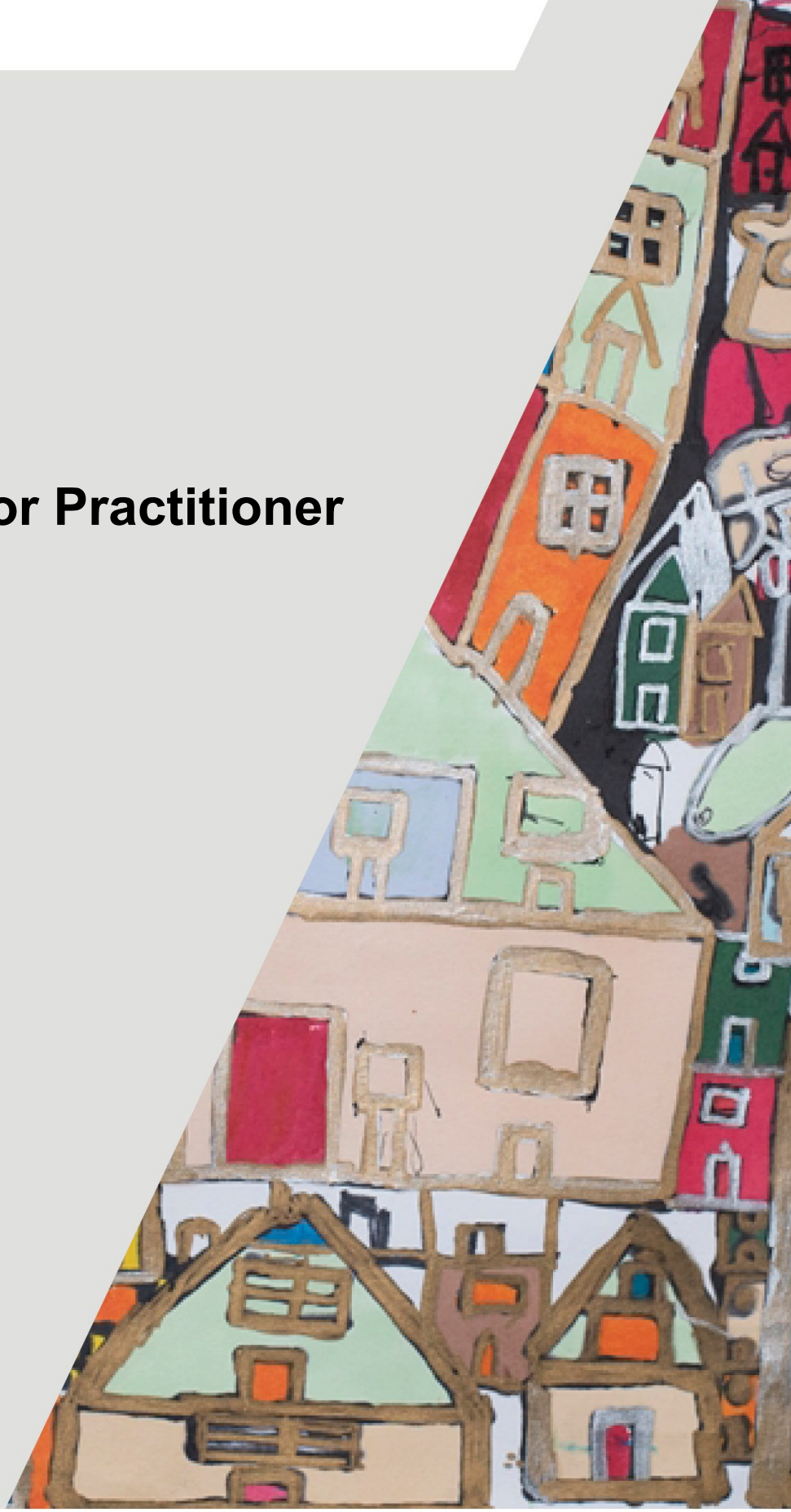
Victorian Senior Practitioner report 2020–21



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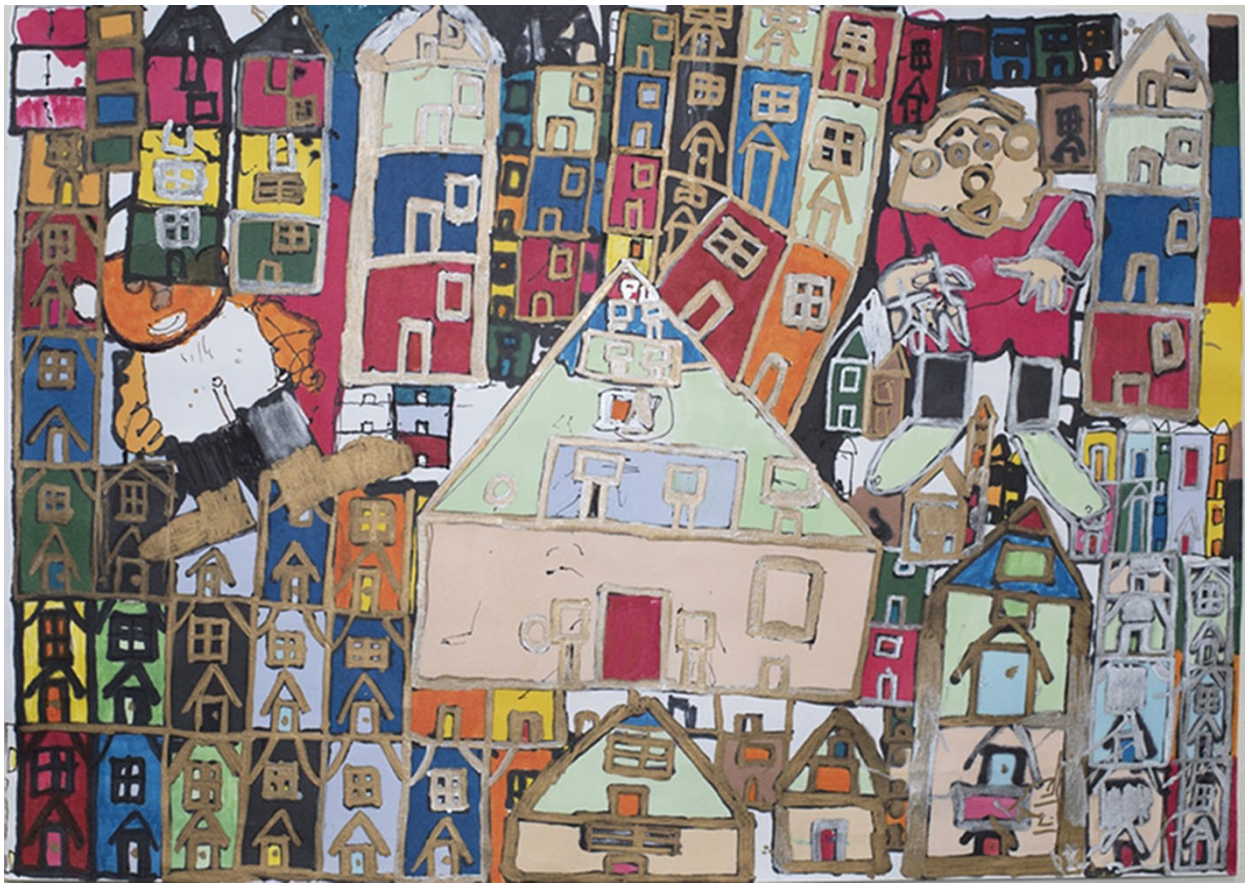

Cover: Painting by David Waterhouse, a winner of the Barbara Donovan Art Competition Award at the Having a Say Conference 2020 (Theme: 'A good life – are we there yet!')

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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

ISSN 2653-0260 (online/PDF/Word)

Available at the Victorian Senior Practitioner web page <https://www.dffh.vic.gov.au/victorian-senior-practitioner>.

(2203205 – cover, artwork)

Message from the Victorian Senior Practitioner

Welcome to the 14th Senior Practitioner report for 2020–21. This report describes the functions and achievements of the work of the Senior Practitioner and the Office during the 2020–21 financial year. Up until the 2018–19 reporting year, the Office reviewed restrictive interventions involving all people who were reported to the Office by disability services. This information was considered and assisted the Office to decide on the focus and types 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.

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 from the Office to use restrictive practices and to report on the use of regulated restrictive practices to the National Quality and Safeguards Commission. This year a further 1,100 people transferred to the NDIS. Also this year data were collected on the use of environmental restraint for the first time. The Commission now monitors and publishes data on the use of restrictive practices by NDIS providers.

This report (refer to Monitoring and evaluating practice section) focuses on:

- the reporting of restrictive practices from 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 (refer to 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 (refer to 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 (refer to Informing public debate and opinion).

From our monitoring of restrictive practices and compulsory treatment over 2020–21, we know that 1,252 people were subject to restraint or seclusion at some time during this period. We also know that NDIS services approved applications for authorisation to use restrictive practices for 1,759 people. The number of people reported to be subject to restrictive practice has continued to decline as people are transferred to NDIS services; for example, compared with 2018–19, there were 1,232 fewer people reported as being subject to restrictive practices.

For state-funded services that reported restrictive practices to the Victorian Senior Practitioner in 2020–21:

- The total number of people reported as being subject to a restrictive practice has reduced as expected and in line with people transitioning to the NDIS (and to national reporting arrangements).
- Environmental restraint was reported for the first time. In 2020–21, 591 people were reported as having restricted access to some or all parts of their environment, including items or activities. Reported environmental restrictions most commonly involved restricted access to internal or external areas, or to household items or personal property.
- Underlying practice has remained stable; for example, although there are fewer state-funded services reporting due to the NDIS transition, the number of people reported per service has remained consistent with previous years at 2.6 people per service.

There was one change of trend: the number of people reported as subject to mechanical restraint increased to 114 in 2020–21, up from 98 in 2019–20 (despite there being fewer overall state-funded services due to the NDIS transition). This is likely to be explained by changes in reporting practice; that is, providers have become better at identifying (and therefore reporting) mechanical restraint. The team will continue to closely monitor authorisation requests involving mechanical restraint from service providers over subsequent reporting periods.

We have continued to work closely with the NDIS Quality and Safeguards Commission, Dr Jeffrey Chan, Senior Practitioner, Behaviour Support, and his team during this further period of transition of services to the NDIS. Dr Chan continued to hold 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 continue to 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 given the continuing challenges in the face of COVID-19 restrictions where we all continued to work from home.

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

10 December 2021

Contents

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 the 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, about 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 to:

- 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 2020 to June 2021.

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, s. 24(1)(h)). The first section of this chapter describes the reported use of restrictive practices by services who received state funding during 2020–21 and compares this, where possible, 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 have been collected since 2011–12. Data on the use of environmental restraint were captured for the first time in 2020–21.

Since 2019–20, the Victorian Senior Practitioner has undertaken another function: a process for authorising and prohibiting the use of restrictive practices for NDIS participants. The second part of this chapter reports on the authorisation of restrictive practices from NDIS-registered service providers, 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 five types of restrictive practices used in their services:

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

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, environmental 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 for restrictive practices reported by disability services in Victoria in 2020–21 and, where possible, compares these findings with previous years given:

- about 1,500 people transferred to NDIS services during 2019–20
- a further 1,100 people transferred to NDIS during 2020–21.

To maximise comparability of results with previous years, absolute numbers – rather than percentages – are reported.

For ease of viewing, tables show the last seven 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).

Key findings

- In the period from 1 July 2020 to 30 June 2021, 1,252 people were reported by disability services to the Victorian Senior Practitioner to be subject to restrictive practices (Table 1).
- This compares with 1,553 people in the previous year (2019–20) and 2,484 people in 2018–19.
- This equates to a 19 per cent reduction compared with the number of people who were reported to the Senior Practitioner in Victoria in the same period in 2019–20 and a 50 per cent reduction compared with 2018–19.

Table 1: Number of people subject to a restrictive practice in Victoria, 2014–15 to 2020–21

Year	Number of people restrained
2014–15	2,215
2015–16	2,326
2016–17	2,339
2017–18	2,408
2018–19	2,484
2019–20	1,553
2020–21	1,252

Table 2 shows the average number of people reported within each provider reporting to the Senior Practitioner.

Table 2: Average number of people subject to any type of restrictive practice per reporting provider, 2014–15 to 2020–21

Year	Average number of people restrained per provider
2014–15	2.66
2015–16	2.76
2016–17	2.61
2017–18	2.65
2018–19	2.65
2019–20	2.58
2020–21	2.59

The average number subject to any type of restrictive practice among reporting providers has remained stable. Therefore, although the overall number of people reported has declined over the past two years (as per Table 1), this is likely fully attributable to state-funded providers transitioning to the NDIS. In other words, there does not seem to be substantial co-occurring changes in the use of restrictive interventions.

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 (s. 3 of the Act provides complete definitions of all restrictive practices).

Key findings

- There has been a reduction in the number of people reported for chemical restraint (Table 3). This reduction is in line with the reduction in the number of services reporting to the Victorian Senior Practitioner.
- Similar to previous years, antipsychotic and antidepressant medications were the most commonly administered chemical restraints (Table 4).
- A significant number of people (36 per cent) were administered a sedative.
- Three-quarters of people who were administered chemical restraint were administered an antipsychotic medication.
- 42 per cent of people were administered an antidepressant medication.

Polypharmacy – defined here as the simultaneous use of two or more chemical restraints – has remained relatively stable in recent years. The proportion of people subject to chemical restraint who experience polypharmacy is shown below in Table 5.

Table 3: Total number of people chemically restrained, 2014–15 to 2020–21

Year	Number of people chemically restrained
2014–15	2,104
2015–16	2,235
2016–17	2,224
2017–18	2,298
2018–19	2,376
2019–20	1,492
2020–21	966

Table 4: Percentage of all people chemically restrained who were restrained with different types of chemical restraint, 2014–15 to 2020–21

Drug type	2014–15 %	2015–16 %	2016–17 %	2017–18 %	2018–19 %	2019–20 %	2020–21 %
Antidepressant	38.6	40.1	40.9	40.8	42.4	42.4	41.6
Antipsychotic	71.2	70.2	71.5	71.2	70.2	72.7	74.6
Benzo/sedative	27.8	30.6	30.4	30.9	33.0	32.8	36.1
Menstrual Suppression	2.1	1.7	2.1	2.5	2.7	2.9	3.6
Mood stabiliser	25.6	25.8	26.9	25.7	25.8	27.6	27.2
Stimulants	9.7	9.9	10.4	11.5	12.1	9.5	4.5

Note: Percentages will not add to 100 per cent because most people were subject to two or more chemical restraints each year.

Table 5: Percentage of people chemically restrained subject to polypharmacy, 2014–15 to 2020–21

Year	Percentage of people subject to polypharmacy *of those chemically restrained* %
2014–15	57.0
2015–16	58.0
2016–17	60.2
2017–18	60.0
2018–19	62.0
2019–20	61.7
2020–21	61.2

Key findings – polypharmacy

- The percentage of people chemically restrained subject to polypharmacy is stable.
- The majority of people chemically restrained experience polypharmacy, which increases their risk of adverse events and drug interactions.
- The following side effects are of particular concern:
  - respiratory depression
  - lowered seizure threshold
  - cardiometabolic liability
  - dementia.

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). Table 6 shows the number of people each year who were mechanically restrained using different types of mechanical restraint.

Key findings

- The total number of people reported as being subject to mechanical restraint increased in the most recent year due to improved identification of practice.
- The total number of people mechanically restrained within respite and shared supported accommodation services rose dramatically in 2020–21 (Table 7).
- The percentage of people subject to each mechanical restraint type varied substantially from practice reported in previous years. This is likely explained by changes in reporting practice; that is, although some providers have become better at identifying (and therefore reporting) mechanical restraint, reporting of some types – buckle guards and harnesses in particular – remains confused – for example, in terms of what constitutes restrictive practice versus safe transportation. Service providers have been encouraged to seek specialist assessment and prescription regarding straps, clothing and other potential forms of mechanical restraint to ensure therapeutic use and – while this advice is pending – to report their use as restrictive practice.
- The percentage of those reporting bedrails and wheelchairs continued to increase slightly in 2020–21; the percentage of those reporting gloves increased slightly, while the proportion of use of most other types of mechanical restraints were similar to previous years (Table 8).

Table 6: Total number of people mechanically restrained, 2014–15 to 2020–21

Year	Number of people mechanically restrained
2014–15	131
2015–16	134
2016–17	141
2017–18	150
2018–19	153
2019–20	98
2020–21	114

Table 7: Total number of people mechanically restrained within respite and shared supported accommodation services, 2014–15 to 2020–21

Year	Number of people mechanically restrained in respite services	Number of people mechanically restrained in SSA
2014–15	54	62
2015–16	52	68
2016–17	55	68
2017–18	55	74
2018–19	54	72
2019–20	31	62
2020–21	7	103

Table 8: Percentage of all people mechanically restrained who were restrained with different types of mechanical restraints, 2014–15 to 2020–21

Restraint type	2014–15 %	2015–16 %	2016–17 %	2017–18 %	2018–19 %	2019–20 %	2020–21 %
Straps	19.8	20.1	21.3	24.0	24.8	29.6	53.5
Gloves	9.2	9.7	7.8	6.0	8.5	6.1	11.4
Splints	9.9	8.2	6.4	7.3	9.2	5.1	1.8
Clothing	56.5	55.2	54.6	50.7	53.6	50.0	24.6
Cuffs	1.5	1.5	2.1	2.0	1.3	2.0	1.8
Helmet	8.4	6.0	6.4	5.3	5.2	6.1	5.3
Wheelchair	5.3	7.5	7.1	6.7	5.9	8.2	10.5
Bedrail	1.5	9.7	7.8	8.0	9.8	12.2	14.9
Furniture	1.5	0.7	1.4	0.0	1.3	1.0	4.4
Other	0.0	0.0	0.7	8.7	2.0	2.0	0.0

Seclusion

Seclusion refers to the sole confinement of a person with 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

- Table 9 shows there was a drop in the number of people subject to seclusion in 2020–21 compared with the previous year (24 people in 2020–21 compared with 50 in 2019–20). This most likely reflects a reduction in the number of people accessing in-kind (non-NDIS) services. Consistent with this, the number of people secluded as a proportion of all people reported as subject to any form of restrictive intervention is relatively stable in recent years (2 per cent of people subject to restrictive practice were subject to seclusion in 2020–21; this compares with 3 per cent reported in 2019–20).
- 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.

Table 9: Total number of people subject to seclusion, 2014–15 to 2020–21

Year	Number of people secluded
2014–15	58
2015–16	43
2016–17	56
2017–18	60
2018–19	62
2019–20	50
2020–21	24

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

- The number of people physically restrained is stable across the last two financial years in terms of both the absolute number and relative proportion; that is, 1.8 per cent of people reported as being subject to restrictive practice in 2020–21 were reported to be physically restrained (Table 10). This is similar to the previous year where 1.3 per cent of people subject to restrictive practice were physically restrained.

Table 10: Total number of people subject to physical restraint, 2014–15 to 2020–21

Year	Number of people physically restrained
2014–15	78
2015–16	90
2016–17	103
2017–18	80
2018–19	68
2019–20	20
2020–21	22

Environmental restraint

Reported by state-funded providers for the first time in 2020–21, environmental restraint is defined broadly as measures that restrict a person's free access to all parts of their environment, including items or activities (for example, surveillance, locked doors, restricted access to some foods or kitchen utensils, internet or mobile devices). The Senior Practitioner began monitoring environmental restraint at the start of 2020–21.

In 2020–21, 591 people were reported to be subject to environmental restraint. As shown in Table 11A and Table 11B, state-funded providers reported detail regarding both:

- *what* was restricted (for example, outside access, food and drink)
- *how* a person's access was restricted (for example, via locked door or surveillance).

Table 11A: Percentage of people environmentally restrained with different types of environmental restraints in 2020–21

Restraint type	Percentage of people subject to each type (of all people environmentally restrained) %
Activity	8.1
Household item	31.0
Internal access	46.9
External access	60.1
Food and drink	51.6
Personal item	27.9
Privacy	8.8
Access (other)	37.1

Table 11B: Percentage of people environmentally restrained with different means of environmental restraints in 2020–21

Restraint means	Percentage of people subject to each means (of all people environmentally restrained) %
Removed object	15.1
Object out of reach	10.0
Supervision	22.7
Disabled utility	5.5
Locked item door	50.6
Locked abode door	76.0
Surveillance	6.3
Applied (other)	39.4

Key findings

- The most common elements of the environment restricted were access to external and internal areas (affecting 60 per cent and 47 per cent of people reported for environmental restraint) and access to specific food or drink (52 per cent).
- Consistent with this pattern, the most common means of restricting the environment is locked doors (at least three in four cases reported involved a locked abode door).
- 6.3 per cent of people reported as subject to environmental restraint were subject to surveillance.

Percentage of people with different disabilities

All service providers are requested to provide information about the person's disability. Table 12 shows the percentage of reported disability types among all people subject to a restrictive practice.

Table 12: Percentage of people reported who have different disabilities, 2020–21

Type of disability	Percentage of all people restrained %
ABI	2
Autism	40
Hearing	20
Intellectual	96
Neurological	20
Physical	12
Psychiatric	21
Learning	3
Speech	23
Visual	10
Sensory (any)	27

Key findings

- Most people subject to restrictive practices were reported to have an intellectual disability (96 per cent).
- Two in five people subject to restrictive practices were reported to have autism.
- About one-fifth were reported to have a hearing impairment.
- About 10 per cent 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

Restrictive practices authorised by the Senior Practitioner

For NDIS participants, the Victorian Senior Practitioner is responsible for approving the use of seclusion, mechanical restraint and physical restraint, and for authorising chemical and environmental restraint. Previously – for state-funded services – authorised program officers (APOs) were responsible for authorising restrictive practices.

The Senior Practitioner and Restrictive Practice Authorisation Team review applications to use restrictive practices to ensure compliance with the following legislative requirements:

- The use of the regulated restrictive practice is necessary to prevent harm to self or others.
- It is the least restrictive practice option under the circumstances.
- There is evidence of planning for reducing the regulated restrictive practice.

Authorised and approved use of restrictive practices in Victorian disability service providers

This section of the report presents the findings regarding restrictive practices approved and authorised by the Victorian Senior Practitione r in 2020–21 in comparison with previous years, noting that, for historical data pertaining to state-funded services, APOs authorised restrictive practices.

To maximise comparability of results to previous years, absolute numbers– rather than percentages – are reported. For ease of viewing, tables show the last seven years of data from 2014–15. Complete tables from 2008–09 can be requested from the Victorian Senior Practitioner.

Key findings

- In the period from 1 July 2020 to 30 June 2021, the Victorian Senior Practitioner approved or authorised the use of restrictive practice for 2,182 people (Table 13).
- The number is consistent with previous years, notwithstanding the slightly lower numbers in 2019–20. This one-year reduction in the number of authorisations is attributable to the transition in reporting and authorisation practice – and providers needing a few months to understand the myriad changes in their obligations – rather than any change in underlying practice.
- The relative stability in total authorisations suggests there has been a reduction in approvals and authorisations for seclusion, chemical, mechanical and physical restraint that has been offset by an increase in authorisations for environmental restraint. This explanation is explored in more detail below.

Table 13: Number of people authorised or approved to be subject to a restrictive practice in Victoria, 2014–15 to 2020–21

Year	Number of people (state-funded)	Number of people (NDIS)	Total number of people*
2014–15	2,146	0	2,146
2015–16	2,205	0	2,205
2016–17	2,228	0	2,228
2017–18	2,269	0	2,269
2018–19	2,288	0	2,288
2019–20	1,203	442	1,542
2020–21	1,012	1,763	2,182

Chemical restraint

Table 14 shows the total number of people authorised by the Senior Practitioner to be chemically restrained and Table 15 shows the breakdown by drug type.

Table 14: Total number of people authorised for chemical restraint, 2014–15 to 2020–21

Year	Number of people authorised
2014–15	1,998
2015–16	2,068
2016–17	2,089
2017–18	2,123
2018–19	2,126
2019–20	1,503
2020–21	1,770

Table 15: Percentage of all people authorised for chemical restraint who were authorised for different types of chemical restraint, 2014–15 to 2020–21

Drug type	2014–15 %	2015–16 %	2016–17 %	2017–18 %	2018–19 %	2019–20 %	2020–21 %
Antidepressant	37.8	38.5	39.1	40.2	41.7	41.3	38.8
Antipsychotic	71.4	71.7	70.9	71.3	73.0	73.8	75.5
Benzo/sedative	33.2	32.4	34.4	35.6	38.0	39.1	44.0
Menstrual suppression	1.7	1.5	2.0	2.4	2.7	2.5	3.7
Mood stabiliser	25.3	25.0	25.8	25.6	26.0	25.5	25.9
Stimulants	9.9	10.5	11.1	12.2	11.1	8.1	4.9

Note: Percentages will not add to 100 per cent because most people were subject to two or more chemical restraints each year.

Key findings

- There has been a 17 per cent reduction in the number of people authorised for chemical restraint compared with 2018–19 (2,126 people down to 1,770). This is likely due to residual confusion among some providers regarding updated authorisation procedures.
- Similar to the restrictive practice monitoring data (and to trends in previous years):
  - Antipsychotic and antidepressant medications were the most commonly authorised chemical restraints (three in four people authorised for chemical restraint were authorised for antipsychotic medication; 39 per cent for antidepressant medication).
  - A significant number of people (44 per cent) were authorised for sedatives.

Mechanical restraint

Table 16 shows the total number of people approved to be subject to mechanical restraint and Table 17 breaks this down by service type. Table 18 shows the percentage of these people each year approved for each type of mechanical restraint.

Table 16: Total number of people approved for mechanical restraint, 2014–15 to 2020–21

Year	Number of people approved
2014–15	170
2015–16	150
2016–17	157
2017–18	169
2018–19	192
2019–20	138
2020–21	260

Table 17: Total number of people approved for mechanical restraint within respite and shared supported accommodation services, 2014–15 to 2020–21

Year	Number of people in respite services	Number of people in SSA
2014–15	74	80
2015–16	62	79
2016–17	58	80
2017–18	59	80
2018–19	67	98
2019–20	30	92
2020–21	37	192

Table 18: Percentage of all people approved for mechanical restraint who were approved for different types of mechanical restraints, 2014–15 to 2020–21

Restraint type	2014–15 %	2015–16 %	2016–17 %	2017–18 %	2018–19 %	2019–20 %	2020–21 %
Straps	17.1	16.7	20.4	21.3	24.5	30.8	47.2
Gloves	7.1	10.0	7.6	7.1	5.7	6.8	5.5
Splints	8.8	8.0	7.0	7.7	7.8	6.8	4.9
Clothing	41.8	44.0	42.0	45.0	40.1	33.3	23.5
Cuffs	1.2	1.3	1.9	1.2	1.6	1.7	1.0
Helmet	8.8	8.0	7.6	7.1	6.3	6.8	7.2
Wheelchair	5.3	6.0	5.1	6.5	7.8	8.5	9.1
Bedrail	2.4	4.7	3.2	2.4	7.3	6.0	5.5
Furniture	1.2	0.7	1.3	0.6	1.0	3.4	3.3
Other	23.5	18.7	22.9	18.3	19.8	25.6	43.6

Key findings

- The total number of people approved for mechanical restraint has increased by 35 per cent compared with 2018–19.
- This increase is driven primarily by Shared Supported Accommodation services, whose approval numbers increased from 92 in 2018–19 to 192 in 2020–21.
- These findings are consistent with the trends observed in the restrictive practice monitoring data and similarly explained by providers' improved identification of practice (rather than changes in actual practice). As noted earlier (refer to key findings for Tables 6–8), although some providers have become better at identifying (and therefore reporting) mechanical restraint, reporting of some types – buckle guards and harnesses in particular – remains confused (for example, in terms of what constitutes restrictive practice versus safe transportation). Service providers have been encouraged to seek specialist assessment and prescription regarding straps, clothing and other potential forms of mechanical restraint to ensure therapeutic use and – while this advice is pending – to seek approval for and report their use as restrictive practice.
- The percentage of use of most other types of mechanical restraints were similar to previous years.

Seclusion

Table 19 shows the total number of people approved for seclusion each year since 2014–15.

Table 19: Total number of people approved for seclusion, 2014–15 to 2020–21

Year	Number of people approved for seclusion
2014–15	49
2015–16	51
2016–17	48
2017–18	51
2018–19	65
2019–20	52
2020–21	81

Key findings

- There was a 56 per cent increase in the number of people approved for seclusion in 2020–21 compared with 2019–20 (81 people in 2020–21 compared with 52 in 2019–20). As reported last year, this ongoing increase will be a focus over 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; 1.9 per cent of people who were reported to be subject to a restrictive practice in 2020–21 were subject to seclusion.

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 assistance. Physical restraint has been reported to the Senior Practitioner since July 2011. From 1 July 2019 the requirement for using physical restraint changed from an emergency and planned emergency basis to a PRN basis (pro re nata – as needed / required) in accordance with the Senior Practitioner physical restraint direction, which was modified to reflect this change. This change means that approval data is only

available for the most recent financial year. In 2020–21 the Senior Practitioner approved 35 people for physical restraint.

Environmental restraint

The Senior Practitioner commenced authorising environmental restraint at the start of 2020–21. In this reporting year, 1,212 people were authorised to be subject to environmental restraint. As shown in Table 20A and Table 20B, providers' applications provide detail about:

- *what* is to be restricted (for example, outside access, food and drink)
- *how* the restriction is to be applied (for example, via locked door or surveillance).

Table 20A: Percentage of people authorised for environmental restraint with different types of environmental restraints in 2020–21

Restraint type	Percentage of people authorised for each type (of all people authorised for environmental restraint) %
Activity	9.0
Household item	34.5
Internal access	43.3
External access	56.0
Food and drink	47.2
Personal item	24.9
Privacy	6.3
Access (other)	33.6

Table 20B: Percentage of people authorised for environmental restraint with different means of environmental restraints in 2020–21

Restraint means	Percentage of people authorised for each means (of all people authorised for environmental restraint) %
Removed object	18.6
Object out of reach	10.5
Supervision	22.3
Disabled utility	3.6
Locked item door	55.8
Locked abode door	69.3
Surveillance	5.4
Applied (other)	35.2

Key findings

- Authorisations were granted most commonly to restrict access to external and internal areas (affecting 56 per cent and 43 per cent of people authorised for environmental restraint respectively) and access to specific food or drink (47 per cent).
- Consistent with this pattern, the most common authorised means of restricting the environment was locked doors (69 per cent of authorisations involved a locked abode door).
- 5.4 per cent of people authorised for environmental restraint were authorised for surveillance.

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 et al. 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 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, which included the requirement for secondary approval from the Senior Practitioner for using restrictive practices.

A small selection of BSPs that required additional approval by the Victorian Senior Practitioner for using restrictive practices were assessed in 2020–21. The sample size of assessments undertaken was too small to suggest trends in quality across the sector, but individual practitioners and NDIS providers benefited from feedback about the quality of their BSPs

Despite the small sample size, all BSPs assessed described:

- 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, together with the use of environmental support, is essential for minimising the use of restraint and seclusion.

All BSPs assessed show that more work is needed on providing:

- a description of the behavioural goals to be achieved during the course of the BSP, so 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, BSPs reviewed in 2020–21 continued to be long and contained jargon and complex language. The needs of support staff implementing BSPs should be considered because they are time poor. Often the behaviour support practitioners provided an easy-read one-page ‘do’s and don’ts’ protocol to support the staff implementing the BSP.

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 (s. 27(2)(c)). Audits are used to identify and examine the actual use of restrictive practices.

With the impact of the COVID pandemic and the Victorian Chief Health Officer directions, the Victorian Senior Practitioner's Restrictive Practices Authorisation team needed to pivot from face-to-face to a 'desktop' style of audit, with a much smaller number of services being audited over the year. Audits were prioritised based on serious concerns raised by the Disability Services Commissioner in relation to unauthorised use of restrictive practices. Often staff training sessions were combined with the audit process for a more streamlined approach and recognition that staff lacked knowledge of the NDIS interface.

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
- the use of restrictive practices without an authorised behaviour support plan in place.

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.

In Victoria there are two RTFs – the Intensive Residential Treatment Program (IRTP) and the Long Term Residential Program (LTRP), which became an RTF from 1 July 2020 following a change in legislation. Both are managed by Forensic Residential Services, which form part of Forensic Disability Services in the Department of Families, Fairness and Housing.

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
- 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, extended supervision orders and security 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, three 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 APO 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 RTFs (except for people subject to custodial supervision orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* [CMIA]). They also provide a proposed treatment plan and supporting material, including a risk assessment. The Senior Practitioner and the Compulsory Treatment team review all the documentation provided. 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, as 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 RTFs, 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 APOs 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 APO is responsible for implementing the treatment plan.

Victorian Civil and Administrative Tribunals 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 APO 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 RTFs (except for people under the CMIA) within the first six months, or 12 months for security orders, 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 APO 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 2020–21 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 RTFs
- 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 and have remained online since. Staff from the Compulsory Treatment team attended all open hearings.

Compulsory treatment data

Forty-eight people were subject to compulsory treatment during 2020–21, including two people who were on extended leave from custodial supervision orders under the CMIA. This increase from 42 to 48 people can be largely accounted for by the LTRP becoming an RTF and the residents now coming under the oversight of the Compulsory Treatment team.

There have been 27 people subject to supervised treatment orders for the whole period of 1 July 2020 to 30 June 2021. This includes four people who were subject to interim supervised treatment orders for part of the period. There was one more person subject to a supervised treatment order than last year.

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 not legally represented.

There was one new supervised treatment order made during the year, and one supervised treatment order was revoked.

Twenty-eight people were subject to a supervised treatment order at the end of 2020–21. This is the same number of people who were subject to a supervised treatment order at the end of 2019–20.

There were 13 people subject to compulsory treatment during the year in the IRTP, which is the same as last year.

One person was subject to a residential treatment order at the start of the reporting period and was transferred to another facility during the year. Three people were admitted to the IRTP under a supervision order during the year, and one of these people was transferred to prison from the IRTP.

Five people were subject to custodial supervision orders under the CMIA for the whole of the reporting period at the IRTP. One person subject to a custodial supervision order under the CMIA who was at the IRTP transitioned to the LTRP during the period. Additionally, two people remained on extended leave from a custodial supervision order throughout the period.

Table 21 shows that, by 30 June 2021, 10 people were subject to compulsory treatment at the IRTP:

- Four people were subject to a supervision order under the *Serious Offenders Act 2018*.
- One person was subject to a security order.
- Five people were subject to custodial supervision orders under CMIA.

Table 21: Number of people subject to compulsory treatment at the IRTP, by order type, Victoria, 2020–21

Order type	July 2020	Admissions during 2020–21	Discharges or extended leave during 2020–21	June 2021
Residential treatment order	1	0	1	0
Supervision order, including interim, under the Serious Offenders Act	2	2	0	4
Supervision order under the *Serious Sex Offenders (Detention and Supervision) Act 2009*	0	1	1	0
Custodial supervision order under the CMIA	6	0	1	5
Security order	1	0	0	1
Extended leave	2	0	0	2
Total	10 in IRTP, 2 on extended leave	3 admissions to IRTP	3 discharges from IRTP, no one from IRTP granted extended leave	10 people at IRTP, 2 on extended leave

As the LTRP came under the oversight of the Senior Practitioner from 1 July 2020, data about the people at this facility is included. Table 22 captures the types of orders people were subject to during the reporting period.

By 30 June 2021, five people were subject to compulsory treatment at the LTRP:

- One person was subject to a supervision order under the Serious Offenders Act.
- Four people were subject to custodial supervision orders under CMIA.

Table 22: Number of people subject to compulsory treatment at the LTRP, by order type, Victoria, 2020–21

Order type	July 2020	Admissions during 2020–21	Discharges during 2020–21	June 2021
Supervised treatment order	1	0	1	0
Supervision order, including interim, under the Serious Offenders Act	1	0	0	1
Custodial supervision order under the CMIA	2	2	0	4
Total	4	2	1	5

Assessment orders

An APO 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 2020–21 no assessment orders were made. The last assessment order was made in 2016–17.

Client demographic data

Of the 48 people subject to a compulsory treatment order in 2020–21, 47 were male and one was female. There have only been four females subject to compulsory treatment since 2008–09.

In 2020–21 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 2020–21 was 40 years, ranging from 20 to 72 years (calculated at 30 June 2021). This is a similar age profile to the previous two years.

Table 23 shows the number of people subject to supervised treatment orders in Victoria by accommodation type as of 20 June 2021.

Table 23: Number of people subject to supervised treatment orders in Victoria by accommodation type, 30 June 2021

Accommodation type	Number of people subject to supervised treatment orders
Non-DFFH specialist forensic disability accommodation (SFDA)	9
Other DFFH accommodation including disability accommodation services and SFDA	1
Transitioned from DAS to NDIS providers	10
Other community services organisations	9
Total	**29**

DAS = disability accommodation services; DFFH = Department of Families, Fairness and Housing; SFDA = specialist forensic disability accommodation

Compulsory treatment restrictive practice data

Table 24 gives a breakdown of the number of people subject to compulsory treatment who were subject to restrictive practices in 2020–21 by the type of order and restrictive practice.

Table 24: Number of people subject to compulsory treatment who were subject to restrictive practices, Victoria, 2020–21

Restrictive practice	Supervised treatment order, including interim	Residential treatment order	Supervision order, including interim	Custodial supervision order under CMIA (including people on leave)	Security order
Routine chemical restraint	13	0	2	5	1
Emergency chemical restraint	6	0	3	5	1
PRN chemical restraint	3	0	1	1	0
Seclusion	3	0	1	0	1
Physical restraint	0	0	1	0	0
Total people throughout year who were on or on leave from an order	**29**	**1**	**6**	**11**	**1**

In 2020–21, 52 per cent of people on supervised treatment orders were administered chemical restraint. This percentage is lower than the 77 per cent of all people reported to the Restrictive Intervention Data System (RIDS) as having been administered chemical restraint in 2020–21. Ten per cent of people on supervised treatment orders were secluded at some time during 2020–21. This percentage is higher than the 2 per cent of all people reported to RIDS for seclusion in 2019–20.

Revocation

The Senior Practitioner, APO 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 APO 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 2020–21 one supervised treatment order was revoked. One person in the IRTP was subject to a supervision order and was transferred from the IRTP to prison, and one person who was subject to a residential treatment order was transferred from the IRTP to another facility.

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' (s. 24(1)(g) of the Disability Act).

The focus this year was on 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.

COVID-19 response

During the second wave of the COVID-19 pandemic in Victoria, outbreaks occurred throughout vulnerable disability and aged care services. Residential, in-home and community supports were affected, with many people with a disability needing to isolate as a close contact or having been diagnosed with COVID-19. This created significant concern, particularly for those people who had difficulty understanding or managing changes to routine, access to community and demonstrated behaviours of concern.

The Victorian Senior Practitioner team provided a dedicated point of contact to support the department's COVID response. The team collaborated with the NDIS Service and Delivery Branch and Child Protection to provide advice around behaviour support recommendations and how restrictive practices could be used appropriately, if required.

The Research and Data team continued to deliver data and commentary on a monthly basis for inclusion in the COVID-19 Social and Justice Services Data Dashboard.

The data delivered was the count of PRN and single-day emergency administrations of restrictive practices reported to RIDS by service outlets that had transitioned from the former Department of Health and Human Services to one of the five in-kind service providers.

The measure monitored the number of reports of these types of restrictive practices on people with disability in transfer services, who may have faced challenges with Chief Health Officer directions.

The environmental restraint project

The Victorian Senior Practitioner, in consultation with the Disability and NDIS branches of the then Department of Health and Human Services, engaged Nous Group to develop and validate a measure of environmental restraint.

As of 1 August 2020, the Victorian Senior Practitioner has been authorising environmental restrictive practices via RIDS.

Two practice guides were developed to assist services to report on 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 also updated. Copies of these three resources can be found on the Victorian Senior Practitioner webpage and the RIDS webpage.

A copy of the final report from Nous to the department can be requested by emailing the Victorian Senior Practitioner.

Enabling Quality Behaviour Support Planning online course

This course was developed by a Scope–University of Melbourne partnership with funding provided by the Victorian Government. It was originally intended to be delivered face to face, but the ensuing COVID restrictions meant that it had to be redesigned to be delivered online using the University of Melbourne's learning management system.

The content includes contemporary evidence-based and person-centred approaches to positive behaviour support and aligns with the knowledge and skills required by the *NDIS positive behaviour support capability framework* <https://www.ndiscommission.gov.au/pbscapabilityframework>. The course is delivered online over eight weeks and offers a learning and development pathway to assist behaviour support practitioners to develop and expand their competences in positive behaviour support.

Participants who successfully complete the course will have demonstrated much of the knowledge and skills required of a 'core practitioner' as prescribed in the NDIS capability framework.

The course was delivered in cohorts across the year, with the last of the intakes to be completed by September 2021. Almost 400 practitioners have been enrolled to date. Following the completion of the course rollout, the data will be reviewed for a final evaluation due in late 2021. This will inform recommendations for future support needs of behaviour support practitioners, as well as how current behaviour support practitioners can maintain and consolidate their knowledge and skills.

Painting by Kyra Drummond, 2019 VALID 'Having a Say Conference' Art Competition (Theme: 'Having a say forever')

Online training for authorised program officers

APOs play a critical role in authorising restrictive practices. As described in the Disability Act, APOs are required to authorise the use of all restrictive practices in their organisation and ensure behaviour support plans are implemented. The Victorian Senior Practitioner acts as a complementary safeguard to the NDIS Commission to authorise or approve regulated restrictive practices.

In 2020–21 the Victorian Senior Practitioner approved 196 new APOs. Many APOs had requested training to help them undertake their legislative responsibilities.

The Victorian Senior Practitioner partnered with the University of Melbourne to develop and facilitate the online training program 'Introduction to critical issues for APOs approving behaviour support plans'.

The objective of the training was to equip APOs with foundational knowledge and skills necessary to effectively exercise their statutory responsibilities in authorising regulated restrictive practices. In doing so, the lives of people with disability would be improved as well as the safety of staff delivering support.

The approach offered four cycles of training in 2021, beginning with a truncated timeline for completion and a smaller number of learners to trial the program in February 2021. The second cycle ended in June 2021. The University of Melbourne has provided a mid-cycle report with an analysis of learning impacts to date based on pre- and post-training self-assessment by learners.

To date 115 APOs have enrolled in cycles one and two. Broadly, the mid-year analysis indicated:

- Course appraisal data were extremely high across 12 domains, indicating the course was exceptionally well received.
- Perceived levels of self-competence in the APO role increased across six key domains, and these improvements were statistically significant in each of the six domains.
- Participants contributed about 25 per cent of their work time to the APO role among other work commitments.

A further 160 APOs have enrolled for cycles three and four to be run in July and October 2021, with the final course analysis to be included in the next annual report.

The Victorian Senior Practitioner is looking to make the program available to all APOs on an ongoing basis subject to the final evaluation report.

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' (s. 24(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 2020–21 including online and virtual opportunities.

Restrictive practices reduction training

The Restrictive Practices Authorisation team continued to provide training to services on understanding restrictive practices and the circumstances under which restrictive practices can be used. Where possible, restrictive practices audits and training were combined to provide a more streamlined approach.

The focus for 2020–21 was on establishing a collaborative working relationship with APOs and behaviour support practitioners of new service providers. This provided the opportunity to enhance their understanding of the role of the Victorian Senior Practitioner, regulated restrictive practices and the integral role of APOs in the authorisation process for submitted behaviour support plans.

The Restrictive Practices Authorisation team presented to more than 450 people in 2020–21, which included:

- registered aged care providers
- Yooralla's Positive Behaviour Support team
- Possability (disability services organisation)
- NDIS-registered behaviour support providers
- NDIS support coordinators and local area coordinators
- the Disability Services Commissioner
- Public Health complex care teams
- departmental behaviour support practitioners.

In addition, the Restrictive Practices Authorisation team worked collaboratively with National Disability Services in contributing to developing:

- a suite of easy read resources relating to defining restrictive practices for NDIS participants
- a 'Foundations of positive behaviour support' video launch
- a workshop for behaviour support practitioners on writing behaviour support plans that adhere to easy/plain English guidelines.

The 'Foundations of positive behaviour support' videos continue to provide the sector with easily accessible information about positive behaviour support. With the NDIS rollout and the subsequent influx of new NDIS service providers, the videos have proved to be an invaluable source of information.

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

Over the year, the Restrictive Practice Authorisation team created or contributed to several easy read resources such as:

- helpful resources during the COVID-19 pandemic for people with disability – refer to the department's website under 'Disability services senior practitioner practice advice' <https://www.dhhs.vic.gov.au/disability-services-sector-coronavirus-covid-19#disability-services-senior-practitioner-practice-advice>
- positive behaviour support and restrictive practices – NDIS Commission
- public housing for NDIS participants – Department of Families, Fairness and Housing.

Specialist communication assessment reports and advice

The Restrictive Practices Authorisation team have continued their commitment to ensuring the communication needs of people with complex behaviour is better understood. The relationship between communication difficulties and behaviours of concern is well documented in the research literature. Where this issue continues to remain undetected and unaddressed behaviours of concern are maintained.

The focus for 2020–21 was on ensuring a better understanding of how people with communication difficulties, specifically those who are non-speaking, communicate pain and discomfort, as well as ensuring that functionally equivalent replacement behaviour strategies selected were based on comprehensive communication assessment reports.

The Restrictive Practices Authorisation team completed two specialist communication assessment reports and provided communication-based advice for 47 people, as a means of ensuring a better match between the recommended positive behaviour support strategies and a person's actual level of skill and ability.

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 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. These are 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. No training or user group sessions were facilitated this year due to difficulties in translating the sessions to online formats. Individual consultancy was provided on request.

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' (s. 24(1)(f) of the Disability Act).

During 2020–21 the team provided 2,169 instances of practice advice, with 1,353 of these being for general advice about behaviour support and restrictive practices. There were 768 enquiries directly related to authorising restrictive practices in behaviour support plans, while 39 were related to concerns about operational service provision by registered providers. Nine enquiries related to requests for organisational education and training.

This equates to a significant rise in the sector reaching out for practice advice, with 1,145 responses having been provided in the previous year. There was also a notable increase in queries that related to individuals with complex presentations, comorbid diagnoses and behaviours of concern that posed significant risk to self or others.

Positive Behaviour Supports NDIS Thin Market Trial Pilot Victoria

In December 2019 the Disability Reform Council (now the Disability Reform Ministers' Meeting) agreed to use a more flexible approach to address NDIS market gaps, with each state and territory hosting a thin market trial.

In Latrobe and Ararat in Victoria, the NDIA undertook a market intervention over 12 months to address unmet needs for specialist behaviour support services. The intervention resulted in five new registered specialist behaviour support providers entering the market in Latrobe, and four in Ararat. A further five providers applied for registration to start delivering specialist behaviour support services in these areas.

The Victorian Senior Practitioner was a member of the Victorian Local Working Group that supported the National Disability Insurance Agency to design and deliver the trial project to test alternative approaches to addressing potential thin market supply issues for behaviour support.

The purpose of this local working group was to consider local thin market issues, designing and delivering a time-limited approach to addressing the thin market issue identified. Learnings will inform future work in similar markets.

Thin market intervention projects are underway in all states and territories. Further information can be found on the NDIS website <https://www.ndis.gov.au/providers/market-monitoring-and-intervention>.

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 APOs, clinicians, direct care (disability) staff and representatives from the Office of the Public Advocate and VCAT.

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

- the Forensic Disability Statewide Assessment Service
- updates from the Disability and NDIS Policy branch
- strengthening proposed reduction plans against treatment goals
- NDIS transition issues, specifically funding processes and the treatment plan being the behaviour support plan.

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

Care team meetings, case consultations and VCAT hearings

The Compulsory Treatment team supports the sector by engaging in case consultations and attending care team meetings for people 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 180 care team meetings during the reporting period. Usually, attendance at the care team meetings is in person; however, during the reporting period attendance was through online platforms. The team also attended approximately 55 VCAT hearings via an online platform during the reporting periods.

Establishing a webpage

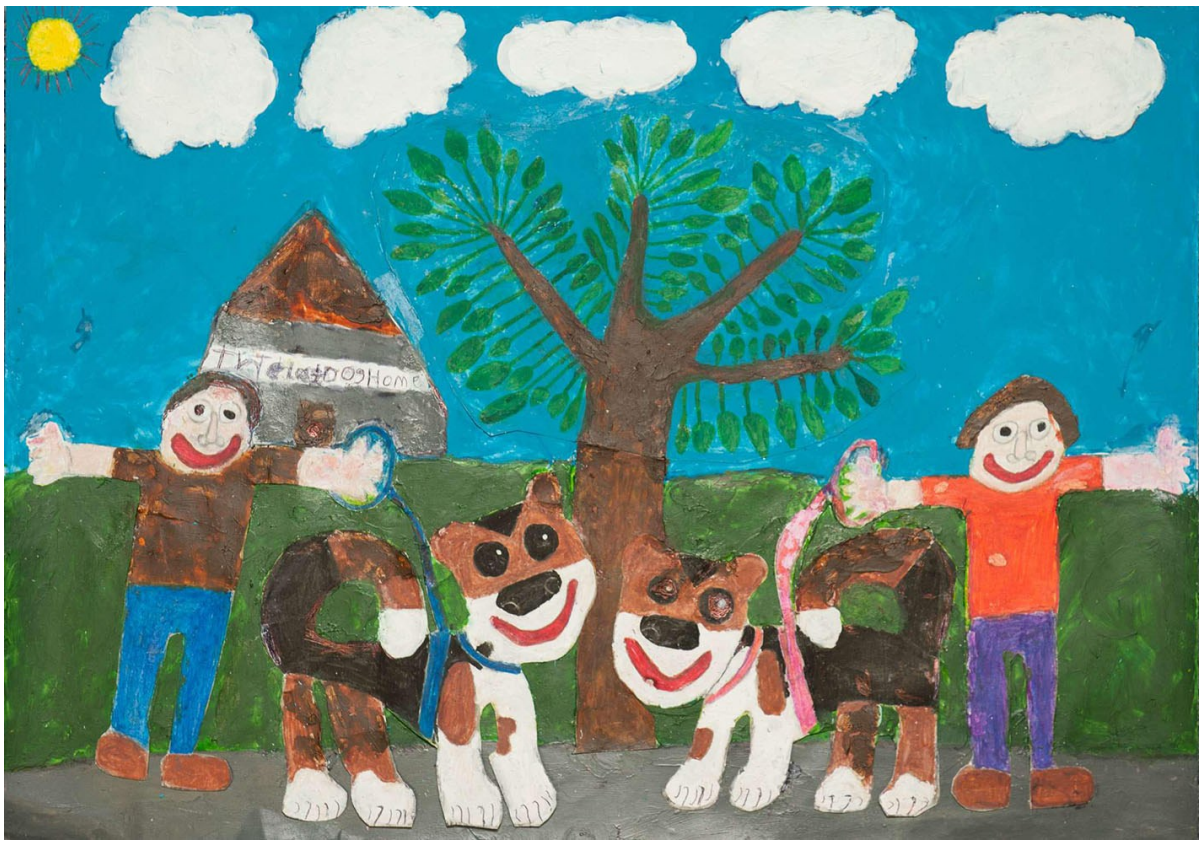
A discrete webpage for the Victorian Senior Practitioner was released on 25 August. The webpage, which is contained within the department's internet site, provides a publicly accessible record for all of the Directions and Prohibitions issued by the Victorian Senior Practitioner. The publication of all directions and prohibitions on the department's internet site is a requirement under ss. ZO(2), 135(7), 186(7) and 27(5C) of the Disability Act.

The webpage is organised around nine key topics:

1. About the Victorian Senior Practitioner
2. Directions and prohibitions for the use of restrictive practices
3. Information for authorised program officers
4. Information for behaviour support practitioners
5. Practice advice for people who support people who show behaviours of concern
6. Information about compulsory treatment
7. How to use the Restrictive Intervention Data System (RIDS)
8. Monitoring and authorising restrictive practices
9. Our research into restrictive practices and compulsory treatment.

We will be adding more information to these pages over time and hope you find the information useful.

Visit the Victorian Senior Practitioner website <https://www.dffh.vic.gov.au/victorian-senior-practitioner>.



Painting by Sarah Veli, 2018 VALID 'Having a Say Conference' Art Competition (Theme: 'Community here')

Informing public debate and opinion

The Senior Practitioner Seminar 2020

Every year the Senior Practitioner Seminar is held to provide feedback and information about the progress of projects being undertaken or commissioned by the Senior Practitioner, as well as information about changes in the system, such as the NDIS. Unfortunately, in 2020, the Senior Practitioner Seminar was not convened due to a range of factors associated with the COVID-19 pandemic.

Publications in peer-reviewed journals

The following book chapter was published:

Lambrick F, Birgden A, Troutman C, McLeod D 2020, 'Protecting the rights of people with intellectual disabilities in correctional settings'. In: Lindsay WR, Craig LA, Griffiths D (eds), *The Wiley handbook on what works for offenders with intellectual and developmental disabilities: an evidence-based approach to theory, assessment, and treatment*, Wiley, Chichester.

Overview of the chapter

A major concern for governments worldwide is to prevent crime, protect public safety, maintain universal human rights and rehabilitate undesirable behaviours. The challenges to achieving these goals are most apparent when a society's most vulnerable individuals are involved, particularly those who have limited insight into the impact of their behaviour on others and are unwilling to comply with treatment.

The chapter provides an overview of the compulsory treatment framework operating under the Disability Act. An in-depth analysis of a cohort of recipients of compulsory treatment focuses on the socio-demographic, historical and clinical characteristics of the men and women with intellectual disability who completed a term of compulsory treatment between 2007 and 2014 in Victoria. Finally, it covers a set of key principles based on human rights and key psychological theories that have been designed to reduce the likelihood of discrimination against forensic disability clients in correctional service settings.

Invited presentations

20 January 2021

The Queensland Mental Health Review Tribunal invited Dr Frank Lambrick to present a masterclass titled 'Introduction and overview of forensic disability'.

References

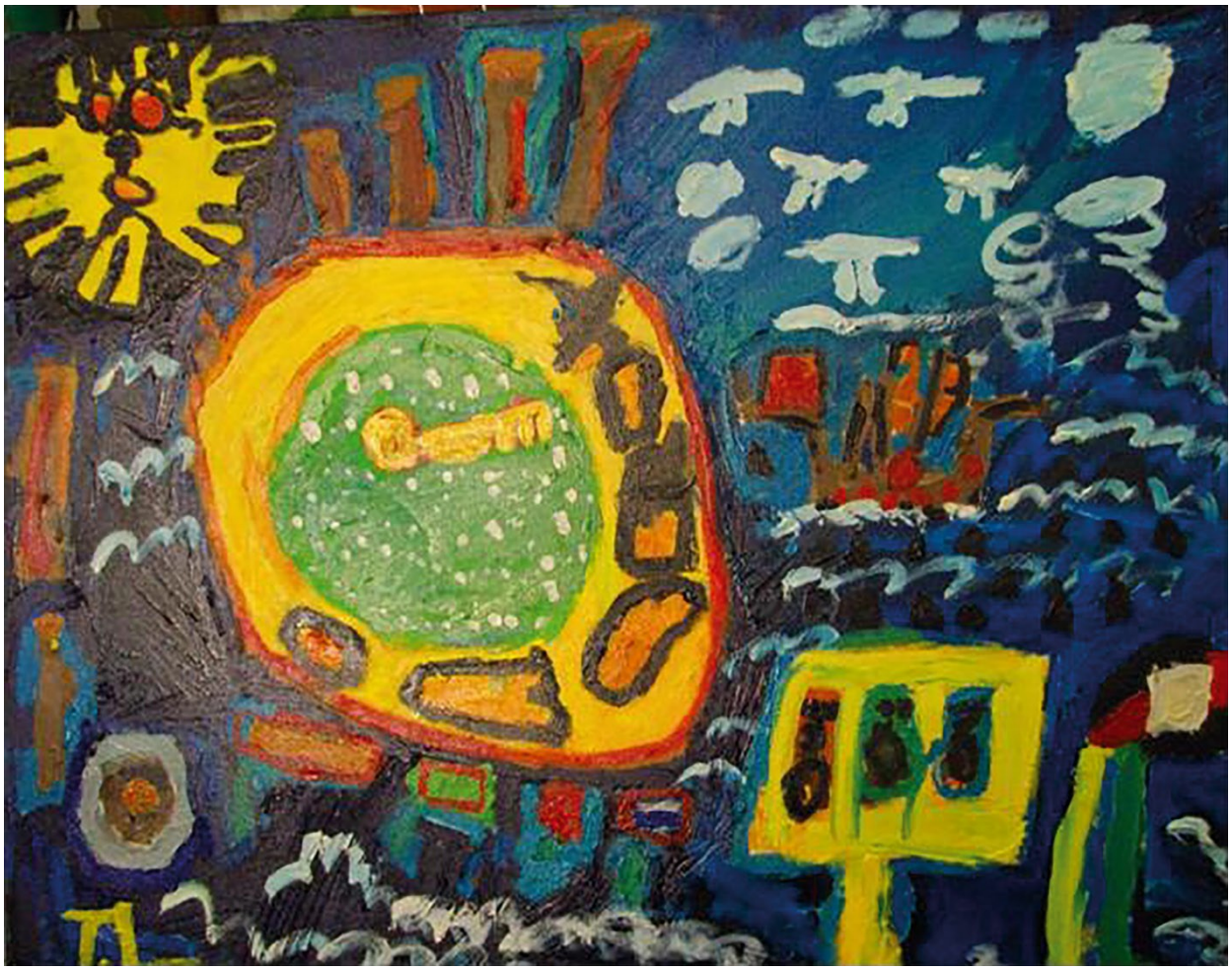
Browning-Wright D, Saren D, Mayer GR 2003, The behavior support plan – quality evaluation guide, viewed 23 October 2014 at Positive Environments, Network of Trainers website <http://www.pent.ca.gov>.

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

Webber L, McVilly K, Fester T, Chan J 2011a, 'Factors influencing quality of behaviour support plans and the impact of plan quality on restrictive intervention use', *International Journal of Positive Behavioural Support*, 1(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*, 36, pp.1–5.

Webber L, 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*, 2(2), pp. 3–11.



Painting by Tim Leembruggen, winner, 2011 VALID 'Having a Say Conference' Art Competition (Theme: 'Dignity')