Victorian Senior Practitioner report 2019–20

VICTORIA State Government
Families, Fairness and Housing

Cover: Painting by Brianna George

The artworks used in this report are by winners of the Barbara Donovan Art Competition Award at the Having a Say Conference 2020. The theme for the 2020 artworks was 'A good life – are we there yet!'.

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Message from the Victorian Senior Practitioner

Welcome to the 13th Senior Practitioner report for 2019–20. This report describes the functions and achievements of the work of the Office during the 2019–20 financial year. For the previous 13 years we 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.

A lot has changed in 2019–20. As well as a name change for my role to the Victorian Senior Practitioner to distinguish me from the role of the Senior Practitioner (Commonwealth), there was a change of terminology from 'restrictive interventions' to 'restrictive practices'. On 1 July 2019, approximately 1,500 people were transferred to National Disability Insurance Scheme (NDIS) service providers. NDIS providers were required to seek authorisation of the use of restrictive practices by the Victorian Senior Practitioner and report on the use of regulated restrictive practices to the National Quality and Safeguards Commission. The Commission will now monitor and publish data on the use of restrictive practices by NDIS providers.

This report (see Monitoring and evaluating practice) focuses on:

- the reporting of restrictive practices of those who were state-funded (in-kind) who reported restrictive practices to the Victorian Senior Practitioner
- the authorisation of regulated restrictive practices of those people who transferred to NDIS services
- the use of compulsory treatment.

In this report we also describe 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 uncover what assistance the sector needs and what additional help 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).

From our monitoring of restrictive practices and compulsory treatment over 2019–20, we know that 1,546 people were subject to restraint or seclusion at some time during this period. We also know that a further 569 applications for authorisation of restrictive practices for a total of 450 individuals were approved from NDIS services. In 2018–19, 2,482 people were reported to be subject to restrictive practices in Victoria. The decrease from 2018–19 to 2019–20 is due to the number of people who were transferred to NDIS services and for whom the services did not seek authorisation for the use of restrictive practices. It should be noted that there may be legitimate reasons for not seeking authorisation, such as family members who administer restrictive practices.

For state-funded services who reported restrictive practices to the Victorian Senior Practitioner in 2019–20, among individuals subjected to any restrictive practice the majority of trends were similar:

- 96 per cent of people who were reported were subject to chemical restraint; in 2018–19 it was also 96 per cent, and this proportion has varied little over the past five years
- 6 per cent of people who were reported were subject to mechanical restraint; in 2018–19 it was also 6 per cent, and this proportion has varied little over the past five years
- A 52 per cent decrease in the percentage of individuals physically restrained (that is, from 2.7 per cent in 2018–19 to 1.3 per cent in 2019–20). This decrease continues the trend observed since 2016–17 where the percentage of individuals physically restrained was 4.4 per cent.

There was one change of trend: a 38 per cent increase in the percentage of individuals secluded (that is, from 2.4 per cent in 2018-19 to 3.3 percent in 2019–20). The trend for seclusion had been level in previous years. While the numbers of people were relatively small (49 people), authorisation requests for the use of seclusion will be a focus in the next few years.

We have continued to work closely with the NDIS Quality and Safeguards Commission, Dr Jeffrey Chan, Senior Practitioner, Behaviour Support, and his team during the transition of services to NDIS. Dr Chan held 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 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 – especially during the half of the year where we all needed to work from home during COVID-19 restrictions.

Finally, I would 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
Victorian Senior Practitioner

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Victorian Senior Practitioner team, February 2020

Hellen Tzanakis and Tiffany Carroll, other members of the Victorian Senior Practitioner team, 2019–20

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

In 2019 the Act was amended. The *Disability (NDIS Transition) Amendment Act 2019* made amendments to the Act to enable Victoria to meet its obligations under the *NDIS quality and safeguarding framework* and ensure safeguards for people with disability in Victoria were not diminished during the transition to full scheme under the NDIS.

Key amendments to the Act included:

- providing a process for authorising and prohibiting the use of restrictive practices by the Senior Practitioner for NDIS participants
- enabling the Senior Practitioner to give directions to registered NDIS providers and to notify the NDIS Quality and Safeguards Commission of matters relating to restrictive practices
- enabling the transfer and disclosure of information relating to registered NDIS providers and NDIS participants.

The Act continues to mandate:

- development of guidelines and standards regarding restrictive practices and compulsory treatment
- research into the use of restrictive practices 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

The Act also mandates specific responsibilities of the Senior Practitioner:

- approve and monitor treatment plans developed for people 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.

The purpose of this report is to outline trends in the use of restrictive practices, 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 2019 to June 2020.

Monitoring and evaluating practice

A function of the Victorian Senior Practitioner is 'to evaluate and monitor the use of restrictive practices across services and to recommend improvements in practice to the Minister and the Secretary' (Disability Act, s24(1)(h)). The first section of this chapter describes the reported use of restrictive practices by services who received state funding during 2019–20 and compares this to 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.

This year the Victorian Senior Practitioner added another function: a process for authorising and prohibiting the use of restrictive practices by the Victorian Senior Practitioner for NDIS participants. The second part of this chapter reports on the authorisation of restrictive practices from NDIS registered services and the quality of behaviour support plans received from NDIS service providers. The last part of this chapter reports on the use of compulsory treatment in Victoria.

Restrictive practices reported to the Senior Practitioner

Victorian disability services must report to the Senior Practitioner about the use of four types of restrictive practices used in their services:

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

Every time a disability service uses a restrictive practice, they must provide information to the Senior Practitioner including:

- information about the person subjected to the restrictive practice, such as their name, gender and disability types
- the type of restrictive practice used (chemical, mechanical, physical restraint or seclusion) and type of administration, that is:
  - 'routine' – 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 line with and authorised within a behaviour support plan and reported at each instance of use
  - 'emergency' – 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 practice and how it benefits the person.

The use of restrictive practices by state-funded (in-kind) services

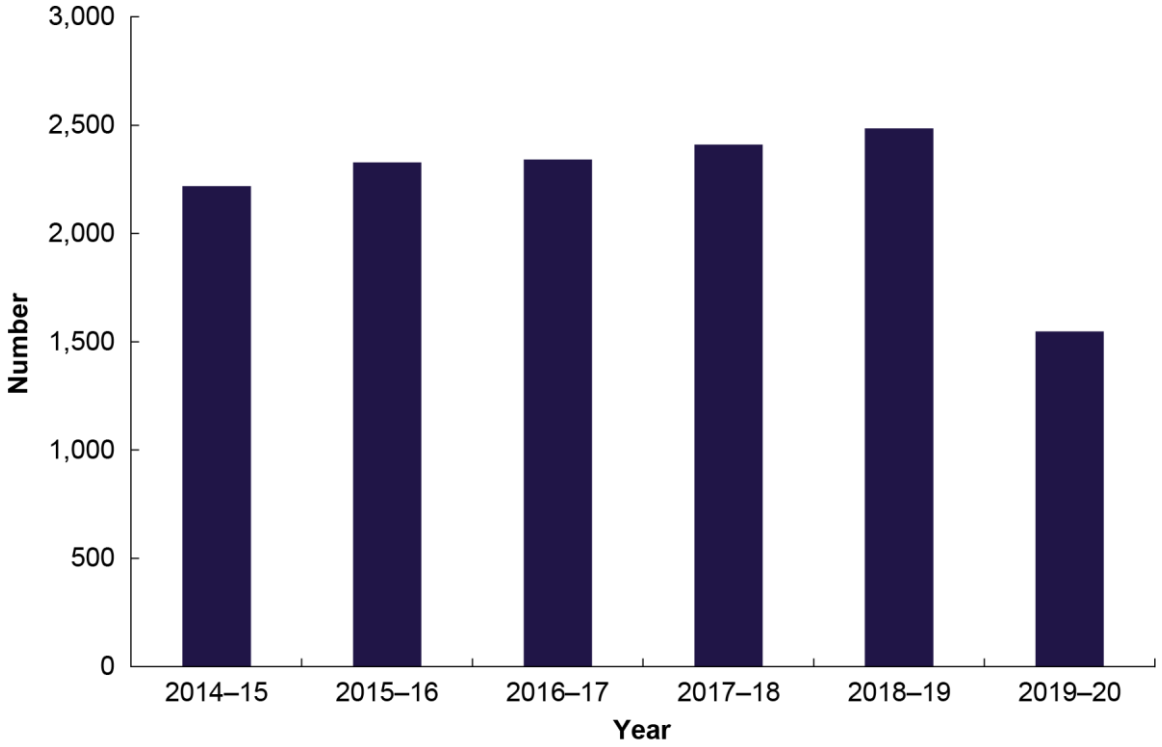
This section of the report summarises findings regarding:

- restrictive practices reported by disability services in Victoria in 2019–20 and, where possible, compares these findings with previous years (about 1,500 people transferred to NDIS services during 2019–20; to maximise comparability of results to previous years, percentages – rather than absolute numbers – are reported).

For ease of viewing, graphs show the last six years of data from 2014–15. Complete tables from 2008–09 can be requested from the Victorian Senior Practitioner. For ease of reporting, percentages discussed in the text have generally been rounded to the nearest whole percentage point (for example, 6.4 will be rounded to 6 and 6.5 will be rounded to 7).

Figure 1 shows the total number of people who were reported each year from 2014–15.

Figure 1: Number of people subject to a restrictive practice in Victoria, 2014–15 to 2019–20



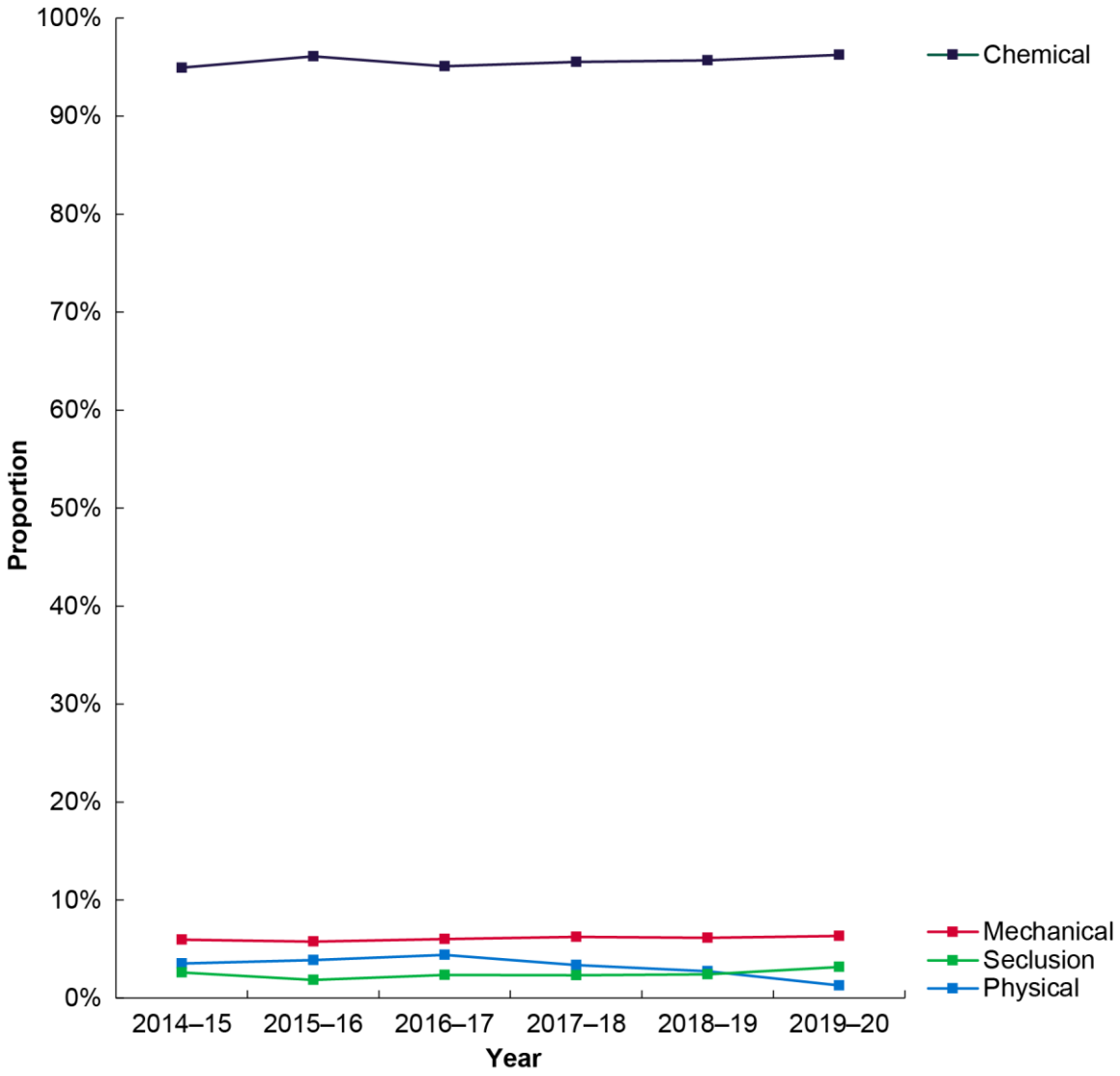
Refer to the Appendix for the Figure 1 data table

Key findings

- In the period from 1 July 2019 to 30 June 2020, 1,546 people were reported by disability services to the Victorian Senior Practitioner to be subject to restrictive practices.
- This compares to 2,482 people in the previous year (2018–19) and equates to 62 per cent of the number of people who were reported to the Senior Practitioner in Victoria in the same period in 2018–19.

Figure 2 shows the proportions of the people who were reported who were subject to chemical, mechanical, physical restraint and seclusion from 2014–15 to 2019–20.

Figure 2: Proportion of people reported who were subject to each type of restrictive practice, 2014–15 to 2019–20



Refer to the Appendix for the Figure 2 data table

The trends of different restrictive practices for those who were reported to the Victorian Senior Practitioner in 2019–20 are mostly similar to those found in previous years, with one exception.

In 2019–20, among individuals subject to *any* restrictive practice:

- 96 per cent of people who were reported were subject to chemical restraint; in 2018–19 it was also 96 per cent, and this proportion has varied little over the past five years
- 6 per cent of people who were reported were subject to mechanical restraint; in 2018–19 it was also 6 per cent, and this proportion has varied little over the past five years

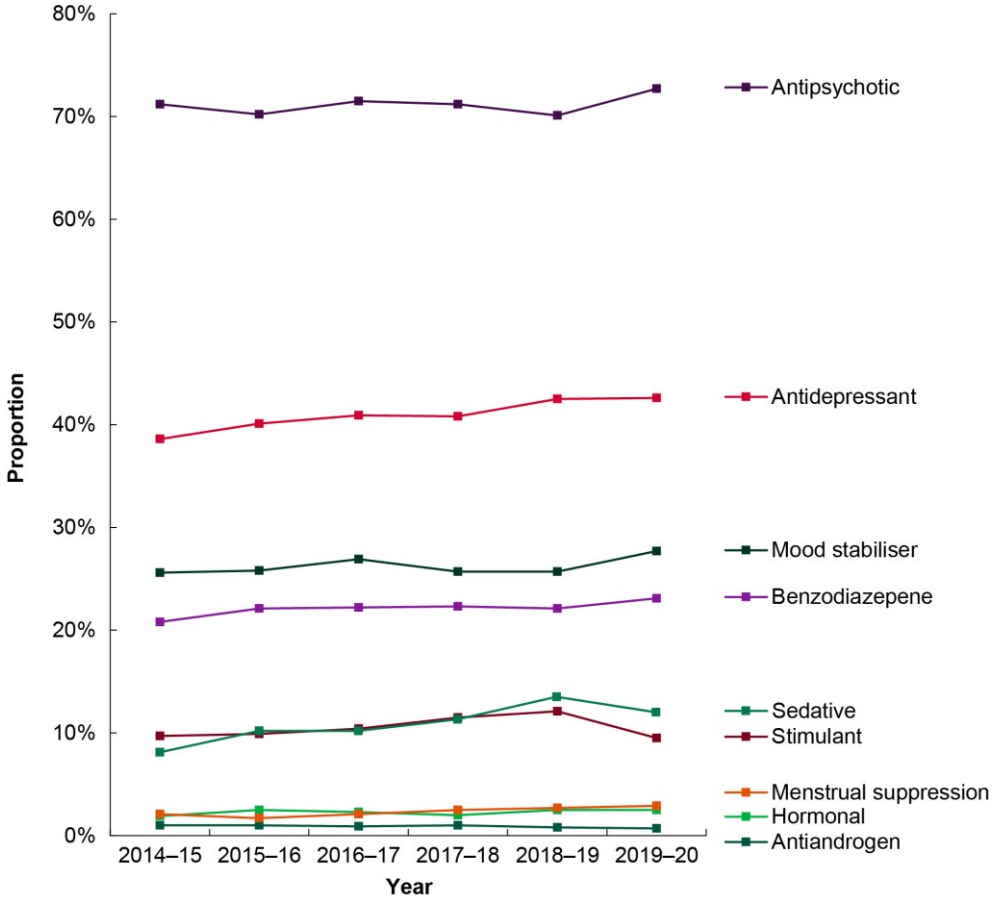
- there was a 52 per cent decrease in the percentage of individuals physically restrained (that is, from 2.7 per cent in 2018–19 to 1.3 per cent in 2019–20). This decrease continues the trend observed since 2016–17 where the percentage of individuals physically restrained was 4.4 per cent.

There was one change of trend: a 38 per cent increase in the percentage of individuals secluded (that is, from 2.4 per cent in 2018-19 to 3.3 percent in 2019–20). The trend for seclusion had been level in previous years. While the numbers of people were relatively small (49 people), authorisation requests for the use of seclusion will be a focus in the next few years.

Chemical restraint

Chemical restraint refers to using medication with a primary purpose to control a person's behaviour rather than as 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 practices).

Figure 3: Proportion of people chemically restrained with different types of chemical restraint, 2014–15 to 2019–20



Note: Percentages will not add to 100 per cent because the majority of people (in 2019–20, 68 per cent) were subject to two or more chemical restraints during that year.

Refer to the Appendix for the Figure 3 data table

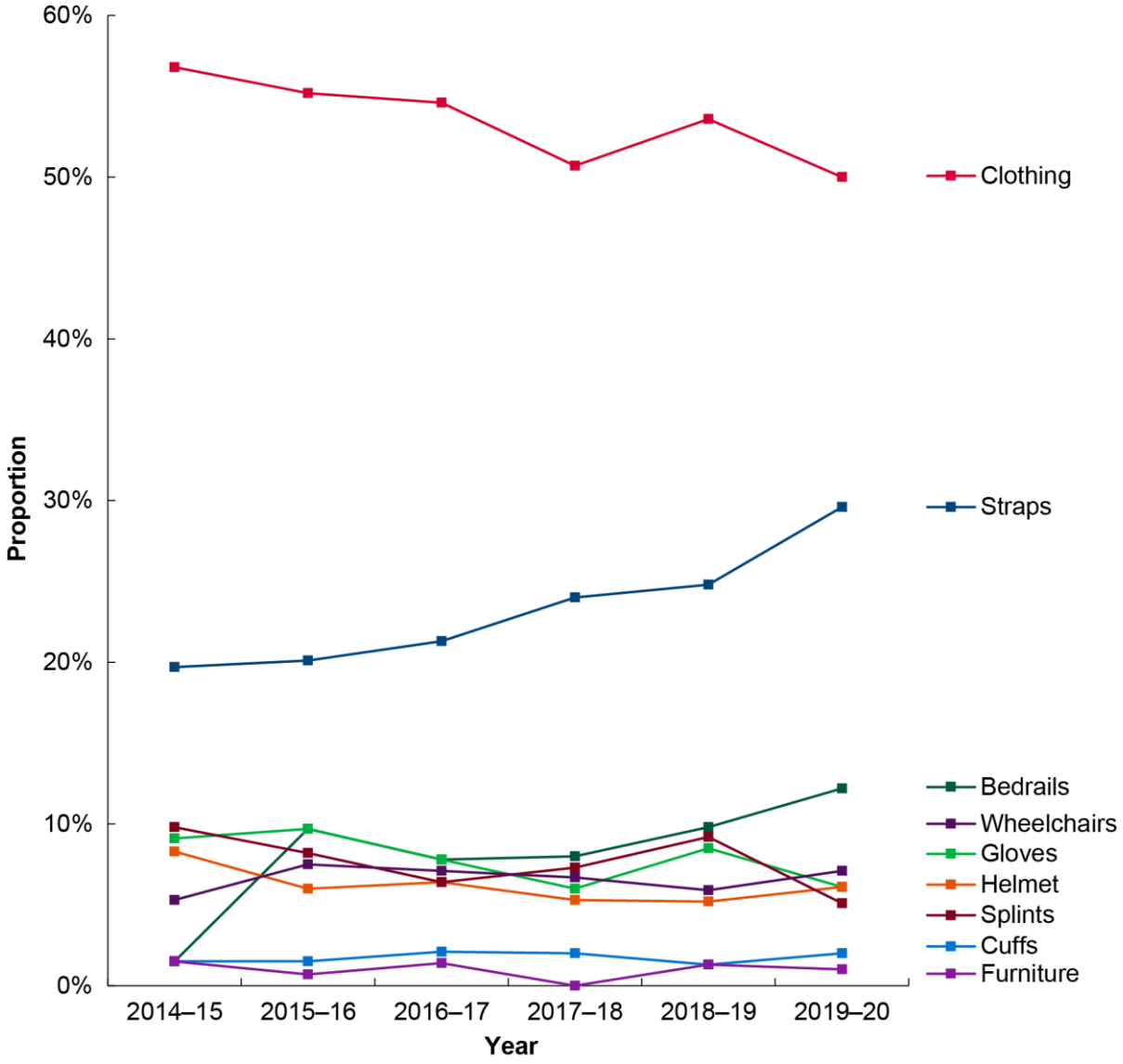
Key findings

- Similar to previous years, antipsychotic and antidepressant medications were the most commonly administered chemical restraints.
- Nearly three-quarters of people who were administered chemical restraint were administered an antipsychotic medication.
- 43 per cent of people were administered an antidepressant medication.
- 28 per cent were administered a mood stabiliser.
- 23 per cent were administered a benzodiazepine.
- 12 per cent were administered a sedative.
- 10 per cent were administered a stimulant – note that guidance on stimulants was changed in 2016–17 which meant that, for example, those with ADHD who were receiving treatment were counted as being restrained; however, this was reverted during 2019–2020 and the percentage has return to previous levels.

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). Figure 4 shows the proportion of people each year who were mechanically restrained using different types of mechanical restraint.

Figure 4: Proportion of people mechanically restrained with different types of mechanical restraints, 2014–15 to 2019–20



Refer to the Appendix for the Figure 4 data table

Key findings

- Similar to the previous year, in 2019–20, 6 per cent of all people who were subject to restrictive practices were mechanically restrained.
- Since 2008–09, between 5 and 7 per cent of people who were subject to restrictive practices were reported to be mechanically restrained.
- As in previous years, two forms of mechanical restraint were the most used mechanical restraints – clothing (50 per cent of those who were mechanically restrained were restrained with some form of clothing) and straps (30 per cent of people who were mechanically restrained were restrained with straps).
- The percentage of those reporting bedrails and wheelchairs increased slightly in 2019–20; the percentage of those reporting splints decreased slightly, while the proportion of use of most other types of mechanical restraints were similar to previous years. (see Figure 4).

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

- 3.2 per cent of people who were reported to be subject to a restrictive practice were subject to seclusion in 2019–20; this compares with 2.4 per cent reported in 2018–19. As mentioned earlier this is a 33 per cent increase from the previous year and as a result, authorisation requests for the use of seclusion will be a focus into the next few years in an attempt to find out why the use of seclusion is increasing and what services can do to decrease its use.
- Since 2008–09, the proportion of people subject to seclusion has ranged from 1.8 per cent to 4.9 per cent of all those subject to restrictive practices.

Physical restraint

The Victorian 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

- 1.3 per cent of people who were reported to be subject to a restrictive practice were reported to be physically restrained. This is a 52 per cent decrease in the percentage of individuals physically restrained (that is, from 2.7 per cent in 2018-19 to 1.3 per cent in 2019-20). This decrease continues the trend observed since 2016-17 where the percentage of individuals physically restrained was 4.4 per cent.
- Since 2011–12 (when physical restraint was first reported), the proportion of people who were reported to be physically restrained has ranged from 5.1 per cent in 2012–13 (second year of reporting physical restraint) to 1.3 per cent in 2019–20.

Proportion of adults and children subject to restrictive practices

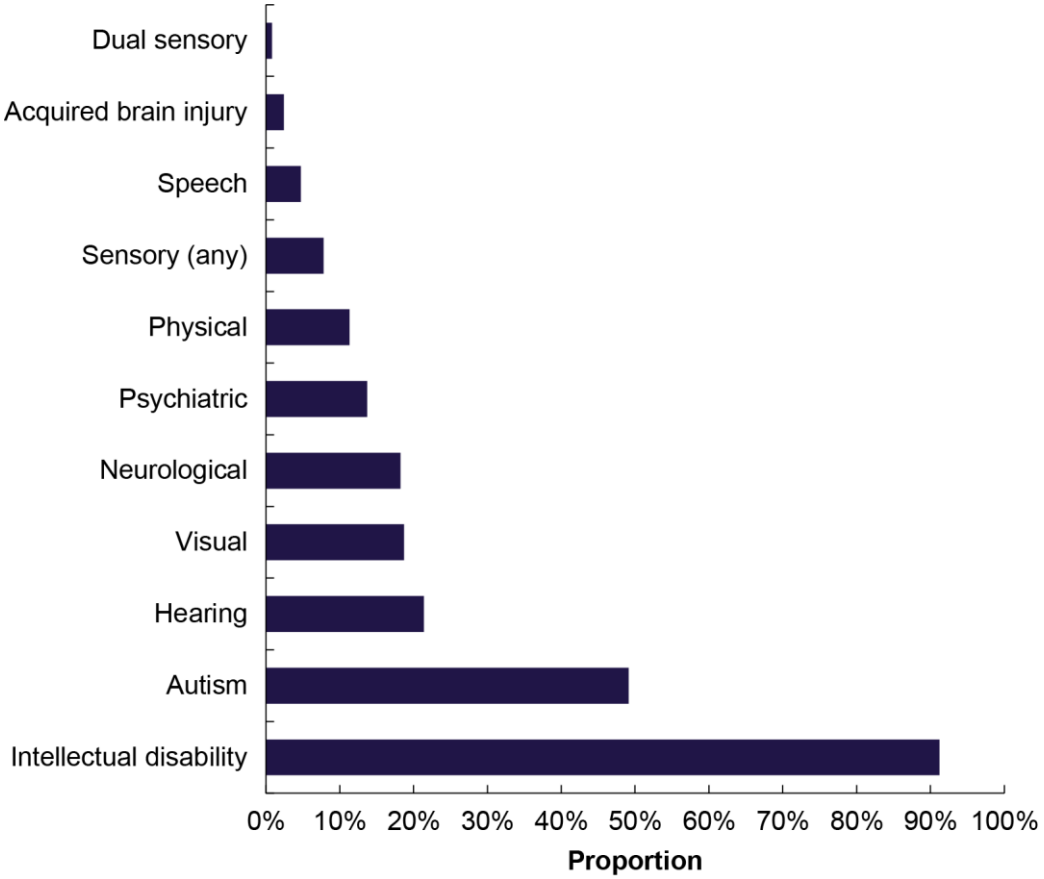
Key findings

- 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 the financial year).
- In 2019–20, 83 per cent of people who were subjected to restrictive practices were adults, compared to 78 per cent in 2018–19. This decrease in proportion of children may be because many children obtain respite services and the majority of respite services transferred to NDIS services in 2019–20 or were not available during COVID-19 restrictions.
- Since 2008–09, adults have been between 78 and 83 per cent of people who were reported to be subject to restrictive practices.

Percentage of people with different disabilities

All service providers are requested to provide information about the person's disability.

Figure 5: Proportion of people reported who have different disabilities, 2019–20



Refer to the Appendix for the Figure 5 data table

Key findings

- The majority of people subject to restrictive practices were reported to have an intellectual disability (91 per cent).
- Around half the people subject to restrictive practices were reported to have autism (49 per cent).
- About one fifth were reported to have a hearing impairment.
- About one fifth were reported to have a visual impairment.

These results suggest that a significant proportion of the people who are subject to restrictive practices are compromised both cognitively and also through hearing and/or vision, making it particularly difficult for those people to understand and communicate with their support workers.

Authorisation and approval of restrictive practices

From 1 July 2019, NDIS services had to seek authorisation and approval of restrictive practices use from the Victorian Senior Practitioner for NDIS participants.

The Victorian Senior Practitioner acted as a secondary safeguard for NDIS participants by providing authorisation or approval for the use of restrictive practices. The use of seclusion, physical restraint or mechanical restraint required additional approval from the Victorian Senior Practitioner. NDIS services had to provide evidence that:

- the use of these restraints was the least restrictive under the circumstances
- the restraints were administered as specified in the *Disability Act 2006*
- there was a plan to reduce these restrictive practices over time.

Key findings

- In 2019–20, the Victorian Senior Practitioner received 729 authorisation and approval requests from NDIS services for 513 NDIS participants.
- 569 requests (78 per cent) were authorised or approved by the Victorian Senior Practitioner.
- 43 requests (6 per cent) were rejected by the Victorian Senior Practitioner.
- No further action was taken on the remaining 16 per cent of requests; either because the restrictive practice was not permitted to be used; or it was not a restrictive practice (e.g., seat belt buckle guard); or the service provider was a family member who did not need to report; or because the service provider did not resubmit the revised restrictive practices for authorisation, and so on.

Behaviour support plans (BSPs) were refused authorisation if the use of restrictive practices within them did not meet the Disability Act criteria (s123ZR). Examples of reasons for being refused in 2019–20 include:

- the restrictive practice described did not relate to a behaviour of concern that caused harm to self or others
- there was no identified replacement behaviour to demonstrate that there was a plan to phase out the need for the restrictive practice
- the BSP contained prohibited physical restraints, such as take-down techniques or prone restraint
- the restrictive practice was not described in enough detail (for example, limits of use, and at what point of escalation it is introduced).

This feedback was provided to authorised program officers (APOs) and behaviour support practitioners, and related directly to the authorisation checklist. Many BSPs were then revised, resubmitted and subsequently received approval.

Table 1 shows the number of types of requests received by the Victorian Senior Practitioner during 2019–20, the largest being for the use of chemical restraint (90 per cent), with only 1 per cent of requests for the use of physical restraint.

Table 1: Number of requests for authorisation of restrictive practices by type of restrictive practice

Type	Number	Percentage
Chemical	505	90%
Mechanical	37	7%
Seclusion	18	3%
Physical	3	1%
Environmental	241	43%

Notes:

1. Authorised or approved requests for authorisation only.
2. Only includes requests for authorisation with complete restrictive practices authorisation information.
3. Seven records were missing information on restrictive practices type and were omitted from the counts.
4. Percentages will not add to 100 per cent because authorisation could be sought for more than one restrictive practice at the same time.

Comparison of authorisation data with state-funded in-kind data for 2019–20

We compared the proportion of individuals whose services sought authorisation for the use of restrictive practices with the proportion of reports of restrictive practices for individual people who received state-funded in-kind services to look for similarities and differences the proportions of these two groups.

Note that environmental restraint was first reported from 1 July 2019 to the NDIS Commission. Although state-funded in-kind services in Victoria in 2019–20 were required to report 'other' types of restraint in BSPs (which included environmental restraint), monthly reporting was not required. Therefore, in this analysis, the proportion of NDIS participants whose services sought authorisation for the use of environmental restraint cannot be compared to the proportion of individuals reported by state-funded in-kind services (see Table 2).

Table 2: Proportion of NDIS participants for whom authorisation was sought for restrictive practices compared to the proportion of restrictive practices reported by state-funded in-kind services in 2019–20

Type of report	Chemical	Mechanical	Seclusion	Physical	Environmental
Authorisation	98%	7%	4%	1%	39%
State-funded in-kind monthly	97%	6%	3%	1%	NA

Note: Authorisation requests that cited only environmental restraint have been excluded.

Table 2 shows that the proportion of NDIS participants for whom authorisation was sought was similar to the proportion of state-funded in-kind service reports. The proportions in the proposed use for NDIS participants and reported use by state-funded in-kind services of chemical, mechanical, seclusion and physical restraints in 2019–20 were similar regardless of whether the person obtained an NDIS service or a state-funded in-kind service.

Behaviour support plan quality evaluations

Any person subjected to restrictive practices in Victoria must have a behaviour support plan or, if they have a compulsory treatment order, a treatment plan.

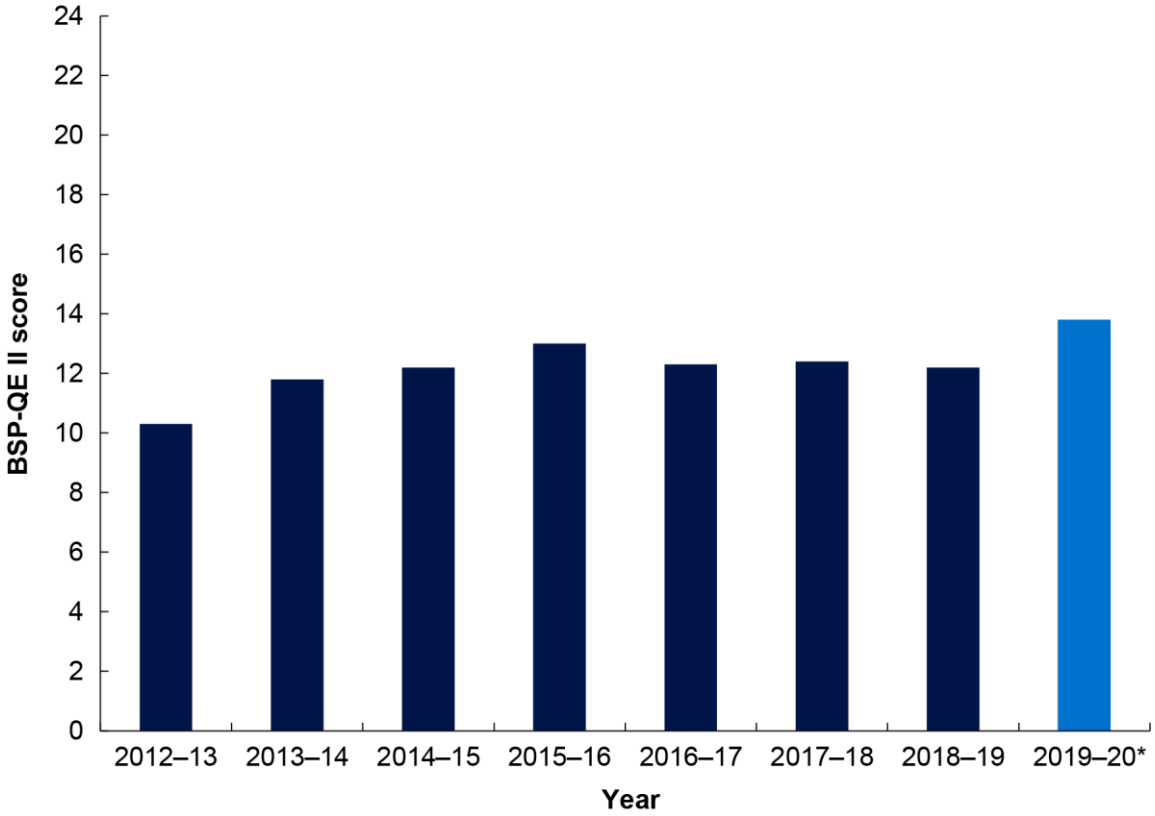
The Senior Practitioner uses the Behavior Support Plan Quality Evaluation II tool (BSP-QE II) (Browning-Wright, Saren & Mayer 2003) to objectively assess the quality of behaviour support plans received from disability services in Victoria. Although the BSP-QE II tool was developed in the United States for children, it was validated by the Senior Practitioner for use in Victoria with adults with an intellectual disability. It was also 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 increased quality of behaviour support plans is associated with reductions in the use of restrictive practices (Webber et al. 2012). This year the focus was on the quality of behaviour support plans submitted by NDIS registered providers who were seeking authorisation for restrictive practices. Feedback was provided to NDIS registered service providers in terms of the quality of the BSP they had developed.

Key findings

In 2019–20, a sample of 35 of the 569 NDIS-funded behaviour support plans were reviewed using BSP-QE II. The average score of these plans was 13.8, higher than the previous years (which has ranged between 10 and 13). However, it should be noted that this score is not directly comparable to previous years since it only includes BSPs that were written by NDIS registered behaviour support practitioners, whereas previous years included all disability services in Victoria.

A score of 13.8 is above the minimum score that is known to result in reduced restrictive practices (that is, 13).

Figure 6: Average BSP-QE II scores, 2012–13 to 2019–20



* The column for the 2019–20 average score is displayed in a different colour to show it is not directly comparable to the previous years, as explained in the text above.

Refer to the Appendix for the Figure 6 data table

The quality review process highlighted areas of strengths in planning from the sector as well as key areas where behaviour support plans could be improved.

Similar to the previous year, most plans described:

- behaviours of concern
- underlying triggers and the common settings where the behaviours occurred
- the function of the behaviour
- environmental supports that address triggers and setting events
- appropriate de-escalation strategies.

We know from research that understanding the function of the behaviours of concern and the trigger-setting events, and together with the use of environmental support, is essential for minimising the use of restraint and seclusion.

Other good news is that this year more of the BSPs included clear replacement behaviours (alternative behaviours the person can be taught to meet the function of their behaviours of concern). The use of replacement behaviours is essential to decreasing behaviours of concern and the use restrictive practices, by providing the person an alternative way to get their needs met.

The results show that more work is needed on providing:

- strategies that staff could use to teach and encourage effective replacement behaviours
- a description of the behavioural goals to be achieved during the course of the BSP, so that the support team is clear on what they are hoping to achieve over the course of the plan (such as increasing the use of replacement behaviour and decreasing the use of behaviours of concern)
- a clear plan for how the support team should work together, communicate and review the progress of the behavioural goals.

In addition, while most BSPs reviewed in 2019–20 contained most of the elements required for a quality plan to some degree, many were long and contained jargon and complex language. The needs of support staff implementing BSPs should be considered – they will be time poor and may have English as a second language.

Restrictive practices audit review

The Victorian Senior Practitioner has powers under the Disability Act to investigate, audit and monitor the use of restrictive practices and compulsory treatment in disability services (s27(2)(c)). Audits are used to identify and examine the actual use of restrictive practices.

During 2019–20, the Victorian Senior Practitioner's Restrictive Practices Authorisation team conducted 35 audits.

Key findings

This year's audits showed several common themes:

- high use of environmental restrictive practices – including locked doors and restricted access to areas of the house (such as the laundry or kitchen) – that have not previously been included in behaviour support plans
- environmental restrictive practices being in place without evidence of risk of harm from a behaviour of concern and implemented as a perceived safety measure for residents of a home
- a lack of knowledge regarding what constitutes chemical restraint, generally due to lack of informed discussion with prescribing medical practitioners
- 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 in use
- the use of restrictive practices without an authorised behaviour support plan in place
- lack of recent allied health professional reports to support therapeutic use of mechanical restraints leading to improper (that is, not strictly therapeutic) use over time.

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 (RTF) under a court order or live in disability residential services in the community under a supervised treatment order.

Currently in Victoria there is one RTF – the Intensive Residential Treatment Program at the Disability Forensic Assessment and Treatment Service (DFATS). The Long-Term Residential Placement (LTRP) will become an RTF from 1 July 2020, following a change in legislation.

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

- physically locking a person in any premises, and
- 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 an RTF through orders including residential treatment orders, parole, custodial supervision orders and extended supervision orders.

The role of the Senior Practitioner for people subject to compulsory treatment

The Senior Practitioner is responsible for ensuring the rights of people who are subject to compulsory treatment and restrictive practices 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 client care team meetings to offer practice advice and to monitor implementation of treatment plans.

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 people in the IRTP (except for people subject to custodial supervision orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (CMIA) 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 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 CMIA in the IRTP, the Senior Practitioner reviews the treatment plan and issues a treatment plan statement, which includes directions and recommendations around 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 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 practices
- 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 being considered for a supervised treatment order, 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.

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 in the IRTP 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 about compulsory treatment matters in 2019–20 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 in the IRTP
- material change hearings when a variation to a plan was requested that would increase restrictions
- revocation of supervised treatment orders.

VCAT hearings changed from face-to-face hearings to online hearings from the end of March 2020 due to COVID-19 restrictions. Staff from the Compulsory Treatment team attended all open hearings.

Compulsory treatment data

Forty-two people were subject to compulsory treatment during 2019–20, including two people who were on extended leave from custodial supervision orders under the CMIA. People who were only ever on extended leave from their orders during the entire period and who were not subject to any other compulsory treatment orders were not included in this count last year.

There have been 26 people subject to supervised treatment orders for the whole period of 1 July 2019 to 30 June 2020. This includes three people who were subject to interim supervised treatment orders for part of the period. There were three more people subject to supervised treatment orders than last year. There was one person who was only subject to an interim supervised treatment order for a short time within the last month of the reporting period.

The interim orders included people who had already been subject to supervised treatment orders but 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, or where a person was unable to attend the VCAT hearing.

There was one new supervised treatment order made during the year for a person who transitioned to the community from the IRTP at DFATS when the residential treatment order expired.

Twenty eight people were subject to a supervised treatment order, including one person who was subject to an interim order, at the end of the 2019–20 year. In comparison, 26 people were subject to a supervised treatment order at the end of the 2018–19 year. There were no revocations from supervised treatment orders during the year.

There were 13 people subject to compulsory treatment during the year in the IRTP, compared to 14 people last year.

Only one person was subject to a residential treatment order for the whole of the reporting period – the same as last year. One person who was subject to a residential treatment order left the IRTP under a supervised treatment order. One person who was subject to a custodial supervision under CMIA was transferred to prison from the IRTP during the year.

Two people were admitted to the IRTP at DFATS during the year – one person was subject to a custodial supervision order under CMIA and one person transferred from prison under a security order. This was the first admission to the IRTP of this kind.

Five people were subject to custodial supervision orders under CMIA for the whole of the reporting period. Additionally, two people had been granted extended leave during the previous year; one remained on extended leave throughout the period and the other transitioned to a non-custodial supervision order. There was also one person who was granted extended leave from a custodial supervision order during the year and was transferred from the IRTP to Kookaburra House.

By 30 June 2020, 10 people were subject to compulsory treatment at the IRTP at DFATS:

- one person was subject to a supervision order under the *Serious Sex Offenders (Detention and Supervision) Act 2009*
- one person was subject to a supervision order under the *Serious Sex Offenders Act 2019*
- one person was subject to a residential treatment order
- one person was subject to a security order
- six people were subject to custodial supervision orders under CMIA.

Table 3 shows the number of people subject to compulsory treatment at the IRTP at DFATS by order type. There were 13 people subject to compulsory treatment at DFATS in 2019–20.

Table 3: Number of people subject to compulsory treatment at the IRTP at DFATS, by order type, Victoria, 2019–20

Order type	July 2019	Admissions during 2019–20	Discharges or extended leave during 2019–20	June 2020
Residential treatment order	2	0	1	1
Supervision order, including interim, under *Serious Sex Offenders Act 2019*	1	0	0	1
Supervision order under *Serious Sex Offenders (Detention and Supervision) Act, 2009*	1	0	0	1
Custodial supervision order under *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*	7	1	2	6
Security order	0	1	0	1
Extended leave	2	1	1	2
Total	11 in IRTP, 2 on extended leave	2 admissions to IRTP	3 discharges from IRTP, 1 from IRTP granted extended leave	10 people at IRTP, 2 on extended leave

Assessment orders

An authorised program officer may apply to the Senior Practitioner for an assessment order to be made for 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 2019–20 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 2019–20, 41 were male and one was female. There have only been four females subject to compulsory treatment since 2008–09.

In 2019–20 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 2019–20 was 38 years, ranging from 19 to 64 years (calculated at 30 June 2020). This is a similar age profile to the previous two years.

At the end of 2019–20, 25 of the 28 people subject to a supervised treatment order lived in non-government accommodation and three people lived in then-Department of Health and Human Services accommodation (Table 4). Nine people were living in non-government accommodation who had transitioned from Disability Accommodation Services (DAS). Two of the supervised treatment orders were being implemented by people who had not previously provided compulsory treatment.

Table 4: Number of people subject to supervised treatment orders in Victoria by accommodation type, 30 June 2020

Accommodation type	Number of people subject to supervised treatment orders
Non-DHHS specialist forensic disability accommodation (SFDA)	7
Other DHHS accommodation including disability accommodation services and SFDA	3
Transitioned from DAS to NDIS providers	9
Other community services organisations	9
Total	**28**

Note: DHHS – Department of Health and Human Services

Compulsory treatment restrictive practice data

Table 5 gives a breakdown of the number of people subject to compulsory treatment who were subject to restrictive interventions in 2019–20 by the type of order and restrictive practice.

Table 5: Number of people subject to compulsory treatment who were subject to restrictive practices, Victoria, 2019–20

Restrictive practice	Supervised treatment order, including interim	Residential treatment order	Supervision order	Custodial supervision order under CMIA (including people on leave)	Security order
Routine chemical restraint	12	0	0	2	0
Emergency chemical restraint	9	0	0	2	1
PRN chemical restraint	3	0	0	0	0
Seclusion	4	1	0	2	0
Physical restraint	0	2	0	3	0
Total people throughout year who were on or on leave from an order	**28**	**2**	**2**	**10**	**1**

Note: CMIA – Crimes (Mental Impairment and Unfitness to be Tried) Act

Forty-six per cent of people on supervised treatment orders were administered chemical restraint in 2019–20. This percentage is lower than the 96 per cent of all people reported to RIDS as having been administered chemical restraint in 2019–20. Fourteen per cent of people on supervised treatment orders were secluded at some time during 2019–20. This percentage is higher than the 3 per cent of all people reported to RIDS for seclusion in 2019–20.

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 show how the person no longer meets all the criteria for a supervised treatment order.

During 2019–20 no supervised treatment orders were revoked. One person in the IRTP was subject to a custodial supervision order and was transferred from the IRTP to prison, and one person who was already on extended leave from a custodial supervision order was transferred to a non-custodial supervision order.

Painting by Rebecca Hell

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' (s24(1)(g) of the Disability Act).

The focus this year was developing and supporting the disability workforce to report on environmental restraint and evidence-informed training programs to support the disability workforce to undertake their work in an evidence-informed way.

The environmental restraint project

Before 1 July 2019, environmental restraint was not required to be monitored or reported monthly in Victoria. The Victorian Senior Practitioner, in consultation with the Disability and NDIS branch of the Department of Health and Human Services, engaged Nous Group (Nous) to develop and validate a measure of environmental restraint that could be used after 1 July 2019. Nous was asked to develop a measure of environmental restraint that would:

- be suitable for use in Victoria and other jurisdictions in Australia
- educate providers
- guide quality improvement
- monitor changes in practice in the use of environmental restraint over time.

Nous's measure was informed by insights derived from four key information sources:

- a comprehensive desktop review and document analysis
- a nation-wide survey of provider attitudes and practice
- individual interviews with 16 national stakeholders
- user testing of the measure with five support workers.

Nous proposed a measure of environmental restraint that consisted of five questions (each with drop down boxes containing most frequent responses):

- what was the person prevented from accessing (such as their bedroom, and so on)?
- why was the restriction applied (for example, to prevent harm to self or harm to others)?
- how was the restriction applied (for example, locking a door)?
- what was the impact of the restraint (that is, how many others were affected and what was being done to reduce the effect on others)?
- when and for how long was the restriction applied (start time and end time)?

The measure was adopted by the Victorian Senior Practitioner for reporting in Victoria from 1 August 2020 and added into the Restrictive Intervention Data System.

Two practice guides were written to assist services to report environmental restraint:

- What Victorian services need to know about environmental restraint (March 2020)
- Is this practice an environmental restraint? (March 2020)

The practice guide *Why is it locked?* was updated. Copies of these three resources can be found on the Victorian Senior Practitioner web page and the Restrictive Intervention Data System web page.

A copy of the final report from Nous to the department can be requested by emailing the Victorian Senior Practitioner <VictorianSeniorPractitioner@dffh.vic.gov.au>.

The Victorian Senior Practitioner 2020–21 report will provide a summary of data collected on environmental restraint during the 2020–21 financial year.

Development of online behaviour support planning training for behaviour support practitioners

One of the challenges brought about by the change to NDIS Quality and Safeguards Commission was that registered NDIS behaviour support practitioners would be needed to develop and lodge behaviour support plans in the NDIS Commission system for people who were subject to restrictive practices. It was clear that there were insufficient practitioners available in Victoria to complete this task for the 2,492 people who were reported to be subject to restrictive practices in Victoria in 2018–19.

The online behaviour support planning project was designed to address this need by providing evidence-informed professional development for people who wanted to provide behaviour support services. An online training package was developed by Professor Keith McVilly and Scope Australia. This eight-week online course offers a learning and development pathway to help behaviour support practitioners develop and expand their competencies in positive behaviour support (PBS). The content includes contemporary evidence-based and person-centred approaches to PBS and aligns with the knowledge and skills required in the *NDIS positive behaviour support capability framework*.

The course consists of eight modules delivered through online teaching and includes individual assessment tasks and a workplace assignment.

The course content covers the following areas:

- biopsychosocial factors that influence behaviours of concern
- quality of life and wellbeing and their relationship with behaviours of concern and PBS
- PBS as a holistic multi-faceted approach
- history and background of PBS and its context within the framework of human rights
- regulated restrictive practices and the relevant laws and policies regarding their authorisation and use
- foundations of functional behavioural assessment
- the NDIS behaviour support plan template (comprehensive)
- foundations of person-centred BSP writing
- strategies that are evidence-based, acceptable and achieve goodness of fit
- evaluating the quality of behaviour support plans and identifying improvements using the Behaviour Intervention Plan Quality Evaluation, Version II (BIP-QEII)
- working with key stakeholders to put a behaviour support plan into action.

The aim of the project was to build the capacity of practitioners in Victoria to deliver good quality positive behaviour support plans for people who were subject to restrictive practices.

Although the course had been planned to be delivered face-to-face, COVID-19 restrictions meant that it had to be redesigned into an eight-week online course using the University of Melbourne's learning management system.

The course was piloted with a group of 10 practitioners in April 2020, will be delivered to 192 practitioners during the rest of 2020 and offered to a further 240 practitioners in January, April and May 2021. Results of this professional development project will be available at the end of June 2021.

Developing online training for authorised program officers

Authorised program officers (APOs) play an important role in the authorisation of restrictive practices. As described in the Disability Act, all APOs are required to authorise the use of all restrictive practices in their organisation. The Victorian Senior Practitioner acts as a complementary safeguard to the NDIS Commission to authorise or approve restrictive practices.

In 2019–20 there were 466 people approved as APOs by the Victorian Senior Practitioner. Many APOs had requested training to help them undertake their legislative responsibilities.

A project was designed to develop an innovative online training package that leverages two evidence-informed approaches: positive behaviour support (PBS) and the roadmap for the reduction of restrictive practices. The aim of the training was to equip APOs with the knowledge and skills necessary to effectively exercise their statutory responsibilities in the authorisation of regulated restrictive practices. In doing so, the lives of people with disability will be improved as well as the safety of staff delivering support.

It is expected that the training will be provided to all APOs who are registered with the Victorian Senior Practitioner from February 2021. If training outcomes are successful it would be expected that there would be an increase in the number of BSPs that are authorised or approved by the Victorian Senior Practitioner (VSP) without requiring resubmission to the VSP. More information about this course will be provided in the next Victorian Senior Practitioner report for 2020–21.

Painting by Kristie Newcombe

Promoting best practice through professional development

A function of the Victorian Senior Practitioner is 'to provide education and information with respect to restrictive interventions and compulsory treatment to disability service providers' (s24(1)(b) of the Disability Act).

This section of the report describes various education and training opportunities that were given to disability support providers in 2019–20.

Restrictive practices reduction training

The Restrictive Practices Authorisation team provided training to services on understanding restrictive practices and how to reduce them. 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.

The team presented to a group of occupational therapists at the head office of the National Occupational Therapists Association to provide education on their role in reducing the use of restrictive practices. The training was conducted to a group of 20 Victorian participants and others based across Australia who accessed the live presentation online.

A second training session was completed for the Australian Physiotherapy Association and Occupational Therapy Australia, following a fully booked session earlier in the year. 70 occupational therapists and physiotherapists attended the session, which also focused on their role in reducing restrictive practices. The presentation was held at the Australian Physiotherapy Association's head office.

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 Restrictive Practices Authorisation team completed one full specialist communication assessment 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 or supervised treatment order (or both).

Online and virtual opportunities

The Victorian Senior Practitioner was involved in the online launch of the National Disability Service's Foundations of positive behaviour support videos – part of their *Zero tolerance framework*. This involved recording a video and participating in a videoconference panel to discuss positive behaviour support.

These videos can be found on the National Disability Service website's Considering additional risks page under 'Foundations of positive behaviour support films' <https://www.nds.org.au/zero-tolerance-framework/considering-additional-risk>.

Also, in recognition of moving to online platforms, the Restrictive Practice Authorisation team created or contributed to a number of Easy Read resources on topics such as:

- helpful resources during COVID 19 for people with a disability – see the Disability services sector - coronavirus (COVID-19) page under Disability services senior practitioner practice advice <**Error! Hyperlink reference not valid.**https://www.dhhs.vic.gov.au/disability-services-sector-coronavirus-covid-19#disability-services-senior-practitioner-practice-advice>
- positive behaviour support and restricted practices – NDIS Commission
- public housing for NDIS participants – DHHS

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, the University of Canberra's Professor Doug Boer.

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. One training and one user group session was 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' (s24(1)(f) of the Disability Act).

In this section of the report we describe our work with our compulsory treatment stakeholders, with the Graduate Learning team and the Department of Education and Training (DET) to facilitate knowledge and training.

Practice advice and consultations

During 2019–20, the team provided 1,113 instances of practice advice. 837 of these were general advice about restrictive practices or the authorisation process (or both), while 276 were related specifically to a person with a disability with a RIDS profile.

Compared to previous years, a large amount of practice queries related to the new authorisation process of restrictive practices, following changes in reporting requirements after the introduction of the NDIS Quality and Safeguards Commission. There was also an increase in more complex restrictive practice queries, which may indicate that more experienced behaviour support practitioners were becoming involved in complex cases.

Compulsory treatment practice forums

The Compulsory Treatment team ran two practice forums during the year. 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 State-wide Assessment Service
- updates from the Disability and NDIS Policy branch
- environmental restraint
- NDIS transition issues, specifically funding processes and the treatment plan being the behaviour support plan
- changes to the authorisation processes with the implementation of the Disability Amendment Act and the NDIS quality and safeguards framework.

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

Care team meetings and case consultations

The Compulsory Treatment team supports the sector by engaging in case consultations and attending care team meetings for individuals subject to compulsory treatment.

The team prioritises attendance at care team meetings based on the person's presentation such as:

- the presence of significant problematic behaviour that requires intervention
- transitioning from the IRTP to the community or between community providers
- 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 an 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).

The team attended approximately 120 care team meetings during the reporting period. Usually, attendance at the care team meetings is in person or can be via teleconference. Due to COVID-19 restrictions, from the end of March 2020 attendance was through online platforms.

Working with a graduate learning team

The department recruits new graduates each year through the Victorian Public Service Graduate Recruitment and Development Scheme. As part of the graduate's learning and development, they participate in graduate learning teams with a departmental group to complete a project.

During the year, three members of the Graduate Learning team worked with the Victorian Senior Practitioner team to prepare a communication that described the main steps involved in the process of developing and authorising behaviour support plans, *Using restrictive practices in Victoria: Step-by-step guide for NDIS registered services.* The publication was sent out to all disability services in Victoria in March 2020 and feedback from services was very favourable. A copy of this document can be found on the Information for authorised program officers web page <**Error! Hyperlink reference not valid.**https://www.dhhs.vic.gov.au/information-authorised-program-officers>.

Working with the Department of Education and Training

Restraint and seclusion in Victorian government schools is guided by Regulation 25 of the *Education and Training Reform Regulations 2017*.

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.

After four years of collaboration with DET, the Memorandum of Understanding with the Senior Practitioner concluded in December 2019. DET has established a new role – Principal Behaviour Support Adviser. This role continues the work of leading practice to reduce and eliminate restraint and seclusion, and leads behaviour support policy and practice in schools. This approach acknowledges that addressing restraint and seclusion is underpinned by building and strengthening effective and positive approaches to behaviour support.

Focusing on behaviour support alongside restraint and seclusion is consistent with contributions made by parents and educators to the Victorian Equal Opportunity and Human Rights Commission's (VEOHRC) *Held back* report of 2012. This report was influential in the original collaboration between DET and DHHS.

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' (s24(1)(c) of the Disability Act).

One of the main ways that the Senior Practitioner shares information is through the annual Senior Practitioner Seminar. In this section we also list our invited seminars that were presented between July 2019 and June 2020.

The Senior Practitioner Seminar 2019

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 19 November 2019 the following presentations were given.

- Associate Professor Paul Ramcharan from RMIT provided an update of the roadmap for reduction of restrictive interventions. This is a project to help build the capacity of services to reduce their restrictive practices. Professor Ramcharan reported that although some services had discontinued their participation in the project due to the demands of the transition to NDIS services, the services who continued reported beneficial results for people with a disability from participating in the program in terms of increasing the choice and control.
- Braedan Hogan, Director NDIS Transition, Department of Health and Human Services provided an update on *Keeping our sector strong: Victoria's workforce development plan for the NDIS.* Considerable training is now available to the Victorian disability workforce through this initiative. Courses can be found through the Victorian Skills Gateway <https://www.skills.vic.gov.au>
- Professor Keith McVilly, University of Melbourne, described a project in collaboration with Scope Australia to design a training course in positive behaviour support to build the capacity of the behaviour support practitioners in Victoria. Training will be available to over 400 practitioners who want to register as NDIS behaviour support practitioners.
- Dr Ben Richardson, the Nous Group, described the development of a model of environmental restraint that would be used to measure and monitor the use of environmental restraint in Victoria. The model will enable the Victorian Senior Practitioner to monitor changes in type and amount of environmental restraints being used in Victoria.
- Dr Rachael McDonald, Swinburne University, provided an update on the outcomes of general practitioner modules. The general practitioner modules were designed to help GPs consider other best practice options for people with a disability. These might include a functional behaviour assessment by a behaviour support practitioner and speech assessments. Dr McDonald reported that sadly there had been very low uptake of the modules by GPs.
- Kerrie Hancox, Director NDIS, Behaviour Support, Tasmania and Victoria, provided an update of the latest news from the Behaviour Support NDIS Quality and Safeguards team.

The 2018 Promoting Dignity Grants and occupational therapy students' poster display 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. The PowerPoint presentations are available from the Victorian Senior Practitioner.

Publications in peer-reviewed journals

The following paper has been submitted for publication: *Factors associated with the use of antipsychotic medications for people with a disability*, Richardson, B., Lambrick, F., Haran, T. & Webber, L.S.

Abstract

Background: Antipsychotic medications used for the treatment of psychosis are also prescribed off-label as a sedative for people with an intellectual disability who show behaviours of concern.

Methods: The Restrictive Intervention Data System in Victoria, Australia was investigated to examine relationships between individual characteristics and antipsychotic use among those restrained between 2008–09 and 2018–19.

Results: People with autism were twice as likely to be restrained using antipsychotics than people without autism. People who had a hearing or intellectual disability were also more as likely to be restrained using antipsychotics as those without those disabilities. Adults compared to children and males compared to females were more likely to be restrained with antipsychotics.

Conclusions: People with certain individual characteristics were more likely to be prescribed antipsychotic medications than others. Understanding that certain people are at greater risk than others is important information for those who provide support and care.

Painting by Ben Chew

Invited presentations

8 August 2019

The Tasmanian Senior Practitioner invited Dr Frank Lambrick to present a paper at a seminar on ‘Stepping beyond risk to manage recidivism: Applying a strengths-based approach to working with offenders with an intellectual disability’.

15 November 2019

The ACT Senior Practitioner invited Dr Frank Lambrick to present a paper as a part of their seminar series on ‘Stepping beyond risk to manage recidivism: Applying a strengths-based approach to working with offenders with an intellectual disability’.

20 November 2019

The ACT Senior Practitioner invited Dr Lynne Webber to present a workshop to ACT behaviour support practitioners about how to use the Behaviour Support Plan Quality Evaluation II tool to assess the quality of behaviour support plans. This was part of the ACT Senior Practitioner Seminar Series.

14 February 2020

NDS WA invited Dr Frank Lambrick to present on restrictive practices oversight in Victoria as part of their Quality and Safeguards Forum.

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Painting by David Waterhouse

Appendix: Data tables for figures

Figure 1: Number of people subject to a restrictive practice in Victoria, 2014–15 to 2019–20

Year	Number
2014–15	2,216
2015–16	2,326
2016–17	2,339
2017–18	2,408
2018–19	2,482
2019–20	1,546

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Figure 2: Proportion of people reported who were subject to each type of restrictive practice, 2014–15 to 2019–20

Year	Chemical	Mechanical	Physical	Seclusion
2014–15	94.9%	6.0%	3.5%	2.6%
2015–16	96.1%	5.8%	3.9%	1.8%
2016–17	95.1%	6.0%	4.4%	2.4%
2017–18	95.5%	6.2%	3.4%	2.3%
2018–19	95.7%	6.2%	2.7%	2.4%
2019–20	96.2%	6.3%	1.3%	3.2%

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Figure 3: Proportion of people chemically restrained with different types of chemical restraint, 2014–15 to 2019–20

Year	Anti-androgen	Anti-depressant	Antipsychotic	Benzo-diazepene	Hormonal	Menstrual suppression	Mood stabiliser	Stimulant	Sedative
2014–15	1.0%	38.6%	71.2%	20.8%	1.9%	2.1%	25.6%	9.7%	8.1%
2015–16	1.0%	40.1%	70.2%	22.1%	2.5%	1.7%	25.8%	9.9%	10.2%
2016–17	0.9%	40.9%	71.5%	22.2%	2.3%	2.1%	26.9%	10.4%	10.2%
2017–18	1.0%	40.8%	71.2%	22.3%	2.0%	2.5%	25.7%	11.5%	11.3%
2018–19	0.8%	42.5%	70.1%	22.1%	2.5%	2.7%	25.7%	12.1%	13.5%
2019–20	0.7%	42.6%	72.7%	23.1%	2.5%	2.9%	27.7%	9.5%	12.0%

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Figure 4: Proportion of people mechanically restrained with different types of mechanical restraints, 2014–15 to 2019–20

Year	Bedrails	Clothing	Cuffs	Furniture	Gloves	Helmet	Splints	Straps	Wheelchairs
2014–15	1.5%	56.8%	1.5%	1.5%	9.1%	8.3%	9.8%	19.7%	5.3%
2015–16	9.7%	55.2%	1.5%	0.7%	9.7%	6.0%	8.2%	20.1%	7.5%
2016–17	7.8%	54.6%	2.1%	1.4%	7.8%	6.4%	6.4%	21.3%	7.1%
2017–18	8.0%	50.7%	2.0%	0.0%	6.0%	5.3%	7.3%	24.0%	6.7%
2018–19	9.8%	53.6%	1.3%	1.3%	8.5%	5.2%	9.2%	24.8%	5.9%
2019–20	12.2%	50.0%	2.0%	1.0%	6.1%	6.1%	5.1%	29.6%	7.1%

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Figure 5: Proportion of people reported who have different disabilities, 2019–20

Disability	Proportion
Intellectual disability	91.2%
Autism	49.1%
Hearing	21.4%
Visual	18.7%
Neurological	18.2%
Psychiatric	13.7%
Physical	11.3%
Sensory (any)	7.8%
Speech	4.7%
Acquired brain injury	2.4%
Dual sensory	0.8%

Return to text following Figure 5

Figure 6: Average BSP-QE II scores, 2012–13 to 2019–20

Year	BSP-QE II score
2012–13	10.3
2013–14	11.8
2014–15	12.2
2015–16	13.0
2016–17	12.3
2017–18	12.4
2018–19	12.2
2019–20	13.8

Return to text following Figure 6