# Senior Practitioner report 2018–19

VICTORIA State Government | Health and Human Services


**Cover: Painting by Kylie N Scott**

The artworks used in this report are by winners of the 2019 VALID Annual 'Having a Say' conference Art Competition sponsored by the Senior Practitioner. The theme for the 2019 artworks was 'Having a Say Forever'.

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# Message from the Senior Practitioner

Welcome to the 12th Senior Practitioner report for 2018–19. This report describes the functions and achievements of the work of the Office during the 2018–19 financial year. For the past 12 years we have reviewed the restrictive interventions of all people who are reported to us from disability services and have used this information to decide on the focus of projects to undertake, training to provide to the sector to improve understanding of reporting requirements, and communications about the ways services can reduce restrictive interventions.

This year will be the last that we will report on restrictive practices in this way; National Disability Insurance Scheme (NDIS) service providers will be instead required to report on the use of regulated restrictive practices to the National Quality and Safeguards Commission from 1 July 2019. Our future reports will focus on the Victorian Senior Practitioner's authorisation of regulated restrictive practices, the use of compulsory treatment and associated activities over the year.

In this report we describe what our monitoring and evaluation of restrictive interventions has revealed (see Monitoring and evaluating practice) and the restraint reduction strategies we are using in our training and research projects (see Projects to deliver evidence-informed outcomes). We continually undertake work to follow up our evaluation, seeking to discover what assistance the sector needs and what additional assistance we can provide (see Promoting best practice through professional development and Supporting best practice through advice, partnerships and consultation). Finally, we report back to the sector through evidence-informed findings (see Informing public debate and opinion).

This past year has seen the final Department of Health and Human Services Areas transition to the NDIS. The work has continued to be challenging with preparations well underway for implementing the NDIS Quality of Safeguarding Framework on 1 July 2019. We have continued to very much appreciate the contributions made by the Disability and NDIS Policy team, the Intensive Support Team and the Disability Justice unit, who have worked collaboratively with us to prepare for and unpack what these changes mean for us, our stakeholders and our clients in our day-to-day work.

From our monitoring of restrictive practices and compulsory treatment over 2018–19, we know that 2,483 people were subject to restraint or seclusion at some time during this period. This is a 3 per cent increase since the previous year. Most of this increase is accounted for by an increase in the number of people subject to chemical restraint. There was a small increase in the number of people reported to be subject to mechanical restraint (two more people) and a small increase in the number of people subject to seclusion (three more people). In contrast, there was a moderate decrease in the number of people subject to physical restraint (15 fewer people, down from 81 people to 66). When we looked at the

people who were subject to physical restraint, we found that 84 per cent were subject to physical restraint once during the year and that most of the people who were physically restrained in 2018–19 were not physically restrained in the previous year. Taken together these results suggest that physical restraint is being used as it should be – that is, the least restrictive under the circumstances.

Most people subject to restrictive practices in 2018–19 were adults (77 per cent) and 23 per cent were children. There was a 2 per cent increase in adults from 2017–18 and a 2 per cent increase in children. As in previous years, most adults and children were subject to routine chemical restraint, and the most commonly used chemical restraint for both children and adults was an antipsychotic medication (74 per cent of adults and 56 per cent of children). This is despite the fact that research has shown that antipsychotic medication only decreases behaviours of concern in the short term and carries significant side effects (see a systematic review by McQuire et al. 2015). To address this issue, we have in previous years developed online education modules for disability support workers and psychiatrists. A revision and reaccreditation process of the online modules for general practitioners (GPs) was also accredited by the Royal Australian College of General Practitioners but, disappointingly, the take-up by GPs was very low. With the implementation of the National Quality and Safeguarding Framework from 1 July 2019, it is hoped that a substantive impact may be made with this issue being progressively brought to the national level.

The number of people who were subject to seclusion and mechanical restraint increased in 2018–19 from the previous year. Although the numbers are low, the use of both these restrictive practices has been increasing over the past few years. To assist services to find ways to decrease their use of mechanical restraint, the office released a new practice guide in 2019: *Recognising and reducing mechanical restraint.* This practice guide is the culmination of four projects focusing on mechanical restraint completed and reported on over previous years and is now available online. With the new authorisation role of the Victorian Senior Practitioner coming into effect on 1 July 2019, the team will be able to concentrate more specifically on the underlying reasons for the use of both of these restraint types, which will be a focus in the coming year's report.

Importantly this year, we have been working with the newly established NDIS Quality and Safeguards Commission, particularly Dr Jeffrey Chan, the Senior Practitioner, Behaviour Support, and his team in preparing for the implementation of framework requirements. Dr Chan instigated quarterly meetings this year with state and territory counterparts, the National Disability Insurance Agency and the Commonwealth Department of Social Services to progress this work and work towards a nationally consistent approach to authorising regulated restrictive practices.

I would like to take the opportunity to thank all of our staff – those who have left, those remaining and those who have joined us – for the dedicated and hard work they have undertaken over the year. The environment that we are working in has become increasingly complex with the changes taking place, and their ongoing commitment and focus on the rights of people with disabilities subject to restrictive practices and compulsory treatment has been outstanding.

Finally, I would also like to acknowledge the contributions of our colleagues, project partners, internal and external stakeholders, disability and NDIS service providers, families, carers, advocates and professionals who collaborate with us in our work. We look forward to continuing this work over the coming year with the ongoing significant changes that will be taking place.

Dr Frank Lambrick
Senior Practitioner – Disability

# Contents

**Victorian Senior Practitioner team, February 2020**

**Rebekah Richardson and Katie White,
members of the Senior Practitioner team, 2018–19**

# The role of the Senior Practitioner

The Senior Practitioner role was established in 2006 when the Victorian Parliament enacted the *Disability Act 2006* (the Act). The Senior Practitioner and his team sit within the Office of Professional Practice branch in the Community Services Operations Division of the Department of Health and Human Services.

The Senior Practitioner is responsible for protecting the rights of people with a disability who are subject to restrictive interventions such as restraint and seclusion, and compulsory treatment, and who receive a government-funded service.

The Act requires population monitoring and reporting of people with a disability who receive a service, and who are subject to restrictive interventions or compulsory treatment.

The Act also mandates:

- development of guidelines and standards regarding restrictive intervention and compulsory treatment
- research into the use of restrictive interventions and compulsory treatment
- provision of relevant education – for example, regarding human rights and positive behaviour support – to workers involved in supporting people with a disability
- specific responsibilities of the Senior Practitioner to:
  - approve and monitor treatment plans developed for people who are subject to compulsory treatment
  - oversee the implementation of supervised treatment orders
  - issue lawful directions to disability services on any law, policy or practice, where relevant, to a compulsory treatment order matter.

Including research and education as mandatory functions of the Senior Practitioner in the Act means it is possible to focus on what the evidence shows in Victoria, and to use this to directly inform policy and practice in disability services.

The research findings from Victoria are unique. Victoria is the only jurisdiction in the world that has collected long-term population-level data on the use of restrictive interventions and behaviour support plans over 12 years.

Collecting population-level data over many years has enabled investigations into what changes over time and what factors affect these changes. Through our research we know that people with certain characteristics tend to be subject to certain types of restraint more than others without these characteristics. For example, people with autism are more likely to be restrained in the long term (for periods over at least three years) with antipsychotic medication than people without autism.

The purpose of this report is to outline trends in the use of restrictive interventions, compulsory treatment and behaviour support planning, and to describe how our safeguarding activities have specifically improved the lives of people with a disability over the course of the financial year from July 2018 to June 2019.

# Monitoring and evaluating practice

A function of the Senior Practitioner is 'to evaluate and monitor the use of restrictive interventions across disability services and to recommend improvements in practice to the Minister and the Secretary' (Disability Act, s. 24(1)(h)). This section of the report looks at the reported use of restrictive interventions during 2018–19 and compares this with previous years. Data on the use of chemical restraint, mechanical restraint and seclusion have been collected since 2008–09, and data on physical restraint has been collected since 2011–12.

## Restrictive interventions reported to the Senior Practitioner

Disability services must report to the Senior Practitioner about the use of four types of restrictive intervention used in their services:

- chemical restraint
- mechanical restraint
- physical restraint
- seclusion.

Every time a disability service uses a restrictive intervention, they must provide information to the Senior Practitioner that includes:

- information about the person subjected to the restrictive intervention, such as their name, gender and disability types
- the type of restrictive intervention used (chemical, mechanical, physical restraint or seclusion) and type of administration, being:
  - 'routine', that is, administered on an ongoing basis, for example, daily or weekly, but reported once a month, if it had been used one or more times in that month
  - 'pro re nata' (PRN) drug administration in accordance with and authorised within a behaviour support plan, and reported at each instance of use
  - 'emergency', which is restraint administered in an emergency and where there is no authorised behaviour support plan, or a restraint is not included in the authorised behaviour support plan
- a copy of the behaviour support plan that describes why the restraint or seclusion is necessary, why it is the least restrictive intervention, and how it benefits the person.

## The use of restrictive interventions in Victoria

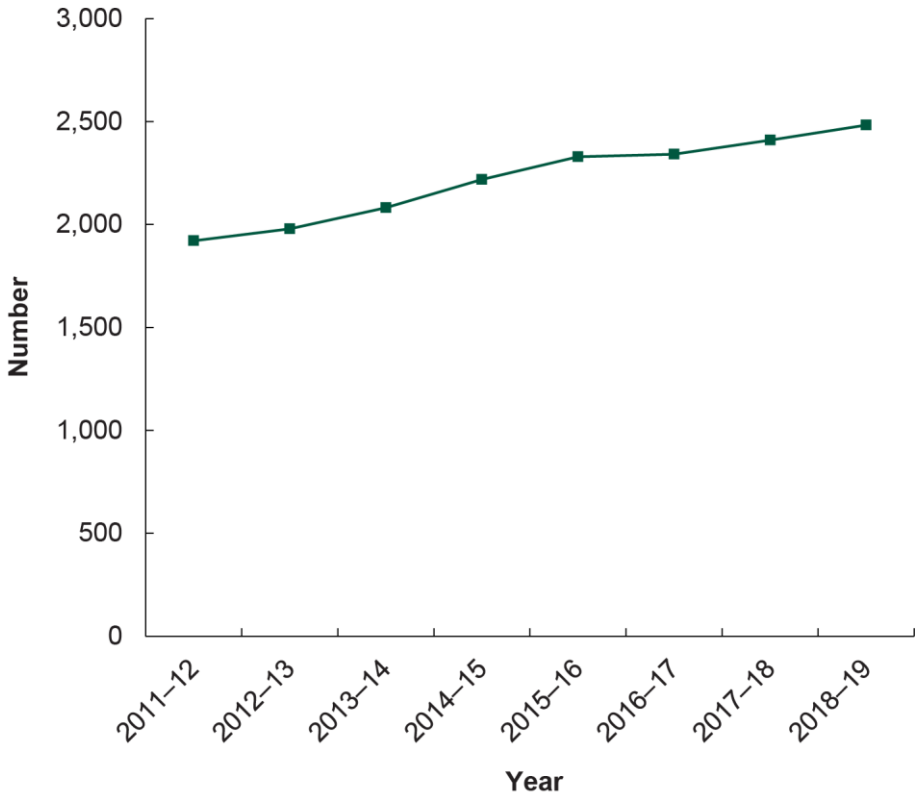
This section of the report summarises the findings of:

- restrictive interventions reported by disability services in Victoria in 2018–19 and, where possible, compares these findings with the previous seven years
- the quality of behaviour support plans written in 2018–19 compared with the previous six years
- the number of people on compulsory treatment orders in 2018–19.

It should be noted that for ease of viewing, graphs only show the last eight years from 2011–12. Complete tables from 2008–09 can be requested from the Senior Practitioner.

Figure 1 shows the total number of people who were reported each year from 2011–12.

**Figure 1: Number of people subject to a restrictive intervention, Victoria, 2011–12 to 2018–19**



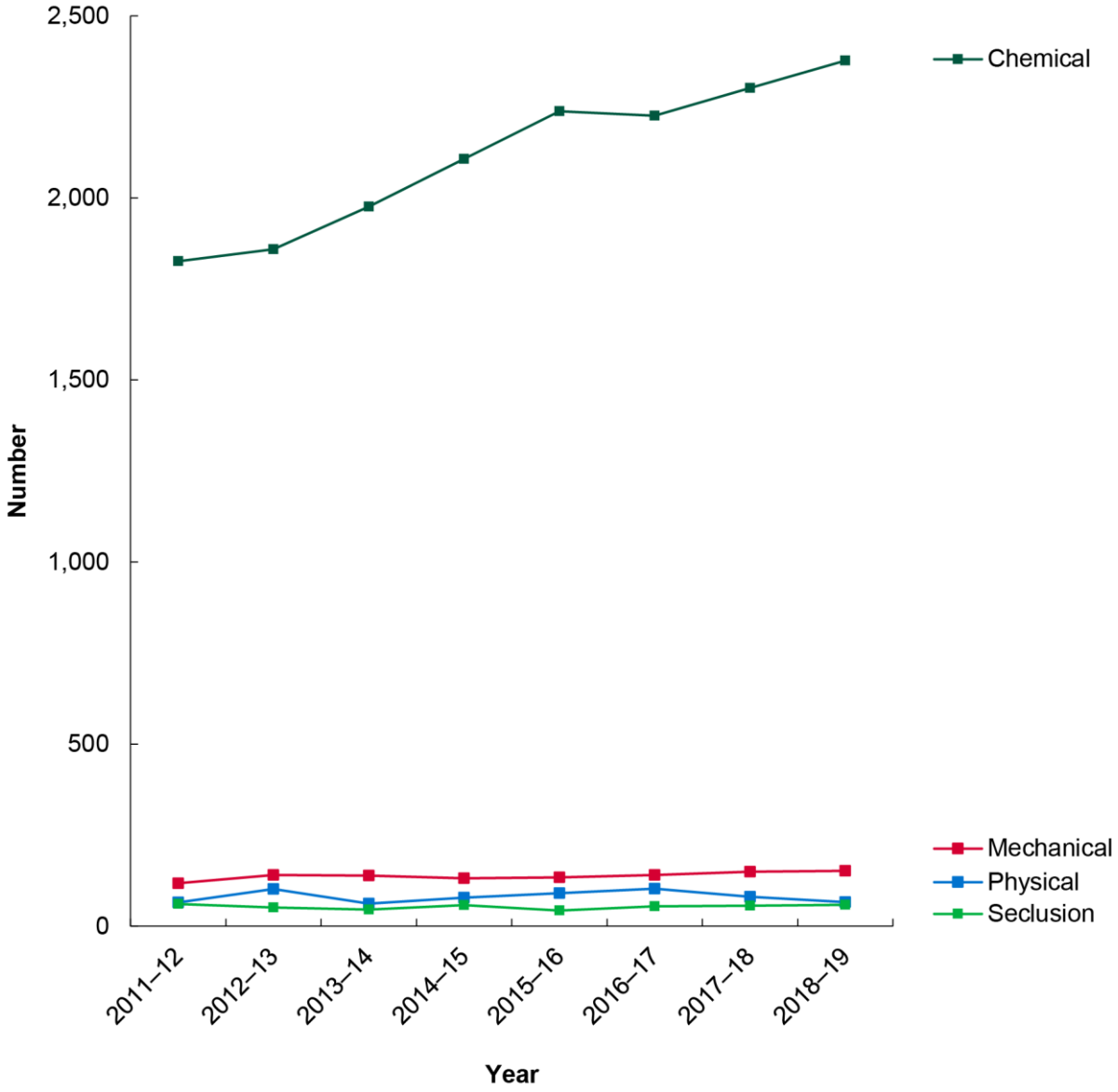

Refer to the Appendix for the Figure 1 data table

## Key findings

- In total, 2,483 people were reported as being subject to restraint and/or seclusion in 2018–19. This number is a 3 per cent increase from 2017–18.
- The number of people who have been reported to be subject to restrictive interventions has been increasing since 2011–12.
- The percentage increase of people varies slightly from one financial year to the next from a less than 1 per cent increase to a 3 per cent increase. There has been a 3 per cent increase per year over the past two financial years (2017–18 and 2018–19).
- Every year new people are reported to be subject to restrictive interventions for the first time. In 2018–19, 310 new people were reported for the first time. This number is similar to the previous four financial years.

Figure 2 shows the total number of people who were subject to chemical, mechanical, physical restraint and seclusion from 2011–12 to 2018–19.

**Figure 2: Number of people subject to chemical, mechanical or physical restraint, or seclusion, Victoria, 2011–12 to 2018–19**




Refer to the Appendix for the Figure 2 data table

## Key findings

- Overall, there was an increase in the number of people who were subject to a restrictive intervention in 2018–19
- There were increases in:
  - the number of people administered chemical restraint (75 more people in 2018–19 than in 2017–18)
  - the number of people administered mechanical restraint (two more people in 2018–19 than in 2017–18)
  - the number of people who were secluded (three more people in 2018–19 than 2017–18).
- There was a decrease in the number of people who were subject to physical restraint (15 fewer people in 2018–19 than in 2017–18).

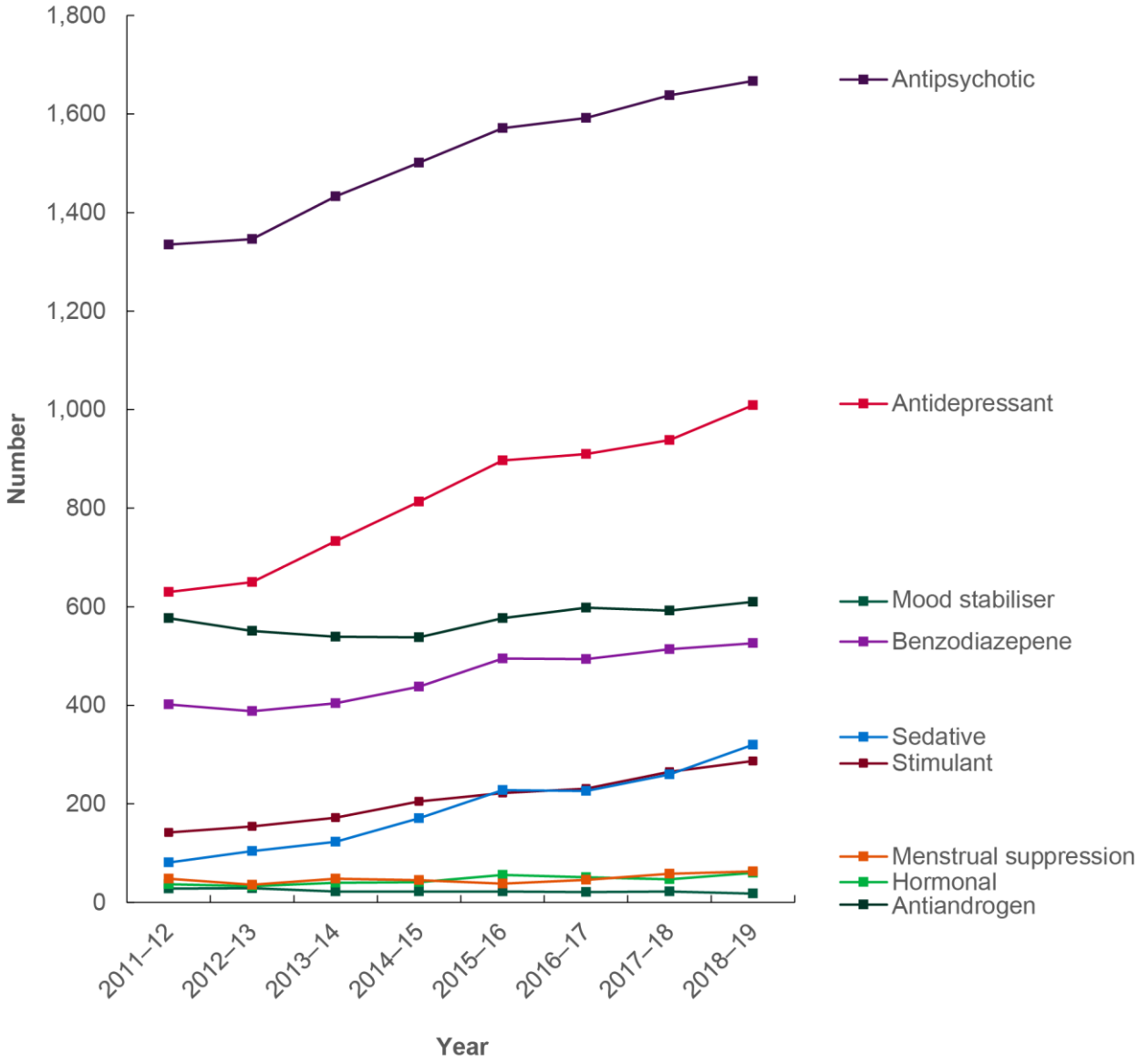
## Chemical restraint

Chemical restraint refers to using medication where the primary purpose is to control a person's behaviour and is not a prescribed treatment for an underlying illness or condition. For example, stimulants are used to treat attention deficit hyperactivity disorder (ADHD) and are not categorised as chemical restraint if being used to treat ADHD. If there is no diagnosis of ADHD and a stimulant is administered, this would be an example of chemical restraint. (Section 3 of the Act provides complete definitions of all restrictive interventions.)

### Key findings

- In 2018–19, 2,377 people or 95.7 per cent of all the people reported to be subject to a restrictive intervention were administered chemical restraint sometime during the year. This is a 3 per cent increase in the number of people from the previous year.
- Antipsychotic and antidepressant medications were the most commonly administered chemical restraints and their use is increasing over time. In 2018–19, 70 per cent of people who were chemically restrained were administered an antipsychotic medication and 43 per cent were administered antidepressant medications (see Figure 3).

**Figure 3: Number of people subject to each type of chemical restraint, Victoria, 2011–12 to 2018–19**




Refer to the Appendix for the Figure 3 data table

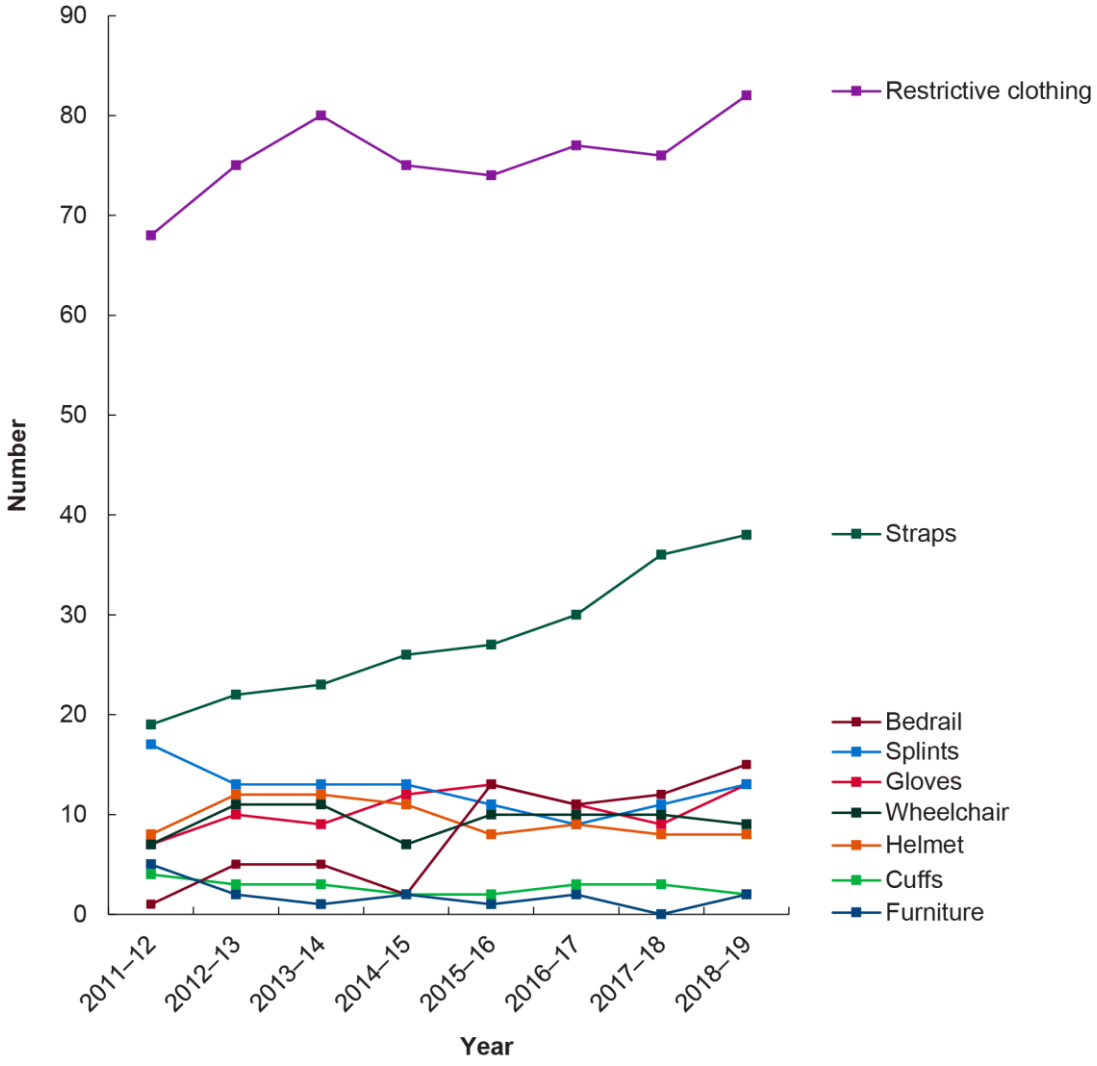
## Mechanical restraint

Mechanical restraint refers to using a device (such as splints or clothing) to control a person's movement. This excludes devices used for therapeutic purposes (such as an arm splint that is used to enable the person to eat independently).

### Key findings

- The number of people subject to mechanical restraint has been increasing gradually from 115 people in 2008–09 to 152 people in 2018–19.
- Most people are mechanically restrained using some form of clothing that they are unable to remove (see Figure 4).

**Figure 4: Number of people subject to each type of mechanical restraint, Victoria, 2011–12 to 2018–19**




Refer to the Appendix for the Figure 4 data table

## Seclusion

Seclusion refers to the sole confinement of a person with a disability at any hour of the day or night in any room or area where disability services are being provided and where the person cannot exit.

### Key findings

- The number of people reported to be subject to seclusion in 2018–19 was 59; this is three more people than the previous year.
- Since 2008–09 the number of people subject to seclusion has declined from 98.

## Physical restraint

The Senior Practitioner defines physical restraint as using physical force to prevent, restrict or subdue movement that is not physical guidance or physical assistance. Physical restraint has been reported to the Senior Practitioner since July 2011.

### Key findings

- Between 2011–12 and 2017–18, the number of people who have been reported to be physically restrained fluctuated between 62 people (in 2013–14) and 103 people (in 2016–17).
- From 2016–17 to 2018–19 there has been a 36 per cent decrease in the number of people subject to physical restraint – from 103 people to 66 people.
- Of those people who were subject to physical restraint in 2018–19, 80 per cent were subject to one physical restraint in the year; another 15 per cent of people were subject to two or three physical restraints in the year. Three people were subject to more than three physical restraints in the year.
- 83 per cent of people who were subject to physical restraint in 2018–19 were not subject to physical restraint in 2017–18. This finding suggests that physical restraint is being used by services as least restrictive under the circumstances.

## Adults and children who were subject to restrictive interventions in disability services

### Key findings

- Since 2008–09 more adults have been reported each year than children (children are defined as people aged 17 years or less at some time during 2018–19).
- In 2018–19, 1,932 adults were reported compared with 580 children.
- In 2018–19 most children who were reported had a reported diagnosis of autism and/or intellectual disability:
  - 74 per cent of children were reported to have autism; this has increased from 61 per cent in 2008–09
  - 64 per cent were reported to have an intellectual disability; this has decreased since 2008–09 when it was reported to be 96 per cent of all children reported to the Restrictive Intervention Data System (RIDS).

The four most commonly used chemical restraints for children in 2018–19 were:

- antipsychotics – 56 per cent of children who were administered chemical restraint – this compared with 74 per cent of adults
- antidepressants – 36 per cent of children who were administered chemical restraint – this compared with 44 per cent of adults
- stimulants – 39 per cent of children who were administered chemical restraint – this compared with 4 per cent of adults
- sedatives – 35 per cent of children who were administered chemical restraint – this compared with 7 per cent of adults).

Adults were more likely than children to be administered mood stabilisers (30 per cent of adults and 12 per cent of children) and benzodiazepines (27 per cent of adults and 7 per cent of children).

## Proportion of children and adults with some disabilities who were administered antipsychotics

### Key findings

Table 1 shows that children and adults with some disabilities are at greater risk of being administered an antipsychotic medication to stop or reduce their behaviours of concern than those without those disabilities:

- 100 per cent of children with acquired brain injury who were reported to RIDS were administered an antipsychotic some time during 2018–19.

- 59 per cent of children and 80 per cent of adults with autism were administered an antipsychotic some time during 2018–19.
- Children and adults who are unable to see and hear and those who have difficulty in communicating their needs are more at risk of being administered an antipsychotic than children and adults without these disabilities.

**Table 1: Proportion of children and adults with some disabilities who were administered antipsychotics, Victoria, 2018–19**

| Age group | Acquired brain injury % | Autism % | Any sensory impairment % | Dual sensory % | Speech impairment % |
|---|---|---|---|---|---|
| Children | 100 | 59 | 61 | 50 | 46 |
| Adults | 70 | 80 | 75 | 72 | 72 |

Note: Because people can have more than one disability, these percentages will not add to 100.

Administration of an antipsychotic cannot help a person communicate or understand others better. Research has shown that antipsychotic medication only decreases behaviours of concern in the short term and carries significant side effects (see the systematic review by McQuire et al. 2015).

## Behaviour support plan quality evaluations

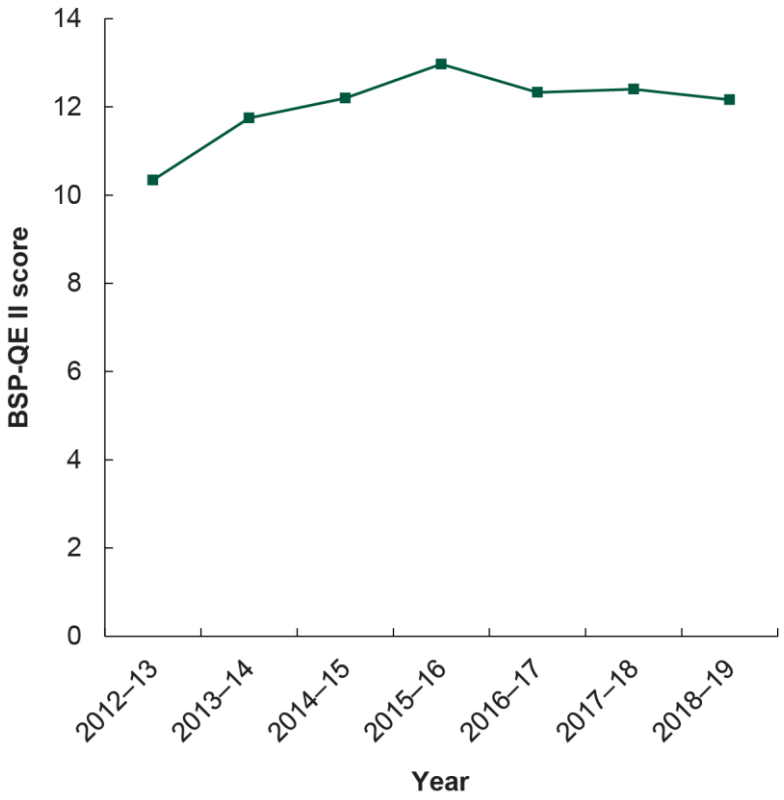
Any person who is subjected to restraint and/or seclusion in disability services in Victoria must have a behaviour support plan or a treatment plan (if they have a compulsory treatment order). In 2018–19 there were 2,991 behaviour support plans received by the Senior Practitioner from services; this was 224 more behaviour support plans than the previous year. It should be noted that a person can have more than one behaviour support plan in a year.

The Senior Practitioner uses the Behavior Support Plan Quality Evaluation II tool (BSP-QE II) (Browning-Wright, Saren & Mayer 2003) to objectively assess the quality of behaviour support plans received from disability services in Victoria. Although the BSP-QE II tool was developed in the United States for children, it was validated by the Senior Practitioner for use in Victoria with adults with an intellectual disability and was found to be a valid and reliable assessment of the quality of behaviour support plans written for adults living in Victoria (Webber et al. 2011a; 2011b). In previous work, the Senior Practitioner also found evidence that increases in the quality of behaviour support plans is associated with reductions in restrictive intervention use (Webber et al. 2012).

### Key findings

- In 2018–19, 85 (3 per cent) of the behaviour support plans received by the Senior Practitioner were assessed using the BSP-QE II.
- The average score was 12.12/24, which is unchanged from the previous two financial years. Figure 5 shows the average score achieved across all services from 2012–13 to 2018–19
- The average score had been improving between 2012–13 and 2015–16. It has plateaued in the three most recent years, and the average achieved is below the score of 13, which is associated with reductions in restrictive interventions. This finding suggests there is a need for services to focus on improving the quality of their behaviour support plans as this is likely to reduce their use of restrictive interventions.

**Figure 5: Average BSP-QE II scores across all disability services, Victoria, 2012–13 to 2018–19**




Refer to the Appendix for the Figure 5 data table

Similar to previous years, the quality review process highlighted areas of strength in planning from the sector as well as key areas where behaviour support plans could be improved.

The good news is that most plans continue to describe:

- the behaviours of concern
- the underlying triggers and the common settings where the behaviours occurred
- appropriate de-escalation strategies.

Understanding the function of the behaviours of concern, and the trigger-setting events, is essential for minimising the use of restraint and seclusion.

The bad news is that few plans described:

- clear replacement behaviours (alternative behaviours the person can be taught to use to meet the function of their behaviours of concern)
- strategies that could be used to teach and encourage effective replacement behaviours
- how the team would work together, communicate and review behavioural goals.

In sum, most plans are poorly developed and are unlikely to result in a reduction of restrictive intervention because they do not help the person get their needs met and tend to only use reactive strategies. This means that people with these plans are likely to continue to be restrained and secluded in the long term.

## Restrictive intervention audit review

The Victorian Senior Practitioner has powers to investigate, audit and monitor the use of restrictive interventions and compulsory treatment in disability services (Disability Act, s. 27(2)(c)).

During 2018–19 the Victorian Senior Practitioner's Integrated Health Care Team conducted 47 audits across rural and metropolitan disability services, including group homes, residential respite and day programs. Audits are used to identify and examine the use of restrictive interventions in practice.

### Key findings

This year's audits showed several common themes:

- high use of other restraints – including locked doors and restricted access to areas of the house (such as the laundry or kitchen)
- these other restraints being in place without risk of harm from a behaviour of concern, with some reported to have 'always been that way'
- a lack of knowledge regarding what constitutes chemical and other restraints, evident in the lack of reporting of some restraints but over-reporting of others
- services placing a focus on the use and reporting of restrictive practices correctly, with reduced focus on implementing strategies and environmental modifications to allow for reductions of use
- the use of restrictive practices without an authorised behaviour support plan in place
- lack of health professional reports for devices that were reported to be therapeutic but could be used improperly as mechanical restraint.

## Compulsory treatment

Compulsory treatment means treatment of a person with an intellectual disability who is at risk of perpetrating serious violence to another person. A person may be admitted to a residential treatment facility under a court order or live in disability residential services in the community under a supervised treatment order. In Victoria there is one disability residential treatment facility – the Intensive Residential Treatment Program at the Disability Forensic Assessment and Treatment Service (DFATS).

Part 8 of the Disability Act allows civil detention to be provided in the community under a supervised treatment order. Detention under the Act is defined as (a) physically locking a person in any premises and (b) constantly supervising or escorting a person to prevent the person from exercising freedom of movement. This part of the Act also legislates for court-mandated detention in a residential treatment facility through orders including residential treatment orders, parole, custodial supervision orders and extended supervision orders.

### The role of the Senior Practitioner for individuals subject to compulsory treatment

The Senior Practitioner is responsible for ensuring the rights of people who are subject to compulsory treatment and restrictive interventions are protected. The Compulsory Treatment Team works for the Senior Practitioner to support these functions. The team comprises a principal practice leader, two senior practice advisers and one program adviser. The team provides practice leadership and training and attends some of the client care team meetings to offer practice advice and to monitor implementation of the treatment plan.

The authorised program officer makes an application to the Victorian Civil and Administrative Tribunal (VCAT) for a supervised treatment order or for a review of a treatment plan for those individuals at DFATS and provides a proposed treatment plan. The Senior Practitioner and the Compulsory Treatment Team review all the documentation provided by the authorised program officer, including the treatment plan and the annual risk assessment. The treatment plan describes the treatment proposed, states how

this will benefit the person and defines the levels of detention, supervision and restrictive practices to be overseen, with a view to move towards lesser levels of restriction, if appropriate.

The Senior Practitioner approves the treatment plan on the directions and recommendations within the treatment plan certificate issued by the Senior Practitioner for a maximum period of one year.

For people subject to custodial supervision orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* at DFATS, the Senior Practitioner reviews the treatment plan and issues a treatment plan statement, which includes directions and recommendations in relation to practice.

During the life of any compulsory treatment order, implementation reports must be completed and submitted at a minimum of six-monthly intervals. The authorised program officers provide these to the Senior Practitioner and they include detailed information about:

- how the person is progressing against their treatment goals
- progress on the directions of the Senior Practitioner within the treatment plan certificate
- any incident reports and data collected
- any changes in restrictive interventions
- quality of life assessments and any additional assessments that have been completed, including any implications for treatment.

The authorised program officer is responsible for implementing the treatment plan.

## Victorian Civil and Administrative Tribunal hearings

A VCAT hearing is convened with the person for whom the supervised treatment order is under consideration, their legal representative, the Office of the Public Advocate, a Senior Practitioner representative, the authorised program officer and any relevant supporting staff from the person's disability residential services present. If VCAT is satisfied that the criteria for a supervised treatment order are met, they will make an order for up to one year, at which point it will be reviewed.

VCAT reviews treatment plans for people subject to compulsory treatment at DFATS within the first six months of the person being admitted and annually thereafter for the duration of the court order.

The Office of the Public Advocate is a party to the VCAT hearings and can make an application to VCAT directing the authorised program officer to make an application for a supervised treatment order if the office is concerned that a person is being detained unlawfully.

The VCAT hearings held in relation to compulsory treatment matters in 2018–19 comprised reviews for supervised treatment orders, including interim orders (which can be made until a supervised treatment order is determined), treatment plan reviews for people under compulsory treatment at DFATS, material change hearings when a variation to the plan resulting in an increase in restrictions was requested and revocation of supervised treatment orders.

There were 66 VCAT hearings during the year, and staff from the Compulsory Treatment Team attended all open hearings.

## Compulsory treatment data

Forty-two people were subject to compulsory treatment during 2018–19, and there have been 23 people subject to supervised treatment orders for the period between 1 July 2018 and 30 June 2019. There was one person subject to an interim supervised treatment order at the start of the financial year, which was made into a supervised treatment order during the year. Four other interim supervised treatment orders were made throughout the year. This included people who had already been subject to supervised treatment orders but where VCAT deemed it necessary to make a short order for all parties to work through issues before returning to VCAT for a supervised treatment order to be determined. In total, there were three new supervised treatment orders made during the year, including one person who

transitioned to the community under a supervised treatment order when his residential treatment order expired. Two supervised treatment orders were revoked during the year because the criteria for a supervised treatment order was no longer met. Both of these people remained living in disability residential accommodation.

Twenty-six people were subject to a supervised treatment order at the end of the 2018–19 year, in comparison with 28 people during the previous financial year. There were 14 people subject to compulsory treatment during the year at DFATS. Only one person was subject to a residential treatment order for the whole of the reporting period, compared with four people in 2017–18. Three of these people exited DFATS during the year: one transitioned to a supervised treatment order; one person returned to the community with no further orders; and one person returned to prison. There were five people admitted to DFATS during the year: one person was subject to a supervision order under the *Serious Sex Offenders (Detention and Supervision) Act 2009*; one was subject to a residential treatment order; and three people were subject to custodial supervision orders under the Crimes (Mental Impairment and Unfitness to be Tried) Act.

By 30 June 2019 there were 11 people subject to compulsory treatment at DFATS: two people were subject to supervision orders under the *Serious Sex Offenders (Detention and Supervision) Act 2009*; two people were subject to residential treatment orders; and seven people were subject to custodial supervision orders under the Crimes (Mental Impairment and Unfitness to be Tried) Act. Additionally, there were two people who had been granted extended leave during the previous year who remained on extended leave throughout the 2018–19 period. Table 2 shows the number of people subject to compulsory treatment at DFATS by order type. There were 14 people subject to compulsory treatment at DFATS in 2018–19.

**Table 2: Number of people subject to compulsory treatment at DFATS, by order type, Victoria, 2018–19**

| Order type | July 2018 | Admissions during 2018–19 | Discharges during 2018–19 | June 2019 |
|---|---|---|---|---|
| **Residential treatment order** | 4 | 1 | 3 | 2 |
| **Supervision order** | 1 | 1 | 0 | 2 |
| **CMIA** | 4 | 3 | 0 | 7 |
| **Extended leave** | 2 | 0 | 0 | 2 |
| **Total** | 9 people at DFATS and 2 people on extended leave | 5 admissions | 3 discharges | 11 people at DFATS and 2 people on extended leave |

CMIA = Crimes (Mental Impairment and Unfitness to be Tried) Act

## Assessment orders

An authorised program officer may apply to the Senior Practitioner for an assessment order to be made in respect of a person with an intellectual disability living in a residential service. If it is necessary to detain the person to prevent a significant risk of serious harm to another person and assessments need to be undertaken to enable the urgent development of a treatment plan, the Senior Practitioner may make an assessment order once for a person, for a maximum period of 28 days. In 2018–19 no assessment orders were made. No assessment orders were made the previous year and one was made in 2016–17.

## Client demographic data

Of the 42 people subject to a compulsory treatment order in 2018–19, 41 were male and one was female. There have only been four females since 2008–09 subject to compulsory treatment.

In 2018–19 the primary types of offending behaviour that resulted in people being subject to a supervised treatment order or residential treatment order were sexual violence and violence (non-sexual).

The average age of people subject to compulsory treatment in 2018–19 was 38 years, ranging from 21 to 63 years (calculated at 30 June 2019). This is a similar age profile to the previous two years.

At the end of 2018–19, 22 of the 26 people subject to a supervised treatment order lived in non-government accommodation and four people lived in Department of Health and Human Services accommodation (Table 3). Seven people were living in non-government accommodation who had transitioned from Disability Accommodation Services (DAS) during the year, and the remaining two people in DAS subject to supervised treatment orders were due to transition within the next month following this reporting period.

**Table 3: Number of people subject to supervised treatment orders, by accommodation type, Victoria, 30 June 2019**

| Accommodation type | Number of people subject to supervised treatment orders |
|---|---|
| Specialist Forensic Disability Accommodation | 10 |
| Other DHHS accommodation including Disability Accommodation Services | 5 |
| Transitioned from DAS to NDIS providers | 7 |
| Other community services organisations | 4 |
| **Total number of people** | **26** |

DHHS = Department of Health and Human Services

## Compulsory treatment restrictive intervention data

Table 4 gives a breakdown of the number of people subject to compulsory treatment who were subject to restrictive interventions in 2018–19 by the type of order and restrictive intervention.

**Table 4: Number of people subject to compulsory treatment who were subject to restrictive interventions, Victoria, 2018–19**

| Restrictive intervention | Supervised treatment order | Residential treatment order | Supervision order | Custodial supervision order under CMIA |
|---|---|---|---|---|
| Routine chemical restraint | 18 | 1 | 0 | 1 |
| Emergency chemical restraint | 5 | 0 | 0 | 0 |
| PRN chemical restraint | 2 | 0 | 0 | 0 |
| Seclusion | 5 | 0 | 0 | 1 |
| Physical restraint | 0 | 1 | 1 | 1 |
| **Total number of people throughout the year who were on each type of order** | **29** | **5** | **2** | **7** |

CMIA = Crimes (Mental Impairment and Unfitness to be Tried) Act

Sixty-two per cent of people on supervised treatment orders were administered chemical restraint in 2018–19. This percentage is lower than the 96 per cent of all people reported to RIDS in 2018–19. Seventeen per cent of people on supervised treatment orders were secluded at some time during 2018–19. This percentage is higher than the 2 per cent of all people reported to RIDS.

## Revocation

The Senior Practitioner, authorised program officer or the person who is subject to the supervised treatment order can apply to VCAT to have their treatment plan reviewed, and the order can be revoked. The Senior Practitioner and VCAT must review supporting documentation before a supervised treatment order expires to determine whether the person continues to meet the legislative criteria for a supervised treatment order and the use of civil detention. The authorised program officer and the Senior Practitioner prepare separate submissions to VCAT to evidence how the person no longer meets all the criteria for a supervised treatment order.

During 2018–19 two supervised treatment orders were revoked. Neither of the individuals involved continued to meet the criteria for a supervised treatment order but continued to live in disability accommodation. The Compulsory Treatment Team remain involved for up to six months after revocation to monitor the person's transition.

One person at DFATS was subject to a parole order and returned to custody during the reporting period.

**Painting by Emily Johnson**

# Projects to deliver evidence-informed outcomes

A function of the Senior Practitioner is 'to undertake research into restrictive interventions and compulsory treatment and provide information on practice options to disability support providers' (Disability Act, s. 24(1)(g)). This section of the report describes the major projects that were undertaken during 2018–19 to deliver evidence-informed outcomes to the sector.

## The impact of the roadmap for reducing restrictive practices and behaviours of concern

Training in the *Roadmap resource for achieving dignity without restraint* was offered jointly by Associate Professor Paul Ramcharan from RMIT University and National Disability Services (NDS) to eight organisations between March and June 2018.

The training focused on assisting disability services to reduce their use of restrictive interventions by understanding the causes of behaviours of concern and applying a values-based approach to re-thinking how to reduce the use of restrictive practices. Two research questions were asked in this project:

1. How successful is the roadmap in reducing behaviours of concern and the use of restrictive practices?
2. Is a single day training intervention sufficient for the successful implementation of the roadmap over one year?

The roadmap training consisted of one day of training:

- The first half of the day explained why the roadmap values are important to consider when understanding behaviours of concern and restrictive practices. These values included: choice and control; reflective practice; trauma-informed care; human rights; risk and benefit; the causes of behaviours of concern; and supporting cultural change in an authorising environment.
- The second half of the day focused on the NDS zero tolerance policy.

A total of 122 disability staff from eight organisations participated. After training each participant completed an action plan for one person they were supporting.

### Following training

- Each staff member developed an action plan for one person they were supporting.
- The majority of participants agreed:
  - the training was of high quality
  - the training would help them plan and target their support better
  - their use of restrictive practices would reduce as a result of implementing the training.

Unfortunately, four of the eight organisations did not participate in the second session six months later, citing competing tasks in getting ready for the NDIS.

Only 20 of the original 122 people were available to participate in the third session. These results suggest that for the few people who implemented their action plans, some small positive changes were seen. As Associate Professor Paul Ramcharan put it:

> Creating freedoms led to motivations to adapt identities and skills that match the freedom being created. It was found that this had happened in many cases and a close association was found between one-to-one support (under the NDIS in at least some cases) and positive outcomes.

Next steps will include using the roadmap with other groups such as authorised program officers, who might benefit and be able to use the techniques to build the capacity of disability support workers. The final report is available by emailing the Victorian Senior Practitioner <Victorianseniorpractitioner@dhhs.vic.gov.au>.

## Mechanical restraint project

The Disability Act describes mechanical restraint as material or devices that prevent a person moving freely and that are not providing treatment or helping the person be more independent. In 2013, responding to no decrease in the number of people reported to be mechanically restrained each year, the office developed a project to examine the use of mechanical restraint and what could be done to reduce its use.

The project had four phases:

- Phase 1 looked at the individual characteristics of those at risk of being subjected to mechanical restraint. (The result of this phase was described in an article 'Factors associated with the use of mechanical restraint in disability services' published in the *Journal of Intellectual & Developmental Disability* by Webber et al. 2019.)
- Phase 2 looked at what was known and had been recommended for a group of 39 people who had been mechanically restrained over a period of years.
- Phase 3 put in place some critical assessments such as functional behaviour assessments with 10 of those people who were mechanically restrained to determine how mechanical restraint could be reduced. (A case study that describes how two service providers successfully eliminated the use of mechanical restraint was published in the journal *Learning Disability Practice* by Webber et al. 2017.)
- Phase 4 provided clinical support to assist services to implement strategies recommended in phase 3 to reduce the use of mechanical restraint, as well as to capture facilitators and barriers for services and staffing groups to implement recommendations to reduce mechanical restraint. We wanted to learn more about these factors to evaluate practices surrounding the use of mechanical restraint and use these learnings to influence future work. This phase of the project was completed in the second half of 2018.

In 2019 the office published a practice guide about the learnings from this project (see *Recognising and reducing mechanical restraint practice guide*, available at the Victorian Senior Practitioner website <https://www.dhhs.vic.gov.au/victorian-senior-practitioner>).

## General practitioner modules

GPs often prescribe medication to people with an intellectual disability (usually psychotropic medication) to 'manage' behaviours of concern. This is usually because medical practitioners have little training in assessing people with cognitive impairment and behavioural presentations or have limited knowledge of positive behaviour support strategies and the availability of the services and resources to support people with a disability who show behaviours of concern.

In 2015–16 the Centre for Developmental Disability Health Victoria, in conjunction with the Department of Health and Human Services, developed guidelines to assist medical practitioners. These guidelines were subsequently included as part of the Royal Australian College of General Practitioners' accredited online learning and training packages. The modules were made freely available online for continuing professional development.

The purpose of the GP modules was to increase the capacity of the medical workforce to effectively assess and respond to health issues with high-quality healthcare and, in doing so, enhance the health and wellbeing of people with intellectual disabilities.

A Swinburne University review revealed that the utility and take-up of the modules among GPs was poor, although the content was judged to be excellent. In response, and on advice from the college, the Senior Practitioner commissioned Swinburne University to develop an online platform for GPs to enable them to conduct a self-audit of their practice using the information in the modules.

The self-audit has been available to all GPs since June 2019; however, again, take-up has been extremely poor.

The results of this project have been shared with the NDIS Commission Senior Practitioner for his information.

## Menstrual suppression project

According to the Disability Act, menstrual suppression is a reportable chemical restraint if it is used to stop behaviours of concern and is not treatment for an underlying health issue. The Victorian Senior Practitioner team has monitored the use of menstrual suppression as a restrictive intervention since 2008.

A number of risks are associated with extended periods of menstrual suppression including significant long-term side effects. Depo-Provera decreases oestrogen levels, which leads to reduced bone density and strength. Reduced bone strength is likely to lead to bone fractures and breaks. Taking the oral contraceptive pill (ethinyloestradiol) can increase the risk of blood clots, which can cause heart attacks and stroke. Similarly, those who are unable to exercise, or have limited exercise, are at increased risk of blood clots. Considering the prevalence of complex communication needs in this population, people may be unable to report pain or injury. This compounds the health risks, as people may be experiencing severe pain regularly but be unable to communicate this.

In the literature there is a lack of information about why menstrual suppression is used, the long-term side effects from supressing menstruation, as well as the side effects of the types of medication used. In response, the menstrual suppression project aimed to report on the factors associated with menstrual suppression use for females with a disability reported to the Victorian Senior Practitioner.

### Key findings

The average age of the participants was 35.6 years, with an age range of 16–53 years. There was no apparent association between increasing age and use of menstrual suppression.

Most participants were either reporting the use of medroxyprogesterone acetate (Depo-Provera or Depo-Ralovera Provera), which is a contraceptive injection, or ethinyloestradiol, which is commonly used in the oral contraceptive pill.

Reported themes for the use of menstrual suppression from participants' behaviour support plans were:

- to reduce distress or anxiety
- to reduce hygiene risk
- to address behaviours of concern related to menstruation
- to address pain or feeling unwell
- the choice of the participant
- for contraception.

The final report will be shared with the NDIS Commission Senior Practitioner.

## Recommendations from the project

- Frontline disability support workers should be trained in the long-term risks associated with menstrual suppression, with the intention of encouraging disability service providers to be aware of and manage health concerns that may arise due to menstrual suppression.
- The *Reducing menstrual suppression for women with an intellectual disability in Victoria* resource should be provided to disability service providers to inform on menstrual suppression and alternative strategies other than menstrual suppression to manage identified concerns.
- The *Supporting women: Information and resources for general practitioners supporting women with intellectual disabilities to manage their menstruation and associated menstrual disorders* guide should be provided to GPs.
- Disability services should develop processes to facilitate collaboration between the woman, their family/decision-maker, disability service provider and the prescribing doctor in relation to menstrual suppression. Disability service providers regularly report difficulty in reducing the use of menstrual suppression due to minimal involvement or opportunity for input in the process of prescribing medication. Research has shown that including all stakeholders from the outset is vital to reducing the use of chemical restraint.

# Promoting best practice through professional development

A function of the Senior Practitioner is 'to provide education and information with respect to restrictive interventions and compulsory treatment to disability service providers' (Disability Act, s. 24(1)(b)). This section of the report describes various education and training opportunities that were provided to disability support providers in 2018–19.

## Behaviour support plan training sessions

The RIDS behaviour support plan toolkit training is an all-day interactive session on how to develop effective behaviour support plans that will meet the requirements of the Act. The content covers the process of understanding the context in which behaviours of concern may occur for a person, and the function or purpose of that behaviour. Participants learn how to identify the best positive behaviour support interventions that would reduce the need to use a behaviour of concern, as well as how to tell if the interventions are working. The training also demonstrates how to upload the plan into RIDS. This session was delivered centrally 14 times during 2018–19, with an average of 30 participants at each session.

## Restrictive intervention reduction training

The Integrated Health Care Team provided training to services on understanding restrictive interventions and how to reduce them. The team combined audits and training to provide more focused and relevant information to professional bodies and discrete individual services. In 2018–19 the team met with advisers from Agency Performance and System Support teams to talk about the role of the Victorian Senior Practitioner and how the Integrated Health Care Team can support new organisations to access resources and training.

During the year there was an increased focus on training more specialised services within the disability sector to increase awareness and understanding of restrictive practices. The training focused on the ways that best practice clinical assessments can highlight the use of previously unauthorised restrictive practices and better address least restrictive alternatives of support. This included training sessions for support coordinators, occupational therapists and physiotherapists, with more than 60 participants in total.

In addition, the Integrated Health Care Team presented on restrictive interventions and the work of the Senior Practitioner at the following events:

- Office of the Public Advocate, Community Visitors Seminar
- National Disability Services, North Eastern Melbourne Regional Forum
- National Disability Services, Geelong Regional Forum.

## Specialist communication assessment reports and advice

People subject to restrictive practices or supervised treatment orders are more likely than the overall population to have undetected language and communication disorders. The presence of an undetected oral language disorder often results in the person not having the necessary skills to cope with verbally mediated interventions aimed at reducing behaviours of concern. The interrelationship between language disorders and behaviours of concern is well documented in the literature, with research supporting the finding that there is a higher proportion of people with undetected oral language disorders. The Integrated Health Care Team completed three specialist communication assessment reports in the last financial year, as a means of fostering a better match between the recommended positive behaviour

support strategies and a person's actual level of understanding of spoken language, as well as ensuring that recommended communication strategies were incorporated in a person's behaviour support plan and/or supervised treatment order.

## Promoting Dignity Grants

Since 2008 the Senior Practitioner has offered disability services small grants called Promoting Dignity Grants. These grants provide a chance for disability service providers to work with the Senior Practitioner team to develop innovative solutions to reduce their use of restrictive interventions for a particular person or people they support who are subject to restrictive interventions. In 2018–19 the focus was on reducing environmental restraint. Six grants were awarded to disability service providers. Unfortunately, two service providers had to discontinue due to other work-related pressures. Four services completed their Promoting Dignity Grants.

One service looked at improving access to an outside area for a young man with high complex needs. They found that the young man enjoyed access to a trampoline in the backyard and enjoyed being outside. Unfortunately, this new access was short-lived. When he stopped taking his medication and his behaviour deteriorated, it became unsafe for him and staff to continue his access to the backyard space. Enabling freedoms safely continues to be a work in progress for this young man.

Another service started with an audit of the number of environmental restraints in one house and found they were able to reduce these by one-third quickly. With the assistance of two masters' students in psychology from Deakin University and two masters' students in occupational therapy from Monash University, staff were able to find ways to improve the quality of life for the five residents. Some of the changes included a better understanding of the needs of the five men from a psychosocial perspective and changes to the home environment so the residents could independently obtain drinks and snacks as well as making the house more homelike and comfortable.

The final service had two grants for two of its day services. Both were used to find ways to reduce environmental restraints that had existed for some time and enabled them to change the environment to make it more accessible to people with a disability. They removed numerous locks and barriers to freedom of access and movement; they also initiated additional modification enhancements to the home to support ongoing access. For example, the water temperature was checked to make sure accidental scalding could not occur and allowed free access. They also ensured all staff understood positive behaviour support and person-centred active support. Finally, they mandated an organisational policy that no locks or other environmental modifications be made without area manager approval.

Posters from these Promoting Dignity Grant projects will be on display at the Senior Practitioner Seminar to be held in November 2019.

## ARMIDILO-S

The Assessment of Risk and Manageability of Individuals with Developmental and Intellectual Limitations who Offend – Sexually (ARMIDILO-S) is a risk assessment and management tool that has been specifically developed for use with offenders with an intellectual disability.

Risk assessment and management is a central consideration for compulsory treatment when working with offenders with an intellectual disability.

The Senior Practitioner facilitates regular training sessions on administering and interpreting this assessment tool conducted by the principal author of the assessment, Professor Doug Boer, from the University of Canberra. Professor Boer and Dr Frank Lambrick also conduct ARMIDILO-S user group sessions. These sessions are targeted at previous participants of the workshops and aim to maintain and enhance practice skills in using the assessment tool and in general risk management. Two training and two user group sessions were facilitated this year.

# Supporting best practice through advice, partnerships and consultation

A function of the Senior Practitioner is 'to develop links and access to professionals, professional bodies and academic institutions for the purpose of facilitating knowledge and training in clinical practice for persons working with persons with a disability' (Disability Act, s. 24(1)(f)). In this section of the report we describe our work with our compulsory treatment stakeholders, students from universities, NDS and the Department of Education and Training (DET) to facilitate knowledge and training in clinical practice.

## Compulsory treatment practice forums

The Compulsory Treatment Team ran five practice forums during the year. The membership is open to staff working with compulsory treatment clients including authorised program officers, clinicians, direct care (disability) staff and representatives from the Office of the Public Advocate and VCAT.

These forums have focused on facilitating information sharing about compulsory treatment, addressing and promoting practice, and supporting professional networking. The forums have covered a number of topics including:

- the Forensic Disability Statewide Assessment Service
- updates from the Disability and NDIS Policy Branch
- the Environmental Restraint Project
- the private practitioner resource list
- NDIS transition issues, specifically information about the Intensive Support Team's role and experience with the compulsory treatment cohort and its interface with the NDIS and the disability justice coordinator roles
- changes to the authorisation processes with the pending implementation of Disability Amendment Act and the NDIS Quality and Safeguards Framework.

The Compulsory Treatment Team has received positive feedback from participants about these forums.

## Compulsory Treatment Team newsletters

Since 2015 the Compulsory Treatment Team has issued newsletters that have included practice advice, links to resources, updates on compulsory treatment forums, stakeholder issues and general information about the Office of the Senior Practitioner. One newsletter was issued in 2018–19.

A survey conducted by the Compulsory Treatment Team has confirmed that the newsletter is beneficial to key stakeholders.

## Care team meetings and case consultations

The Compulsory Treatment Team supports the sector by engaging in case consultations and attending care team meetings for Compulsory Treatment Team clients. The team prioritises attendance at care team meetings based on the client's presentation such as:

- the presence of significant problematic behaviour that requires intervention
- significant issues with implementing the treatment plan
- the presence of significant service gaps that affect risk management and meeting the client's need
- multiple diagnoses that contribute to a complex presentation
- recent use of seclusion and physical restraint

- when a client is noncompliant with the order, if the client is on a new order, revocation or preparation for revocation, and if the client is going through a transition period (with accommodation, support services and clinical support).

## Working with postgraduate students

Two psychology masters' students and two occupational therapy masters' students worked together to assist a service provider to reduce their environmental restraint use and to understand the psychosocial needs of five men who shared a house. The five men had lived together for many years and, over time, there had been an increase in the number of environmental restraints to prevent two of the men from hurting three others.

The psychology students interviewed the house staff to get an understanding of levels of behaviours of concern shown by each of the men, their quality of life, and human rights. The assessments showed that all of the men had very low quality of life and that three of the men were often in fear of two other men. The report recommended that alternative accommodation be found for the two aggressive men and that an active night be provided to reduce the likelihood of adverse incidents at night to the vulnerable men.

The two occupational therapy students worked closely with the service provider to suggest some evidence-informed changes that could be made to the house that would improve the quality of the environment of the house and at the same time provide functional activities for the men to be engaged in. These changes included setting up activity sites around the house such as a coffee maker, a small refrigerator that the men could use to help themselves to food and drink and a board maker that the men could use to communicate.

During the project, the staff removed one-third of the environmental restraints. Since the introduction of the active night and changes to the house, the staff report that adverse events have decreased significantly.

## Working with university occupational therapy students

During 2018–19 the Compulsory Treatment Team hosted and supervised two Bachelor of Occupational Therapy students from Monash University as part of the students' Participatory Community Practice unit.

The students completed a project that focused on active support for the forensic disability population. They produced two educational modules to increase occupational therapists' knowledge and awareness of the need for active support with this cohort.

## Working with the Department of Education and Training

A dedicated Principal Practice Leader (Education) position was established in August 2015 to work with DET under the guidance of the Senior Practitioner. Brent Hayward was appointed to the position in November 2018 following the departure of Mandy Donley.

DET has continued to monitor the use of physical restraint and seclusion, further implementing policy to reduce and eliminate physical restraint and seclusion in Victorian government schools. A published review of restraint and seclusion policy in Australian government schools shows that Victoria, along with the ACT, is leading policy in this area. However, there is still work to do.

A focus of the Principal Practice Leader's work has been revising the policy implemented in June 2017. This revision has been informed by feedback from members of the original reference group. It has also considered suggestions to improve the operational application of the policy for school staff through simplified navigation and improved clarity of practices. Associated with this policy revision is a plan to implement a new incident reporting system for schools, which will improve the quality of restraint and seclusion data.

DET is considering options for establishing a governance structure for restraint and seclusion when the memorandum of understanding with the Department of Health and Human Services concludes in December 2019.


**Painting by Kyra Drummond**

# Informing public debate and opinion

A function of the Senior Practitioner is 'to provide information with respect to the rights of persons with a disability who may be subject to the use of restrictive interventions or compulsory treatment' (Disability Act, s. 24(1)(c)). One of the main ways the Senior Practitioner shares information is through the annual Senior Practitioner Seminar. In this section we also list our peer-reviewed publications and conference papers that were published or presented between July 2018 and June 2019. Most of these have been written either in collaboration with our partners in universities or with our services.

## The Senior Practitioner Seminar 2018

Every year the Senior Practitioner Seminar is held to provide feedback and information about the progress of projects being undertaken by or commissioned by the Senior Practitioner, as well as information about changes in the system such as the NDIS. On 6 December 2018 the following topics were presented:

- Associate Professor Paul Ramcharan provided an update of the *Roadmap for reduction of restrictive interventions*.
- James MacIsaac, Director of Disability and NDIS Policy, talked about changes to NDIS for the disability workforce.
- Brent Hayward presented on the monitoring and oversight of restrictive practices in Victorian government schools.
- Lynne Webber summarised 11 years of research by the Senior Practitioner, from 2007 to 2018.
- Todd Davies provided an update on an evaluation of GP education guidelines and modules.
- Darren Parnell presented an update of research from the Compulsory Treatment Team.
- Katie White presented on staff perspectives on the use of mechanical restraint and the potential facilitators and barriers to restraint reduction and elimination in disability services.

The Promoting Dignity Grants posters were available during lunch for people to read and discuss with the authors. The Senior Practitioner received positive feedback from many people about the seminar. These PowerPoint presentations are available from the Victorian Senior Practitioner.

## Publications in peer-reviewed journals

Two papers were published in peer-reviewed journals in 2018–19.

### Factors associated with the use of mechanical restraint in disability services

*Authors:* Lynne S Webber, Ben Richardson, Kathryn L White, Padraig Fitzpatrick, Keith McVilly and Sheridan Forster

*To cite this article:* Webber LS, Richardson B, White KL, Fitzpatrick P, McVilly H, Forster S 2019, 'Factors associated with the use of mechanical restraint in disability services', *Journal of Intellectual & Developmental Disability*, 44:1, 116–120, DOI: 10.3109/13668250.2017.1310814

*To link to this article:* Factors associated with the use of mechanical restraint in disability services <https://doi.org/10.3109/13668250.2017.1310814>

**Abstract**

*Background:* Mechanical restraint refers to the use of materials or devices to restrict the behaviours of a person with a disability, where the restraint is neither for therapeutic purposes or required by law. The inappropriate use of mechanical restraint is recognised in legislation and policy as a violation of people's

human rights, and a risk to their health and wellbeing. Understanding who is at risk of mechanical restraint may assist service providers to better support people with a disability.

*Method:* Statewide data collected between July 2012 to June 2013 were sourced. Odds ratios were used to describe the associations between individual characteristics and whether an individual was subjected to mechanical restraint.

*Results:* Individuals with certain characteristics, such as the presence of a hearing, physical, neurological, communication or visual impairment, and autism spectrum disorder, had an increased likelihood of being mechanically restrained.

*Conclusion:* Initiatives to reduce mechanical restraint should pay particular attention to the support needs of those with sensory impairments and complex communication support needs including those with autism spectrum disorder and those with a physical impairment.

### Factors associated with long-term use of restrictive interventions

*Authors:* Ben Richardson, Lynne S Webber and Frank Lambrick

*To cite this article:* Richardson B, Webber LS, Lambrick F 2019, 'Factors associated with long-term use of restrictive interventions', *Journal of Intellectual & Developmental Disability*, DOI: 10.3109/13668250.2019.1639895

*To link to this article:* Factors associated with long-term use of restrictive interventions <https://doi.org/10.3109/13668250.2019.1639895>

**Abstract**

*Background:* Despite agreement that restrictive intervention (RI) should only be used as a last resort and for as long as required, little is known about long-term RI among people with a disability. This study examines long-term RI use.

*Method:* From the RIDS dataset, a cohort of 1,414 people reported to be restrained or secluded between July 2008 and June 2010 were identified. The primary outcome was restraint during the follow-up period (July 2013 to June 2015). The secondary outcome, reasons for restraint cessation, were measured via a self-report survey completed by 54 service providers.

*Results:* At follow-up, 74 per cent of the cohort was still subject to RI. Antipsychotic medication use, a diagnosis of autism and communication difficulties were associated with RI at follow-up.

*Conclusions:* Long-term RI is prevalent but can be minimised by positive behaviour support.

## Invited presentations

### 30 October 2018

The ACT Senior Practitioner invited Dr Frank Lambrick to facilitate a workshop on risk assessment for the disability sector as part of the ACT Senior Practitioner Seminar Series.

### 17 January 2019

The NDIS Commission Senior Practitioner invited Dr Lynne Webber to present a workshop to the behaviour support lead practitioners from all states and territories about how to use the Behavior Support Plan Quality Evaluation II tool to assess the quality of behaviour support plans.

## 21 February 2019

The South Australian Positive Behaviour Support Community of Practice invited Dr Frank Lambrick to present on the Victorian experience of reducing and eliminating restrictive practices.

## 23 May 2019

The Northern Territory Office of Disability invited Dr Frank Lambrick to present on forensic disability at the NDIS Behaviour Support Training Forum.


**Painting by Tammy Smith**

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# Appendix: Data tables for figures

### Figure 1: Number of people subject to a restrictive intervention, Victoria, 2011–12 to 2018–19

| Year | Number |
|---|---|
| 2011–12 | 1,921 |
| 2012–13 | 1,979 |
| 2013–14 | 2,081 |
| 2014–15 | 2,219 |
| 2015–16 | 2,329 |
| 2016–17 | 2,341 |
| 2017–18 | 2,410 |
| 2018–19 | 2,483 |

Return to text following Figure 1

### Figure 2: Number of people subject to chemical, mechanical or physical restraint, or seclusion, Victoria, 2011–12 to 2018–19

| Year | Chemical | Mechanical | Physical | Seclusion |
|---|---|---|---|---|
| 2011–12 | 1,826 | 118 | 65 | 61 |
| 2012–13 | 1,859 | 141 | 102 | 51 |
| 2013–14 | 1,976 | 139 | 62 | 46 |
| 2014–15 | 2,107 | 132 | 78 | 58 |
| 2015–16 | 2,238 | 134 | 91 | 43 |
| 2016–17 | 2,226 | 141 | 103 | 55 |
| 2017–18 | 2,302 | 150 | 81 | 56 |
| 2018–19 | 2,377 | 152 | 66 | 59 |

Return to text following Figure 2

## Figure 3: Number of people subject to each type of chemical restraint, Victoria, 2011–12 to 2018–19

| Year | Antiandrogen | Antidepressant | Antipsychotic | Benzodiazepine | Hormonal | Menstrual suppression | Mood stabiliser | Stimulant | Sedative |
|---|---|---|---|---|---|---|---|---|---|
| 2011–12 | 28 | 630 | 1,335 | 402 | 37 | 48 | 577 | 142 | 81 |
| 2012–13 | 29 | 650 | 1,346 | 388 | 33 | 36 | 551 | 154 | 104 |
| 2013–14 | 22 | 733 | 1,433 | 404 | 40 | 48 | 539 | 172 | 123 |
| 2014–15 | 22 | 813 | 1,501 | 438 | 41 | 45 | 538 | 205 | 171 |
| 2015–16 | 22 | 897 | 1,571 | 495 | 56 | 38 | 577 | 222 | 228 |
| 2016–17 | 21 | 910 | 1,592 | 494 | 51 | 46 | 598 | 231 | 226 |
| 2017–18 | 22 | 938 | 1,638 | 514 | 47 | 58 | 592 | 265 | 226 |
| 2018–19 | 18 | 1,009 | 1,667 | 526 | 60 | 63 | 610 | 287 | 320 |

Return to text following Figure 3

## Figure 4: Number of people subject to each type of mechanical restraint, Victoria, 2011–12 to 2018–19

| Year | Straps | Gloves | Splints | Restrictive clothing | Cuffs | Helmet | Wheelchair | Bedrail | Furniture |
|---|---|---|---|---|---|---|---|---|---|
| 2011–12 | 19 | 7 | 17 | 68 | 4 | 8 | 7 | 1 | 5 |
| 2012–13 | 22 | 10 | 13 | 75 | 3 | 12 | 11 | 5 | 2 |
| 2013–14 | 23 | 9 | 13 | 80 | 3 | 12 | 11 | 5 | 1 |
| 2014–15 | 26 | 12 | 13 | 75 | 2 | 11 | 7 | 2 | 2 |
| 2015–16 | 27 | 13 | 11 | 74 | 2 | 8 | 10 | 13 | 1 |
| 2016–17 | 30 | 11 | 9 | 77 | 3 | 9 | 10 | 11 | 2 |
| 2017–18 | 36 | 9 | 11 | 76 | 3 | 8 | 10 | 12 | 0 |
| 2018–19 | 38 | 13 | 13 | 82 | 2 | 8 | 9 | 15 | 2 |

Return to text following Figure 4

## Figure 5: Average BSP-QE II scores across all disability services, Victoria, 2012–13 to 2018–19

| Year | BSP-QE II score |
|---|---|
| 2012–13 | 10.34 |
| 2013–14 | 11.75 |
| 2014–15 | 12.20 |
| 2015–16 | 12.97 |
| 2016–17 | 12.33 |
| 2017–18 | 12.40 |

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