Guide to Psychology and Behaviour Support | Bloom Healthcare

Canonical: https://bloom-healthcare.com.au/blog/psychology-and-behaviour-support-whats-the-difference-and-how-do-they-work-together/

Details:

If the main problem is how someone feels, start with psychology. If the main problem is what is happening in daily life and whether it is safe, start with positive behaviour support. Both are capacity building supports under the NDIS, but they sit in different budget lines, they are delivered by differently regulated professionals, and only one of them operates under a formal regulatory framework administered by the NDIS Quality and Safeguards Commission. Many people end up with both, and that is not a failure to choose properly. It is often the right answer.

This page is about making the choice. If you want the full detail on either service on its own, including assessments, timelines and fees, read the positive behaviour support and psychology and counselling service pages.

A short decision rule

Ask yourself which sentence describes the situation better.

"They are struggling with how they feel." Anxiety, low mood, grief, trauma, poor self-esteem, difficulty with change, relationship strain, adjusting to a new diagnosis. The work is largely internal, and progress looks like better insight, better coping and more settled emotions. That is psychology.

"Something is happening that is not safe, or it is shutting them out of ordinary life." Aggression, self-injury, absconding, property damage, behaviour that has led to exclusion from school, work or the community, or behaviour that has led someone to use a restrictive practice. The work is largely environmental, and progress looks like fewer incidents, safer responses from the people around them, and more access to everyday activities. That is positive behaviour support.

If both sentences are true, and for a lot of people they are, the question stops being which one and becomes which one leads. More on that below.

What each discipline is actually accountable for

A psychologist is accountable for understanding and treating the internal picture. That means assessment, formulation, and therapy delivered mostly one to one, using structured approaches such as cognitive behavioural therapy or acceptance and commitment therapy, or more flexible trauma informed work. Psychologists also produce assessments, including cognitive and functional capacity assessments, that are used as evidence for NDIS decisions.

A behaviour support practitioner is accountable for a document. Specifically, a functional behaviour assessment and then a behaviour support plan that other people have to follow. The practitioner works out what a behaviour is doing for the person, what sets it off and what keeps it going, then writes strategies that change the environment, the routine and the responses of everyone around them. Much of the work is not done with the person in a room. It is done with families, support workers, teachers and accommodation providers, and it is judged by whether those people can carry it out consistently.

That difference in accountability explains most of the practical differences you will notice. Psychology sessions are usually scheduled and predictable. Behaviour support involves observation in real settings, meetings with the support network, and long stretches of writing and training.

The regulatory difference that matters most

This is the part that surprises people. Psychology and behaviour support are not regulated in the same way, and the gap is wide.

Who is allowed to do the work

Anyone delivering specialist behaviour support under the NDIS must be a practitioner the NDIS Commission has assessed as suitable to develop functional behaviour assessments and behaviour support plans, working under a provider registered in the specialist positive behaviour support registration group. That suitability assessment is a specific regulatory step that exists only for behaviour support. Psychologists are registered health practitioners, but they do not go through that particular assessment, and being a psychologist does not by itself make someone a behaviour support practitioner.

Deadlines that apply to one and not the other

Once a specialist behaviour support provider is engaged, an interim behaviour support plan must be developed within one month, and a comprehensive behaviour support plan within six months. Plans containing regulated restrictive practices must be reviewed if the person's circumstances change, and at least every twelve months regardless. Nothing equivalent applies to psychology. There is no statutory deadline for a psychology report and no mandated review cycle.

Restrictive practices

Regulated restrictive practices sit inside the behaviour support framework and nowhere else. A behaviour support plan that includes one must state it clearly and in language the person can understand, and it must be authorised by the relevant state or territory body. The practice has to be a last resort, used for the shortest time possible, proportionate to the risk and the least restrictive option available, with the plan working towards reducing and eliminating it. Providers who use an authorised restrictive practice report that use to the NDIS Commission monthly. Use of an unauthorised restrictive practice is a reportable incident: within twenty four hours if it caused harm, and within five business days otherwise.

If a restrictive practice is being used or has been proposed for someone, behaviour support is not optional and psychology cannot substitute for it. That is the clearest either/or in this whole comparison.

Funding: two different budget lines

Both services are capacity building, but they generally come out of different parts of the plan.

Psychology is usually funded under Capacity Building: Improved Daily Living . It covers one to one therapy, assessment and skills training, emotional regulation and coping strategies, social skills and identity work, parent or carer coaching, and reports written for plan reviews.

Specialist behaviour support is usually funded under Capacity Building: Improved Relationships . It covers functional behaviour assessment, writing and implementing the behaviour support plan, training the support workers who have to follow it, and the work of reducing restrictive practices.

Both can sit in the same plan at the same time, and having one does not use up the other. Whether you have either is a question about your specific plan, so check your plan document or ask your support coordinator or plan manager. If a category is missing, that is a plan review conversation, not a reason to give up on the service.

Medicare funds one of these and not the other

Psychology has a second funding door. Through Medicare's Better Access initiative, a person with a diagnosed mental health condition and a mental health treatment plan from a GP, psychiatrist or paediatrician can claim rebates for up to ten individual and up to ten group sessions per calendar year, with referrals usually written in blocks of up to six sessions and reviewed after that. Medicare psychology is aimed at clinical treatment of a diagnosed condition. NDIS psychology is aimed at disability related function and participation. They answer different questions, which is why some people legitimately use both.

Positive behaviour support has no Better Access equivalent. It is an NDIS support. If you are looking for behaviour support for an older person outside the NDIS, the funding position is not something we can state generally, and you would need to check with My Aged Care or an aged care assessment service about what is available in your circumstances.

Which one leads: four common situations

A newly diagnosed autistic child having meltdowns at home and at school. Behaviour support usually leads, because the fastest change comes from adjusting the environment, the routine and the responses at both sites. Psychology often joins to help the child build their own regulation strategies once the surroundings are calmer.

An adult with an intellectual disability with a history of restrictive practices. Behaviour support leads without question, because the regulatory obligations attach to that service. Psychology commonly runs alongside to work on trauma and emotional resilience, which is a large part of why the behaviour occurs at all.

A teenager with ADHD refusing school and withdrawing socially. Psychology usually leads on the anxiety and motivation. Behaviour support is valuable if the school needs a structured, agreed plan with graded steps, scheduled breaks and consistent responses from staff.

An adult whose main issue is grief, low mood or a life transition, with no safety concerns. Psychology, on its own. Adding behaviour support here would not help, and if there are no behaviours of concern it is unlikely to be considered reasonable and necessary.

What it looks like when both run at once

The risk with two therapists is two sets of advice that quietly contradict each other. Avoiding that is a coordination job, not a lucky accident. When Bloom delivers both, the two clinicians work as one team: they share assessment findings rather than each starting from scratch, they agree the goals they are both working towards, they meet as a care team to check progress and work through barriers, and they make sure the family and support workers get one consistent message instead of two competing ones. Information moves between clinicians with your consent, and you can say what you do and do not want shared.

The person, their family and their support network are part of the behaviour support planning itself, not just recipients of it. A plan the people around you cannot actually follow is a plan that will not work.

Adding the other service at plan review

If you want to add behaviour support to a plan that only funds psychology, or the reverse, the evidence that carries weight is about function and participation rather than diagnosis. Useful material includes concrete examples of what is happening and where, what has already been tried and why it was not enough, any functional behaviour assessment findings on triggers and patterns, progress reports from the service you already have, and outcomes that are visible in daily life such as community outings completed, routines followed without support, or reduced crisis driven service use. A report from your current clinician that identifies a component they are not the right discipline to address is often the most persuasive single document.

Starting with the wrong one is recoverable

People worry about this more than they need to. Starting with psychology and finding that behaviour and safety are the real barrier is common, and so is starting with behaviour support and finding that unresolved trauma is limiting progress. Neither is wasted time. Both build the picture that justifies the change. What matters is noticing it and saying so, rather than continuing with a service that is not moving anything.

How to start

You do not need a GP referral to start either service under NDIS funding, the way you do for Medicare psychology. A referral can come from you, a family member, a support coordinator, a plan manager, a GP, psychiatrist or paediatrician, a school, or another provider already involved. Bloom delivers both services in homes, schools, clinics and by telehealth, so where you live does not usually decide which one you can get.

If you are not sure which service fits, say that when you call. Working it out is part of the intake conversation, not something you are expected to have solved beforehand. Call 1300 771 465 or use the contact page .

Common questions about psychology and behaviour support

Can I have both psychology and behaviour support in the same NDIS plan?

Yes. They usually sit in different capacity building categories, psychology under Improved Daily Living and specialist behaviour support under Improved Relationships, so funding one does not consume the other. Whether both are in your plan right now is a question about your specific plan document.

Is a psychologist allowed to write my behaviour support plan?

Only if that psychologist has been assessed by the NDIS Commission as a suitable behaviour support practitioner and works under a provider registered for specialist positive behaviour support. Being a registered psychologist is not by itself enough. Some clinicians hold both roles, most do not.

A restrictive practice is being used for my family member. Which service do I need?

Behaviour support. Regulated restrictive practices can only sit inside a behaviour support plan, need authorisation from the state or territory body, and carry reporting obligations to the NDIS Commission. Psychology does not carry those obligations and cannot replace that plan.

How quickly will I get something in writing?

From behaviour support, an interim plan within one month of engaging the provider and a comprehensive plan within six months. Psychology has no equivalent statutory deadline, so report timing is agreed with your clinician.

Which one should I start with if I honestly cannot tell?

Start with whichever concern is causing the most harm right now. If it is distress, start with psychology. If it is safety or exclusion from school, work or the community, start with behaviour support. If neither is clearly larger, ask for an intake conversation and let the assessment decide.

Can I use Medicare for behaviour support the way I can for psychology?

No. The Better Access rebates apply to psychological treatment of a diagnosed mental health condition, not to specialist behaviour support. Behaviour support is funded through the NDIS.

Does psychology count as behaviour support if it is about behaviour?

No. A psychologist can absolutely work on behaviour, but specialist behaviour support is a defined NDIS support with its own registration group, its own plan deadlines and its own restrictive practice rules. The two are not interchangeable for funding or regulatory purposes.

Will the two clinicians actually talk to each other?

Where both are delivered by Bloom, yes, as a matter of process rather than goodwill. They share assessment information with your consent, set shared goals, and coordinate what families and support workers are told so the advice does not conflict.

Can my child see both at once, or is that too much?

That depends on the child and what else is in their week. Two services can be more effective than one because they change different things, but session load is a real consideration for children. Raise it directly at intake and it can be staged rather than started all at once.

Who can refer me?

For NDIS funded work: you, your family, a support coordinator, a plan manager, a GP, psychiatrist or paediatrician, a school, or another provider involved in your supports. For Medicare rebated psychology you need a mental health treatment plan from a GP, psychiatrist or paediatrician.

What if my plan has neither category funded?

Contact Bloom anyway on 1300 771 465. The practical path is usually gathering evidence of functional impact through your existing supports and putting it to your next plan review or a plan reassessment request. What your plan will fund is decided by the NDIA, so nothing here should be read as a

guarantee.

Does behaviour support ever finish?

It is designed to. The aim is a plan the people around you can run without the practitioner present, with restrictive practices reduced or removed. Plans containing regulated restrictive practices are reviewed at least every twelve months while they are in force, and sooner if circumstances change.

Can I have both psychology and behaviour support in the same NDIS plan?

Yes. They usually sit in different capacity building categories, psychology under Improved Daily Living and specialist behaviour support under Improved Relationships, so funding one does not consume the other. Whether both are in your plan right now is a question about your specific plan document.

Is a psychologist allowed to write my behaviour support plan?

Only if that psychologist has been assessed by the NDIS Commission as a suitable behaviour support practitioner and works under a provider registered for specialist positive behaviour support. Being a registered psychologist is not by itself enough. Some clinicians hold both roles, most do not.

A restrictive practice is being used for my family member. Which service do I need?

Behaviour support. Regulated restrictive practices can only sit inside a behaviour support plan, need authorisation from the state or territory body, and carry reporting obligations to the NDIS Commission. Psychology does not carry those obligations and cannot replace that plan.

How quickly will I get something in writing?

From behaviour support, an interim plan within one month of engaging the provider and a comprehensive plan within six months. Psychology has no equivalent statutory deadline, so report timing is agreed with your clinician.

Which one should I start with if I honestly cannot tell?

Start with whichever concern is causing the most harm right now. If it is distress, start with psychology. If it is safety or exclusion from school, work or the community, start with behaviour support. If neither is clearly larger, ask for an intake conversation and let the assessment decide.

Can I use Medicare for behaviour support the way I can for psychology?

No. The Better Access rebates apply to psychological treatment of a diagnosed mental health condition, not to specialist behaviour support. Behaviour support is funded through the NDIS.

Does psychology count as behaviour support if it is about behaviour?

No. A psychologist can absolutely work on behaviour, but specialist behaviour support is a defined NDIS support with its own registration group, its own plan deadlines and its own restrictive practice rules. The two are not interchangeable for funding or regulatory purposes.

Will the two clinicians actually talk to each other?

Where both are delivered by Bloom, yes, as a matter of process rather than goodwill. They share assessment information with your consent, set shared goals, and coordinate what families and support workers are told so the advice does not conflict.

Can my child see both at once, or is that too much?

That depends on the child and what else is in their week. Two services can be more effective than one because they change different things, but session load is a real consideration for children. Raise it directly at intake and it can be staged rather than started all at once.

Who can refer me?

For NDIS funded work: you, your family, a support coordinator, a plan manager, a GP, psychiatrist or paediatrician, a school, or another provider involved in your supports. For Medicare rebated psychology you need a mental health treatment plan from a GP, psychiatrist or paediatrician.

What if my plan has neither category funded?

Contact Bloom anyway on 1300 771 465. The practical path is usually gathering evidence of functional impact through your existing supports and putting it to your next plan review or a plan reassessment request. What your plan will fund is decided by the NDIA, so nothing here should be read as a guarantee.

Does behaviour support ever finish?

It is designed to. The aim is a plan the people around you can run without the practitioner present, with restrictive practices reduced or removed. Plans containing regulated restrictive practices are reviewed at least every twelve months while they are in force, and sooner if circumstances change.