Comprehensive Behaviour Support Plan

CONFIDENTIAL

Person details

Person's name:	Peter Clarke	**NDIS Participant #:**	430937558
Date of Birth (age):	28/05/1977	**Gender:**	Male
Address:	11 Wilkinson Ct Numurkah VIC 3636	**State or Territory:**	VIC

Plan dates

Comprehensive BSP date:	12/11/2025	**BSP Review date:**	12/05/2026

Practitioner and provider details

NDIS Behaviour Support Practitioner:	Katie Cummins	**Contact details:**	katie@momentum-360.com 1300 360 123
Specialist Behaviour Support Provider:	Momentum 360 Partners & Co Pty Ltd	**Registration ID:**	P1714681

Contents

Purpose

The purpose of this Comprehensive Behaviour Support Plan is to:

- Respect and uphold the person's rights **and dignity**.
- **Improve quality of life** and support progress towards positive change.
- Provide **detailed and holistic information about the person** with disability and their needs.
- Provide **person-centred, proactive and evidence-informed strategies** such as environmental changes and skill development to improve overall quality of life, self-determination and **address the underlying function(s)** of the person's behaviour.
- Provide **response strategies** to keep the person and others safe.
- Where relevant, **identify any regulated restrictive practices** used and how they will be reduced and eliminated. Note restrictive practices should **only be used as a last resort** and may not be necessary to minimise the risk of harm.

Consultation

Consultation with the Person

What was the person consulted about, when and how	Details provided about intent to include RRP
Observed Peter at PALS Hub and at home with InLife supports. He confidently showed the practitioner around the hub and engaged in relaxed conversation. During afternoon tea at home, Peter shared his likes, wants, and daily routines, demonstrating comfort, pride, and positive engagement in both settings.	N/A

Consultation with Others

Name, role and contact details	What were they consulted about, when and how	Details provided about intent to include RRP
Parents: Jean and Noel	Via phone June 2025	N/A
PALS Careteam- various support workers at the day program and Manager (Kerry) CEO (Erina)	Spoke to multiple support workers in person at the PALs Hub/day program. Kerry in person and via email Spoke to the PALS team via the phone and email.	N/A N/A N/A N/A
Inlife- House Manager (Denise) - Support workers - Team leader	Via phone and via email Discussed behaviours, incidents of behaviours.	N/A
Support Coordinator- Kate Wright	Via phone and via email	N/A
OT-Nadine Holgate	Reviewed OT report July 2024 In person training and care teams and case consultation	N/A
Speech Therapist -Sharna Demaio	Reviewed Mealtime management report February 2025 and care team meetings and case consultation	

Other Sources of Information

Assessor / Report Writer Details	Name of Assessment / Report	Date Conducted
Nadine Holgate	OT Functional Assessment	July 2024
Sharna Demaio	Mealtime management report	February 2025
Katie Cummins	Interim Positive Behaviour Support Plan	April 2025
Katie Cummins	Behaviour monitoring Forms	November 2025

About the Person

Peter, a 48-year-old man with a diagnosis of an Intellectual Disability, chromosome abnormalities, and partial hearing loss. He is living in supported accommodation in his local hometown of Numurkah. This is managed by Xander Care, who took on the role when Housetides, the original provider, ceased trading. In-Life supports, who are a registered NDIS provider currently supporting Peter.
Peter is described as caring, polite, and social. Peter enjoys activities such as swimming, darts, bowling, and following sports, particularly his passion for the Essendon footy team. He enjoys watching television shows and pursuing hobbies, such as collecting Coke bottle tops and participating in a weekly disco. Although Peter occasionally exhibits oppositional behaviour when he feels he is being told what to do, particularly when he feels unheard or left out, he generally responds positively when assisting with meaningful tasks and interacting with others.
Peter has successfully transitioned to supported accommodation over the past 12 months. While he has settled in well, the provider's transition to a new team may cause him some concern due to his relationship-oriented nature.

Current Support

Peter currently attends the PALS day program 5 days a week from 9-3 pm and participates in various activities including bowling, cinema visits, and local road trips. He is actively involved in sports and trains weekly for the tri-state games. His enjoyment of community interactions is evident, and he enjoys being active. He has a clear preference for familiar supports who understand and can effectively support his needs. Peter displays a strong desire for social engagement and participation in activities. His challenges are primarily related to communication, social interactions, and behavioural responses when feeling frustrated.

Health

Peter has a diagnosis of intellectual disability, chromosome abnormalities, and partial hearing loss, which impact his communication skills and understanding. This can sometimes lead to frustration and challenging behaviours; however, his regular supporters can comprehend his communication style. Hearing aids are used to support his communication and have been a positive addition to his communication. Peter has the following health conditions and is supported by his parents to attend medical appointments:

- Intellectual Disability
- Translocation rearrangement of chromosomes 15 and 16
- Previous hip fracture (Oct 2020)
- Hearing loss resulting in his loud communication and the use of hearing aids
- Head Injury 2013
- HX of recurrent aspiration pneumonia
- Severe Oro-Pharyngeal Dysphagia
- Stigmatism of the eye

NDIS Goals

- For Peter to increase his participation in the community outside of his day program.
- For Peter to explore and transition into new supported living accommodation and to increase his independent living skills.
- For Peter to continue to maintain his health and to stay active.
- For Peter to have support to increase his emotional regulation skills.

Reason for Referral/ Behaviour Support History

Peter's actions are best understood as forms of communication and connection. He responds positively to meaningful engagement, predictable routines, and supportive social interaction. His

mother, Jean, reports that Peter manages well at home when he experiences consistent attention, structure, and connection from his parents. He may become frustrated when experiencing communication or hearing difficulties.
Peter previously engaged with behaviour support through 360 Health following the breakdown of a prior living arrangement in 2021, which led to his return to his parents' home. He re-engaged with behaviour support in 2024, during which the current practitioner supported his transition into his current home. Once settled, no ongoing behaviour support was required, and feedback from Housetides/Xander Care, his parents, and PALS indicated minimal behaviours and a positive adjustment.
With the introduction of InLife supports, observations and data identified some emerging communication and environmental challenges, including reduced engagement in self-care routines, fatigue, and difficulty connecting with a previous housemate. Following a compatibility breakdown, the housemate moved out in August 2025. A new participant has since joined the home who requires higher levels of support, which has been challenging for Peter, who values connection and enjoys being socially central. At times, Peter's communication style may appear controlling or dominant; however, this is best understood as his way of seeking connection and maintaining a sense of belonging.
InLife staff have demonstrated strong observation and documentation of these patterns, helping ensure Peter's needs are understood and supported in a neuroaffirming and person-centred manner. It is believed that Peter's communicative behaviours have been present for some time but may have been underreported in previous support settings.

Likes

- Routine
- Personal space to relax on his own
- Shaking Peter's hand when you meet him
- Home and Away and Neighbours
- Having "happy hour" with his father at the end of the day
- Sharing a cup of tea with his family when he gets home
- Peter has an interest in sports such as swimming, darts, and bowling.
- He also enjoys playing music such as John Farnham.
- Watching sports, particularly AFL, where he supports the Bombers team.
- Watching passing cars.
- Collecting Coke bottle tops.
- Stacking coins.
- Attending the weekly disco outside of day programs.
- Attending day programs- PALS

Dislikes

- Talking to him when he needs to process his day
- Not having his alone time
- Noise
- Too many questions
- Being "bossed around" or dominated, especially by peer

Risks of Harm

Description of behaviour	*Communication and Frustration (which can appear as Aggression)* Peter can sometimes appear agitated or frustrated when he is trying to express his needs or concerns and feels misunderstood. At these times, his communication may become louder or more assertive, and he may display mild forms of verbal aggression as part of his attempt to be heard. These behaviours are best understood as expressions of frustration rather than deliberate aggression. When frustrated, Peter may: ● Yell loudly to himself or towards others ● Swear, call names, or repeat phrases such as “no” ● Raise his voice or engage in repetitive vocal outbursts ● Pace or move quickly around the environment when feeling anxious or overstimulated These behaviours are most likely to occur during times of transition or increased demand, during Morning routines, When being told “no” or denied a preferred item or choice (even if this is in his best interest to say no), when items like his earring aides are missing or routines change unexpectedly and when communication styles feels abrupt, firm, short or unfamiliar to him. Early signs that Peter is becoming stressed include visible agitation, shaking his head, or making self-directed comments. These cues often occur when he is not being understood or is unable to clearly articulate his needs. Peter’s parents are highly attuned to his communication style and can often anticipate his needs before frustration develops. This difference in understanding can cause distress for Peter when he returns to his Supported Independent Living environment after being home, as staff may not yet interpret his communication cues as effectively as his long term carers.
Frequency / Duration	Weekly however recent incidents state daily Once he was upset in his room for a few hours after he left the hearing aid at PALS
Intensity	Very Mild- Likely communication of his needs, not aggression
Low Risk Scenarios	● Having time to process: ○ the situation ○ the question ○ the request ○ The day that he just had ● Being allowed to verbalise his thoughts without interruption in a space where he can do so without being asked to be quiet ● Answering his questions, which can be repetitive until he has processed the plans or situation ● Having a routine ● Role modelling tasks and completing tasks alongside a support worker to reduce the cognitive demands, and knowing what is expected. ● Reading Peter's body language if he wants alone time, don’t talk to him or make requests until he engages with you (usually 15-30 minutes maximum) ● Having processing time for new information

	● Having his hearing aids working and backup batteries ready if they go flat
High Risk Scenarios	● Not hearing: Hearing aids missing, not working or batteries going flat ● Change of support services (Christmas and now with new supports) ● Being asked to be quiet or less noisy, especially when he is processing the day ● Interrupting his processing (which includes verbalising and being loud to others) ● Change of routine or plans without telling him ● Not able to verbally express his needs ● Stimuli once heightened/ overwhelmed, such as too much talking or questions. ● Tired at the end of the week - Fatigue ● Transitions - inpatient with others who are not keeping up with his timeline and expectations eg, during the morning routine to go to PALS
Antecedent (Warning Sign)	Areas of additional support that need to be addressed before other behaviours appear: ● Ignoring or doing the opposite of what is requested is a lead-up behaviour ● Moving away from the trigger or stimulus ● Being fidgety and looking upset
Setting events (Internal & External)	● Being told what to do ● Feeling he is not in control, that others are making decisions for him, not with him ● Not having his needs met (hearing aids) ● Not being understood
Triggers	● Fatigue ● Waiting ● Other people in his space ● People “bossing” him ● Not having his requests met (eg, hearing aids) ● Not having space from others once he has moved himself to express what he needs ● Having the expectation that he will do what he is asked once someone tells him to do something, like being quiet or less noisy ● Not understanding his requests or needs, and the early warning signs are missed ● Unscheduled change
Risks	If Peter's needs are not met, several risks may arise. Not supporting him in developing meaningful therapeutic relationships with the new supporting person (staff) is a risk, as it could lead to behaviours of concern, as he relies on others to support him to communicate. Unmet basic needs, such as his hearing, can cause significant distress. Peter may struggle to understand that the supporting person is aware of his needs and is there to help. This fear of not having his needs met can lead to increased assertiveness in his attempts to communicate his concerns. Ultimately, these factors can create a cycle of frustration and anxiety, further impacting his well-being and emotional stability.
Function	The function of Peter's behaviour serves as a way to communicate his needs. When these needs are unmet, he tends to increase his level of communication.

	This behaviour is aimed at achieving specific outcomes, such as obtaining tangible items, escaping a situation, or retreating to reflect on his day. By allowing him to self-regulate and addressing his needs, we can help prevent situations from escalating

Description of Behaviour	*Seeking Connection via unconsented touch* Peter seeks physical contact (hugging from behind, hand-holding, attempts to kiss) with staff, typically framed as friendly or affectionate. Behaviours are not aggressive but socially inappropriate and cause discomfort. He is seeking connection and touch, however it seems to come unexpectedly. PALS have reported they provide a hug to him when he requests. Moving into staff's personal space and attempting hugs, handholding, or close proximity standing to seek touch whilst using terms like "girlfriend" in relation to them being his girlfriend or asking if they are.
Frequency / Duration	Occasional (approx. monthly), lasting under a minute if redirected.
Intensity	Low–moderate; responds to firm, calm boundaries. Distress or looking sad may follow redirection.
Low-Risk Scenarios	● Familiar staff ● Clear routines ● Consistent communication of personal-space rules
High-Risk Scenarios	● Transitions (arriving home or after outings) ● When feeling lonely or seeking attention ● When seeking reassurance ● With new or female staff
Antecedent (Warning Sign)	● Standing close behind staff ● Smiling and open body language ● Increased proximity ● Seeking reassurance
Setting Events (Internal / External)	Internal: ● Need for affection or attention ● Boredom ● Low emotional support as he is surrounded by paid support ● Loneliness ● Low emotional insight or confusion about professional relationships External: ● Reduced interaction with parents for various reasons (eg:holidays) ● No receiving hugs and connection from his informal supports or friends ● Quiet/unstructured time ● Presence of preferred staff ● Different rules for different locations

Triggers	• Unstructured greetings and confusing how to greet people (eg: hugs instead of a handshake) • Physical proximity to support people in his space • Social conversations about relationships
Risks	• Staff discomfort • Unintentioned boundary violations • Risk of misinterpretation of who he can hug • Receives staff attention (positive or corrective) which is confusing and boundaries cannot be established with inconsistent feedback
Function	To gain attention, affection, or connection; need for belonging. Receives staff attention (positive or corrective)

Description of Behaviour	*Risk taking: (food seeking and risky food consumption leading to frustration)* Peter requires a puree diet and at times can eat foods that are not appropriate for needs leading to choking, coughing and possible aspiration that has led to chest infections. Peter can refuse food modifications (e.g., puree). He has independently microwaved food that was not modified, or eats unsafe textures like potato chips. When he has had to wait for his food to be prepared he has escalated to verbal expression and has thrown objects (e.g., breakfast bowl). He has attempted to grab or pretend that he will grab by making grabbing motions toward staff when frustrated. Incidents linked to waiting for food and waiting have been recorded and noted. Displays of looking upset, shaping up, yelling which have led to hitting out. This has only verbally been reported however no formalised reports have been sighted. Frustration around food has been highlighted when he seeks food that is not a part of his meal plan - non pureed foods.
Frequency / Duration	Rare (single recorded incident of throwing items in the past 3 months).This data may be under reported and it is necessary to highlight this
Intensity	Moderate; limited physical harm but emotionally distressing to throw food Moderate medical risk to eating foot that is not prepared for him
Low-Risk Scenarios	• Structured meal preparation • Reassurance • Short waiting periods • Early food time options (when he wakes, around 6pm dinner)
High-Risk Scenarios	Delays in meals, hunger, or confusion about routine. Eating alone or unsupervised, food delays, refusal periods.
Antecedent (Warning Sign)	• Repetitive demands for food • Raised voice

	• Reaching for food items • Refusal to accept food texture changes • Preparing own meals quickly • Shaking his head
Setting Events (Internal / External)	Internal: • Hunger • Fatigue • Unable to wait for a reasonable time whilst staff prepare his foods • Low patience • Sensory preferences External: • Unclear communication • Unclear meal times and routines around food • Delays in preferred meals • Reduced supervision.
Triggers	• Food removal without a replacement item • Being told to wait or waiting • Food taken away to be pureed and is out if sight or not involved
Risks	Staff injury, loss of trust, property damage. Choking, aspiration, medical emergency.
Function	To gain immediate access to food; Desire to have control over accessing food

Description of Behaviour	*Withdrawal from Daily tasks* Peter has increasingly withdrawn to his bedroom and often appears sad and disengaged. He may lie on his bed for extended periods and decline offers of support to shower or eat his meals. He has also begun refusing to attend day programs or engage with Inlife supports. Peter often presents as quiet or tearful. While he can appear defiant with some staff, others are able to encourage him to participate in daily living activities or community engagement. These behaviours have become more frequent over the past three months, and he has been observed crying at times and appearing lonely.
Frequency / Duration	Intermittent 1–2 times monthly increasing to 3 times per week. Duration from 30 min – 2 hrs. At times he will not perform hygiene tasks around once a week on average or have his evening meal which is less frequently.
Intensity	Low; minimal disruption to others however limiting his own quality of life.
Low-Risk Scenarios	• Predictable routines • Offered supported choice • Adequate rest • Interaction with supports

High-Risk Scenarios	• When unwell • When fatigued • Pressured to do tasks • Overwhelmed by conversation • Overwhelmed by sensory input
Antecedent (Warning Sign)	• Reduced speech • Avoidance, saying “no” • Limited eye contact • Tearful
Setting Events (Internal / External)	Internal: • Fatigue, • Low mood, • Headache • Unable to self instigate the need to rest • Missing his parents External: • Change in staff or schedule, • Overstimulation during the day or a busy day with minimal break • Parents away or travelling
Triggers	Being asked to shower or attend a day program when tired or sick. Being asked to do a task
Risks	• Missed personal-care routines, • Reduced engagement, • Escalation if pressured • Miss interpretation why he is displaying these behaviours
Function	To escape task demands and regain control; to self-regulate when overwhelmed.

Description of Behaviour	*Dominance in Shared Spaces* Peter demonstrates dominant behaviours within shared environments of his home such as the lounge, dining area, or bathroom. Peter appears to have reduced understanding of personal and social boundaries in communal settings and can become preoccupied with who uses certain spaces or items. This may include directing peers where to sit, blocking access to shared areas, or asserting that a particular seat or room belongs to him. Situations that involve staff attention being directed toward another person, or when peers move past his room or use his preferred space, can act as immediate triggers. In these moments, Peter may raise his voice, use assertive language, or physically position himself to control the environment which

	can scare and intimidate others. It also results in increased staff attention or leading him alone to reduced demands for him to share the space or move away to leave him, which reinforces the pattern over time that others will leave and he does not need to share the shared space when he is present.
Frequency / Duration	Can be daily via verbal reports and assessments 2 times monthly increasing to 3 times per week according to reporting data. Duration from 30 min – 2 hrs.
Intensity	● Low; disruption to others however over time this can cause stress for co-residents and a co-resident has left due to this behaviour
Low-Risk Scenarios	● Supervision and support ● Other locations to have alone time such as a chair outside in the sun, a space in the outdoor area and his room having a TV set up or a desk ● Adequate rest ● Interaction with supports
High-Risk Scenarios	● When fatigued ● Overwhelmed by conversation ● Overwhelmed by sensory input ● Left alone to navigate social communication
Antecedent (Warning Sign)	● Reduced speech ● Avoidance, saying “no” ● Limited eye contact ● Forceful and abrupt
Setting Events (Internal / External)	Internal: ● Fatigue ● Unable to self instigate alone time in other areas ● Unable to share a space or compromise watching a particular TV show or activity ● Reduced understanding of personal and social boundaries and his role as a co-resident as opposed to being in charge or the boss External: ● Staff attending to others ● Supervision ● Lack of clear or concrete structure in shared environments
Triggers	● Peer using or entering shared spaces (chair, lounge, toilet access) ● Staff directing attention to another peer ● Peer walking past Peter’s room or sitting in a preferred spot ● Being denied first choice of activity, seat, or space
Risks	● Missed personal-care routines, ● Reduced engagement, ● Escalation if pressured ● Miss interpretation why he is displaying these behaviours

	• Gains sense of control over environment and peers when he receives his preferred seat or space over another person. Reduces need to share or negotiate space when peers withdraw as opposed to making a compromise
Function	Control over the environment

Behavioural Function	**Reasons why**
Communication of needs	When Peter feels misunderstood or unheard, he increases verbal or assertive behaviour to gain clarity or control or to get his point across.
Connection and belonging	Seeks physical and social closeness for security and comfort.
Escape / Avoidance	Withdraws from tasks or conversation to self-regulate or recover from overload.
Tangible access (Wanting an item)	Food or items used as coping mechanisms and means of control over routine.

History

Peter has engaged with Positive Behaviour Support (PBS) services intermittently over several years. His journey reflects periods of growth and stability, mainly when living with his parents, alongside challenges related to communication differences, sensory processing needs, and the consistency of support within his environment.

After moving from his family home into Supported Independent Living (SIL), Peter received support through Housetides/Xander Care. During this period, incidents were recorded as minimal and often described as “low-level,” typically involving moments of frustration when his hearing aids were not working or when his needs were misunderstood. For example, Peter once became upset when his hearing aids were left at his day program (PALS) and could not be retrieved until the following day. He vocalised frustration in his room but settled once the issue was resolved. Later review, however, showed that these reports did not fully capture the frequency or context of Peter’s behaviours, which were largely communicative and related to unmet needs which he was requesting be met.

Under Xander Care, Peter’s expressions of distress were often normalised and not reported. Currently he displays behaviours if his communication style was not consistently supported. Peter’s manner of communication can be loud and, at times, seem abrupt, an outcome of his hearing impairment and expressive-language differences rather than aggression. When his needs are unmet or he feels unheard, Peter may raise his voice louder again or speak forcefully to make himself understood. For

people unfamiliar with his communication profile, this can appear intimidating, though it is simply his way of trying to connect and ensure his needs are met.

When Inlife Independent Living took over the living support in 2025, it was the first time data-informed information had been collected about Peter's daily communication and emotional regulation patterns. Through structured observations, staff reflection, and ongoing PBS collaboration, Inlife has identified that Peter's behaviours are connection-seeking and communicative, often arising when he wants staff support to himself, when his environment feels unpredictable, or when he needs reassurance that his needs will be met.

Formulation

Peter's behaviours of concern are best understood as communication and coping responses that arise from his communication differences, sensory sensitivities, and strong need for structure and predictability. Biologically, Peter experiences hearing fatigue and dysphagia, which can make daily tasks, transitions, and waiting periods physically and emotionally demanding. Psychologically, his reduced expressive and receptive language skills and limited social understanding mean he often relies on behaviour such as loud self-talk, seeking proximity, or directing others to express his needs, manage uncertainty, and re-establish a sense of control. Socially, inconsistent staffing, limited one-to-one support, and unclear routines can contribute to confusion, anxiety, or frustration when expectations or attention shift unexpectedly.

Peter's behaviours are most likely to be maintained when his communication is misunderstood, when staff responses differ across shifts, or when distress leads to the removal of demands or environmental changes that inadvertently reinforce avoidance. Despite these challenges, Peter's protective factors are significant: he is warm, humorous, affectionate, and thrives on routine, familiarity, and connection with others. His strong family involvement, love of music and shared activities, and willingness to help with household tasks provide excellent opportunities for skill building and engagement.

Some of Peter's actions in shared spaces such as directing peers, seeking one-to-one time with staff, or asserting control were previously perceived as challenging. However, these behaviours reflect his drive for connection, reassurance, and predictability, not malice or intent to intimidate. When Peter feels uncertain or when staff attention is divided, he naturally seeks reassurance or attempts to structure the environment around him to regain a sense of safety. Without consistent modelling or clear communication supports, these behaviours were occasionally reinforced unintentionally. This dynamic created challenges within the home, particularly as both Peter and his co-residents required high levels of support, leading one peer to move to another setting to better meet individual needs.

Overall, Peter's behaviours reflect an adaptive response to unmet communication and emotional needs rather than deliberate opposition. With consistent communication supports, clear structure, and proactive teaching of social and emotional regulation skills, Peter is capable of maintaining stability, increasing independence, and enhancing his participation and quality of life across all environments.

Goals

Goal	Positive Strategies	Reinforcers
By December 2025, all support staff working with Peter will demonstrate increased accuracy and consistency in identifying and responding to Peter's body language cues, using proactive and trauma-informed strategies to prevent escalation and maintain positive engagement. Time-Bound Progress will be reviewed quarterly, with expected full competency achieved by December 2025, or earlier if staff demonstrate consistent application for two consecutive months.	Staff will learn to interpret and respond appropriately to Peter's non-verbal communication (e.g., posture, eye contact, pacing, withdrawal) to identify early signs of stress or disengagement. Measurable Support materials (body language guide, visual prompts) will be available in all environments.	Peter's engagement in daily routines and positive interactions will increase, evidenced by staff logs and qualitative observation. This goal directly supports Peter's behaviour support outcomes by enhancing staff capability to respond to his communication style, reducing the likelihood of physical or verbal aggression, and improving Peter's sense of control and safety.

Preventative strategies

Situation	In the Moment	Proactively
Communication / Frustration	Validate ("I can see you're upset"); reduce verbal input; allow time; redirect once settled.	Predictable routine and visuals; choices not demands; morning prep done early; check hearing aids and batteries.
Touch / Boundary Behaviour	Neutral response ("No thank you, I'm your worker"); step back; redirect to handshake or high-five; praise respectful touch.	Visual "safe touch" poster; daily modelling of appropriate greeting; consistent staff responses; structured connection activities.
Food-related Behaviour	Stay calm; step back; offer safe replacement; avoid arguing and provide food quickly without delay.	Pre-prepared texture-modified meals; photo snack box with safe options; meal supervision and clear timing.
Withdrawal / Shutdown	Allow space (15–30 min); gentle check-in ("Would you like a drink?"); no pressure.	Schedule quiet time daily; low-demand activities post-PALS; consistent staff and visual supports.

Shared-Space Control	Calmly redirect to an alternative area or task; acknowledge his feelings ("You like this chair – let's find your spot").	Define personal vs shared areas with pictures on doors; visual roster of housemates; promote jobs list and choice between "chill or job."

Capable environments

Capable environments, within the framework of Positive Behaviour Support (PBS), refer to thoughtfully designed spaces that promote positive interactions and enhance the well-being of individuals receiving support. This involves recognising Peter's behavioural patterns, sensory sensitivities, and communication styles, allowing for tailored strategies that suit his unique needs.It is important that Peter's daily life includes the following:

- Repetition: When Peter is repeatedly exposed to a predictable environment, it can effectively help him manage any feelings of anxiety and promote a sense of security. When Peter is consistently exposed to a predictable environment, it supports his nervous system in achieving a state of safety and stability.
- Predictable routines: Create a routine chart or checklist for morning, afternoon, and evening routines, and do your best to follow them. Peter likes and does well with clear boundaries and "rules" which support the routines.
    - Morning: wakes early, packs bag, hearing aids in.
    - Afternoon (after PALS): yoghurt + coffee, makes coffee for everyone, activity or chill time.
    - Peter and his father sit down at 5 pm, have a drink together, and chat about their day. This lasts around 30 minutes. Including this part of his routine can help him connect with the supporting person and better understand his communication style.
    - Dinner, medication, Co- resident showers then Peter.
    - Watch Home and Away 7 pm, TV/coffee until 8–9 pm bedtime.
- Visual Schedule: Create a visual schedule as per the OT and speech therapist recommendations that includes photos of the supporting people/ staff members and family. This visual aid will help Peter understand who will be present and who is on the roster later, providing him with a sense of familiarity and reducing stress about the unknown.
- Relationship: Providing unconditional, positive interactions that establish and promote trust however maintaining boundaries regarding personal space.
- Sensory Tools and Supports: Provide sensory tools such as headphones, calming music, and fidget items, like his coins or bottle tops, in a small ziplock bag. These items can help to mitigate the sensory experiences of others while also allowing Peter to regulate his sensory input, thereby reducing the potential disruption caused by his louder behaviour.

- Shaking hands on greeting, calm tone, positive conversations before demands.

- Quiet areas - bedroom, chair at front door or outside; used for processing and watching cars; respect this as his alone time.

- Food - Pre-prepare meals and provide clear timeframes for meals. Supervise mealtimes; use appealing texture-modified options such as food molds provided to Peter by his speech pathologist.

- Shared communal space: Calm redirection; offer alternative space/activity; facilitate fair turn-taking. Clear structure in communal areas; defined “Peter space” elsewhere; teach compromise with visuals

End-of-Day Processing

At the end of each day, set up Peter in his quiet space to facilitate his processing ritual. This strategy supports the self-regulation skills Peter has developed over time. Ensure he is in an environment where he will not irritate others as he expresses/talks to himself. Peter requires time to talk out loud and vocalise his thoughts before he can settle and move to the evening activities. To help facilitate this, the following is required:

- Designated Quiet Space: Allow Peter to retreat to his room or other designated spaces to process his day without feeling pressured to maintain silence or be triggered by others asking him for quiet. Currently, his area of choice is his room which is safe, comfortable, and easily accessible. His room is a space that allows him to vocalise his thoughts without disturbing others.
- Respect for Personal Space: It is crucial to respect Peter’s privacy in his designated quiet space. The supporting person should knock on the door and wait for him to invite them in verbally, rather than entering unannounced. This practice helps reinforce his sense of personal space and control.

Communication

When needs are unmet (hearing, predictability, connection, hunger), Peter escalates communication to gain items/escape/space or connect. Meeting the need and allowing self-regulation prevents escalation and supports dignity and choice.

Peter is a limited verbal communicator who uses a combination of speech, gestures, some signs, and vocalisations to engage in basic conversation. His speech pathologist, Sharna Demaio, indicated that Peter has challenges with expressive, receptive, and pragmatic language, resulting in difficulties with speech intelligibility, volume, and fluency. Since receiving hearing aids in 2024, Peter has been able to wear them daily, leading to improvements in his speech and comprehension.

- When speaking to Peter, he may not initially respond verbally, relying instead on non-verbal cues such as:
    - Nodding,
    - Shaking his head,
    - Walking away.
- Familiar individuals can better understand him than strangers, and he may become frustrated when unable to convey his message.
- Peter has a tendency to repeat questions as a conversation starter or a way to engage with others.
- He has previously used Makaton signs with his parents, and his support staff have begun incorporating signing techniques, which have shown positive results. Further speech pathology input and training for new staff is recommended.
- Visual aids significantly benefit Peter by assisting him in expressing his thoughts, feelings, and needs.
- Peter will come to where you are and connect when he wants to talk and chat; ask him how his day was.

- Peter may need more time than others his age to process requests or respond to questions.
- When Peter is talking, don't jump in - count to 30 in your head before jumping in before clarifying or trying to guess what he is saying. This can prevent communication from happening and build frustration as he cannot convey his message effectively. Peter will disengage once he is ready for his own time.

Peter's speech pathologist also listed supportive ways to assist Peter in communicating

- Use clear and specific language
- Make connections between words
- Explain new words by linking it with familiar words
- Allow Peter extra time to concentrate on his speaking skills
- Provide positive support and encouragement when he is attempting to speak
- Make sure you have Peter's attention before providing instructions
- Break down instructions into smaller chunks
- Allow time for Peter to ask a question
- Get Peter to repeat instructions in his own words to ensure he has understood.
- Provide visual cues or hand gestures where possible
- Provide a visual timetable/schedule that he can understand

Peter C Passport to support (2025)

About me: I am a 48-year-old man who is polite, caring, and social. I have an intellectual disability, partial hearing loss, and I wear hearing aids. I am a limited verbal communicator, but I use a variety of ways to get my message across, including speech, gestures, and signs. I may also repeat questions as a way to start a conversation or engage with you. I lived with my parents my whole life. They cared for me very well.

Things about me
- Friendly, social, enjoys meeting new people.
- Loves collecting 20c coins and bottle tops, watching TV shows (Today Show, Home and Away, Death in Paradise), and playing games like Uno, Ludo, and Go Fish.
- Barracks for Essendon Football Club.
- Enjoys PALS day program.
- Attends community activities like darts, disco, swimming, bowling.
- Likes making cups of tea for others as a way of caring.
- I am getting older, sometimes I need a rest
- I get hungry
- I like an early tea and a relaxing evening in front of the TV to relax

How I communicate

Speech: Sometimes unclear; familiar people understand best.
Gestures/Signs: Uses some Makaton (e.g., "eat," "drink," "toilet," "no"). May shake head, walk away, or say "no."
Repetition: May repeat questions to process or engage.
Body Language:
- Smiling, relaxed = ready to engage.
- Avoids eye contact / turns away = needs space.
- Restless or fidgeting = becoming unsettled.
- Loud self-talk = processing the day.

Things I'm good at
- I enjoy being social and meeting new people.
- I like helping others, such as making cups of tea.
- I know my routines well and can follow daily activities with support.
- I'm good at playing games (Uno, Ludo, Go Fish)
- I can show people around my home and explain what each space is for.
- I enjoy walking and can walk several kilometres with supervision.
- I manage many self-care tasks independently (showering, dressing, hygiene) with some prompts.
- I use my iPad to check the date and track my routines
- I love listening to music, especially John Farnham and Jimmy Barnes.

How to Support My Communication
- Get my attention before speaking.
- Use short, clear instructions (1–2 steps).
- Allow extra processing time before repeating or asking again.
- Encourage me to repeat instructions back in my own words to check I understood.
- Use visuals: daily timetable, first–then cards, signs/gestures.
- Check hearing aids are in and working. Have spare batteries ready.
- Be patient with my speech—ask me to repeat if unclear, don't pretend to understand.

What Helps When I Am Upset
- Give me space (15–30 minutes).
- Acknowledge my feelings ("I know it's frustrating when…") but don't overload me with words.
- Allow me to go to a quiet or private space.
- Offer calming activities I like (TV, games, drinks).
- Respect my boundaries and wait until I re-engage.
- When I'm calm, reconnect with me in a positive way.

How I Show I Am Frustrated
- Talking more loudly to myself or others.
- Shaking head, fidgeting, or moving quickly.
- Facial expressions that look "grumpy."
- Withdrawing to my room for quiet time.

Things That Make Communication Harder
- Too much talking or too many questions at once.
- Sudden changes in routine without explanation.
- Being rushed or told to be quiet while I'm processing.
- Hearing aids missing, flat, or not working.
- New people not using visuals or signs.

Mini Communication Passport Peter.pdf

Transitions / Change of environment / Unscheduled changes

When communicating plans to Peter, it is essential to ensure that he understands what is happening. Begin by clearly outlining the plan and checking that he is actively listening. Observe his facial expressions for signs of engagement, and encourage him to ask questions. To confirm his

understanding, ask Peter to repeat back what the plan entails, which helps eliminate any surprises.He may do this in a few words or gestures. Not word for word.

It is worth noting that Peter often responds with “no” initially. When this occurs, remain calm and avoid reacting negatively, it's best to nod and not say anything. Give him the time he needs to process the information; he is likely to reconsider and express willingness to undertake the request after 15 minutes or sooner, once he feels ready and understands the request.

Peter's parents explained that if you try to negotiate, encourage, or re-request something from him, he is likely to resist and respond with a firm "No." This can lead to agitation or frustration on his part because he feels unheard. Attempting to push the issue will only prolong the process, rather than making it quicker. It’s better to set the question aside and allow him a few minutes before he returns to you on his own, and it's a likely yes.

- Give him time to process the change. Tell Peter he can ask any questions to help him understand, as changes can be hard to understand
- Changes occurring - use a visual to help Peter see that the tasks or order of tasks have changed (use a photo on your phone, on his iPad)

Work on:

- Prepare Peter for unexpected changes - talk to him about what would happen if his support person X is away, so when it happens, you can refer to this conversation

High Value Items (need to increase this list)

Use these high-value items to help him feel special or connected. Use them to connect and build rapport:

- Uno
- Music - John Farnham and Jimmy Barnes (80s and 90s)
- Collections - 20c pieces and coke bottle lids.

Skill Development

Skill	Rationale	Teaching Strategy	Reinforcement
Safe social interaction and personal boundaries	Peter seeks physical contact (hugging, touching) to gain connection; needs to learn appropriate ways to connect.	Model and role-play greetings (handshake, wave, verbal “hello”); visual “Safe Touch” poster; praise appropriate greeting immediately.	Verbal praise (“Good handshake, Peter”), social attention, and inclusion in preferred activities (music, coffee, job task).
Waiting and patience	Becomes frustrated when asked to wait (e.g., meals, routines, bus).	Use a visual Time Timer or countdown; narrate wait times (“5 more minutes”); pair waiting with a regulating task (music, bottle-top sorting).	Positive acknowledgment after successful waiting, access to the next preferred activity, or small tangible reward (e.g., coffee, coin).

Turn-taking and sharing space	Struggles with co-residents using shared areas; seeks control.	Teach structured turns in games and chores; visual "My turn / Your turn" cue; use First–Then language ("First Rory's seat, then Peter's").	Praise for sharing, joint activity with preferred staff, or visual token system leading to chosen leisure activity.
Task initiation and completion (Active Support)	Withdraws or avoids tasks when tired or unsure; needs scaffolding to start.	Use Little-and-Often method; break tasks into steps; complete alongside him with clear modelling ("Let's do it together").	Immediate praise, recognition on job list, participation in relaxing routine after completion.
Emotional regulation / "Shake-it-off" strategy	Displays frustration or self-talk when overstimulated.	Co-regulate through breathing toy or counting; prompt "Let's shake it off" and model deep breathing; offer outdoor seat for regulation.	Verbal praise, access to calming activity (music, garden time).
Safe eating practices	Impulsive eating of non-pureed foods places him at risk.	Teach visual food safety: "Green ✓ = safe" snacks in fridge box; involve him in meal prep with correct texture; reinforce safe choice.	Immediate access to safe preferred food, verbal praise for making safe choice.
Self-advocacy / communication of needs	Frustration often stems from not being understood or heard.	Encourage him to repeat requests using key words, gestures, or Makaton; staff wait 30 seconds before responding; use visual communication book.	Praise for clear communication, affirmation ("Thanks for telling me, Peter"), and quick fulfilment of the communicated request when safe.
Transition tolerance	Becomes anxious when routines change.	Visual daily schedule; pre-warn of changes; "repeat-back" check of understanding; use 10-minute countdown.	Verbal praise for coping with change, favourite activity (music, car watching).

How to implement

Active Support

Active support is essential for building meaningful relationships through positive interactions between individuals and their support networks. By applying active support in Peter's daily life, we encourage his independence, empower him to articulate his needs, and strengthen his connections with others. This approach enriches his experiences and contributes significantly to his overall happiness. Active Support involves transitioning Peter from a "Hotel" model of care to an "Active Support" model that fully engages him in his daily tasks. By doing so, we aim to involve him in activities such as personal care, meal preparation, and other daily living tasks, promoting

independence and enhancing his quality of life. Further support from the writer can be provided to help Peter and his care team implement active support in his routine, if required.

Little and often

Peter will experience new and improved routines and tasks with his new house staff. Use the "Little and often" technique to introduce new things to his life. Little and often helps you recognise:

- Peter has a short concentration span
- Peter, like all of us, may like to dip in and out of activity depending on his mood, fatigue and feelings on the day

Using little and often means you:

- Support Peter to take a break if he needs one
- Support Peter to return to an activity when he is ready

Little and often also helps you recognise:

- Doing new activities can be hard and may mean Peter participates for only a short time or watches to begin
- As Peter gets more familiar with an activity, he may participate for longer
- When Peter stops participating, he may return to it later

When explaining the new routine or task to Peter, ensure:

- He can hear you
- Speak clearly and not too fast
- Use short sentences and words familiar to Peter
- Give one message at a time
- If Peter hasn't understood, restate the message using shorter sentences and focusing on key words
- Use objects, gestures, facial expressions or pictures as well as words to make the message clearer

When undertaking the activity, you must pay attention to Peter to ensure he understands and is happy:

- How much is he engaged in the activity?
- Does he want to continue or have a break?
- If he has a break, make sure he has an opportunity to return
- Watch out for when he is ready to return

When Peter is engaged in a new experience:

- Give him time to see what it is like, how to do it and what's involved
- Ensure he has another opportunity to try it for a longer period. This can help to build up experience and competence.

Skill Development for Staff

Body Language cues, the meaning and what to do

Body Language Cue	What this means	What to do
Smiling / relaxed body	Peter is calm, comfortable, and ready to engage.	Chat with him, build rapport, use active support, and involve him in tasks or social interaction. Ask him for a hand to do jobs and praise.

Avoiding eye contact	He may not want interaction and is signalling a need for space.	Respect this signal, reduce verbal demands, and allow him quiet time until he re-engages.
Turning body away / moving to isolated space	Peter is seeking personal space or a lower stimulation environment.	Do not follow or pressure him. Allow him to regulate in his chosen space. Check in gently later.
Closed posture (arms crossed, hunched shoulders)	He is feeling defensive, unsettled, or not ready to engage.	Avoid confronting or crowding him. Give him more personal space and reduce requests.
Minimal or brief responses	He is not ready for conversation or task engagement.	Avoid pushing for answers. Step back, give processing time, and return to the topic later. Mirror him with minimal questions etc
Seeking private space (e.g., going to his room)	Clear signal that he needs time alone to regulate.	Respect his choice and allow private time. Ensure the environment is safe and calm (have locations for him to retreat at various activities/environments)
Restlessness or fidgeting (tapping, shifting, pacing)	He is becoming unsettled or overstimulated.	Offer the option of quiet time or redirect him to a calming activity. Reduce stimulation in the environment.
“Grumpy” facial expression, pacing, or moving quickly	He is feeling frustrated, impatient, or overwhelmed (often linked to waiting or not having a need met).	Acknowledge his frustration, check if a need is unmet (e.g., food, hearing aids), and support problem solving calmly. Ask if he wants to shake “it off”
Sighing, deep breaths, visible tension	Escalation he is showing stress or overwhelm.	Stay calm, lower your tone, reduce verbal input/talking, and check if a need can be met quickly.
Yelling / loud vocalisations	He is communicating distress or a need/ request in a heightened way.	Identify the unmet need and provide what he is requesting if safe/appropriate. Then allow him time alone to decompress/ relax.
Calmer body language / readiness to reconnect	He is moving into recovery after escalation.	Reconnect calmly. Offer a drink, listen, and provide reassurance. Treat the situation as a clean slate. Ask if he wants to shake “it off” Model deep breathing Sit with him without speaking

Response strategies

Emotional regulation skills/ Breathing via Co-Regulation:

Co-regulation is the process where individuals support each other in managing emotions and responses. It often involves one person modelling calming techniques, like deep breathing, to help another person regain emotional balance. This collaborative approach enhances self-regulation skills and develops a sense of safety and connection.

It is important to teach Peter effective strategies for managing his emotions, including:

- Deep breathing (staff breathe with him)
- Counting to ten (staff count for him)
- Taking breaks when he feels overwhelmed (staff prompt and move with him to another space)

Supports should verbally prompt and demonstrate these techniques to serve as role models. Over time, we will observe whether Peter can synchronise his breathing with the staff member, which may help him calm, or if taking a break is sufficient to manage sensory overload or fatigue. Additionally, providing Peter with opportunities to practice these skills in different situations will enhance his ability to regulate his emotions. Engaging in deep breathing exercises together will not only reinforce these techniques but also strengthen the supportive relationship between Peter and the staff.

Personal Space

Remove and keep Peter separated from his triggering co-resident after days spent together at PALs or on day trips, allowing Peter to have his own space and time without others. It's important to note that in a family environment, family members do not spend 100% of their time together; co-residents should have their own interests and time apart.

- Move/redirect the co-residents away from Peter when he wants alone time
- Peter is to be asked if he would like to move away to a space where he can have time alone, especially after a day out with co-residents
- Have a space set up in both communal spaces that is his, along with his room
- Remind Peter that he needs to share the lounge room at times with others, and if he wants his own space, he can go to the courtyard, his room, the kitchen or other spaces where others are not present

First Line Strategies

NARS have been shown to be more effective than restrictive procedures in reducing episodic severity and keeping people safe. The key is that the person is not distressed by these approaches and would not have any concerns about them being used at any time. Non-aversive reactive strategies are the first line of support

Non-Aversive Reactive Strategies (NARS) are methods used to bring incidents to a rapid end without causing distress to the person involved. Strategic capitulation is a planned approach where we give Peter what he wants to prevent things from escalating. This can be done alongside other preventive strategies until he learns new behaviours, if needed.

Examples of these may include:

- Provide the desired outcome to him- Give him what he wants/ needs.
- Respond to what Peter is trying to communicate, e.g.
    - "This is too noisy" = Turn it down
    - "Leave me alone" = give him time alone
    - "Spend time with me" = give him a few minutes then schedule 1:1 time and tell him

when this will be.
    - "I want to do more of this activity" = keep going, tell him you are going to use a timer to tell you when you need to end the activity.
    - “Wants a coffee” = help him make one
- Distraction/diversion strategies to be used
    - Introducing competing contingencies, offering an alternative option that is more rewarding eg- distract with an icecream or game they like
- Active listening and doing tasks alongside Peter to help motivate him

Using Peter's love of music, fun, and laughter can distract him at appropriate times by:

- Interactive Games that Peter enjoys, such as Uno, which is portable and can be played anywhere.
- Add in games that require no equipment, such as 'I Spy', or who sings this song (sing a familiar song he likes) to promote engagement during downtime and stimulate his connection with the supporting person (if he wants to engage)

Triggers	**Strategies to Eliminate Triggers**
Fatigue	Allow Peter to have time to sit and be alone. He will move away if he needs his own space, either his room or to his seat at the front door. He is happy not to talk and enjoys having time alone despite being a friendly and social person. You do not have to talk to him all the time. Allow him time alone.
Morning routine/ inpatient to leave	Help Peter as needed, and tell him if you cannot keep up with his requests and expectations. For example, if his lunch is not ready but he is ready to leave, verbally tell him you are making it as quickly as possible, and he can come to help put it into the lunchbox if he likes. Often, Peter will run early and then wait in his seat for an extended period of time for the bus. This is a time that he will be processing and preparing for his day. If you tell him to slow down or wait, as he has heaps of time, he can become frustrated. It is best to do his morning routine on his timeline and then allow him to be ready and wait. He will be calm and ready for the day if this is supported.
Other Clients/ Co-residents	Be observant and intervene when Peter has difficulty managing interactions with other clients. For example, he is told by the other participant that he can’t have something or it's not his turn, you will be required to help sort out the situation, as Peter does not have the skills to help him navigate tricky relationships. Remind Peter that if he has any issues regarding the other participants or co-residents, he should speak with the supporting person, and they will help him to resolve it
Not having space from others/down time	Provide a location that is just Peter’s. He can move himself to that space when he is fatigued, overwhelmed, processing or waiting for the bus to go to PALs. Initially, set him up each day with a designated location where he can have space and remind him where it is until it becomes a natural place for him (e.g., a Seat outside, his bedroom, a second living area, or an area in the garden). Place special items in the space, such as a photo of his family, his Uno cards or bottle tops.
Questions about what is	Answer his questions about the plans. He will eventually process the information; if you ignore him, he will become upset and frustrated.

happening	Plan: Set up a visual schedule on his iPad and on the wall in the house so he can be redirected there as well as have his questions answered.

Escalation- (Not usual)

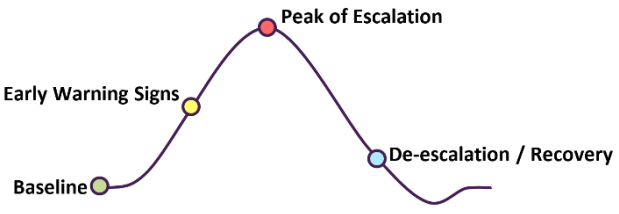
Ensure own safety (Has not been required to date)

- Reduce personal risk factors (e.g. lose jewellery or hair) and the person-centred factors, things said or done that may further agitate Peter.
- Stand in the safe stance pose.
- Stay calm, control your breathing, lower your voice, call Peter by his name, and respond to the demands of the situation.
- Assess the risks to Peter, yourself and others. Increase personal space. It may be necessary for you and others to leave the scene. The priority is always to protect people, not property .
- Stand in the protective/blocking stance.
- Stop everything else that is happening, e.g. pull the car over to the side of the road, turn off the stove or the TV (to reduce unnecessary noise which can add extra input and can overstimulate the situation)
- Bring extra support to help calm the situation.
- Observe carefully and keep records of everything that happened, and learn from the experience. This is critical if a future situation is to be avoided or managed effectively

Emergency Response (Has not been required to date)

- Attempt to create space between yourself and Peter - Move away
- Very firm and loud instructions,'Peter stop' with a sign (hand up, palm facing Peter)
- Move away and remove others. If not compliant, call for help
- Practice protective / blocking stance - elbows bent, hands together at chest height, ready to raise hands and block hits if required
- Use footwork to side step away from Peter, moving to where there is space and towards a door if possible
- Speak in a calm tone, using simple instructions, 'Peter, Stop'
- Ask Peter what he would like,and encourage him to use visuals to show you what he needs. Try to follow through with the request where possible
- If Peter tries to stand over the support person, the support person should stand up straight and show Peter that you are not afraid of him, holding your hand out to stay 'stop' - with distance and stepping back at the same time.
- Call the ambulance/police if deemed necessary for support

Safe Stance	Protective Stance
	
• Feet are shoulder width apart • Arms remain close to your body • Elbows are bent, hands at belly button height • Palms of hands are open, and face your belly button • One palm rests on the back of the other hand • Keep eyes on Peter, side-stepping away towards a door or somewhere where it is safe to move out of Peter's direct line of contact if required, while remaining in the Safe Stance position	If Peter tries to come towards you, attempting to hit or place force on you, we move from the Safe Stance to the Protective / Blocking Stance: • Feet are shoulder-width apart • This time, one foot is in front of the other, to help with balance • Elbows are bent, palms are open • If Peter enters your personal space, this time, palms face Peter and elbows are at chest height • One hand on back of the other open palm • Elbows are always light and bent • If Peter hits you, you may use your open palms to block the hit/punch etc with arms or open palms • THERE MUST NEVER BE ANY FORCE EXERTED ON Peter, palms/elbows will absorb the hit/punch, but never apply force back on Peter • You must continue to dodge and sidestep into a safe space



Reading Peter's Body Language

What this looks like	What to do
Baseline • Smiling • Relaxed body	• Engage and chat • Work on your connection and relationship • Active Support
Early Warning Signs • Avoiding Eye Contact: When Peter looks away or avoids making eye contact, it typically signals that he prefers to be alone and not spoken to at this time. • Turning Away: If Peter physically turns his body away from others or positions himself in an isolated space or area, it may indicate that he needs space or wants to move away from a simulation. • Closed Posture: Peter might stand with his arms crossed, his shoulders hunched, or in a defensive way, called a closed posture or defensive stance. • Minimal Response: Providing minimal or brief responses to questions or social prompts may indicate a lack of interest or readiness to engage in conversation at that moment. • Seeking private space: Peter actively moving towards a secluded or private area, such as his room, or a quiet corner, is an indicator that Peter is seeking to be alone. • Restlessness or Fidgeting: Signs of restlessness, such as tapping fingers, shifting in his seat, or exhibiting agitation, often signal that Peter needs alone time.. • Facial expression: If Peter shows a "grumpy" facial expression, along with crossed arms, pacing, or moving quickly	• Avoiding Eye Contact: This behaviour is an important indicator that he might not be in the mood for interaction right now. • Turning away: This behaviour should be respected as a clear indication of his need for alone time and it's his way of regulating his feelings • Closed Posture: These actions are physical ways he communicates that he may want more personal space and might not want to socialise or do the task. • Minimal Response: Recognising this behaviour can help workers avoid overwhelming Peter with further interaction and provide him space until he is ready to interact. • Seeking private space: Respect his choice and grant him the time he needs, will reduce behaviours of avoidance. • Restlessness or Fidgeting: Peter needs alone time. These cues can suggest that he is feeling overwhelmed and requires a break. Offer him the option to have alone time or direct time to another space. • Facial expression: It suggests that he is feeling frustrated or impatient, possibly due to waiting for something he wants.

What this looks like	What to do
 **Peak of Escalation** • Non-verbal cues, including sighing, deep exhalation, or displaying signs of tension or stress,. • Yelling	• Work out what he is communicating • Give him what he wants • Give him the unmet needs he is requesting • Once you have done the above, Give him alone time- these behaviours may indicate Peter's desire to be alone and to decompress from social stimuli
 **De-escalation / Recovery** • Ready to reconnect	• Reconnect • Give him a drink and sit with him. • Listen Give him a clean slate. It was not anyone's fault, and this was not personal.

Regulated Restrictive Practices

None currently in place

Implementation support and monitoring

Action area	Task	Person(s) responsible	Timeframe
RRP Authorisation (if required)	N/A	PBS Practitioner, if the current situation changes	1 month of RRP if required
Training	Staff training online and in person Video recordings to be developed and shared	PBS Practitioner	1-3 months
Implementation of strategies	Support stuff		Ongoing
Monitoring (e.g., feedback from the person, incident reports and data collection)	Reporting of incidents to PBS practitioner to support developing strategies	All Staff, Peter's care team PBS to give guidance and support	ASAP when there is an incident or issue
Reporting (e.g., to NDIS Commission)	N/A for RRP at this time.		

Action area	Task	Person(s) responsible	Timeframe
Communication (including post incident de-briefing)	Team meetings Sharing of incident reports Contacting PBS Practitioner	Organisation to invite PBS practitioners to team meetings to help support care	ASAP when required. Team meetings monthly
Development of Comprehensive BSP	PBS practitioner to gather data and provide a comprehensive report if required. Or outcome report and ongoing recommendations deemed appropriate	PBS Practitioner	6 months

Practitioner declaration

I declare that:

- I have been considered suitable as an NDIS behaviour support practitioner as defined in section 5 of the *NDIS (Restrictive Practices and Behaviour Support) Rules 2018* (the Rules).
- I am duly authorised by the specialist behaviour support provider (as stated in this form) to submit this behaviour support plan.
- I understand the requirements of registered NDIS providers in relation to reporting the use of regulated restrictive practices.
- I have read the NDIS Quality and Safeguards Commission's (NDIS Commission) Practice Guidance about regulated restrictive practices and behaviour support.
- I understand that I can use the Behaviour Support Plan (BSP) Checklists to check the quality of the behaviour support plan and ensure compliance with requirements.
- I have developed this behaviour support plan in accordance with the legislative requirements as set out in the Rules and in accordance with the state or territory's restrictive practice authorisation and consent requirements, however described.
- I understand that behaviour support plans containing regulated restrictive practices must be lodged with the NDIS Commission, consistent with the Rules. For Comprehensive BSP this includes attaching a copy of the functional behavioural assessment.
- I understand that the NDIS Commission is bound by the *Privacy Act 1988* in relation to the collection and use of personal information, and that more information can be found in the Privacy Collection Statement and Privacy Policy at www.ndiscommission.gov.au/privacy.
- I understand that the NDIS Commission will, if required, use the information contained in the BSP to undertake compliance and enforcement activities consistent with the *National Disability Insurance Scheme Act 2013* (the Act) and any Rules established under the Act.
- I acknowledge the NDIS Commission may share the information contained in the behaviour support plan with relevant Commonwealth, State, and Territory agencies including the Police.
- To the best of my knowledge, the information provided in this behaviour support plan is true, correct and accurate.
- I acknowledge that the giving of false or misleading information to the Commonwealth is a serious offence under section 137.1 of the schedule to the *Criminal Code Act 1995*.

Practitioner's electronic signature:

Practitioner's name: Katie Cummins

Practitioner ID #: P1714681

Job title: Positive Behaviour Support Practitioner

Date: 12/11/2025

Appendix

Appendix 1

Functional Behaviour Assessments

BPI-S : Completed 20/12/24 (Parents), 12/12/24 (PALS), 10/04/25 (Xander Care), Inlife 8/09/2025			
The Behaviour Problems Inventory-01 (BPI-01) is an informant-based behaviour rating instrument that was designed to assess maladaptive behaviours in individuals with intellectual disabilities (ID). Its items fall into one of three sub-scales: Self-injurious Behaviour (14 items), Stereotyped Behaviour (24 items), and Aggressive/Destructive Behaviour (11 items). Each item is rated on a frequency scale (0 = never to 4 = hourly), and a severity scale (0 = no problem to 3 = severe problem). The BPI-01 has been successfully used in several studies and has shown acceptable to very good psychometric properties.			
Behaviours that occur Multiple Times per Day	Behaviours that occur Daily	Behaviours that occur Weekly	Behaviours that occur Monthly
-	- Verbally abusing others - Bullying others - Yelling & Screaming - Pacing, Jumping, Bouncing, Running	- Repetitive Hand and / or Finger Movements - Pacing, Jumping, Bouncing, Running - Pacing, Jumping, Bouncing, Running - Pacing, Jumping, Bouncing, Running	- Bodyhitting - Hitting others - Kicking others - Grabbing and pulling others
Total Score			Severity Rating
Self Injurious	0 00 1		000 2
Aggression	000 9		000 6
Stereo Typical	2 2 2 2		

Reference:
Rojahn, J., Rowe, E.W., Sharber, A.C., Hastings, R., Matson, J.L., Didden, R., Kroes, D.B.H. and Dumont, E.L.M. (2012), The Behavior Problems Inventory-Short Form for individuals with intellectual disabilities: Part I: development and provisional clinical reference data. Journal of Intellectual Disability Research, 56: 527-545. doi:10.1111/j.1365-2788.2011.01507.x
Form retrieved from : http://bpi.haoliang.me/pdf/BPI-S/BPI-S%20English.pdf

QABF : Completed 11/3/24 Xander / Inlife 08/09/2025				
The Questions About Behaviour Function is an assessment designed to assist in the assessing of the function of aberrant behaviours in individuals diagnosed with a developmental disability. Developed by Johnny Matson.				
Attention/ Connection	Escape	Non-Social	Physical	Tangible

10 **12**	10 10	12	5	11

Appendix 2

Behavioural Intensity Table

Minimal	• No injury or illness • No disruption to support / services provided • No impact on a person's health and ' or wellbeing
Minor	• First Aid • No disruption to support / service • Minimal impact on a person health or wellbeing • Monitor at service delivery entry
Moderate	• Medical treatment • Temporary disruption to support / service provided • Impact on a person's health and wellbeing requiring engagement from a health care provider • (Medication incidents are usually considered moderate)
Major	• Lost time injury • Lost time to injury • Suspected abuse, neglect or exploitation • Disruption to service provided over on support period • Impact on a person's health and wellbeing requiring engagement of a healthcare provider and monitoring also • Medication incident requiring healthcare provider intervention
Severe	• Fatality or hospital admission • Suspected abuse, neglect or exploitation • Permanent disruption to support / service • Major impact on the person's wellbeing requiring engagement of a healthcare provider or hospitalisation • Medication incident requiring healthcare provider