeguarding Framework, 2016).
Behaviour support assessment	A broad term that recognises the holistic and varied assessment considerations that go beyond functional assessment procedures. It is a human-rights and values-led approach that involves understanding human rights principles and actively promoting and protecting those rights. It incorporates person-centred approaches that consider the various dimensions of wellbeing and quality of life directed by the person's values and preferences. It should include a full biopsychosocial assessment to understand the broader context of the person's life, circumstances, and rights and how this supports a holistic formulation as to why behaviour occurs. The functional behaviour assessment is only one component of a comprehensive behaviour assessment.

Term or abbreviation	Description
Behaviour support plan	A document prepared in consultation with the person with disability, their family, carers, and other support people. The BSP contains person-centred, proactive, and evidence-informed strategies to enhance the person's quality of life. It addresses the needs of the person and reduces the likelihood and impact of behaviours of concern. There are two types of BSPs: interim and comprehensive.
Behaviour Support Rules	National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 (Cth).
Evidence-informed practice (also 'evidence-based practice')	Integrating the rights and perspectives of the person with disability, with the best available research, professional expertise and information from the implementing or practice contexts.
Functional behaviour assessment	The process for determining and understanding the function or purpose of a person's behaviour. This may involve the collection of data, observations, and information to develop an understanding of the relationship of events and circumstances that trigger and maintain a particular behaviour.
High-risk practice	A practice that places a person with disability at high risk of harm and is associated with adverse and/or catastrophic outcomes, such as long-term psychological or physical injury and/or death.
Implementing Provider	An NDIS provider who, in the course of delivering NDIS supports, implements behaviour support plans, and/or uses regulated restrictive practice.
NDIS behaviour support practitioner	A person who is considered suitable by the NDIS Commissioner (following an assessment undertaken pursuant to section 181D (2) of the NDIS Act 2013) to undertake behaviour support assessments (including functional behaviour assessments) and to develop behaviour support plans for NDIS participants that may contain regulated restrictive practices. An NDIS behaviour support practitioner is also an NDIS worker.
NDIS Code of Conduct	National Disability Insurance Scheme (Code of Conduct) Rules 2018, which applies to all NDIS providers regardless of whether they're registered.

Term or abbreviation	Description
NDIS Commission	The National Disability Insurance Scheme Quality and Safeguards Commission is a federal government agency established by section 181A of the *National Disability Insurance Scheme Act 2013* (Cth) to improve the quality and safety of supports and services delivered to people with disability.
NDIS worker	A person who is employed or otherwise engaged by an NDIS provider to provide NDIS supports and services to people with disability. An NDIS behaviour support practitioner is also an NDIS worker.
Operational definition of behaviour	A description of a target behaviour that is specific and objective and described in observable and measurable terms.
Participant	A person with disability who is a participant in the National Disability Insurance Scheme (NDIS). They have an NDIS plan and use the funding in that plan to purchase supports and services.
Person-centred practice	An approach underpinned by recognition of the fundamental human right to equality and self-determination, and the recognition and facilitation of what matters to that person. It is a holistic approach that prioritises wellbeing and quality of life directed at the person's will and by the person's needs and preferences in the context of the person's world (including environments and relationships), individual expression, values, and beliefs.
Positive Behaviour Support Capability Framework	The Positive Behaviour Support Capability Framework (PBS Capability Framework) outlines the capabilities required of individuals providing specialist behaviour support under the National Disability Insurance Scheme (NDIS).
Prohibited practice	Practices that are prohibited in the relevant state or territory in which a registered NDIS provider provides supports or services to a person with disability.
Restrictive practice	Any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability.

Term or abbreviation	Description
Regulated restrictive practice	A restrictive practice is a regulated restrictive practice if it is, or involves, any of the 5 types of restrictive practices that are subject to regulation and oversight by the NDIS Commission: (1) seclusion; (2) chemical restraint, (3) mechanical restraint, (4) physical restraint, and (5) environmental restraint.
Specialist behaviour support provider	A registered NDIS provider whose registration includes Module 2, the provision of specialist behaviour support services (i.e. registration group 110).

20. Where to get more help

Deciding With Support – a supported decision-making toolkit designed for behaviour support developed by Flinders University and funded by the NDIS Commission.

Evidence matters: Developing Quality Behaviour Support Plans – a literature summary by University of Queensland and funded by the NDIS Commission.

The Right Direction – a suite of resources to strengthen participant and provider connections with the goal to improve behaviour support outcomes. It was developed by the University of Melbourne and funded by the NDIS Commission.

Compendium of resources for positive behaviour support – provides behaviour support practitioners with a comprehensive list of positive behaviour support assessment tools that can be used for the purposes of behaviour support assessment, planning, intervention, monitoring and review.

Policy Guidance – outlines the NDIS Commissioner's expectations of providers and practitioners to work within their scope of practice when developing behaviour support plans and reduce and eliminate restrictive practices.

The Positive Behaviour Support Capability Framework – outlines the knowledge and skills required to deliver contemporary, evidence-informed behaviour support, and is used to consider a practitioner's suitability.

Position Statement: Practices that present high risk of harm to NDIS Participants – outlines practices that present an unacceptable risk of harm to participants and must not be used by registered and unregistered NDIS providers.

Interim and Comprehensive Behaviour Support Plan Templates – revised BSP templates (V3.0) reflect contemporary evidence-informed practice informed by consultation with people with disability, family members, practitioners, providers, peak bodies and the state and territory restrictive practice authorisation bodies.

Interim and Comprehensive Behaviour Support Plan Checklists – tools that outline good practice and the requirements when developing behaviour support plans.

Practice Guides around restrictive practices: provides guidance about regulated restrictive practices.

Self-Assessment Resource Guide – provides guidance to behaviour support practitioners (whether they are registered providers, or employed or otherwise engaged by registered providers) on how they can assess their own capabilities against the PBS Capability Framework.

21. References

Australian Government. (2013). *National Disability Insurance Scheme Act 2013*. Retrieved from the Federal Register of Legislation website.

Australian Government. (2018a). National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018. Retrieved from the Federal Register of Legislation website.

Australian Government. (2018b). National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018. Retrieved from the Federal Register of Legislation website.

Australian Government. (2018c). National Disability Insurance Scheme (Code of Conduct) Rules 2018. Retrieved from the Federal Register of Legislation website.

Australian Government. (2018d). National Disability Insurance Scheme (Quality Indicators) Guidelines 2018. Retrieved from the Federal Register of Legislation website.

British Institute of Learning Disabilities (BILD). Capable Environments infographic (2022) BILD website

Bolton, J. W. (2014). Case formulation after Engel—the 4P model: a philosophical case conference. Philosophy, Psychiatry, & Psychology, 21(3), 179-189.

Browning-Wright D, Mayer GR, Saren D. Behavior intervention plan quality evaluation scoring guide II. California (USA). Positive Environments, Network of Trainers (PENT); 2013.

Dallman, A. R., Williams, K. L., & Villa, L. (2022). Neurodiversity-affirming practices are a moral imperative for occupational therapy. The Open Journal of Occupational Therapy, 10(2), 1-9.

Davis, E., Young, D., Gilson, K. M., Swift, E., Chan, J., Gibbs, L., ... & Williams, K. (2018). A rights-based approach for service providers to measure the quality of life of children with a disability. Value in Health, 21(12), 1419-1427.

Dwyer, P. (2022). The neurodiversity approach (es): What are they and what do they mean for researchers? Human development, 66(2), 73-92.

Emerson, E. (1995) Challenging behaviour: analysis and intervention in people with learning difficulties, Cambridge University Press, Cambridge.

Fisher, A., Louise, K., Dobek, M., & McRae, J. (2024). Positive Behaviour Support Process and Planning Tool. Flinders University, PBS Teaching & Practice resource.

Fisher, A., Louise, K., Dobek, M., McRae, J., Clissold, M., Reschke, K., ... & Freeman, R. (2025). A positive behaviour support practice framework for disability and community services in Australia that prioritises human rights and evidence-based practices. Disability and Rehabilitation, 47(11), 2948-2959.

Gore, N. J., Sapiets, S. J., Denne, L. D., Hastings, R. P., Toogood, S., MacDonald, A., ... & Williams, D. (2022). Positive behavioural support in the UK: a state of the nation report. International Journal of Positive Behavioural Support, 12(1), i-46.

Jessel, J., Beaulieu, L., & Rajaraman, A. (2025). How to conduct more culturally responsive and trauma-informed functional assessment interviews: A tutorial. Behavior Analysis in Practice, 1-16.

Jorgensen, M., Nankervis, K., & Chan, J. (2023). 'Environments of concern': reframing challenging behaviour within a human rights approach. International Journal of Developmental Disabilities, 69(1), 95-100.

Kincaid, D., Dunlap, G., Kern, L., Lane, K. L., Bambara, L. M., Brown, F., ... & Knoster, T. P. (2016). Positive behavior support: A proposal for updating and refining the definition. Journal of Positive Behavior Interventions, 18(2), 69-73.

Leif, E. S., Fox, R. A., Subban, P., & Sharma, U. (2023). Editorial for the special issue: 'positive behaviour support: moving toward a human rights-based model of support.' International Journal of Developmental Disabilities, 69(1), 1-4.

McGill, P., Bradshaw, J., Smyth, G., Hurman, M., & Roy, A. (2020). Capable environments. Tizard Learning Disability Review, 25(3), 109-116.

Miltenberger, R. G., Bloom, S. E., Sanchez, S., & Valbuena, D. A. (2016). Functional assessment. Handbook of evidence-based practices in intellectual and developmental disabilities, 69-9

Nankervis, K & Vassos, M (2023). Evidence Matters: Developing quality behaviour support plans. NDIS Quality and Safeguards Commission.

National Collaborating Centre for Mental Health (UK. (2015). Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges.

OECD (2024), "Explanatory memorandum on the updated OECD definition of an AI system", OECD Artificial Intelligence Papers, No. 8, OECD Publishing, Paris, OECD website.

Vassos, M & Nankervis, K (2025). Positive Behaviour Support Plan Quality Evaluation Tool Retrieved from The University of Queensland website.

Ramcharan, P., Nankervis, K., Strong, M. and Robertson, A. 2009. Experiences of restrictive practices: A view from people with disabilities and family carers (A final research report to the Office of the Senior Practitioner). Retrieved from the Victorian Government website.

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. (2023). Final Report Volume 3: Nature and extent of violence, abuse, neglect, and exploitation.

Speech Pathology Australia (2023). Retrieved from the Communication Hub website.

United Nations. (2006). United Nations Convention on the Rights of Persons with Disability. Retrieved from the UN High Commissioner of Human Rights website.

Webber, L., Richardson, B., Lambrick, F., & Fester, T. (2012). The impact of the quality of behaviour support plans on the use of restraint and seclusion in disability services. International Journal of Positive Behavioural Support, 2(2), 3-11.