

Frequently Asked Questions for Service Providers
CLBC Behaviour Support and Safety Planning Policy Framework
Updated: November 2025



*This document is intended to provide answers to common questions related to CLBC’s Behaviour Support and Safety Planning (BSSP) Policy and Guide for Service Providers. This FAQ will be updated as needed and reposted on CLBC’s website. Updates will be highlighted as ***NEW*** and will appear at the bottom.*

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FREQUENTLY ASKED QUESTIONS

Q 1. What does the new Behaviour Support and Safety Planning (BSSP) Policy clarify when it comes to restricted practices?

- The Policy clearly outlines when and how restricted practices may be used and provides direction on what information is required before a safety plan containing restricted practices can be implemented.
- Restraint and restriction of rights definitions have been updated in order to clarify what constitutes a restricted practice.
- It provides improved clarity for all of the roles involved in the process; behavioural consultants, service provider, and CLBC.

Q 2. What has changed with restricted practices?

The changes to restricted practices include:

- **Addition of Environmental Restraint** - While examples of Environmental Restraint were often included in Safety Plans, the term was not previously defined in our policies and guides. A definition has now been provided.
- **Updated definitions** - Physical restraint, mechanical restraint, and restriction of rights now have updated definitions, and outline what these practices include and do not include.
- **Exclusionary time out removed** – If this practice exists on a Safety Plan, review the updated definitions, and determine the type of update needed in alignment with the policy.
- **Chemical restraint removed** - Chemical Restraint or the use of medication to affect behaviour, is no longer considered a restricted practice within the Guide. While use of this type of medication can be identified as part of a behavioural approach, it does not require an authorized Safety Plan. Medications prescribed by a health professional must not represent the primary behavioural strategy used with an individual.

Q 3. The definition of Restriction of Rights has been updated to include actions that restrict an individual’s autonomy and choices. Does this include any situation when an individual is offered limited choices?

No. As part of a supportive approach, it is common to provide an individual with limited choices so as not to be overwhelming (e.g.: choice between the red or blue shirt vs all the shirts). This practice becomes restrictive when the limited choice is the **only** option provided without flexibility, even if the individual is not satisfied with the options given.

Q 4. When is a locked exterior door considered a type of restraint within the policy?

It is considered a restricted practice when a lock or device is specifically installed on an exterior door for the behavioural purpose of restricting the individual’s access, and/or making the lock inaccessible or more difficult to use (i.e.: installing it out of reach or using a puzzle lock).

Q 5. Are staff ‘safe rooms’ considered an environmental restraint, i.e.: when staff remove themselves to a safe space when an individual presents with critical and unsafe behaviours?

No, if the space is not an area that the individual would typically have access to, such as a staff office, then this would not be considered a restricted practice within the Policy. However, data should still be collected about this practice, and consideration given to a more frequent review of behavioural incidents to ensure progress occurs on expected outcomes for Behaviour Support Planning.

Q 6. In the old Service Provider Guide there were three categories of behaviour. Why are there now five categories?

The three original categories of challenging behaviour remain reflected in the updated guide:

1) Difficult/Unconstructive, 2) Serious, and 3) Critical/Unsafe.

Two additional categories were added:

- 1) **Positive/Productive** - this was added to identify a target baseline that Service Providers and Behavioural Consultants should support individuals to maintain or work towards.
- 2) **Changing Behaviours** – this category was added to highlight the importance of recognizing and responding to early behavioural cues an individual may use to express a want or need. The sooner these cues are noticed and responded to, the more likely it is that behaviour will not continue to progress or become challenging.

Q 7. CLBC refers to Behaviour Support Plans and Safety Plans, but my Behavioural Agency also creates other types of plans. Is this allowed?

CLBC only requires Behaviour Support Plans and Safety Plans to comply with the Behaviour Support and Safety Planning Policy.

Q 8. Is a Safety Plan required for all critical and unsafe behaviour?

No. A Safety Plan is only required to outline parameters related to the use of restricted practices. When restricted practices are not needed, then a Behaviour Support Plan is sufficient.

Q 9. How quickly do we need to work to have all plans in compliance with the updated policy?

- All new Behaviour Support Plans, and Safety Plans created after July 2024 should conform with the updated Policy and Guide.
- Historically created plans that do not meet current policy requirements, key content, or expectations can be updated as part of the Behaviour Support Plan review, and/or Safety Plan Review process.

Q 10. What has changed with the requirement to obtain a Physician's Authorization on a Safety Plan?

In the original policy and guide, a physician's authorization was required on ALL Safety Plans. However, moving forward:

- Authorization can be provided by **either** a Medical Practitioner (i.e.: physician), or Nurse Practitioner, and
- Is mandatory **only** when physical or mechanical restraint forms part of the Safety Plan.

Broadening the type of practitioner who can authorize a Safety Plan means that there is a wider range of professionals who may do this, as compared to what was permissible in the policy historically.

Q 11. What is the new Safety Plan: Medical Considerations Form, and why do I need to complete it?

This mandatory form verifies that biological or medical factors that may influence an individual's behaviour have been explored and are being appropriately followed up on. This document forms part of the Safety Plan and must be used for any Safety Plans created after July 2024.

Q 12. Whose responsibility is it to complete the CLBC Safety Plan: 6-Month Review Form, and is the updated form mandatory?

Behavioural Consultants work with Service Providers and other key partners to document their review of the current Safety Plan and associated Behaviour Support Plan. Behavioural Consultants submit this form to CLBC once complete. The CLBC Safety Plan: 6 Month Review Form is now mandatory to promote consistency. Behavioural Consultants may still provide additional data or summaries to CLBC when applicable or requested.

Q 13. The new guide states that when restricted practices have not been needed or used in 12 months or more, the practice should be discontinued. What should I do in this situation?

Behavioural Consultants and Service Providers must work closely together with the individual, their family and/or support network and other involved partners to develop an approach to fade restricted practices that are no longer required. In some cases, this will result in the Safety Plan being discontinued.

Q 14. Parameters for emergency use of restricted practice were updated, what happens if an emergency use of restricted practice is needed 3 or more times per year?

According to the Behaviour Support and Safety Planning: A Guide for Service Providers (Service Provider Guide), this would no longer be considered unanticipated or infrequent, and further planning must occur. Notify CLBC as soon as possible to discuss support options, if engagement from a Behavioural Consultant may be needed.

Q 15. Parameters for restricted practices required for a medical purpose have changed. What is my role as a Service Provider?

When a regulated health professional recommends the use of a restricted practice for a medical purpose, Service Providers are responsible for understanding the parameters for use and ensure

they have clearly documented this or request written documentation from the regulated health professional.

It is important to remember that a regulated health professional may recommend the use of a restricted practice for a medical purpose, however, may not do so related to an individual's behaviour.

Q 16. Why did the guiding principles change?

Principles outline the values by which CLBC wants the work of behaviour support done and were updated to highlight the importance of quality of life, respect for individual rights and identity, prioritizing least intrusive alternatives, and the importance of ongoing assessment/monitoring.

Q 17. Why did the expected outcomes of Behaviour Support Planning, and Safety Planning change?

Expected outcomes of behavioural services are more clearly identified in the Service Provider Guide, and now align with the guiding principles of behaviour support. Progress made on expected outcomes is reported to CLBC via the Safety Plan: Six Month review process and must also be monitored as part of annual Behaviour Support Plan reviews, when a Safety Plan does not exist.

Q 18. When an individual agrees to the use of a restricted practice, is this still considered “restricted”?

Yes. Consent or agreement to use restricted practices is a key component of the policy. When the practice meets the policy definition of “restricted practice,” it should be identified as such in the Safety Plan.

Q 19. Should families and natural support people who are not acting as a legal substitute decision maker continue to sign Safety Plans?

Yes. Having those who participated in the development of a Behaviour Support Plan and Safety Plan sign off is encouraged. It is important to know that those whom the individual trusts to support them with decisions agree with the service delivery approach. The roles of formal or informal supports, and legal substitute decision makers should be clearly identified on the Safety Plan authorization/signature page.

Q 20. Do restrictions that are court-ordered, identified by a review board panel, or a condition of discharge from hospital need to be captured within a Safety Plan?

No. While an individual may receive orders or conditions, a Safety Plan must not be developed unless the need for a Safety Plan also complies with our Policy. Service Providers play an important role in supporting an individual to understand and comply with court orders and

conditions and may be required to notify a key partner when the individual engages in actions that fall outside of these orders or conditions.

Q 21. Is the use of chimes considered allowed under the updated Policy and Guide? Is it a restricted practice?

Yes. The use of chimes is considered a permissible restricted practice when used in response to critical or unsafe behaviour. The use of chimes is considered a restriction of rights as outlined in the Behaviour Support and Safety Planning Policy and thus must be contained within a Safety Plan.

Q 22. Do plans authorized under the policy prior to July 2024 require a review from a Service Provider and/or Behavioural Consultant to determine whether they meet the current policy authorization requirements?

No, CLBC is reviewing all plans authorized prior to July 2024 that may not meet current policy requirements relating to consent. CLBC is taking a staged approach to this review. Your Liaison Analyst will contact you further so that CLBC can appropriately authorize these plans, if required.

This may involve confirming with various parties that consent was originally sought from the individual before using a substitute decision maker. In the meantime, Behaviour Consultants should complete a Safety Plan: Six Month Review as regularly scheduled, and document why consent cannot be obtained.

Q 23. Can a Substitute Decision Maker (as laid out in the Policy) be asked to consent to a Safety Plan instead of gathering the individuals' consent?

No. An individual's consent must be sought first. The only instance when consent should be sought from a Substitute Decision Maker would be when it's believed the individual is incapable of providing consent.

Q 24. Does a Safety Plan: Medical Considerations Form need to be completed for Safety Plans that were created prior to the July 2024 BSSP Policy Update?

No. Safety Plan: Medical Consideration Forms are only required for plans created after the July 2024 policy update. However, in complex instances where an individual's critical and unsafe behaviour has not been effectively addressed by a Behaviour Support Plan or Safety Plan over time, it would be best practice to ensure the individual has been seen by a medical practitioner to rule out any underlying biological factors that may contribute to the critical or unsafe behaviour addressed in the Safety Plan.

Q 25. Is a Safety Plan required when the use of a chime or motion sensor exists for a non-behavioural purpose?

No. A restriction of rights, or privacy, to address an individual’s health and personal care needs does not require a Safety Plan and can be included in person-centered planning or other planning done with health professionals. Service providers must consider the “intent” behind the practice. For instance, a bedroom chime intended to alert staff when an individual wakes up at night to provide personal care is considered supportive, not restrictive, as long as it does not aim to redirect, restrict, or prevent behavior.

Q 26. Is a Safety Plan always required for environmental restraints used for ‘increased effort’?

Yes, while these practices may be considered a 'less intrusive' alternative to other types of restraint, they still require careful planning. Although deterrents used for ‘increased effort’ are intended to permit access, barriers of this type can unintentionally signal that certain areas or items are ‘off-limits’, potentially interfering with the individual’s ability to make independent choices. Further, services should focus on removing accessibility barriers, when possible, making regular review essential.

Q 27. In situations where there is a restricted practice in place for critical or unsafe behaviour, but a mitigation strategy has also been put in place, does the restricted practice need to be included in the Safety Plan? For example, when the front door is locked to prevent elopement but not locking the back door.

Yes. Any restricted practice that is put in place in response to critical or unsafe behaviour must be documented in a Safety Plan.