

# Senior Practitioner report 2015–16



**Cover: 'Connecting to Others', painting by Steve Canning**

*My painting is a puzzle. I had a dream when I was painting the dots. I'm showing the important picture of some people who don't have vision. I was thinking about many people around the world who have a disability, people who are blind and need help. My feeling of painting is a vision of miracles, to touch, to smell, to hear. A person with disability can achieve anything in life.*

The artworks used in this report are by winners of the 2016 VALID Annual 'Having a Say' conference Art Competition sponsored by the Senior Practitioner.

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# Message from the Senior Practitioner

The work of the office during 2015–16 has focused on consolidating the work we have undertaken over the years to inform and support the process of transition to the National Disability Insurance Scheme (NDIS), commencing in Barwon and North East Metropolitan Areas from July 2016.

The role of the Senior Practitioner provides a particularly important safeguard in protecting the rights of people with a disability who are subject to restrictive practices and compulsory treatment. The maintenance and consolidation of this role as we progress through this transition therefore takes on particular importance.



My office has been collecting data on restrictive interventions, compulsory treatment and behaviour support plans since 2007. The picture that's emerging, in terms of restrictive interventions, is that some people with a disability are more at risk than other people with a disability of being subjected to restrictive interventions. In particular, males, people with autism, and children are all more at risk than females, people without autism and adults.

The majority of people who are reported to my office are at risk of being subjected to chemical restraint on a routine basis (every day) and many are at risk of being subjected to ongoing chemical restraint over a period of years.

Each year some people are no longer reported and we are looking at why this is the case in the cohort project. At the same time, there is a group of new people reported for the first time. Since 2011–12, there has been a gradual increase in the number of people reported as being subjected to restrictive interventions.

There may be several reasons for this increase. Firstly, there has been an increase in the number of services reporting to the Senior Practitioner since 2011–12, which could account for some of the increase in total numbers of people reported. Secondly, services have been reporting more episodes or transactions of restrictive interventions since 2011–12, which may mean that services are more aware of what needs to be reported. A third factor is that the reporting of physical restraint was added to the list of restrictive interventions needing to be reported in 2011.

While chemical restraint continues to account for the majority of increase in restrictive interventions, seclusion and mechanical restraint have both shown a decrease from 2014–15. Physical restraint has shown a slight increase.

On the positive side, there have been gradual increases in the quality of behaviour support plans, as assessed by the Behaviour Support Plan Quality Evaluation tool II (BSP-QE II). In 2015–16, the average BSP-QE II score reached the level associated with decreases in restrictive interventions. This result is most likely due to the education that has been delivered by my staff. This education includes face-to-face behaviour support plan toolkit sessions, as well as resources available online, such as the behaviour support plan toolkit.

One challenge for the future is to assist services to continue to find the best individualised support they can, especially for those with high complex needs who may not have the ability to communicate to their support workers or carers. Another challenge is to increase awareness of services staff that many people with moderate to profound intellectual disability have underdiagnosed health issues, which may be difficult to diagnose and therefore treat appropriately.

A significant development this year has been the establishment of the principal practice leader (education) position with the Department of Education and Training. This position is part of the Special Needs Plan for Victorian Schools, and has been designed to improve the management of behaviours of concern in government schools, and oversee the reduction of restraint and seclusion in schools.

The position reports directly to me, carries out visits, and works with government schools throughout Victoria to gain an understanding of current processes and staff knowledge in relation to restrictive practices. The position also provides advice related to best practice approaches and processes for supporting and responding to students with behaviours of concern.

The team has been busy throughout this year supporting the sector, not only with the formal projects and activities described in this report, but in the myriad day-to-day activities that consolidate the work we do. In particular:

- the research and service development team has spent much time fielding queries about the Restrictive Intervention Data System (RIDS)
- the compulsory treatment team has been working on case conferencing related activities
- the integrated healthcare team has dealt with restrictive intervention queries.

The team has also been contributing to the various activities and forums around development of the NDIS quality and safeguarding framework.

Finally, I would like to take the opportunity to thank all our staff – those who have left, those remaining and those who have joined us – for what has been another year of hard, innovative and client-focused work.

I would also like to acknowledge the contributions of our colleagues, project partners, internal and external stakeholders, disability service providers, families, carers, advocates and professionals who collaborate with us in our work. We look forward to continuing this relationship over the coming year and to embracing the challenges that lie ahead, particularly with the commencement of the transition to the NDIS.



Dr Frank Lambrick  
Senior Practitioner – Disability

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'The Tree of Strength', painting by Jane Rosengrave

# 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 of the Operations Division of the Department of Health and Human Services (DHHS).

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 subjected to restrictive interventions or compulsory treatment.

The Act also mandates:

- 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 the person who is subject to compulsory treatment
  - oversee the implementation of supervised treatment orders
  - issue lawful directions to the service on any law, policy or practices where relevant to the compulsory treatment order matter.

The inclusion of research and education as mandatory functions of the Senior Practitioner in the Act means that it is possible to focus on what the evidence shows, 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 population use of restrictive interventions and behaviour support plans over nine years. Queensland has recently commenced data collection that is framed by their legislative requirements. The collection of population level data over years has enabled investigation into what changes over time and what factors impact on these changes.

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 year from July 2015 to June 2016.

# Promoting best practice through professional development

The Senior Practitioner supports professional development and practice leadership across the disability sector by sharing information on how to use contemporary evidence-based practices.

Information is distributed in a variety of ways, including the provision of training within the context of restrictive interventions and/or compulsory treatment under the Act.

We provide training to diverse professional groups who are working across the disability sector. Specific areas of interest are covered, such as:

- reflective practice about forensic disability
- working with complex clients
- trauma and attachment in persons with an intellectual disability
- use of anti-libidinal medication in sex offenders with an intellectual disability
- strength-based approaches to assessing and managing risk in offenders with intellectual disability
- promoting collaborative practice through joint case planning with offenders with intellectual disability.

Referrals and requests for these training sessions came from a range of service streams across the state, including, but not limited to, the Department of Health and Human Services (the department), community service organisations, Corrections Victoria (Department of Justice and Regulation), and Victoria Police.

Evaluation and feedback was collated for most of the training sessions and reflected positive outcomes across a variety of professional groups.

## Behaviour support plan toolkit training

The Restrictive Intervention Data System (RIDS) behaviour support plan toolkit training is a four-hour interactive workshop on how to develop high-quality behaviour support plans that will meet the requirements of the Act.

The content covers:

- understanding a person's needs
- what a person's behaviour of concern might mean
- how to identify the best positive behaviour support interventions that would reduce the person's need to use a behaviour of concern
- how to tell if the interventions are working.

The training also demonstrates how to upload the behaviour support plan into RIDS.

From July 2015 to June 2016, the RIDS behaviour support plan training was delivered across Victoria 24 times to a total of 564 participants. Our results on the quality of behaviour support plans showed that people who completed the training produced better quality plans than those who had not undertaken the training.





**The Senior Practitioner – Disability Research and Service Development team**

## **ARMIDILO-S and user group sessions**

The Assessment of Risk and Manageability of Individuals with Developmental and Intellectual Limitations who Offend (ARMIDILO) is a risk assessment and management tool that has been specifically developed for use with this group.

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 conducted by the principal author of the assessment, Professor Doug Boer, from the University of Canberra. ARMIDILO user group sessions are also facilitated by the Senior Practitioner. Two sessions were convened this year to maintain and enhance practice skills in the use of this assessment tool by those who attended Professor Boer's workshops.

## **People who are identified as fire-setters with an intellectual disability**

In December 2015, the Senior Practitioner and Principal Practice Leader, Compulsory Treatment, provided training to disability support staff, case managers, practitioners and youth justice workers in relation to people who were identified as fire-setters with a disability. This training was delivered in response to feedback provided in an initial training session delivered in the previous reporting period.

The aim of the training was to increase awareness of professionals when working with people with a disability who light fires, and to manage the risks associated with regional work and the bushfire season.

The compulsory treatment team has developed a risk management plan for practitioners and support staff to use as both a preventative and monitoring risk framework for people who present with fire-setting behaviour and disability. This plan is used to improve operational practice beyond these training sessions.

## **Chemical, physical, mechanical and other restrictive interventions**

In October 2015, the integrated healthcare team provided training to disability support staff, case managers, practitioners, youth justice workers and people working in out of home care.

The content of the training covered:

- the *Disability Act 2006*
- the *Charter of Human Rights and Responsibilities Act 2006*
- exploration of case scenarios
- frequently asked questions.

The purpose of the training was to discuss the expectations under the Act and the Charter, how to apply the Act in practice, and what is considered duty of care in this context.

# Monitoring and evaluating practice

## Restrictive interventions reported to the Senior Practitioner

Disability services must report to the Senior Practitioner about their use of four types of restrictive interventions used in their services by their staff. These include:

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

**Chemical restraint** refers to the use of medication where the primary purpose is to control a person's behaviour. This excludes the use of medication for treating an illness or condition.

**Mechanical restraint** refers to using a device (such as splints and bodysuits) to control a person's movement. This excludes devices used for therapeutic purposes or to enable safe transportation (such as a buckle guard on a seatbelt in a car).

**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. Section 3 of the Act provides complete definitions of these restrictive interventions.

Chemical restraint, mechanical restraint and seclusion have been reported to the Senior Practitioner since July 2007.

**Physical restraint** is defined by the Senior Practitioner as the use of physical force to prevent, restrict or subdue movement, which is not physical guidance or physical assistance. Further information about physical restraint is contained in the *Direction on physical restraint* available online. Physical restraint has been reported since July 2011.

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), as required 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
- 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 is of benefit to the person.

## The use of restrictive interventions in Victoria

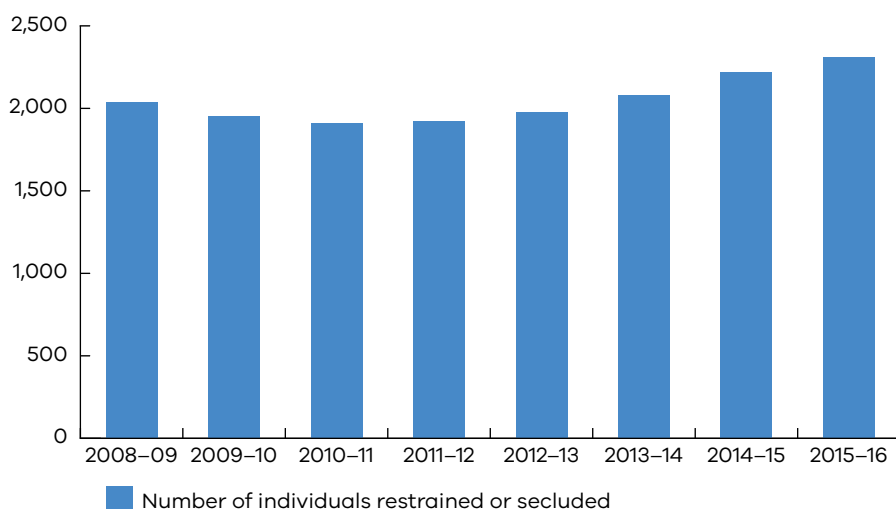
This section of the report summarises the findings of:

- restrictive interventions reported from disability services in Victoria in 2015–16, and where possible compares these findings with the previous six years
- the quality of and adherence to the legislation of behaviour support plans written in 2015–16 compared with the previous year 2014–15
- the number of people on compulsory treatment orders in 2015–16.

The total number of people who were subjected to restraint and or seclusion in 2015–16 was 2,310 people, an increase of four per cent compared with 2014–15 (see Figure 1). The total number who have been reported to be subjected to restrictive interventions has been increasing since 2011–12.

Some of this may be accounted for by the increase in the number of services reporting to the Senior Practitioner each year, which increased from 742 services in 2008–09 to 760 in 2011–12 to 840 in 2015–16. It should be noted that data for the Senior Practitioner report only includes services that have reported restrictive interventions. Services with no reporting of restrictive interventions are not included in the data set. This is also true for the total numbers of clients who are and are not subject to restrictive interventions, so it is not possible to evaluate whether any change in the number of services results in a change in client numbers.

**Figure 1: The total number of people reported to be restrained and or secluded, 2008–09 to 2015–16**







**The Senior Practitioner – Disability team**

Shared supported accommodation and respite services reported most of the restrictive interventions, and this has been increasing since 2011–12. There have been increases in the proportion of:

- people with autism – increased to 47 per cent of all people reported to RIDS, up from 43 per cent in 2011–12
- children (aged under 18 years of age) – increased to 24 per cent of all people reported to RIDS, up from 21 per cent in 2011–12
- people subjected to the use of chemical restraint and physical restraint (described below).

The proportion of people with psychiatric disorders has decreased since 2011–12 from 15 per cent to 12 per cent of all people reported to RIDS. The proportion of people with a hearing impairment has decreased since 2011–12 from 31 per cent to 22 per cent.

The reason for these two trends are not clear, but it is possible services are more aware that if a person is receiving medication for a psychiatric disorder, it is not chemical restraint. It is also possible that services are more aware of the needs of people with communication difficulties, such as hearing impairments. These possibilities will be explored further in the cohort study.

## Chemical restraint

In 2015–16, almost all people (96 per cent) who were reported to be subjected to a restrictive intervention were subjected to chemical restraint. Figure 2 shows that the total number of people subjected to chemical restraint has been increasing gradually since 2011–12.

**Figure 2: The number of people reported to be subjected to chemical, mechanical, physical restraint and seclusion, 2008–09 to 2015–16**



\* Reporting of physical restraint became mandatory on 1 July 2011. Data collection commenced from this date.

## Types of chemical restraint administration

Chemical restraint can be administered as a:

- routine medication
- PRN medication (as required or needed)
- in an emergency (not included in a behaviour support plan).

Within a reporting year, it is possible for people to be administered all three types of chemical restraint.

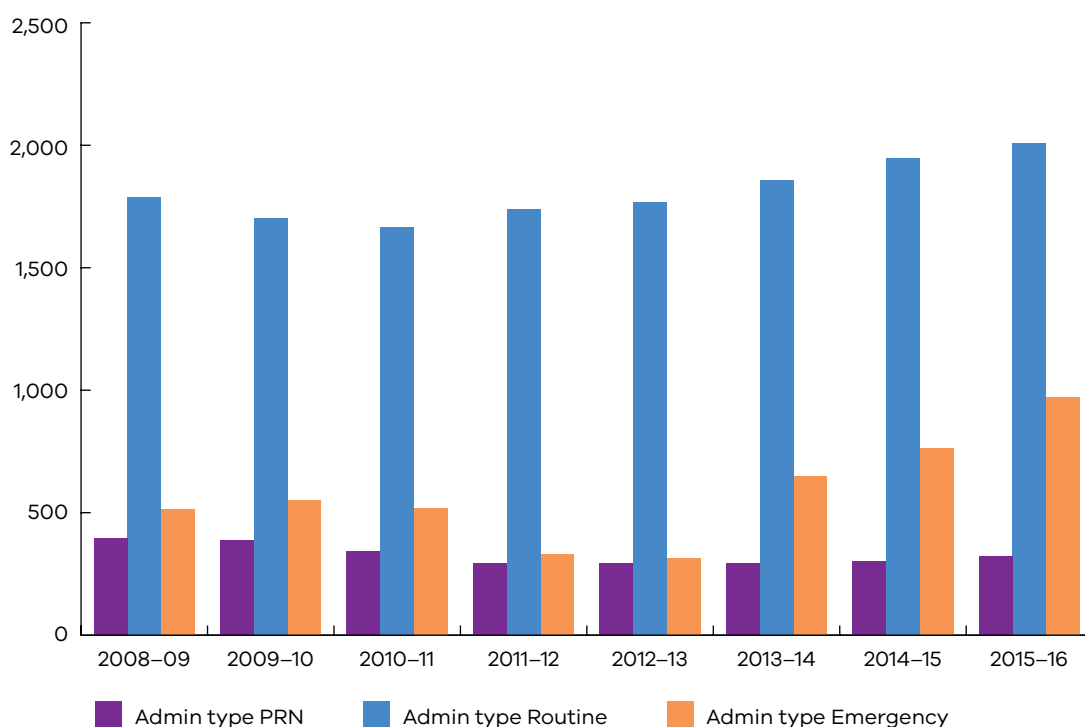
Figure 3 shows the total number of people who were administered chemical restraint routinely, PRN and in an emergency.

Most people were administered chemical restraint routinely in 2015–16 (90 per cent of all people administered chemical restraint were administered chemical restraint routinely). Although the proportion of people administered routine chemical restraint has been decreasing slightly since 2010–11 (95 per cent in 2011–12), this decrease is offset by increases in emergency reporting.

The proportion of people reported to be administered chemical restraint in an emergency has increased since 2011–12, when it was 18 per cent. In 2015–16, 44 per cent were reported to be administered chemical restraint in an emergency. It appears that most of this reporting is actually routine chemical restraint, but reported as an emergency due to the lack of a behaviour support plan or a behaviour support plan being in place that does not cover a chemical restraint that is to be used.

In 2015–16, 14 per cent of people administered chemical restraint were administered a PRN medication. The proportion of people administered PRN chemical restraint is the same as 2014–15 and has decreased since 2011–12 when it was 16 per cent.

**Figure 3: The number of people reported to be subjected to PRN, routine and emergency chemical restraint, 2008–09 to 2015–16**



### Chemical restraint types of medications

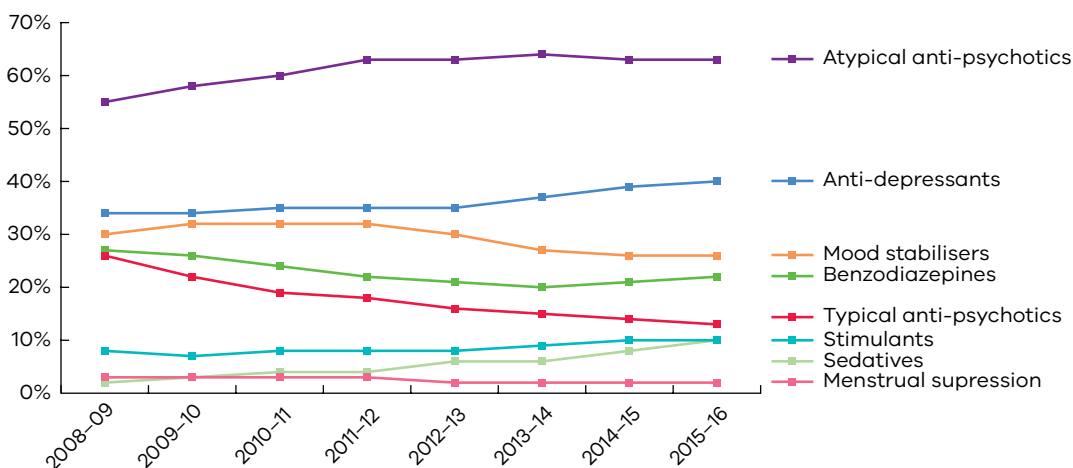
The majority of people who are subjected to chemical restraint were administered atypical antipsychotics (63 per cent of all people reported to be subjected to chemical restraint in 2015–16). This proportion (63 per cent) has remained relatively unchanged since 2011–12.

The proportion of people administered stimulants has increased since 2011–12 from 8 per cent to 10 per cent in 2015–16. The proportion of people administered antidepressants has been increasing from 35 per cent in 2011–12 to 40 per cent in 2015–16. The proportion of people administered sedatives has also increased from 4 per cent in 2011–12 to 10 per cent in 2015–16. The proportion of people administered benzodiazepines fluctuated slightly from 2011–12 to 2015–16 between 20 and 22 per cent.

At the same time, the proportion of people administered typical antipsychotics decreased from 18 per cent in 2011–12 to 13 per cent in 2015–16. The proportion of people administered menstrual suppression has also decreased (3 per cent in 2011–12 to 2 per cent in 2015–16). The decrease in the use of typical antipsychotics and menstrual suppression has probably been a result of education initiatives established by the Senior Practitioner around the use of these two types of chemical restraint.

It should be noted that in all the years shown in Figure 4 a majority of people were administered more than one type of chemical restraint over the course of the year (see Polypharmacy section below).

**Figure 4: The proportion of people subjected to different types of chemical restraint, 2008–09 to 2015–16**





### Polypharmacy

Polypharmacy is defined as the use of two or more medications to treat the same condition (for chemical restraint, this is the simultaneous use of more than one medication for behaviours of concern).

**Figure 5: The number of people subjected to polypharmacy compared to the number of people subjected exclusively to single chemical restraint, 2008–09 to 2015–16**

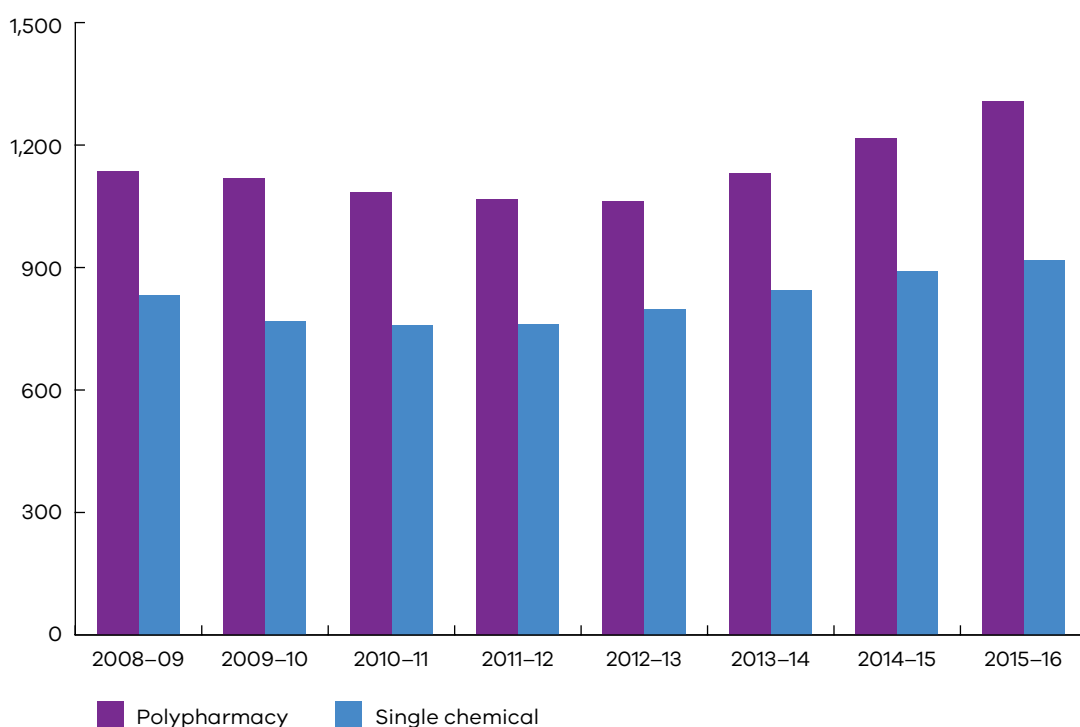
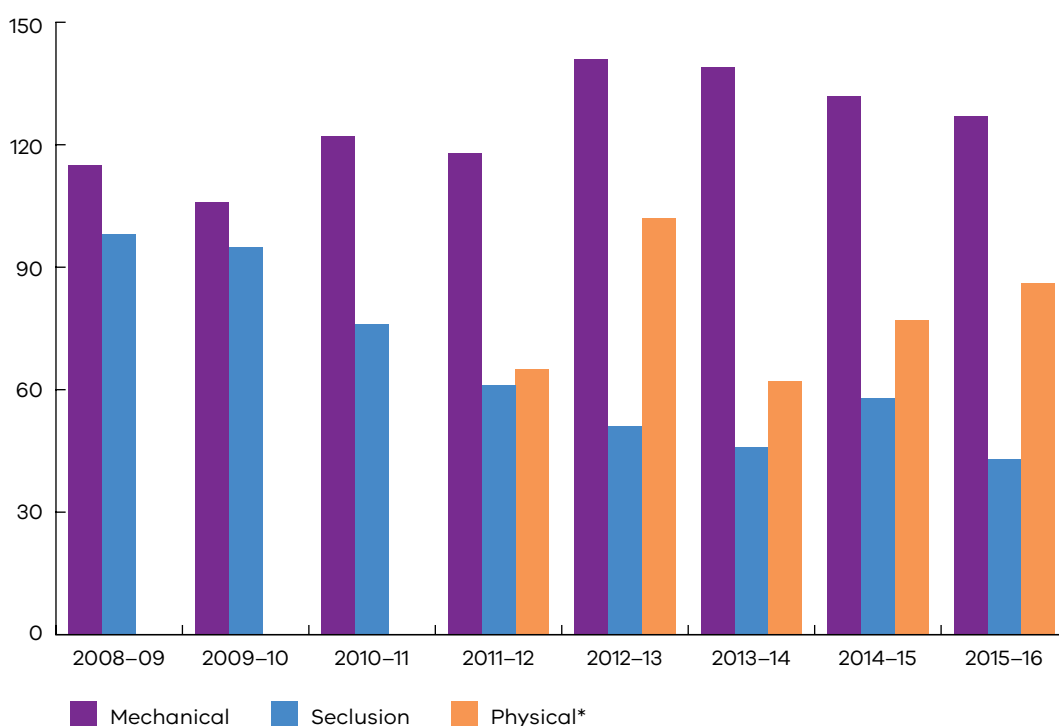


Figure 5 shows that the proportion of people who were subjected to polypharmacy at least once within a reporting year has been relatively constant. Each year, between 57 and 59 per cent of people who were chemically restrained were administered two or more medications to control their behaviours of concern.

## Mechanical restraint, physical restraint and seclusion

The total number of people who were subjected to seclusion and mechanical restraint has decreased from 2014–15 to 2015–16, as seen in Figure 6. At the same time, the total number of people subjected to physical restraint has increased slightly.

**Figure 6: The number of people reported to be subjected to mechanical, physical restraint and seclusion, 2008–09 to 2015–16**



\* Reporting of physical restraint became mandatory on 1 July 2011. Data collection commenced from this date.

### Mechanical restraint

The number of people who were reported to be mechanically restrained peaked in 2012–13 and has been decreasing each year since that time. This decrease is most likely due to the mechanical restraint reduction project that was commenced in 2012–13 to examine who was at risk of mechanical restraint and what could be done to reduce the risk for those individuals.

### Seclusion

The total number of people who were reported to be secluded in 2015–16 decreased by 15 people from 2014–15. The decrease was seen across all services except shared supported accommodation, with respite services accounting for the majority of the decrease (eight people less than in 2014–15).

### **Physical restraint**

A total of 86 people were reported to be physically restrained at some time in 2015–16. The majority were males (80 per cent). The total number has increased from 2014–15 by nine people. The majority of this increase was reported by shared supported accommodation and respite services. It should be noted that these services provide care to the majority of people with a disability.

### **Behaviour support plan reviews**

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 2015–16, 2,797 behaviour support plans were received by the Senior Practitioner from services.

The Senior Practitioner uses the Behaviour Support Plan Quality Evaluation tool II (BSP-QE II) (Browning-Wright, Saren and 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, McVilly, Fester and Chan 2011a).

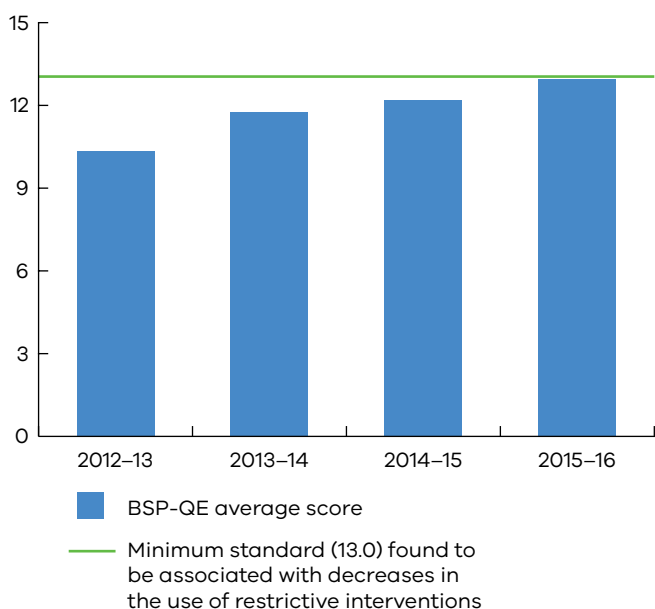
In previous work, the Senior Practitioner also found evidence that the quality of behaviour support plans is associated with reductions in restrictive intervention use (Webber, McVilly, Fester and Zazelis 2011b; Webber, Richardson, Lambrick and Fester 2012).

### **Behaviour Support Plan Quality Evaluations**

In 2015–16, 367 (13 per cent) of the behaviour support plans received by the Senior Practitioner were assessed using the BSP-QE II. Figure 7 shows the average score achieved across all services from 2012–13 to 2015–16 and as demonstrated, there has been a steady improvement over these years.

The average score achieved in 2015–16 was 12.96, with a range of 4 to 23 out of a possible 24. The average score has been improving every year since 2012–13, and in 2015–16 it has, for the first time, reached the minimum BSP-QE II score found to be associated with decreases in the use of restrictive interventions (Webber, Richardson, Lambrick and Fester 2012).

**Figure 7: Average BSP-QE II scores across all services, 2012–13 to 2015–16**



The quality of behaviour support plans can be improved by linking what triggers the behaviour of concern with what can be changed in the person’s environment and skills to decrease the likelihood they will need to use the behaviour of concern. For example, a person who is blind and is triggered to self-harm by loud noises because they can’t make sense of the loud noise, can be helped to be aware of what’s happening in their environment by the support person telling them what is occurring.

A person who is experiencing gastrointestinal pain that triggers behaviours of concern, may be helped into a more comfortable position and given appropriate pain-relieving medication (note in this example, the medication is NOT a chemical restraint, because it is being used to reduce pain).

### **Disability Act clinical reviews 1 July 2015 – 30 June 2016**

The Senior Practitioner also completes a number of clinical reviews of behaviour support plans where there is concern that there is excessive use of restraint or seclusion, or where the person is at risk of compulsory treatment or where they have a complex presentation that the service needs support to manage. This type of review considers not only the behaviour support plan, but the accompanying documents and assessments, as well as a discussion with the service.

Often, the most pressing issue brought to light by the clinical review is not with the person’s presentation, but with the systems that are supporting the person. Examples include issues with team coordination, role clarification of support staff, effective data recording and analysis to inform the behaviour support plan, and understanding what priorities need to be put in place to maximise implementation of plans. Effective case management is needed to facilitate the implementation of support for clients.



## **Disability Act legislative reviews 1 July 2015 – 30 June 2016**

The Senior Practitioner also conducts legislative reviews on behaviour support plans. Disability services that propose to apply restrictive interventions to a person with a disability are required by the Act to include this proposal within a behaviour support plan. The components required to be in a behaviour support plans are outlined in Part 7 of the Act.

One hundred behaviour support plans with a start date between 1 July 2015 and 30 June 2016 were reviewed against the components required to be included in a behaviour support plan in the Act.

The reviews revealed that services continued to face challenges in:

- working together with other services who were also supporting the person
- describing how the restrictive intervention is the least restrictive option
- describing the circumstances under which the restrictive intervention would be applied
- describing de-escalation strategies that matched to the person's presentation to safely manage behaviours of concern.

On the positive side, the reviews revealed an increase in the number of services who:

- incorporated the behaviour support plan into a larger planning process
- clearly defined the behaviour of concern
- linked the behaviour of concern in a logical manner to the use of the restrictive intervention
- provided evidence of how the team would coordinate to implement the plan.

If services want to check whether their behaviour support plans are legislatively compliant, they can use a checklist, which can be found in section 4 of the [RIDSeBSP toolkit](http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/behaviour-support-planning-practice-guide-senior-practitioner), *What the Disability Act 2006 asks for in a behaviour support plan* <<http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/behaviour-support-planning-practice-guide-senior-practitioner>>.

## **Restrictive interventions audit review**

The Senior Practitioner is required to investigate, audit and monitor the use of restrictive interventions and compulsory treatment in disability services (Disability Act 2006, s.27(2)(c)). During 2015-16, the Senior Practitioner's integrated healthcare team audited a variety of disability services, including group homes, residential respite and day programs.

These audits identified common findings with previous years, including:

- poor recognition of practices as restrictive (particularly medication used as chemical restraint)
- the use of restrictive interventions without approval in a behaviour support plan
- restrictive interventions used after the expiration of behaviour support plans.

Poor practices concerning chemical restraint often related to incorrect interpretations of the Act, and the development of local practices based on word of mouth, rather than legislation. Limiting access to common areas of group homes, not providing access to personal property, as well as detaining residents also continued to be identified.

Disability services are being increasingly reminded of their obligations in the Act to identify restrictive interventions. The Senior Practitioner's integrated healthcare team continues to identify cases where disability services have erroneously relied on the advice of clinicians, particularly medical practitioners, to interpret if an intervention is restrictive.

Disability services are reminded that it is their responsibility to apply the Act, not a medical practitioner or other clinician. These practitioners do not have the necessary understanding of the Act, or the obligation to interpret it as a disability service provider must.

Future work will be undertaken to address this in the broader disability sector.

The Senior Practitioner began testing an online audit database that directly interfaces with RIDS, to decrease handwritten documentation and more quickly compare restrictive practices with those in approved and submitted behaviour support plans.

In addition, the Restrictive Intervention Self Evaluation Tool (RISET) commenced development. RISET is designed for staff of disability services to audit their own practices to identify restrictive practices and take necessary action. The tool has been developed to reduce the large number of inquiries to the Senior Practitioner's practice advisers and to increase the legislative compliance of disability services. It will be released to the sector in the coming year.



**The Senior Practitioner – Disability Administration team**

## **Compulsory treatment monitoring**

A small group of people subjected to restrictive interventions are detained or supervised at all times for the purpose of treatment, because they pose a significant risk of harm to others. Part 8 of the Act allows for the provision of civil detention in the community through a supervised treatment order, which is applied for and made by the Victorian Civil and Administrative Tribunal (VCAT).

This part of the Act also permits court-mandated detention and treatment in a residential treatment facility through orders such as residential treatment orders, parole, custodial supervision orders and extended supervision orders.

The Senior Practitioner is responsible for supervising the implementation of treatment provided to these people by monitoring the approved treatment plan and ensuring it will benefit the person. The authorised program officer is responsible for the implementation and monitoring of a treatment plan, as well as for reporting back to the Senior Practitioner on the person's progress during their treatment.

The Senior Practitioner issues a treatment plan certificate to the authorised program officer, with directions regarding variations to the treatment plan, practice advice and specifying the period of approval for the plan. Monitoring requirements are also stipulated.

The Office of the Public Advocate is also a party to these treatment plan reviews 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 a person is being detained unlawfully. VCAT determines whether a treatment plan is appropriate (having regards to specific criteria) and may confirm or vary a treatment plan. VCAT will issue an order for the duration of the treatment plan or in line with the outcome of the hearing.

In 2015–16, 32 people (approximately one per cent of the people reported to the Senior Practitioner) were subject to a compulsory treatment order. There were 33 people in 2014–15 and 37 people in 2013–14. Although there have been three new people on compulsory treatment in 2015–16, there has been a positive trend in the number of revocation applications. This means that less people are staying on compulsory treatment orders for extended periods of time. At the end of the 2015–16 year, 25 people were subject to compulsory treatment.

## **Residential treatment facilities**

Victoria's disability residential treatment facility is known as the Intensive Residential Treatment Program within the Disability Forensic and Assessment Treatment Service. People sentenced to reside at the disability residential treatment facility are not always considered to be a compulsory treatment client, depending on the type of order.

The compulsory treatment team conducts ongoing reviews of all clients' plans at the Disability Forensic and Assessment Treatment Service. The Senior Practitioner has a responsibility to provide advice or directions in relation to restrictive interventions and compulsory treatment, as well as behaviour support plans and treatment plans. The Senior Practitioner also issues recommendations or directions addressing areas of practice or direction, in relation to restrictive interventions.

## Client demographic data

Of the 32 people subject to a compulsory treatment order in 2015–16, 31 were male and only one was female. This is a common profile in compulsory treatment, where the majority of clients are male. There have only been three females in total since 2008 who have been subject to compulsory treatment.

The primary types of offending behaviour that resulted in people being subject to a supervised treatment order or residential treatment order included sexual violence, violence (non-sexual), and fire-setting behaviours.

The average age of people subject to compulsory treatment in 2015–16 was 41 years, ranging from 19 years to 64 years. This is similar to the findings of the previous two years. Eleven people resided with community service organisations, 13 resided in Department of Health and Human Services accommodation and five were sentenced to the Residential Treatment Facility in the Disability Forensic and Assessment Treatment Service.

There is significant variation in the characteristics and needs of each person subject to compulsory treatment, which places emphasis on an individualised approach for this group. A study conducted by the compulsory treatment team in 2014 found that 62 per cent of people subject to compulsory treatment since the commencement of the Act had more than two diagnoses, including psychiatric, emotional and physical disorders.

This study also revealed two distinct groups within the compulsory treatment cohort. One group was more likely to have a less severe intellectual disability with increased prevalence of personality disorders, behaviour disorders and suicidal ideation. The second group displayed characteristics and needs that were more typical of a mainstream disability service user, including lower levels of intellectual disability and autism spectrum disorder.

## Compulsory treatment restrictive intervention data

In 2015–16, a total of 78 per cent of the 32 people who were on compulsory treatment were reported to be subjected to a restrictive intervention during the year. The restrictive interventions that were reported are included in the table below.

| Restrictive intervention     | 2014–15<br>Total=35 | 2015–16<br>Total=32 |
|------------------------------|---------------------|---------------------|
| Routine chemical restraint   | 16                  | 14                  |
| Emergency chemical restraint | 9                   | 9                   |
| PRN chemical restraint       | 3                   | 1                   |
| Seclusion                    | 6                   | 4                   |
| Physical restraint           | 8                   | 3                   |

While overall there is a percentage increase in restrictive interventions in this group compared to 2014–15 when 55 per cent of people on compulsory treatment were subject to restrictive interventions, the number of people in this group are small and the individual differences between people are large.

Two trends are consistent with the broader findings. While the number of people subjected to chemical restraint has increased, the number of people subjected to seclusion has decreased. Physical restraint, on the other hand, has decreased, which has occurred at the same time people have moved from residential treatment orders to treatment orders in the community, where physical restraint is less likely to be used.

### **Treatment order reviews**

The number of reviews for compulsory treatment gradually increased across each quarter in 2015–16. On average, 3.3 hearings occurred each month. Each hearing requires the compulsory treatment team and authorised program officer to conduct a clinical review of the material and circumstances under review by VCAT.

For each supervised treatment order and interim supervised treatment order made by VCAT, the Senior Practitioner reviewed the treatment plan and issued a treatment plan certificate approving the treatment plan. During 2015–16, 40 treatment plan reviews occurred, divided into:

- 27 reviews for supervised treatment orders
- 8 interim supervised treatment orders
- 5 annual reviews for residents under compulsory treatment at the Disability Forensic and Assessment Treatment Service.

### **Victorian Civil Administrative Tribunal Hearings**

During 2015–16, the compulsory treatment team attended 40 VCAT hearings, 15 less than 2014–15, but similar to the number of hearings in years prior to 2014. During 2015–16, eight interim supervised treatment orders were made by VCAT. This means that eight people presented with a significant risk of harm and required to be detained in the community until a supervised treatment order could be confirmed within a formal hearing. The orders permit the implementation of an approved treatment plan, while waiting for the supervised treatment order application to be heard by VCAT.

### **Assessment orders**

The Act enables the Senior Practitioner to make an assessment order for a person with an intellectual disability residing in residential service. These orders are made when there is a concern that the person may pose a significant risk of harm towards others and requires immediate detention to manage that perceived risk.

The order is made to allow for assessments to be undertaken to determine the nature of the person's risk and presentation, and for a treatment plan to be developed. These orders can only be made once for a person, for a maximum period of 28 days. In 2014–15, the Senior Practitioner approved one assessment order. In 2015–16, no assessment orders were required.

## Material changes to treatment plans

A material change is a variation to a treatment plan that no longer reflects the terms that all parties originally intended (those approved by the Senior Practitioner and VCAT).

To be a material change, this variation to the plan must be considered to be 'significant and relevant' – for example, affecting important parts of the plan or the rights of the person. The two types of material changes that can occur during the life of an approved plan are:

- a change that involves increased restrictions beyond what was originally approved
- a change that does not involve an increase in restrictions, but is considered to vary the treatment plan from what was originally approved.

During 2015–16, 16 emergency material change applications were submitted to the Senior Practitioner and seven were approved and then considered by VCAT. One was approved by VCAT retrospectively, due to an oversight in reporting.

Additional material change requests involving decreases in restrictions were submitted to the Senior Practitioner. These applications were able to be approved by the Senior Practitioner and did not require VCAT approval.

The number of material change applications increased over the last four years. In practice, this trend demonstrates that authorised program officers are implementing this safeguard within the Act appropriately by seeking appropriate approval for any changes in restrictions for people under compulsory treatment. The rise in material change applications also highlights the complexity of this client group.

## Revocation

Under the Act, the Senior Practitioner, authorised program officer or the person with a disability can apply to VCAT to have their treatment plan reviewed, with the intention of a supervised treatment order being revoked or ended. This system is in place as an additional safeguard to protect the rights of the person subject to compulsory treatment, and ensures there is continuous oversight of these orders within a legal framework.

Prior to the expiration of a treatment plan (and supervised treatment order), the Senior Practitioner and VCAT must review supporting documentation to decide if the person continues to meet the legislative criteria for compulsory treatment and the use of civil detention. This discussion assists both parties to prepare separate submissions to VCAT outlining the legislative criteria and the reasons the person no longer meets the criteria.

The Office of the Public Advocate is also informed as early as possible, in order to prepare a position on a supervised treatment order that is no longer being required.

During 2015–16, eight compulsory treatment orders were revoked.

Of the eight revocations, two orders expired and all individuals transitioned into the community successfully. Another six orders were revoked by VCAT. Of these, two people returned to prison, one person transitioned to another disability residential service under a new order, and two people successfully transitioned to living independently or under less restrictions.



As per the Act, all people who have had their orders revoked continue to be monitored by the Senior Practitioner's compulsory treatment team for at least a six-month period. This follow up allows for information to be gathered regarding the continuation of support available to the person. This information is used to advise services about pathways for persons who have been subject to civil detention to transition safely into the community.

With the introduction of the National Disability Insurance Scheme (NDIS), this information will be of particular relevance for the provision and continuation of quality services to this population.



**'Happy Homes', painting by James Barden**

# Undertaking projects to deliver evidence-informed outcomes

Every year, the Senior Practitioner examines the trends in restrictive interventions, compulsory treatment and behaviour support plan quality. The staff then undertake projects to find ways to assist services to reduce their use of restrictive interventions and improve the quality of life of those at risk of restrictive interventions and compulsory treatment.

Projects that were completed or commenced in 2015–16 included the:

- data warehouse project
- restrictive intervention data system
- compulsory treatment RIDS module implementation
- cohort project.

## Data warehouse project

The Senior Practitioner is undertaking a data warehouse project, which will enable integration and storage of data from different systems. The data warehouse will be able to address quality issues in the data collected and business rules at any stage between loading the data into the warehouse and the delivery of data.

This project will deliver high-quality data for reporting and analysis for the office and the disability sector. Other benefits will include restructuring the data so that it makes sense to people who use the data and reduce the time taken to deliver new information products.

The data warehouse project is currently as complete as it can be; however, it will be developed further over the coming months.

## Restrictive intervention data system

There is good evidence to show that organisational use of restrictive intervention data is an important component in reducing their use of restrictive interventions (Williams and Grossett, 2011). This research found that monthly status reports describing the use of mechanical restraint were crucial as one of the restraint reduction strategies in significantly reducing the use of mechanical restraint by 80 per cent over a 17-month period.

The Restrictive Intervention Data System (RIDS) was developed to assist the Senior Practitioner to effectively monitor and evaluate restrictive interventions used in disability services in Victoria. RIDS enables timely collection by the Senior Practitioner of data on restrictive interventions for people with a disability, without compromising the privacy and sensitivity of the information.

All services who report to RIDS can obtain reports of their use of restrictive interventions from RIDS; but very few services have used this reporting function. The aim of the current project was to find a way to assist services to use their data to monitor their use of restraint and seclusion.

In consultation with a project group of departmental and community sector organisations, 18 data reports were selected to be of interest. These reports were sent to all the authorised program officers to evaluate, and to find out the extent

to which these reports meet the needs of these services in monitoring their use of restrictive interventions and behaviour support plans.

Responses from services showed that five reports were judged to be really useful. These included service-based reports on:

- chemical restraint by calendar year (see example)
- routine chemical restraint by calendar year
- the ten most commonly prescribed medications for chemical restraint
- mechanical, physical restraint and seclusion by calendar year
- time of day that people were restrained or secluded.

These reports will be sent to all services in each quarter, beginning in 2017.

## **Compulsory treatment RIDS module implementation**

In April 2015, the electronic treatment (e-treatment) plan was made available to the sector. During the past year, the primary focus for the compulsory treatment team has been on implementation of this new RIDS module and evaluating its usefulness for all key stakeholders.

During this past year, five training sessions were provided to the sector on how to use the e-treatment plan and compulsory treatment system. This has resulted in 100 per cent of compulsory treatment clients now having treatment plans submitted electronically to the Senior Practitioner and VCAT. All material change requests or variations to the treatment plan are now lodged electronically, allowing the Senior Practitioner, authorised program officers, Office of the Public Advocate and VCAT to better monitor and consider the approval of any changes to the use of restrictive interventions. This is an additional safeguard for persons subject to compulsory treatment.

The development and implementation of the compulsory treatment RIDS module has been a collaborative process across a number of key stakeholders including the Office of the Public Advocate, community service organisations, the department, Disability Accommodation Services, independent clinicians and VCAT. Feedback from the sector has been collated throughout the year and has led to further changes being made to the plan and the system.

The outcome of these changes will improve the usefulness and accountability within this system and are expected to be released in the coming reporting year. These changes will further promote practice consistency across the sector, and assist authorised program officers to comply with legislation involved with compulsory treatment.

To support the implementation of the RIDS module, a number of resources have been developed including:

- a treatment plan practice guide
- a RIDS module practice guide specific for each relevant user (VCAT and Office of the Public Advocate, and authorised program officers)
- an implementation report practice guide.

## The cohort project

We know that people can be reported at one point in time to be subjected to restrictive interventions and not reported again, and some people are reported for years. We don't know what the risk factors are for long-term reporting. To address this gap in our knowledge, the Senior Practitioner examined a cohort of people who were subjected to restrictive interventions sometime in 2008–10 and also in 2013–15, and compared this to people who were subjected to restrictive interventions in 2008–10, but not in 2013–15.

The results of this analysis showed that people who had autism, were adults or were administered chemical restraint in 2008–10 were more at risk of being subjected to restrictive interventions in 2013–15 than those without these characteristics.

We wanted to know about the outcomes for those people who were reported in 2008–10 but not in 2013–15. We designed a survey in collaboration with services that was sent to all accommodation services, which were of interest because they provide long-term support to people with a disability, unlike other services.

The survey looked at four possible reasons why a person was no longer reported, including that:

- the person had moved to another service
- the person had passed away
- the behaviour support the service used had worked
- the person had a diagnosed physical or mental illness, so that the chemical restraint was no longer deemed to be a chemical restraint.

The results are currently being analysed and will be reported in the next Senior Practitioner report.

# Supporting best practice through advice, partnerships and consultation

The Senior Practitioner's team has been busy sharing expertise through advice, partnerships and consultation with our stakeholders.

## Senior Practitioner seminar 2015

A day-long seminar on 26 November 2015 presented the results of projects commissioned by the Senior practitioner during the previous year. The projects included:

- Roadmap towards restraint reduction (Professor Paul Ramcharan, RMIT University) – an organisational strategy showed decreases in some behaviours of concern and increases in positive communication between clients and staff
- Mechanical restraint project (Lynne Webber and Katie White, Office of Professional Practice) – the results showed that people who are subjected to mechanical restraint have high needs and few ways to communicate needs
- Is camera surveillance in disability services really the answer to abuse and neglect concerns? (Brent Hayward, Office of Professional Practice) – the paper provided a summary of the existing evidence about practical use of camera surveillance in protecting the welfare of people with disabilities in residential services
- Positive behaviour support and behaviour support planning 4 day project (Carol O'Dwyer and Professor Keith McVilly, Deakin University) – results showed training resulted in improvement in quality of behaviour support plans and decreases in behaviours of concern
- Intellectual disability, criminal offending and victimisation in Victoria (Dr Margaret Nixon, Swinburne University) – results showed that people with a disability were more likely than people without a disability to have a record of offending, and also more likely than other people without a disability to have a record of violent or sexual victimisation
- Compulsory treatment pathways project (Danielle McLeod, Melbourne University). This project examined the individual needs of people on compulsory treatment orders.
- Monash occupational therapy students presented papers on their work completed with the Senior Practitioner on:
  - engaging people with disabilities in meaningful occupations (Jacinta Giuliano and Hannah Myer)
  - development of an oral hygiene resource for disability residential services (Kim Barker and Bridget Maguire)
- the Promoting Dignity Grant Posters celebrated the results of promoting dignity grants received by service providers, which described how they had intervened to decrease the use of restrictive interventions.

Over 100 people attended from services including departmental and community service organisations and other stakeholders, such as advocates, parents, researchers and academics.

## **Compulsory treatment practice forums**

Over the year, the compulsory treatment team ran four practice forums that targeted staff involved in compulsory treatment matters. Attendees at these forums included authorised program officers, clinicians, case managers, direct care (disability) staff, and representatives from the Office of the Public Advocate and from VCAT.

The purpose of these forums is to facilitate information sharing related to compulsory treatment, to address and promote practice, and to support professional networking. Outcomes associated with these forums are measured by attendance and participation from the sector. To date, there has been positive feedback about these forums.

## **Compulsory treatment newsletters**

In 2015, the compulsory treatment team expanded its sector outreach by issuing a quarterly newsletter. The content of these newsletters reflects the discussions targeted within the compulsory treatment practice forums. They also include links to a number of different practice resources developed within the compulsory treatment team for the sector. These regularly include legislative flow charts, a treatment plan practice guide and an implementation report practice guide.

Informal feedback has been provided from a range of key stakeholders demonstrating a positive response to the use of the newsletter as a communication strategy.

## **Case consultations**

Compulsory treatment team members extend support to the sector by engaging in case consultations and attending care team meetings for compulsory treatment clients. The work undertaken by the compulsory treatment team for these consultations ranges from attendance at care team meetings, assessments, clinical reviews of behaviour support plans and feedback issued, brief case consultation reports, legislative review and/or training.

Several requests were made about:

- a person with a disability who was either at risk of having contact with the justice system or being subject to compulsory treatment
- practice advice for a person subject to other criminal orders, and those persons who are considered as being detained unlawfully, and therefore requiring consideration for a compulsory treatment order.

On average, the team attended 24 care team or professional meetings per month during 2015–16 and conducted 25 case consultations.



## **Work with the Department of Education and Training**

A dedicated principal practice leader (education) position was established and appointed for two years from August 2015 to work with the Department of Education and Training, but still under the direction and guidance of the Senior Practitioner.

The principal practice leader (education) has been visiting and working with government schools throughout Victoria to gain an understanding of current processes and staff knowledge, and to provide advice related to best practice approaches and processes for supporting and responding to students with behaviours of concern, including restrictive practices.

The position has a particular focus on:

- examining and assessing existing legislation, policies and guidelines
- advising the Department of Education and Training on how to improve and align policy and processes with best practice
- assessing how the Department of Education and Training collects and reports on data advising on the need for professional learning and training
- identifying trends and opportunities to reduce the use of restraint, using the Department of Education and Training data
- providing reports summarising data and advice, including recommendations for how the Department of Education and Training and schools could improve approaches to behaviours of concern.

## **Occupational therapy students in the Office of Professional Practice**

The integrated healthcare team again hosted and supervised two Bachelor of Occupational Therapy students from Monash University for their Participatory Community Practice unit. In this subject, students develop and implement an occupationally relevant project that contributes to the work of the Senior Practitioner. This year, the team supervised an additional two students from the Master of Occupational Therapy Practice course.

The students produced two resources for the Senior Practitioner, which are available on the [Office of Professional Practice webpage](http://www.dhs.vic.gov.au/officeofprofessionalpractice) <www.dhs.vic.gov.au/officeofprofessionalpractice>.

## **Transportation of children with disabilities who display behaviours of concern**

This document, while primarily designed for occupational therapists, is useful for anyone supporting a person with a disability who displays behaviours of concern during transport. It outlines relevant legislation, understanding the child's needs, non-restrictive and restrictive interventions, and additional resources. Importantly, the document helps to explain the requirements of the Act in relation to mechanical restraint and devices for safe transportation.

## **From presence to participation: A resource to promote social inclusion within group homes**

This resource is designed to assist disability service providers to meet their obligations under section 54 of the Act, by offering a process and resources to identify, write, plan and review goals for the social inclusion of people with disabilities. The document takes a deliberate approach to meaningful participation, rather than simply presence in the community.

The team will continue to supervise students in future years to produce useful resources for the sector, and to provide opportunities for students to learn more about supporting people with disabilities. This will hopefully develop an interest in working clinically in this area.

## **Wandering/elopement resource**

Over the previous years, the integrated healthcare team has collaborated with AMAZE (Autism Victoria) to develop a resource about elopement (sometimes called 'wandering') in people with autism spectrum disorder.

This resource originated from an increasing number of inquiries to both the Senior Practitioner's team and AMAZE about people who elope, and also about the use of GPS devices. Because there was no existing source of information about elopement or the use of GPS devices, research was undertaken to inform the development of the resource.

An article was published in the *Journal of Policy and Practice in Intellectual Disabilities*, *GPS devices for elopement of people with autism and other developmental disabilities: A review of the published literature* (2016). Another article about websites promoting GPS devices for elopement in autism has also been accepted for publication.

This research contributed to the publication of a document which outlines why elopement may occur, evidence-based interventions for elopement, and practical strategies to assist staff, families and carers. The resource is available on the [Office of Professional Practice webpage](http://www.dhs.vic.gov.au/officeofprofessionalpractice) <[www.dhs.vic.gov.au/officeofprofessionalpractice](http://www.dhs.vic.gov.au/officeofprofessionalpractice)>.

# Informing public debate and opinion

The Senior Practitioner has also been busy informing public debate and opinion around the use of restrictive interventions and compulsory treatment. The following is a list of articles published and conference papers presented during 2015–16.

## Publications

Hayward, B Ransley, F & Memery, R 2016, 'GPS devices for elopement of people with autism and other developmental disabilities: a review of the published literature', *Journal of Policy and Practice in Intellectual Disabilities*, vol. 13, no. 1, pp. 69–74.

Webber, LS & Harkness, T 2016, 'Supporting people with high complex needs in the disability sector. Cover feature – Psychology innovation in the public sector', *InPsych*, vol. 38, no. 3, p. 9.

## Conference presentations

Hayward, B 2015, *Prophylactic camera surveillance in disability residential services: the state of the evidence*. Australasian Society for Intellectual Disability 50th Annual Conference, Melbourne, 11–13 November 2015.

Hayward, B 2015, *An evaluation of behaviour support training units against elements of training in PBS*. Australasian Society for Intellectual Disability 50th Annual Conference, Melbourne, 11–13 November 2015.

Lambrick, F & Troutman, C 2015, *Stepping beyond risk to manage recidivism: Applying a strengths based approach to working with offenders with an intellectual disability subject to compulsory treatment*. 8th ACSO International Criminal Justice Conference, Melbourne, 22–23 October 2015.

O'Dwyer, C 2015, *Impact of professional development in positive behaviour support on outcomes for people with a disability who show behaviours of concern*, The Australian Psychological Society conference, Gold Coast.

Webber, LS et al. 2015, Co-presented with government and non-government services a symposium on *Working together to improve the quality of life of people we support*. The Australasian Society for Intellectual Disability Conference, Melbourne.

Webber, LS & Harkness, T 2015, *Potential role for state governments in improving practice and preventing restrictive practices in disability services under NDIS*. The Australian Psychological Society conference, Gold Coast.

Webber, LS & Lambrick, F 2015, *The use of positive behaviour support in hospitals: A strategy implementation for delivering harm free care for patients with a cognitive impairment*. The 10th National seclusion and restraint reduction forum, 'From here to there: Shaping the path to harm free care', Melbourne.

## Invited presentations

Hayward, B 2016, *Can surveillance technologies ever be consistent with PBS?* British Institute of Learning Disabilities International Positive Behaviour Support Research and Practice Conference, Liverpool, UK, 4–6 May.

Lambrick, F, 2015, Panellist, *Masterclass: People with complex needs in the criminal justice system*. 8th ACSO International Criminal Justice Conference, Melbourne, 22–23 October 2015.

Lambrick, F 2015, *D Psych (forensic) Seminar: Assessment and treatment of offenders with intellectual disability*. Department of Psychology, Deakin University, 12 August 2015.



'People', painting by Brady Freeman

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*Disability Act 2006*, State Government of Victoria at [Victorian Legislation and Parliamentary Documents website](http://www.legislation.vic.gov.au) <www.legislation.vic.gov.au>.

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Webber, LS McVilly, K Fester, T Chan, J 2011a, 'Factors influencing quality of behaviour support plans and the impact of quality of plans on restrictive intervention use', *International Journal of Positive Behavioural Support*, vol. 1, pp. 24–31.

Webber, LS McVilly, K Fester, T & Zazelis, T 2011b, 'Assessing behaviour support plans for Australian adults with intellectual disability using the "Behavior Support Plan Quality Evaluation II" (BSP-QE II)', *Journal of Intellectual and Developmental Disability*, vol. 36, pp. 1–5.

Webber, LS Richardson, B Lambrick, F & Fester, T 2012, 'The impact of the quality of behaviour support plans on the use of restraint and seclusion in disability services', *International Journal of Positive Behavioural Support*, vol. 2, no. 2, pp. 3–11.

Williams, DE & Grossett, DL 2011, 'Reduction of restraint of people with intellectual disabilities: an organizational behaviour management (OBM) approach', *Research in Developmental Disabilities*, vol. 32, no. 6, pp. 2336–39, viewed 13 July 2011 at [Science Direct website](http://dx.doi.org/10.1016/j.ridd.2011.07.032) <http://dx.doi.org/10.1016/j.ridd.2011.07.032>.