

Office of the Senior Practitioner

Annual report 2008–2009

*Supporting people
to achieve dignity
without restraints*

A Victorian
Government
initiative



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Abbreviations used in this document

APO	Authorised program officer
BSP	Behaviour support plan
CDDHV	Centre for Developmental Disability Health Victoria
CRU	Community residential unit
CSO	Community service organisation
DAS	Disability accommodation services
DHS	Department of Human Services
DSD	Disability Services Division
DSP	Disability service provider
FBA	Functional behaviour assessment
GP	General practitioner
OSP	Office of the Senior Practitioner
PRN	Pro re nata (as required)
PPS	Partnerships for Positive Solutions
RIDS	Restrictive Interventions Data System
SSA	Shared supported accommodation
STO	Supervised treatment order
VCAT	Victorian Civil and Administrative Tribunal

Note: All percentages in this report have been rounded to the nearest whole number.

Letter to the minister

The Honourable Lisa Neville, MP
Minister for Community Services
Level 50 Lonsdale Street
Melbourne VIC 3000

Dear Minister

In accordance with section 24(2) of the *Disability Act 2006*, I am pleased to submit the Senior Practitioner's second annual report. This report outlines the functions and activities of my office for the period 1 July 2008 to 30 June 2009.

I am pleased to report that the objectives and intent of the Disability Act as described in the role of the Senior Practitioner have been met.

Thank you for your continued support of the role of the Senior Practitioner.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Jeffrey Chan', with a large, stylized flourish on the left side.

Jeffrey Chan, PhD
Senior Practitioner
September 2009

A message from the senior practitioner



“Change will not come if we wait for some other person or some other time. We are the ones we’ve been waiting for. We are the change that we seek.” (Barack Obama).

It is pleasing to note there have been some gains made in this second year of the implementation of the *Disability Act 2006*. You will read of these gains and the modest but important decrease in restrictive interventions.

Following the first stakeholder survey evaluation of this office’s performance, I have quickly acted upon your feedback for the period 1 July 2008-30 June 2009. Some of these actions included:

- developing an enhanced Restrictive Intervention Database System (RIDS) module, making it more user-friendly so that data was available on a real-time basis and directly available to service users,
- establishing a RIDS service users group to seek feedback on how RIDS can be further improved,
- reconfiguring the structure of my office to better respond to your requests,
- expanding the focus of the active prevention strategy to include children and adolescents,

- increasing training, advice and consultancy when requested,
- increasing the number of collaborative projects with our key stakeholders.

Over the past year, I have noted an increased level of awareness of the work of the office by disability service providers. I am aware of the many positive and creative solutions being implemented across the state to promote the dignity of people with a disability. And there is tremendous effort among disability service providers and practitioners to further improve.

In the first annual report, I argued that there must be sustainable change in the environment and service system if we want to bring about a continuing positive change in a person’s behaviour. Research commissioned by the office last year reinforces this notion; a person’s behaviour of concern is often a response to experiences and environments that impact negatively on them. Sometimes these environments are themselves ‘of concern’ when they do not provide the opportunity for a person with a disability to learn new skills, acquire new life experiences or experience positive social role-modelling. Robert Martin¹, an internationally-recognised self-advocate leader, described his ‘challenging behaviours’ as a response to his negative environment. His story is similar to the many stories of people with a disability²; we need to do more to change these ‘environments of concern’³.

Research literature provides many solutions for how we can improve the environment to better support the person. In Victoria, we have legislation such as the *Charter of Human Rights*

1 Mr Robert Martin was in Melbourne on two occasions at the invitation of the office in partnership with VALID and Office of the Public Advocate, as a keynote speaker.

2 There is ample research evidence that highlights that the environment can have a negative impact on the behaviours of people with a disability.

3 The term “environment” is broadly defined to include the physical environment, the service or support system/model and the responses of the people that support a person with a disability.

and *Responsibilities 2006* to guide our practice. Internationally there is the *United Nations Convention for the Rights of People with Disabilities 2007*. These offer an effective framework for empowering people with a disability to exercise their rights and allow disability support professionals to promote the rights of people with a disability. Behaviours of concern are less likely to occur when people are supported, when we understand their responses, when their needs are met, when they have a level of control and self-determination, and when their dignity is upheld.

Behaviours of concern are less likely to occur when people are supported, when we understand their responses, when their needs are met, when they have a level of control and self-determination, and when their dignity is upheld.

Well-supported and qualified disability support professionals are an important part of the solution. Continuing and contemporary education is only one aspect of supporting professionals to do their job well. Disability support professionals need to develop greater expertise relevant to their work, subscribe to professional ethics and human rights and apply these in their daily practice. The need to have improved staff support systems, increased staff capability in practical problem-solving skills, proper debriefing and clinical assistance to implement recommendations from complex reports is a common theme expressed to me by disability support professionals.

In addition, managers play a key role in providing leadership that supports the dignity of risk and applies human rights criteria to daily practice and management decision-making. People with a disability who present with behaviours of concern

have already experienced significant trauma and negative life experience in their past. Our response must be therapeutic and compassionate, not one where further restrictions are the starting point of a support plan. Supporting the dignity of the person is not taking the moral high ground; upholding human rights is everyone's business every day. Dignity is an inalienable human right regardless of the severity of the behaviour of concern.

Our response must be therapeutic and compassionate, not one where further restrictions are the starting point of a support plan.

In conclusion, I wish to acknowledge the continuing support of the team, disability service providers, various stakeholders, DHS regional managers and colleagues and disability support professionals as we work together towards a restraint-free environment. I wish to particularly thank people with a disability and family carers for their insight and wisdom on steering the direction of the office. It is their insight that will guide the change towards supporting dignity without restraints.

Thank you.



Jeffrey Chan, PhD
Senior Practitioner
August 2009



Top: Support Partnerships and Service Development team. Back row from left: Savva Zavou, Dr Lynne Webber, Anthony La Sala. Front row, from left: Michael Stone, Daryl Lang, Maree Skiadas.

Bottom: Practice Leadership and Quality of Life team. Back row from left: Simon Wardale, Brent Hayward, Kylie Saunders, Dr Frank Lambrick, Moira Buchholtz. Front row, from left: Hellen Tzanakis, Janice Rouhan, Rod Carracher, Mandy Donley.

Section 1

Summary of achievements

It has been another busy and productive year. We have been humbled by the openness of many disability service providers and people with a disability to effect change. Together we achieved the following:

Reviewing the support needs of people

- Reviewed about 1357 behaviour support plans⁴ and made recommendations in two reports,
- Reviewed 306 people living in 75 community residential units across all eight regions of Victoria as part of the chemical restraint review strategy. This included both Department of Human Services (DHS) managed services and community service organisations (CSO). The strategy included treatment sheet reviews and recommendations for all cases,
- Analysed an average of 2653 restrictive intervention episodes each month,
- Analysed and reviewed 30 treatment plans for supervised treatment orders and monitored their progress,
- Undertook individual clinical reviews and monitoring of 18 persons with high needs and high risk, as well as conducting five service reviews,
- Trialled implementation of an active prevention strategy for children and young persons. We conducted 20 individual reviews and five training sessions with 44 participants at four sites,

- Responded to over 1560 phone enquiries, to support regions with RIDS.

Learning and Development

- Delivered and produced more than 43 workshops, seminars, conference presentations and information sessions with more than 550 people attending. These included 17 workshops on designing behaviour support plans, four on risk assessment, four on the authorised program officer's role, nine on trauma, attachment and psychotherapeutic intervention, and six on what chemical restraint means,
- Implemented an eight-month intensive clinical and practice coaching workshop for 44 staff members from the DHS and CSO service providers. Four sessions were held for this year,
- Implemented the enhanced RIDS across the state and conducted more than 30 training sessions on the trial use of the database system.

Research and practice

- Undertook research on the views of people with disability and their family carers on their experiences of restrictive practices. Published a report, *Experiences of restrictive practices: A view from people with disabilities and family carers*, by Paul Ramcharan et al in 2008,
- Undertook a comprehensive systematic literature review on physical restraints and published a report, *Physical Restraint in Disability Services*:

⁴ Defined in the Act as behaviour management plans.

Current Practices Contemporary Concerns and Future Directions, by Dr Keith McVilly from RMIT University. This report and *Restrictive Practices in Disability Services: The Views of People with Disabilities and Family Carers* informed the office's position on physical restraints. A recommended position to move forward on this matter will be released shortly,

- Funded \$233,047 in Senior Practitioner research partnerships grants and \$36,500 in promoting dignity grants to disability support professionals,
- Achieved two Australian Research Council grants totalling about \$1.4 million as an industry partner with Monash and La Trobe universities, and diverse stakeholder groups; and initiated two PhD scholarships,
- Partnered with Yooralla and Monash University on a Mindfulness pilot project,
- Partnered with Monash University's Centre for Developmental Disability Health Victoria (CDDHV) on research into depression, behaviours of concern, and restrictive interventions,
- Partnered with CDDHV on research on the effect of individual and organisational factors on restraint use,
- Partnered with CDDHV on research investigating the effect of exposure to challenging behaviour on support workers' well-being,

Partnerships

- Collaborated with DHS regions to implement the recommendations by independent psychiatrists on 76 people from the previous Kew Residential Services, and published a report on the findings of this review by CDDHV,
- Launched the Senior Practitioner dignity seminar series of three seminars and collaborated with stakeholders to invite speakers from Australia and overseas to share their knowledge and experiences,
- Partnered with Scope on building foundations for effective communications, assessment and intervention,
- Partnered with the Office of the Public Advocate on a review of the implementation of supervised treatment orders (STOs) and the balance between restrictive interventions, therapeutic outcomes and human rights for people subject to orders under the *Disability Act 2006*,
- Worked with a range of stakeholders (such as the Chief Psychiatrist, Royal Australian and



Above: Office of the Senior Practitioner Research Grants forum initiative 26 May 2009. From left: Senior Practitioner, Dr Jeffrey Chan; Dr Karen Crinall; Marie Feeley; Arthur Rogers; Dr Debra Manning.

New Zealand College of Psychiatrists, General Practice Victoria and Monash University) on a mental health project that will inform best practice standards and guidelines,

- Worked with a range of professional bodies (such as the Australian Psychological Society, Australian Society for the Study of Intellectual Disability, disability support workers) to advance the objectives of the office,
- Undertook a stakeholder survey evaluation of the office's performance, with a return rate of close to 53 per cent (418 respondents).

The activities and projects described above do not include ongoing telephone or face-to-face enquiries, advice, consultancy or meetings that the team participated in. You will read in this report how the work of the team has also effected change for individuals as well as the service system.

The way forward

In the past year, the office focussed on supporting disability service providers to meet legislative requirements. In the next year, the office will focus on 'raising the bar' as we approach our third year of implementation of the Act. We will be working towards a best practice standard. For example,

disability service providers will need to demonstrate what specific steps they are taking to reduce the use of restrictive interventions and *what/how* they are going to measure progress, including analysing data collected of the intervention. This applies particularly to those subject to compulsory and supervised treatment orders. The office will assist disability service providers towards achieving best practice standards.

Disability service providers will need to demonstrate what specific steps they are taking to reduce the use of restrictive interventions and what/how they are going to measure progress, including analysing data collected of the intervention.



Above: Office of the Senior Practitioner Research Grants forum initiative 26 May 2009. From left: Senior Practitioner, Dr Jeffrey Chan; PhD scholarship student, Louise Mountford; PhD scholarship student, Jo Watson; Executive Director Disability Services, Arthur Rogers.

Section 2

Meeting legislative requirements

Behaviour support plans

Sections 140 and 141 of the Disability Act require that any use of restraint and seclusion must be included in a behaviour support plan (BSP). The disability service provider is required to review the BSP regularly (at least every 12 months) and the Senior Practitioner is responsible for monitoring and reviewing the BSPs to ensure that the rights of the person are protected.

What we did

All BSPs sent to the office were reviewed to make sure they provided information specified in the Disability Act. Any BSP that did not meet the legislative requirements was returned to the authorised program officer (APO) for completion. In addition, a sample of the BSPs that met the requirements of the Act was reviewed in detail to examine the extent to which they showed evidence of best practice in behaviour support planning. We also piloted a BSP quality tool that had been developed in the US on another sample of BSPs to:

- find out how useful the tool was on understanding the quality of BSPs developed in Victoria; and
- assess the degree these BSPs met quality criteria established as best practice.

What we found

During the reporting period 1 July 2008 to 30 June

2009, 1357 BSPs were received and reviewed by the office⁵.

1. Review of behaviour support plans

The Act specifies that the BSP⁶ must provide identification details about the person, details of their support (people consulted in the preparation and approval process) and details of the proposed restrictive interventions. This information formed the basis of the review. Table 1 shows the percentage of the reviewed BSPs that provided the necessary information about the person, their supports and the details about the use of the restrictive interventions.

The good news about BSPs that were submitted and reviewed is that there has been a significant improvement on 2007-2008 data. However, many BSPs could do better in providing information on restrictive interventions –*how* and *when* the restrictive intervention would be used, *why* the restrictive intervention was necessary, *how* it would benefit the person, and evidence that the restrictive intervention used was the ‘least restrictive option’. This information is important because it is unlikely that all staff will be able to support the person appropriately if they are not clear about what the restrictive interventions are and how, when and why they should be used.

⁵ This does not include plans that are due to the office but not submitted on time.

⁶ Referred to in the *Disability Act (2006)* as behaviour management plan.

2. Good practice in behaviour support planning

A total of 114 plans were further examined more closely, 54 for good practices and 60 for their quality. The plans for 54 people⁹ were examined in detail for three main elements of good practice in behaviour support planning:

- evidence that recent assessments (especially the use of functional behaviour assessments) provided a good understanding of the problem
- evidence the intervention was based on the assessment findings
- evidence that the plan would be monitored and reviewed to evaluate the effectiveness of the interventions included in the plan.

Evidence that recent assessment(s) provided a good understanding of the support needs of the person.

The majority of plans (69 per cent) reported that formal assessments such as functional behaviour assessments had been completed, but only half the plans provided evidence that a functional assessment had been completed for all behaviours of concern. Identifying the function of the behaviour of concern is important so that targeted interventions can be developed that will reduce the behaviours of concern and the use of restrictive interventions.

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Reported interventions were based directly on outcomes of functional behaviour assessment and other relevant assessment results.

All BSPs that were reviewed provided information about the inclusion of positive behaviour strategies but only 39 per cent of the BSPs had developed interventions based on the results of the functional

Table 1. Percentage of behaviour support plans that provided required information

Information	2008–2009 %	2007–2008 %
About the person:		
• Name of the person with a disability	100	NA*
• Name of disability service provider	97	NA*
People consulted in development and approval of the BSP:		
• Where applicable ⁷ , the guardian had been consulted	65	24
• The independent person	84	12
• The authorised program officer	74	22
• The person with a disability	52	53
Details about the use of the restrictive interventions:		
• The type of restraint and seclusion used	97	87
• If they planned a review within 12 months	90	5
• When the restrictive intervention would be used	75	54
• Evidence that the restrictive intervention was necessary to prevent harm to self and or others	65	57
• An explanation of how the restrictive intervention would benefit the person	57	NA*
• The restrictive intervention was least restrictive option ⁸	31	50

* This data was not collected in 2007-08

behaviour assessment. This meant that the majority of interventions, while positive, were less likely to reduce the behaviours of concern because they did not address the function of the behaviour of concern.

The majority of BSPs (65 per cent) were likely to provide evidence that a crisis plan was in place. These crisis plans were for the most part reactive and some (15 per cent) showed the use of strategies that were ‘consequence-driven’ – staff controlling the person’s behaviour through means such as removal of activities, removal of ‘privileges’, over-correction and time-out. Consequence-driven strategies are not likely to lessen the behaviour of concern because they do not target the function of behaviour. For

⁷ The person was over 18 years of age.

⁸ Evidence was provided that showed that less restrictive options had been tried.

⁹ These were plans that met the legislative requirements as specified in the short review.

example, when a person expresses his/her upset or disagreement (*function of behaviour*) by yelling at others (*behaviour*), the person may be sent to seclusion or may have his/her activity withdrawn or removed (*consequences*). There is evidence that the use of consequence-driven strategies are likely to lead to disempowerment or behaviours of protest which, in turn, are likely to result in a greater use of restrictive interventions¹⁰.

There is evidence that the use of consequence-driven strategies are likely to lead to disempowerment or behaviours of protest which, in turn, are likely to result in a greater use of restrictive interventions.¹⁰

Evidence that the BSP will be monitored and reviewed.

Only a minority of BSPs provided information about how the interventions would be reviewed. For example, four per cent of plans provided information about how the effectiveness of positive interventions would be evaluated and nine per cent of plans provided information about how the effectiveness of the restrictive interventions would be evaluated. Monitoring and reviewing are important in determining the effectiveness of the interventions. Best practice suggests that all interventions need to be monitored and reviewed and evidence should be provided to show they work to reduce behaviours of concern and increase quality of life.

Best practice suggests that all interventions need to be monitored and reviewed and evidence should be provided to show they work to reduce behaviours of concern and increase quality of life.

3. Quality evaluation of behaviour support plans

In order to evaluate the quality of behaviour support plans, we applied an established valid and reliable measure of behaviour support plan quality, the Behaviour Support Plan-Quality Evaluation II (BSP-QE II)¹¹, on a sample of 60 BSPs. The BSP-QE II was developed by Browning-Wright, Mayer and Saren (2003) in the US and examines the presence of six concepts considered necessary for adequate behaviour support planning:

1. behaviour function
2. situational specificity
3. behaviour change
4. reinforcement
5. reactive strategies
6. team coordination and communication.

Of the 60 BSPs that were examined using the BSP-QE II guide, 36 of them needed rewriting and the other 24 needed alterations to clearly embody best practice. None of the plans were judged to be likely to be able to effect a change in behaviour of concern. Most of BSPs reviewed provided a clear description of the behaviour of concern, predictors of behaviour, analysis of what was supporting the behaviours of concern, the environmental changes that needed to be made, reactive strategies and evidence of team coordination. Only a few plans described the predictors related to the function of the behaviour of concern. None of the plans provided adequate details about what strategies would be taught, how reinforcement would be used, the specific goals and objectives of the BSPs, or how the information about the success of interventions would be communicated. Whilst the sample of 60 BSPs reviewed is small, the findings appear indicative of the office's concern about the quality of plans and similar to the findings based on last year's analysis of 1521 BSPs.

Taken together, the results of the above reviews of BSPs show that there have been some positive changes since last year:

¹⁰ Ramcharan, P. et al (2009). *Experiences of restrictive practices: A view from people with disabilities and family carers.*

¹¹ The office is examining appropriate instruments to assess the quality of BSPs. The use of the BSP-QE II is a trial to ascertain its applicability to Victoria.

1. Basic information provided about the person and the types of restrictive intervention has improved. People designing plans appear to be more knowledgeable about what is required. There is some evidence that those disability service providers who use the guide provided by the office produce more complete and better quality plans than those who use other formats, suggesting that the *Behaviour Support Guide* has been somewhat useful in producing better quality plans.
2. Increased number of functional behaviour assessments and interventions based on functional behaviour assessments suggests that the workshops provided by the office in 2008 have been useful to those who have developed the plans.

The way forward

Areas for improvement for disability service providers are:

1. Including the person with a disability and other stakeholders in the planning. There is capacity for greater teamwork within and across services, including involving various stakeholders. This type of team work will increase the likelihood that the plan is implemented in all settings. This includes working together on a 'one-person-one-plan' approach where a person may be receiving multiple services.
2. Conducting functional behaviour assessments for all behaviours of concern.
3. Making sure all interventions are based on the functional behaviour assessments and providing evidence that interventions are implemented, monitored, reviewed and changed, if necessary, over time.
4. Having an inter-disciplinary team to provide assistance to house staff in undertaking functional behaviour analysis and implementation of recommendations of reports, particularly for those individuals who present with high needs or high risk.
5. Ensuring a comprehensive assessment or review (such as physical health checks, environmental scan) of a person, particularly when behaviours of concern are escalating with increasing use of restrictive interventions.

6. Reviewing current use of consequence-driven strategies, particularly when the data shows no improvement in a person's behaviour. Instead use positive strategies such as active support, positive behaviour support, treating the person with dignity, offering new skills and experiences, engaging the person in leisure and physical activities, etc.

What we will do to support disability service providers

1. To provide disability support professionals with the information and skills needed for good behaviour support planning, the office will continue to provide a series of workshops where required. Disability service providers can contact the office for training.
2. The office has also run a series of monthly forums advancing practice in behaviour support. These provide detailed ongoing support to a group of disability support professionals from all regions (both DHS and CSOs), covering in detail various aspects of best practice in behaviour support planning (see Learning and development: putting research into practice).
3. The office is liaising with the Australian Psychological Society to develop a position paper, *Promoting evidence-based alternatives to restraint & seclusion in human services*. This paper will be made available to members of all specialist services and behaviour intervention support teams.
4. Further, the office has funded projects that will inform better practice and supporting direct support professionals.

Reporting the use of restraints and seclusion

The *Disability Act 2006* outlines a new set of reporting requirements for disability service providers (DSPs) regarding the use of restrictive interventions. Any DSP that administers chemical restraint, mechanical restraint or seclusion must be approved

to administer the restraint or seclusion and report the use of such restraint to the office via RIDS.

The Disability Act defines restraints as follows:

Mechanical restraint means the use, for the primary purpose of the behavioural control of a person with a disability, of devices to prevent, restrict or subdue a person's movement but does not include the use of devices:

- a) for therapeutic purposes
- b) to enable the safe transportation of the person.

Chemical restraint means the use, for the primary purpose of the behavioural control of a person with a disability, of a chemical substance to control or subdue the person but does not include the use of a drug prescribed by a registered medical practitioner for the treatment, or to enable the treatment, of a mental illness or a physical illness or physical condition.

Seclusion means the sole confinement of a person with a disability at any hour of the day or night:

- a) in any room in the premises where disability services are being provided of which the doors and windows cannot be opened by the person from the inside
- b) in any room in the premises where disability services are being provided of which the doors and windows are locked from the outside
- c) to a part of any premises in which disability services are being provided.

All approved DSPs are required to submit a monthly report to the Senior Practitioner about routine, 'as required' (PRN) and emergency use of chemical and mechanical restraint and seclusion. 'Routine' refers to administering a restrictive intervention that has a scheduled pattern or cycle within stated intervals, 'PRN' is the administration of a restrictive intervention as the situation or circumstance requires and 'emergency' use is reported if the restraint and or seclusion has not been authorised within a BSP.

What we did

All DSPs who administer chemical or mechanical restraint or seclusion must be registered to administer restraint and seclusion and report the

use of such restraint to the Office of the Senior Practitioner via RIDS every month. The following are key findings of the RIDS data received by the office between 1 July 2008 and 30 June 2009.

Data entry

Reporting to the office has changed over the past two years from the majority of RIDS reports sent on paper forms (in July 2007, 99 per cent of RIDS reports to the office were provided using paper-based returns) to all reports sent by electronic submission (by June 2009, 100 per cent were provided by electronic submission). This change has meant data submissions are now received in a timely manner. Data quality has improved because the authorised program officer must check all reports before they are sent to the office.

What we found

Number of approved disability service providers

As of June 2009, there were 160 approved service providers, comprising eight regional DHS providers and 152 CSOs.

Table 2. Number of approved services registered to administer restrictive interventions.

Service type	DHS	CSO	Total
Shared supported accommodation	541	414	955
Day programs	4	231	235
Respite	31	127	158
Residential institutions	3	1	4
Criminal justice services ¹²	3	1	4
Other ¹³	40	273	313

The majority of services that were approved to administer restraint and seclusion were shared supported accommodation services. Most of the day programs that were approved to administer

¹² Criminal justice services refer to those services provided within Disability Services.

¹³ 'Other' includes complex case management, facilitation, family options, flexible support packages, futures for young adults, individualised support packages, outreach, transitional accommodation support, pre-employment training and recreational respite.

restraint and seclusion were operated by CSOs. The majority of people were reported from residential accommodation services (67 per cent) and respite services (28 per cent). DHS services provided reports for 60 per cent of all people who were subjected to restraint and seclusion and CSOs provided reports for 47 per cent of people reported (these percentages do not add to 100% because some people were reported from both DHS and CSOs).

People reported to be subjected to restraint and seclusion

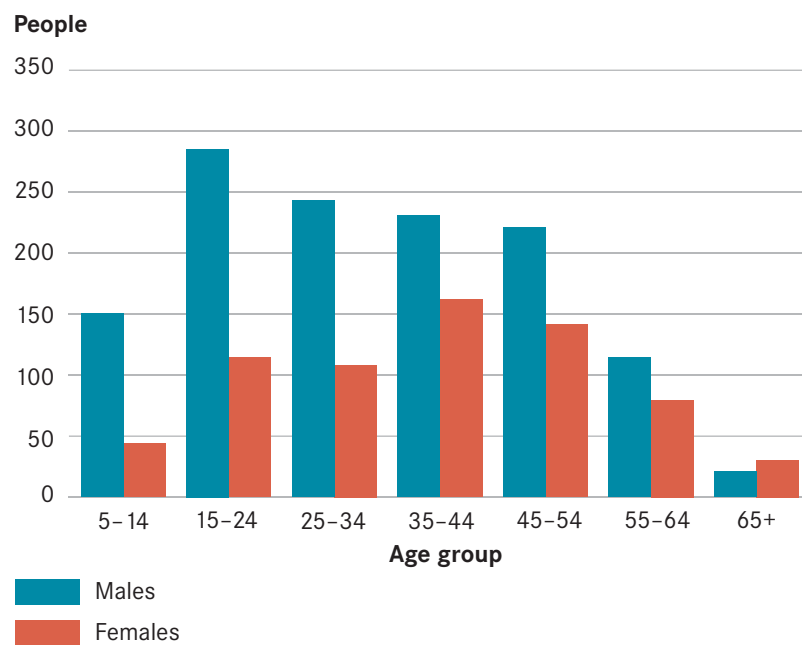
A total of 2036 people were reported to the Senior Practitioner as having been subjected to restraint and/or seclusion at least once from 1 July 2008–30 June 2009. This number is similar to the total number of people reported in the previous year (2193).

As can be seen in Figure 1, more younger males than older males were subjected to restraint and seclusion, while more older females than younger females were subjected to restraint and seclusion. The reason for this age pattern is not clear and more research is needed to determine how different biological, social and psychological factors interact to influence behaviour.

When compared to the 2007–2008 financial year, the following were noted:

- the number of people aged between 5 and 24 increased (from 562 to 631)
- the number of people older than 25 decreased (from 1531 to 1405)¹⁴
- the number of people with autism increased (673 to 699)
- the number of people with a psychiatric disability decreased (409 to 332)
- the number of people reported from respite services remains the same at 580 to 578
- the number of people reported from accommodation services decreased (from 1452 to 1361). These latter two findings may be due to increased knowledge of who is to be reported.

Figure 1: Age and gender of people subjected to restraint and seclusion during the year 1 July 2008–30 June 2009



- the number of people reported from both Eastern metropolitan region and Southern metropolitan region increased (Eastern from 353 to 386, Southern from 367 to 377), while the number of people from other regions has stayed the same or decreased slightly. These latter two increases are broadly consistent with population trends within Victoria.

Types of restraint and seclusion

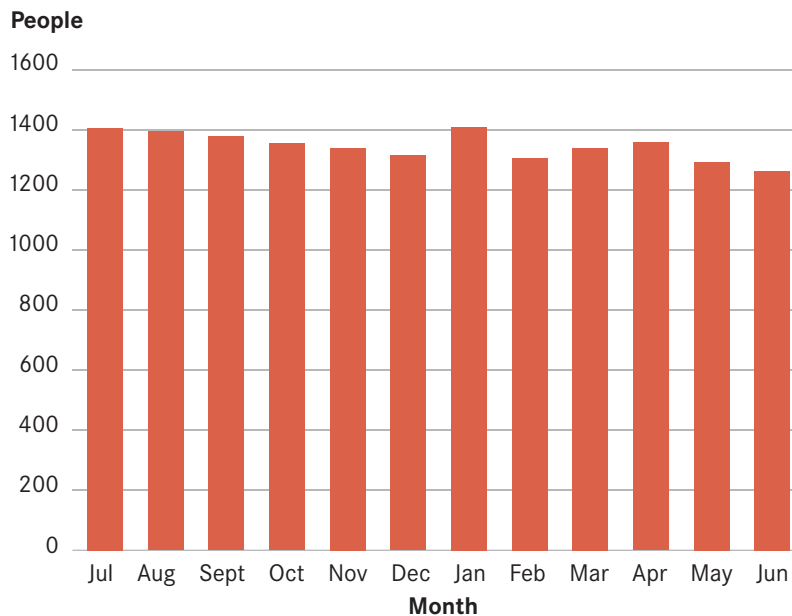
Chemical restraint

The majority of the 1957 people reported to RIDS were subjected to some form of chemical restraint (96 per cent of the total group) during July 2008–June 2009. Figure 2 shows the number of people who were reported to be subjected to chemical restraint during the year. The graph shows, with the exception of January, a decline in the total number of people subjected to chemical restraint over the past 12 months.

No particular age group was found to be more at risk of being subjected to chemical restraint than another. However, younger males (especially those aged between 5 and 14) are more at risk of being subjected to chemical restraint than females the same age.

¹⁴ These increases are consistent with population trends within Victoria.

Figure 2. Total number of people subjected to chemical restraint during July 2008-June 2009.



We also found:

- 75 per cent of the people subjected to chemical restraint had more than one disability reported (35 per cent had autism, 19 per cent had a neurological impairment, 20 per cent had a speech impairment and 17 per cent had a psychiatric illness)¹⁵
- the number of people reported *every month* over the past two years has increased from 525 in 2007-08 to 660 in 2008-09, meaning there has been an increase in reporting the use of routine chemical restraint since 2007-08. It should be noted that this finding may reflect better reporting practices by services and/or new people receiving a service.

The most commonly used chemical restraints were:

1. atypical antipsychotics risperidone (566 people), olanzapine (401 people) and quetiapine fumarate (132 people). A total of 1069 people were prescribed atypical antipsychotics during the year 2008-2009
2. mood stabilisers sodium valproate (363 people), and carbamazepine (180 people). A total of 623

people were prescribed some type of mood stabiliser during the year 2008-2009

3. benzodiazepine diazepam (295 people). A total of 464 people were prescribed benzodiazepines during the year 2008-2009
4. Typical antipsychotics chlorpromazine hydrochloride (245 people) and haloperidol (174 people). A total of 507 people were prescribed typical antipsychotics during the year 2008-2009
5. antidepressants sertraline hydrochloride (197 people) and fluoxetine hydrochloride (140 people). (A total of 657 people were prescribed antidepressants during the year 2008-2009.

The number of people subjected to more than one chemical restraint was 1190; that is, 61 per cent of the people subjected to chemical restraint were subjected to more than one chemical restraint. People with more than one disability were more likely to be subjected to more than one chemical restraint than people with one recorded disability.

People with more than one disability were more likely to be subjected to more than one chemical restraint than people with one recorded disability.

There have been some decreases in chemical restraint use from the year 2007-2008 to 2008-2009 specifically in the number of people prescribed:

- atypical antipsychotics (nine fewer people in 2008-2009)
- typical antipsychotics (115 fewer people in 2008-2009)
- mood stabilisers (29 fewer people in 2008-2009)
- benzodiazepines (60 fewer people in 2008-2009)
- use of multiple medications (70 fewer people in 2008-09).

The use of anti-depressants and/or psychostimulants has also decreased slightly but this finding may be due to a better understanding about chemical restraint, namely that treatment for an underlying mental illness, such as depression or attention deficit hyperactivity disorder does not need to be reported to RIDS.

¹⁵ These percentages will not add to 100 per cent because some people had multiple disabilities.

The reported use of anti-androgens has remained the same, while the reported use of sedatives has increased by 50 per cent (from 26 people to 39) and the reported use of medication for menstrual suppression has also increased. Taken together, these findings suggest that the chemical restraint strategy and associated information sessions and publications from the office may have helped to reduce the use of some forms of chemical restraint and may also have led to more informed reporting of chemical restraint.

The rate of routine chemical restraint showed:

- the rate of routine chemical restraint in Victoria was found to be 72.8 per 1000¹⁶ people
- the rate of routine chemical restraint in metropolitan regions was lower than rural regions (metropolitan regions were 66.8 per 1000 people; rural regions were 79.2 per 1000 people)
- Eastern metropolitan region reported the lowest rate of routine chemical restraint at 55.9 per 1000 people
- Barwon south-west reported the highest rate of routine chemical restraint at 87.3 per 1000 people.

It was not possible to examine differences between DHS and CSO services for routine chemical restraint rates because routine chemical restraint is mostly reported from accommodation services and most accommodation services are provided by DHS.

The rate of PRN chemical restraint showed:

- no differences overall between metropolitan regions when compared to all rural regions
- Eastern metropolitan region reported the lowest rate at 12.9 per 1000 people

- Hume reported the highest rate at 22 per 1000 people
- substantial differences between DHS and CSO services in reporting rates of PRN chemical restraint, regardless of whether the region was a metropolitan or rural region DHS services reported a higher rate of PRN chemical restraint use than CSOs (31.6 per 1000 people for DHS; 8.1 per 1000 people for CSOs).

The rate of emergency chemical restraint showed:

- Grampians region reported the highest use of emergency chemical restraint at 30.2 per 1000 people
- Barwon south-west region reported the lowest rate of emergency use at 11 per 1000 people.
- As with PRN use, there were differences between the reporting rates from DHS and CSO services. Overall, DHS' services reported a higher rate of emergency use than CSO services (31.3 per 1000 people for DHS; 13.4 per 1000 people for CSOs).

Mechanical restraint

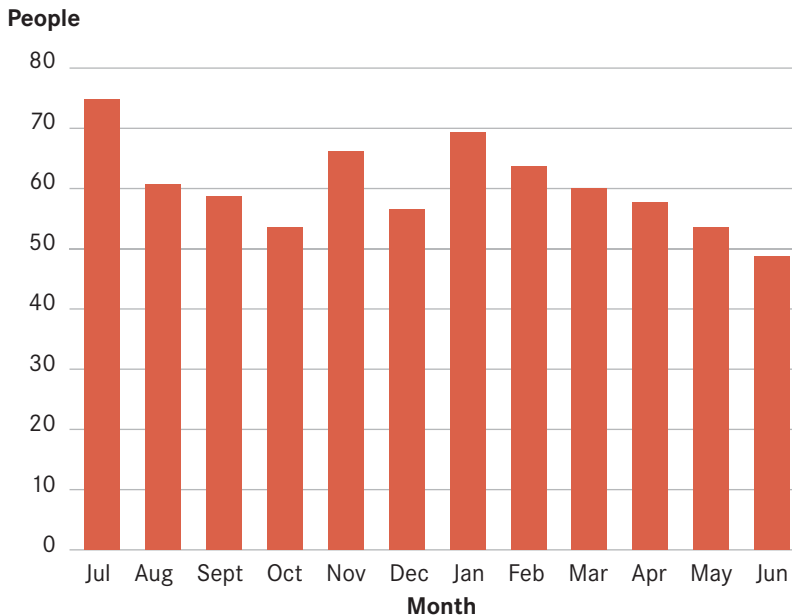
A total of 136 people (7 per cent of the total of people who were restrained) were reported to be subjected to mechanical restraint during July 2008–June 2009. As can be seen in Figure 3, the total number of people subjected to mechanical restraint over the course of the year peaked in July, November and January.

July appears to be accounted for in increase in reports from day programs, November increases came from reports from respite services and January increases came from increases in reports from residential accommodation services (including a small number of institutions) and respite services.

The majority of these increases have occurred between 9am and 3pm and have been reported from DHS and respite services especially during holiday periods, suggesting that changes in staff and poor briefing of casual staff may lead to increases in the use of mechanical restraint.

¹⁶ Based on the Victorian Quarterly Data Collection of all people with an intellectual disability receiving a funded disability service during 2007–2008. It should be noted that rates are calculated using data from the preceding year, and include people in all service types (not just those registered to use RI) and therefore should be regarded as being indicative only.

Figure 3. The total number of people subjected to mechanical restraint in the period 1 July 2008-30 June 2009.



With the exception of females aged between 45 and 54, more males were subjected to mechanical restraint than females at all other ages. Young males aged between 15 and 24 and people with more than one disability, especially those with autism, a physical disability, speech impairment or neurological impairment were most at risk of being subjected to mechanical restraint.

Young males aged between 15 and 24 and people with more than one disability, especially those with autism, a physical disability, speech impairment or neurological impairment were most at risk of being subjected to mechanical restraint.

Eighty-six per cent of people who were subjected to mechanical restraint had more than one disability¹⁷ – 38 per cent had autism, 38 per cent

had a physical disability (most of these people were in wheelchairs and mechanical restraints included the use of clothing where a sleeve had been sewn closed to prevent the person chewing their hand, or their wheelchair had been disabled to prevent them moving), 42 per cent had a speech impairment and 32 per cent had a neurological impairment.¹⁸

In addition, a significant number of people had more than two disabilities; 12 per cent of the people with a physical disability also had autism, and 16 per cent of those with autism also had some other form of neurological impairment. People who show self-harm are particularly at risk of being subjected to mechanical restraint (93 per cent).

As can be seen in Table 3, while the total number of people subjected to mechanical restraint has decreased since 2007-2008 by 17, the number of people subjected to the common forms of mechanical restraint (such as belts, straps) has remained much the same from 2007-2008. The overall decrease is accounted for by decreases in the use of 'other' mechanical restraints. Apart from body suits, other preventative clothing and wheelchair brakes, most of the reports included in the category 'other restraints' were not mechanical restraints, but other types of restrictive interventions such as physical restraint and locked doors.

There were some differences in reporting mechanical restraint between the DHS and CSOs in different regions. In the past year across Victoria, 6.7 per 1000 people in the department's services and four per 1000 people in CSO services were reported to be mechanically restrained. However, there was substantial variation both across and within regions, with Hume reporting the lowest use of mechanical restraint (1.4 per 1000 people for DHS; 1.6 per 1000 people for CSOs). The findings will be discussed at Partnerships for Positive Solutions forums in the regions.

When compared to 2007-2008, the number of people who were reported to be subjected to mechanical restraint every month has increased from 11 to 21 people in 2008-09. The increase may reflect better reporting or new people receiving services.

¹⁷ This is what was reported and therefore likely to be a conservative estimate of the rate of multiple disability.

¹⁸ These percentages will not add to 100 per cent because some people had multiple disabilities.

Seclusion

A total of 107 people (5 per cent of the total group) were reported to be subjected to seclusion during July 2008–June 2009. Figure 4 shows the total number of people subjected to seclusion during the period 1 July 2008–30 June 2009. As can be seen apart from July, November and January, the total number of people subjected to seclusion decreased over the year.

Increases in the number of people subjected to seclusion during July, November and January were due to increases in reporting from shared supported accommodation services during these months. More information is required to interpret these increases and they will be raised at Partnerships for Positive Solutions meetings. One possible explanation for the peaks in July, November and January may be due to changes to staff (staff leave) and programs at this time of the year.

Summary profile of people who were subject to seclusion:

- With the exception of those aged 35 and 44, more males than females were subjected to seclusion.
- Males aged between 25 and 34 were most at risk of being subjected to seclusion.
- 97 per cent people who show harm to others are most at risk of being subjected to seclusion
- 83 per cent had more than one disability type and of these
 - 52 per cent had autism
 - 34 per cent had a psychiatric illness
 - 22 per cent had a speech impairment
 - 21 per cent had a neurological impairment.

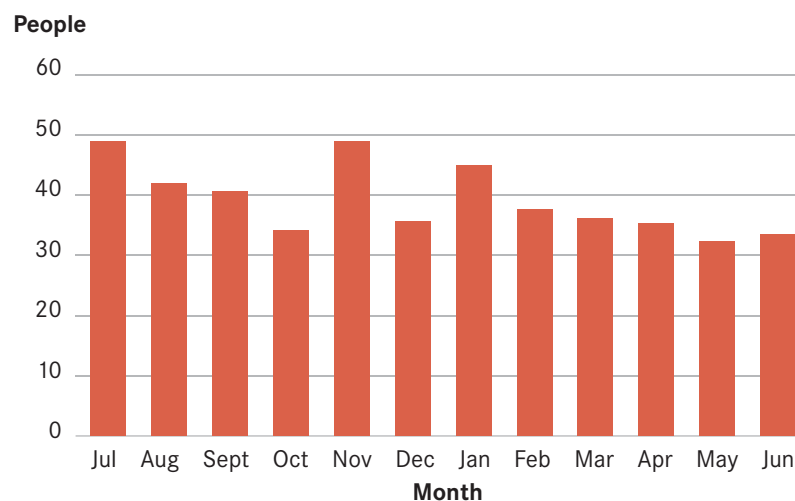
Reported use of seclusion in and within regions showed the following differences:

- As with mechanical restraint, the department's services reported a higher use of seclusion than CSOs across Victoria (7.3 per 1000 people for the DHS; 2.3 per 1000 people for CSOs).
- Rural CSOs reported the lowest rates of seclusion at 0.7 per 1000 people and the DHS' rural services reported the highest rates at 8.7 per 1000 people.

Table 3. Number of people subjected to different types of mechanical restraint in 2007-2008 and 2008-2009.

Restraint Type (not mutually exclusive)	2007-08		2008-09	
	Count	Percentage	Count	Percentage
Belts/Straps	37	24%	33	24%
Bolsters	3	2%	2	1%
Cuffs	4	3%	7	5%
Gloves	14	9%	9	7%
Harnesses	28	18%	23	17%
Sheets	1	1%	3	2%
Splints	24	15%	21	15%
Other Restraints	105	69%	73	54%
Total People Receiving Mechanical Restraint	153	100%	136	100%

Figure 4. Total number of people subjected to seclusion during the period 1 July 2008–30 June 2009.



- Metropolitan CSO and DHS rates were in between CSO and the department's rural rates (6 per 1000 for DHS; 3 per 1000 for CSOs).
- Wide variation was noted between rural regions, with Gippsland reporting no use of seclusion in either the department's or CSO services.
- The department's Loddon-Mallee region reported the highest rates at 24.5 per 1000 people and CSOs in Loddon-Mallee reporting no use of seclusion.

When compared to July 2007–June 2008, the number of people who were reported to be subjected to seclusion every month increased from five to six people in 2008-09.

PRN and emergency use of restraints and seclusion

The total number of people who were subjected to PRN (as required) or in an emergency (that is, not authorised in a behaviour support plan) during the year can be seen in Figure 5. While the number of people subjected to the use of PRN decreased throughout the year with peaks in July, December, January and February, the number of people subjected to emergency use increased throughout the year, peaking in March.

Although the use of emergency restraint and seclusion was raised at the Partnership for Positive Solutions forums in May–July 2009 (with the exception of one region), no changes were discernible as of June 2009, so this issue will be raised at the other meetings throughout the year.

When compared to the previous financial year, the 2008–2009 financial year showed increases in the use of PRN chemical restraint during all times of the day and night (including weekdays,

weekends and holiday periods) in both residential accommodation and day services and in both DHS and CSO facilities. The reason for the increase in PRN use from 2007–2008 may be due to several factors including the increase in medical attention from specialists such as psychiatrists (the number of general practitioner-only prescribers has decreased during this time, while the number of psychiatrist-only and paediatrician prescribers has increased). Changes may be due to more informed reporting practices on the part of services. It is also possible that PRN chemical restraint is being used to replace other forms of restraint (mechanical and seclusion).

People who have been subjected to restraint and seclusion for at least 20 months over the past two financial years (at least 10–12 months in each year)

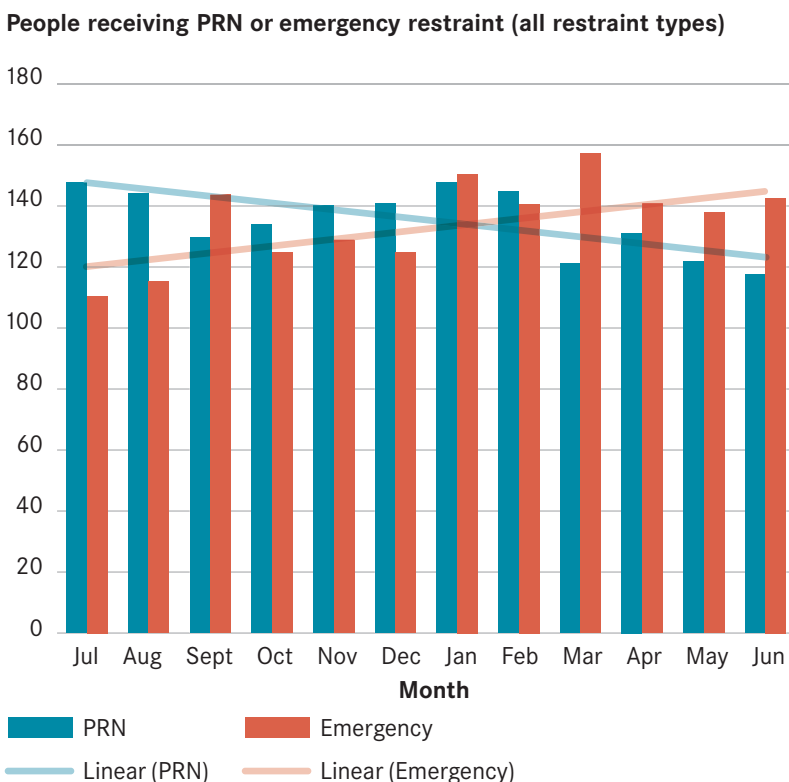
In this section, a further analysis was undertaken to examine and compare two groups of people who were subjected to restraint and seclusion: those who were subjected on an episodic basis between a 1 and 3 month period in a year, and those who were subjected on a continual basis at least 10–12 months in each year. The purpose was to understand the profile of people who are subject to continual restraints and seclusion (at least 10–12 months in each year) and to review whether restraints and seclusion have been effective in reducing behaviours of concern.

An examination of the 2459 people subjected to restraint and seclusion over the past two years showed that 68 per cent of the total group (1670 people) were reported to be subjected to restraint and seclusion at least once (an episode of restraint or seclusion) in the past two financial years. Of this group:

- six per cent (93 people) were reported to be subjected to restraint and seclusion between one and three months of each year,
- 50 per cent (827 people) were reported to be subjected to restraint between 10 and 12 months of each year, or a minimum of 20 months over the total period.

Of the 827 people reported to be subjected to restraints on a fairly regular continual basis (at least 10–12 months in each year):

Figure 5. The total number of people subjected to restraint and seclusion on a PRN or emergency basis during the year 1 July 2008–30 June 2009.



- the majority were males (67 per cent, 552 people),
- most were aged between 15 and 44 (59 per cent, 490 people),
- most had multiple disabilities (78 per cent, 644 people),
- 35 per cent (288 people) had autism,
- their levels of speech impairment (27 per cent, 225 people), neurological impairment (22 per cent, 178 per cent), sensory disability (15 per cent, 123 people) and psychiatric diagnoses (19 per cent, 155 people) were all higher than those found in others subjected to restraint and seclusion on a more episodic basis over the same period,
- they were reported to show more indicators of ‘harm to self’ (97 per cent, 802 people), ‘harm to others’ (93 per cent, 768 people) and ‘damage to property’ (80 per cent, 663 people) than others subjected to restraint and seclusion,
- all but one person was subjected to routine restraint,
- 40 per cent (329 people) were subjected to PRN restraint,
- 32 per cent (262 people) were subjected to emergency restraint and seclusion.

As a group they received, on average, more routine, and PRN restraint and seclusion than others who were subjected to restraint and seclusion on an episodic basis.

Taken together, these findings paint a picture of a group of people with high needs who are subjected to high levels of restraint and seclusion. The profile indicates that there is a need to re-think how support and therapeutic services are delivered to a very vulnerable group of people.

The way forward

Areas for improvement for disability service providers:

1. Consider and address the contextual reasons for the high use of PRN or emergency restraints and seclusion during specific periods of the year, week or times of the day as highlighted in this report. Examine rostering practices and ensure consistency of staff support during peak use of PRN and emergency restraints and seclusion.
2. Ensure regular clinical reviews of a person’s health and medication prescriptions, particularly when the evidence over time indicates no improvement in the behaviours of concern and the use of continual restrictive practices.
3. Review the restrictive interventions of young people identified in this report.
4. Consider training staff on practical problem-solving skills when they are faced with a behaviour of concern.
5. Consider, where appropriate, intensive individualised therapy for people with high needs and multiple disabilities that focus on:
 - understanding the person’s learning and whole-of-life needs,
 - clearly knowing all the triggers that give rise to behaviours of concern,
 - implementing person-centred active support,
 - continually adapting the environment and staff responses to the person’s needs to avoid the triggers,
 - psychological therapy, including specific cognitive training and counselling where appropriate,
 - medication, if required, to treat underlying mental illness symptoms such as anxiety and or depression, and monitoring the use of medication.

What we are doing to support disability service providers?

1. The office has put several projects in place to assist disability support professionals to better understand and support the needs of people with high needs and to move away from using restraint by providing good assessments and integrated therapies:
 - The active prevention project for children and adolescents subject to restraint works with parents and disability support professionals to find best ways to support young people

without using restraint. Over the course of the project they have assisted in eliminating the use of eight body suits for nine children, and with only one child continuing to require a body suit,

- The chemical restraint reduction strategy project has provided advice to disability professionals on health needs of people subjected to chemical restraint. It encourages support professionals to make sure people they support on chemical restraint are reviewed by a psychiatrist at least every year. The reduction of the number of people on atypical and typical antipsychotics, mood stabilisers and benzodiazepines is probably due in part to the chemical restraint reduction strategy. Disability service providers are encouraged to request training and consultancy from the office,
 - The office is available to assist in reviews of persons with high needs and high risk when requested, noting that local services such as disability specialist services teams and mental health teams should be sought in the first instance.
2. The office continues to work with various peak body professional groups and relevant government services to ensure the needs of people with disability are considered, (such as psychiatry, general practice, psychology, etc).
 3. Where appropriate the office is working in partnership with service providers or funded projects at the local level, such as co-funding a part-time fixed-term psychiatric nurse position.
 4. The office has funded several projects to build capacity in service providers to support people with high needs more effectively and to move away from using restraint. These include:
 - the Scope communication project to develop ways to build capacity in disability professionals and speech pathologists to provide more assessments and interventions to people with complex communication needs,
 - the promoting dignity grant program, which provides funding to disability professionals

to try out alternative ways to support people with high needs without using restraint. The results of the first round of grants showed that many services had attempted to change practice to person-centred positive support and by doing so had reduced the use of restrictive interventions,

- a project led by Monash University that will look closely at the medications used and make recommendations to medical practitioners and psychiatrists on medication review needs of people who are prescribed chemical restraint,
- a project led by Yooralla and Monash University to teach staff mindfulness techniques to use to increase their capacity to be mindful about the support they provide to people with a disability.

Summary

- Overall the RIDS reporting of restraint and seclusion shows that the majority of people who are subjected to restraint and seclusion are subjected to some kind of chemical restraint. While the overall use of chemical restraint has shown a slight decrease over the past financial year, the total number of people subjected to chemical restraint remains much the same, with a younger group of people replacing older people.
- The number of people subjected to some types of older chemical restraints has decreased.
- Attention needs to be focused on the increase in the number of people since last financial year who are prescribed PRN chemical restraint and the increase within the past financial year on the use of all emergency restraint.
- Both mechanical restraint and seclusion use show decreases over the past financial year but peaks throughout the year, especially around changes of staff. While staff changes are unavoidable, it is important for service providers to both inform clients well for such changes and brief casual staff well enough so that clients can be supported without increasing the use of restraint.

- The results also show that there is a group of people who have been subjected to ongoing restraint and seclusion over the past two years where the restraint and seclusion is clearly not working to reduce behaviours of concern. It is possible that many of these people have disabilities that are likely to give rise to behavioural dysregulation (underlying neurological impairments resulting in an inability to regulate one's behaviour especially in high-demand situations such as a change in staff).
- Research is needed to better understand the impact of multiple disabilities on the regulation of behaviour and how disability support professionals can best support people who, due to underlying neurological impairments, have extreme difficulty in regulating their own behaviour.

Supervised treatment orders

Supervised treatment and assessment orders and other orders of compulsory treatment

The *Disability Act 2006* provides a legal framework for protecting the rights of people with an intellectual disability who are subject to compulsory treatment orders because of the significant risk of serious harm they pose to others. The Act engages the Senior Practitioner to ensure these rights are protected and that treatment is provided to benefit the person through the implementation of an approved treatment plan.

With this provision in the Act, a small number of people across the state are subject to supervised treatment orders. These are civil orders issued by the Victorian Civil and Administrative Tribunal (VCAT). There are also a small number of people subject to other forms of compulsory treatment orders including:

- residential treatment orders made under the *Sentencing Act 1991*,
- parole orders made under the *Corrections Act 1986*,
- custodial supervision orders made under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*,

- extended supervision orders made under the *Serious Sex Offenders Monitoring Act 2005*.

An assessment order is another provision within the Act, which can be issued by the Senior Practitioner to enable a person to be detained for a period of up to 28 days while an assessment is undertaken and a treatment plan developed.

People on Orders

Supervised treatment orders

During this reporting period, 1 July 2008 to 30 June 2009, there were 31 people subject to supervised treatment orders and/or interim supervised treatment orders. Of these 31 people, 30 people had also been subject to orders during the previous year. Three people had their orders revoked during the year.

At the end of the reporting period, there were 28 people subject to supervised treatment orders.

Assessment orders

There was one assessment order issued by the Senior Practitioner during the year and at the conclusion of the 28-day order, the person was placed on an interim supervision order issued by VCAT. The order was revoked when the person moved to reside and receive support interstate.

Other compulsory treatment orders

There were 11 people subject to other compulsory treatment specified in the Act:

- five people on residential treatment orders (three people commenced orders during this reporting period),
- three people on custodial supervision orders,
- two people on parole orders,
- one person on an extended supervision order.

Eight of these people reside at the residential treatment facility in the Disability Forensic Assessment and Treatment Services and three people reside in a residential institution.

What we did

Approval of treatment plans

The office received and reviewed treatment plans for all people subject to compulsory treatment

during the year. For people subject to (or being considered for) a supervised treatment order, a treatment plan certificate approving the treatment plan was issued by the Senior Practitioner. The certificate specifies the approval period and generally provides directions to the disability service provider regarding implementation of the plan and aspects to be considered during the approval period or when undertaking a review of the plan.

During the year, the office introduced a draft certificate to provide advice on treatment plans submitted for people on other compulsory treatment orders. Whilst the Act does not expressly require a certificate to be issued by the Senior Practitioner for people on orders other than supervised treatment orders, VCAT had on several occasions requested that the office make comment on proposed treatment plans. The draft certificate was introduced as a means of providing advice and the draft certificate format has been viewed as a positive addition by VCAT. This process remained in draft at the end of the reporting period.

Protecting rights

The office developed guidelines and provided training to office staff on the obligations of the Senior Practitioner under the *Victorian Charter of Human Rights and Responsibilities 2006*. The guidelines, *Enlivening Human Dignity and Rights – Guidelines for Staff*, have been completed and all staff in the office participated in training prior to implementation. The guidelines have provided office staff with a process of human rights analysis, particularly relevant to circumstances where people's rights are limited when subject to compulsory treatment and restrictive interventions. A similar guideline has been developed for stakeholders and training will commence shortly.

Providing directions

The office has provided disability service providers with a greater level of direction regarding treatment planning through the treatment plan certificate. Case conferencing during the development of treatment plans has also been utilised by a number of disability service providers aimed at improving the

quality of plans. The case conferencing is beneficial in the development of a quality treatment plan.

What we found

During this reporting period there was only one person on an interim supervised treatment order (STO) who wasn't part of the analysis provided for people on supervised treatment in last year's report. Therefore the profile of this group of people remains consistent with last year. There were also three additional people who were subject to residential treatment orders. These people also have similar presentations to the group reported on last year.

An analysis of people on compulsory treatment compared with others subject to restrictive interventions reported to RIDS has been undertaken. Of the 42 people who were subject to compulsory treatment (32 interim and STO, and 11 other orders) during this 12-month period, 32 (76 per cent) were reported to RIDS.

People on STOs when compared to others reported to RIDS were:

- mostly males (96 per cent compared to 67 per cent on RIDS)
- mostly young (89 per cent younger than 45 years of age compared to 70 per cent of those on RIDS younger than 45 years of age)
- less functionally disabled than the others on RIDS (they are less likely to have autism or a speech impairment than those on RIDS)
- more likely to have a psychiatric disability (27 per cent of people on STOs versus 18 per cent on RIDS).

When compared with others in RIDS of the same age and gender, people on compulsory treatment:

- were more likely to have been prescribed:
 - anti-androgen – 20 times more likely
 - mood stabilisers – 1.4 times more likely
 - anti-depressants – 1.3 times more likely
 - typical anti-psychotics – 1.3 times more likely
- were a little less likely to have been prescribed atypical anti-psychotics (48 per cent of those on orders compared with 56 per cent in others of the same age/gender)

- were more likely to be prescribed multiple classes of medication (74 per cent versus 57 per cent in others of the same age/gender)
 - were more likely to be prescribed medications from a psychiatrist (100 per cent versus 36 per cent in others of the same age/gender)
3. To promote cultural change in the way people on compulsory treatment orders are supported and provided with the appropriate treatment, there is a need to observe and celebrate progress and success. The office will encourage disability service providers supporting these people to gather data that will assist in identifying gains made by the person and the success in treatment delivered by the disability service provider. Data collection and analysis must form part of the treatment process.

Submission of treatment plans

Timeliness of submissions of treatment plans remain a concern for the past two years. The office has requested that treatment plans be submitted at least 20 days before expiry or prior to a VCAT hearing. This enables 10 days for the office to review the plan and issue a certificate and enables service providers to submit the necessary documents to VCAT 10 days prior to a hearing as requested by VCAT.

The way forward

1. The support and treatment for people subject to compulsory treatment must continue to be dynamic and holistic. The office intends to broaden the use of case conferencing in the treatment plan preparation/review phase.
2. There is a need for disability service providers supporting people subject to orders to be able to keep abreast of all the necessary processes they are required to adhere to. The office will introduce a new component of RIDS that will assist the authorised program officer, the office, VCAT and the Office of the Public Advocate (where necessary) to all be informed when the plans need review, when reports are due and when hearings are scheduled.
4. A comprehensive guideline is being developed on compulsory treatment to assist disability service providers to understand the fundamental processes in providing treatment for someone on an order and further understand the requirements of legislation when doing so.

The office will encourage disability service providers supporting these people to gather data that will assist in identifying gains made by the person and the success in treatment delivered by the disability service provider. Data collection and analysis must form part of the treatment process

Section 3

Listening to the voices of families

A story written by Hayden's mother

The cost of restrictions to liberty and the price of freedom: working together to improve a young man's quality of life

Last year Hayden's parents contacted the office because they were concerned that the supports contained within his behaviour support plan and the restrictions on his liberty were simply not working for Hayden.

Hayden likes his freedom, he had always liked to walk almost more than anything else, but now he spent a lot of time locked inside a house with other people he didn't like and was fearful of.

His support workers wanted to keep him safe by keeping him locked inside his house. His chemical restraint had been increased to two anti-psychotics and he was becoming increasingly depressed and angry, often engaging in self-injury and property damage. The restraints were not benefiting Hayden and some people realised something had to change.

The office with the regional senior practice advisor instigated a case review, bringing together all interested stakeholders, including Hayden's parents, to find a way forward. A decision was made to move Hayden to another house, one that was not locked, and to allow him to be able to walk in the day.

Now, a year later, Hayden is a much happier person. He is slowly having one of the anti-psychotics reduced to nothing, his self-injury and property damage behaviours have almost disappeared and he still likes to walk and returns every night. He won't walk every day and will spend more time at home if his co-residents are out (he doesn't like spending time with his co-residents). He feels safer in the new house, although he would prefer to live with someone who did not have a disability. He now stays in at night even though the house is not locked.

Now, a year later, Hayden is a much happier person. He is slowly having one of the anti-psychotics reduced to nothing, his self-injury and property damage behaviours have almost disappeared and he still likes to walk and returns every night.

What has worked best in the new house is people understanding Hayden's likes and dislikes and supporting him to live the life he wants to live. Like many people, Hayden has certain clear likes and dislikes (and like other people, many of these have come from past experiences with other people). For example, he generally prefers the company of females because males in the past have

used physical force with him. He prefers people who speak quietly and don't force him or impose their views on him. And like most other people, he likes to be able to negotiate limits rather than having limits imposed.

Not surprisingly, he doesn't like other people touching his possessions in his room, especially his paintings which are very important to him. And like most people, Hayden likes to have some predictability in his life. He is happier when he knows what is going to happen in the future and how many 'sleeps' he needs to wait for something. Calendars have been useful as well.

He likes people who talk to him normally rather than loudly, people who don't insist he shake hands (he doesn't like being touched by other people; it makes him feel nervous if he is asked to shake hands). He likes to be busy and likes nothing better than going to a shopping centre finding some wool and a knitting nancy making up a cord or shoe lace and throwing it at some random person in the shop as a gift ... this is 'Hayden's work'.

Like many others with autism, Hayden has several chronic ongoing health issues. He has a brain tumour in his frontal lobes which causes complex partial seizures. He has to take two types of anti-convulsants to control the seizure activity. Both anti-convulsants and anti-psychotics result in several side effects, including sedation (sleepiness in the afternoon) and weight gain.

He has gastrointestinal pain from food intolerances on a regular basis because one of the side effects of anti-psychotics is increase in appetite which has increased his tendency to binge on foods he is intolerant to.

Hayden has a number of strengths. He can learn, he is able to work out quickly which people he can trust to support him and which people he should stay away from. He likes to have choices and for the most part will work within those.

Looking back it would appear that many of Hayden's behaviours of concern were actually 'behaviours of protest' (coined by Paul Ramcharan) caused by an environment that he didn't want to be in, an environment he felt very unsafe in. When the environment was changed to one that Hayden felt

safe in, his behaviour changed so that behaviours of protest such as self-injury and property damage were no longer used by Hayden.

Looking back it would appear that many of Hayden's behaviours of concern were actually 'behaviours of protest' (coined by Paul Ramcharan) caused by an environment that he didn't want to be in, an environment he felt very unsafe in. When the environment was changed to one that Hayden felt safe in, his behaviour changed so that behaviours of protest such as self-injury and property damage were no longer used.

The impact of practitioners

Unfortunately, early interaction with a practitioner who used behaviour modification techniques and aversive therapy did much harm. This was compounded by school personnel who tied Hayden to chairs and routinely used seclusion. This early trauma probably led to post-traumatic stress disorder, shown now as anxiety and depression, and why he is so nervous in the company of people who are loud or rough. His post-traumatic stress disorder will require intensive therapy to make any difference.

On the other hand, a speech assessment in his early 20s made a huge difference. To be able to communicate to other people was such an enabler. Having Simon Wardale (regional senior practice advisor, North and West region) being involved has been very helpful because Simon has worked on an ongoing basis directly with the staff to help them understand Hayden and the best ways to support him. In this way, Simon has been able to build capacity within the regional disability support staff to improve practice for all people who they support.

What is the way forward?

For Hayden, it's having his own home. Hayden doesn't like living with other people with disabilities who might touch him or make too much noise. He tells everyone he wants to live in his own home with no 'staff room'. Hayden's parents feel he could live with a support person who would keep an eye on him but allow him to live as independently as possible. Perhaps a lead tenant situation may work.

The bottom line is that there is a cost of restrictions to liberty and it's about trauma experienced and distrust that is built. And there's a price of freedom that involves taking a risk to enable independence and dignity. Behaviours of concern that are really 'behaviours of protest' once understood as such and acted on can lead to positive changes and better overall wellbeing for people with a disability who show these behaviours.

Behaviours of concern that are really 'behaviours of protest' once understood as such and acted on can lead to positive changes and better overall wellbeing for people with a disability who show these behaviours.

Adam's story: preventing out of home care placement

Adam is a 14-year-old boy with a severe intellectual disability, autism, epilepsy and significant difficulties with communicating. He lives at home with his parents and older sister. He has no verbal communication skills and has been unable to use non-verbal communication aids. He requires assistance with regular toileting and most other activities of daily living. He attends a full-time special school and accesses regular respite and recreational services.

Over the past year his behaviours of concern have escalated to extreme episodes of aggression towards others, often resulting in physical harm to others and property damage. Other behaviours

of concern have included pinching carers' arms, grabbing others around the neck, slapping, hitting with the flat of his hand, kicking, biting, soiling and stripping off his clothes. His behaviour has resulted in the withdrawal of in-home support services due to concerns about staff safety. Adam has also posed a significant risk of causing serious harm to family members at home, leading to his family's distress at having to consider relinquishing him into full-time care.

This situation led Adam and his family to be referred to the Active Prevention Project by their case manager because services were withdrawing as a result of his behaviour. He had been subject to physical restraint and seclusion and previous intensive behavioural interventions had limited positive outcomes for Adam, his family and service providers. The project practice advisors visited the family home and the respite service that Adam regularly attended.

The practice advisors immediately liaised with the family GP and successfully initiated a referral for review by a child and adolescent psychiatrist. The practice advisors also developed an interim behaviour support plan to assist service providers in safely maintaining their support of Adam. A referral was also instigated to an autism-specific assessment and intervention service that visited the home and school environment in order to develop further behaviour support strategies. As part of this a sensory assessment by an occupational therapist (OT) was also conducted.

The practice advisors have maintained an advocacy role for the family and case management providers in obtaining services to best meet Adam and his family's needs, in addition to providing active support to the respite service around best practice in behavioural and communication strategies to reduce the incidences of behaviours of concern. Adam's behaviour continues to be unstable across all environments due to the complex nature of his intellectual disability, neurobiological disorders (severe autism and severe uncontrolled epilepsy) and communication difficulties. The positive outcome to date is that Adam continues to live at home with his family with the assistance of increased respite services.



Left: Hayden

The positive outcome to date is that Adam continues to live at home with his family with the assistance of increased respite services.

Henry's story: linking people to services and facilitating ongoing support

Henry is a six-year old boy with a severe intellectual disability and autistic disorder living with his mother and older brother in regional Victoria. He has no verbal communication skills but will lead others by the hand to what he wants. He prefers to spend most of his time alone doing things that interest him. He attends a special school and recently started attending weekend respite once a month.

Henry has a history of engaging in a number of behaviours of concern, including escaping from home, smashing light globes, hitting and biting others, climbing over household furniture and breaking it. In addition, Henry is extremely physically active, which requires that his mother and carers maintain constant observation of him to make sure he doesn't injure himself. Henry takes medication to promote sleep at night and this has been very successful. He also wears a harness when in the community to prevent him from running away from his mother and carers.

The practice advisors conducted assessment of Henry's behaviours and reviewed his developmental and health history as well as the wider family's

needs. They visited Henry's home, school and respite, observed him in all these settings and spoke with staff that supported him. It became clear that Henry's mother had little support herself, while respite and school were also struggling to support Henry in their programs. There was concern from everyone involved that as Henry became older and bigger, his aggression in particular would become more difficult to support.

The practice advisors arranged for Henry and his mother to be reviewed by a child psychiatrist to investigate if there was an underlying cause to Henry's behaviours and suggest appropriate interventions. The practice advisors also referred Henry and his family for case management and for functional behaviour assessment and intervention. Arrangements were also made for a sensory assessment and opinion regarding the use of the harness by an OT and communication assessment by a speech pathologist.

The practice advisors also assisted the respite service in devising an interim behaviour support plan, which included the limited use of the harness while assessments were being undertaken. Henry's behaviour and needs are still being assessed and the practice advisors remain involved to ensure that he and his mother receive the assistance they require. His mother and respite service have reported that they feel more supported in obtaining relevant services for Henry.

Section 4

Working together to improve support for people

Supporting people subject to restrictive interventions

Reducing chemical restraints

The chemical restraint reduction strategy commenced in August 2007 and has continued throughout this 12-month period. The strategy aims to provide information and guidance to disability support professionals and middle managers relating to assessments and specialist reviews for people subject to chemical restraint. The strategy has involved the review of individual treatment sheets with actions plans clearly documenting areas to be addressed.

What we did

Between July 2008 and June 2009, the practice leader-integrated health care practice visited 75 community residential units across all eight regions of Victoria, including both DHS-managed services and CSOs.

The strategy included treatment sheet reviews conducted for 306 people and recommendations were made in all cases. Generally, action plans contained more than one action for each person. The implementation of the action plans were not considered as completed unless each item of action for a person was addressed. The office was aware that some of the action plan items included referrals to medical specialists and potentially a long wait-list for the person to be seen by the medical specialist.

Table 4 presents a summary of the number of community residential units (CRUs) and persons reviewed by the practice leader and action plans developed. The office will follow up on the actions plans. A progress report regarding the completion of the action plans will be reported later when all the action plans have been submitted for analysis.

What we found

Systemic issues

- As with last year's findings, direct support professionals need support to make sense of the recommendations from assessments by medical practitioners and how to implement the recommendations,
- Access to local medical specialists (such as psychiatrists) to conduct reviews remains an issue both in rural and metropolitan areas,
- Menstrual suppression continues to be applied for women with a disability for behaviours of concern,
- The majority of staff were unaware of the purpose of psychotropic medication.
- There was little evidence of the use of an augmentative communication system and vocabulary to address communication needs (for example, to express side effects of medication),
- Risk assessments have not been carried out for people living in units where the doors are locked or barriers built to parts of a house (such as

kitchens), preventing free access to common areas of the residential service or free exit from the building.

The way forward

The following are proposed to address some of the issues identified:

- People subject to chemical restraints or psychotropic medications should be reviewed on a regular basis,
- The establishment of local networks and partnerships with generic or specialist services (such as those initiatives occurring in several regions),
- The office will continue monitoring and reviews of these people, and welcomes referrals from disability service providers.

Children and Young Persons Active Prevention Pilot Project

The Children and Young Persons Active Prevention Pilot Project (the project) has focused on the importance of maintaining the best interests of families and service providers of children and young people with a disability and behaviours of concern, within a least restrictive framework of support. The project included providing support to families and disability service providers in planning and decisions regarding developmentally-appropriate supports. This was done by promoting relationship-building and enhancing the capacity of families and disability service providers to provide good practice approaches in supporting children and young people.

What we did

Initially, an analysis of RIDS and review of behaviour support plans (BSPs) of child respite facilities was done. Referrals were also sought from disability service providers.

Children and Young People Active Prevention strategy practice advisors Kylie Saunders and Brent Hayward met with families to discuss their concerns

Table 4. Report data July 2008–June 2009: Total number of CRUs, persons and action plans (disability accommodation support [DAS] and CSO)

Region	Number of CRUs visited		Number of persons reviewed		Number of action plans developed	
	DAS	CSO	DAS	CSO	DAS	CSO
North and West Metropolitan	13	1	44	5	13	1
Southern Metropolitan	4	1	15	5	4	1
Loddon Mallee	7	8	13	29	7	8
Hume	12	2	34	7	12	2
Eastern Metropolitan	4	3	18	32	4	3
Gippsland	4	2	26	5	4	2
Grampians	0	7	0	18	0	7
Barwon South Western	7	0	55	0	7	0
Subtotal	51	24	205	101	51	24
Total July 08–June 09	75		306		75	
Grand total August 07–June 09	174		632		174	

and difficulties, reviewed existing reports and gathered information about behaviours of concern. As part of their clinical assessments, they evaluated behaviours in all settings, including home, school and respite, and importantly, assessed the needs of families in supporting their children with disabilities.

Individual reviews of 20 children and young people in both metropolitan and regional areas were conducted (12 identified as high-need and high-risk), with a focus on seeking the views and identifying the needs of all service providers and families. This aided in:

- improving everyone's understanding of the behaviours,
- identifying particular areas of further individual or family service need,
- implementing appropriate and consistent approaches to behaviour and/or family support,
- considering alternatives to restrictive interventions.

In addition to these, the active prevention strategy promoted developmentally-appropriate

consideration of behaviour, especially in relation to puberty and emerging sexuality. Other specific considerations viewed as impacting upon behaviour were the impact of the severity of intellectual disability, trauma and disrupted attachment histories and an understanding of behaviour in the context of autism spectrum disorders and communication abilities. These were achieved by:

- conducting training for disability support professionals,
- actively supporting disability support professionals in their work with clients,
- liaising with health professionals to improve service provision and outcomes,
- assisting in development of behaviour support plans,
- facilitating referral to a range of health, welfare and support services,
- advocating for access to case management and funding,
- providing secondary consultation to disability services,
- identifying individuals who access multiple respite services in order to promote the use of one single behaviour support plan for each person.

What we found

There were 423 children and young people aged 5-18 initially identified through RIDS as subject to restrictive interventions. Of these:

- Seventy-four were subject to the most serious restrictive interventions where there were multiple services involved,
- Of the 74, 73 per cent were male, 42 per cent were aged 15-18 and 64 per cent were attending a respite service,
- Chemical restraint was the overwhelmingly most commonly used restrictive intervention, with 37 per cent of these clients subject to multiple anti-psychotic medications.

The project team also identified 12 high-needs high-risk children and young people in collaboration with disability service providers from both

metropolitan and non-metropolitan regions through RIDS and direct referrals to the pilot project. Seven of these 12 were male with a mean age of 14.4 years. Six had a severe intellectual disability, while ten had an autism spectrum disorder and only two had verbal communication skills. The three most common behaviours of concern were aggression towards others, self-injurious behaviour and demanding behaviour. Intensive active prevention strategy commenced for the 12 persons.

Through a review process and supporting staff and families, we eliminated the use of mechanical restraints in nine out of ten children in a respite service.

Feedback from families and disability service providers

Families and service providers of children and young people with disabilities and behaviours of concern who have been involved in the pilot project have felt that the focus on families and young people's specific needs has been very helpful. Feedback has included the following:

"Achieved extra needed respite and was linked with other new services." (parent)

"This is a fantastic initiative that we have seen has had so many beneficial outcomes. It would be great to see this project continue and expand in the future to assist more clients." (respite service)

"For the first time, the families dealing with the most difficult and stressful situations, are getting provided with the specialist care and support they require to continue caring for their children at home. Without this continued support, families are at serious risk of breakdown and/or facing relinquishment possibilities." (CSO case management service)

"The OSP were able to concentrate on interventions and co-ordinating the required and specific supports related to behaviours of concern and use of restrictive interventions." (CSO)

“Provided a fresh new perspective on the situation, review of medications and referrals for assessments which were helpful.” (CSO)

“Very prompt in initial consultation with family and providing family and care workers with comprehensive behavioural strategies which were very useful.” (CSO)

The way forward

The Children and Young Persons Active Prevention Pilot Project has highlighted the need for an increased preventative and developmental approach through the early identification and early intervention of children and young people with an intellectual disability, autism spectrum disorder and complex behaviours of concern. They are at increased risk of being subject to high levels of restrictive interventions. The additional intensive outreach support provided within the family home and/or respite service in addition to leading clinical case coordination, has provided a positive and effective service provision that is otherwise lacking within the existing service system.

Follow-up of former Kew Residential Services residents who received an independent psychiatric review

What we did

The office ensured that 79 former residents received an independent psychiatric review by December 2008 and that a plan for follow-up treatment addressing recommendations made by the reviewing psychiatrist was developed. The Centre for Developmental Disability Health Victoria (CDDHV) was commissioned to conduct 65 of the 79 psychiatric reviews and prepare a summary report of their findings. The remaining 14 independent psychiatric reviews were conducted by regional psychiatrists for former residents now residing in rural Victoria.

What we found

An analysis of the psychiatric reviews conducted indicated that 36 (46 per cent) of 79 former residents who previously had a diagnosis of mental illness were diagnosed with autism spectrum disorder and only three (6 per cent) of the 45 former residents with a diagnosis of psychotic disorder not otherwise specified (NOS) had their diagnosis confirmed.

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Of the 65 reviews conducted by CDDHV, the most common side effects associated with the prescribed medication included constipation (32 per cent or 14 people), obesity (20 per cent or 13 people) and gastro-oesophageal reflux (11 per cent or seven people). Other side effects identified included akathisia, tardive dyskinesia and over-sedation.

The findings from this project have further reinforced the importance of annual psychiatric reviews, especially given the difficulties in making a reliable diagnosis for people with severe communication difficulties and the potential impact of psychotropic medication on individual health and well-being. Annual psychiatric reviews are strongly indicated for people with a diagnosed mental illness as well as the cohort of people prescribed psychotropic medication for the primary purpose of behavioural control. The development of mental health plans is essential in ensuring

continuity of care for people diagnosed with a mental illness and should be reviewed regularly to reflect the actual support required. Finally, given that all psychotropic medications have associated side effects, direct support professionals should obtain product information from the dispensing pharmacist and report the presence of any side effects that an individual is displaying to the treating practitioner.

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The way forward

The office continues to work with disability service providers to ensure the recommendations of the review of each person is implemented and incorporated as part of the health-care plan of the person.

Partnerships for positive solutions

What we did

Under the *Disability Act 2006*, the Senior Practitioner is required to provide education and information with respect to restrictive interventions and compulsory treatment to disability service providers (DSPs). The Senior Practitioner is also required to provide advice to DSPs to improve

practice in relation to restrictive interventions and compulsory treatment. The Partnerships for Positive Solutions (PPS) forums provide this opportunity to inform DSPs of issues arising from the use of restrictive interventions and compulsory treatment practices, as well as provide the opportunity for DSPs to develop action plans to address identified service system and individual client issues.

What we found

The PPS forums have continued on a quarterly basis in each region over the past year. Each region has continued to develop action plans in response to individual client and systemic issues raised at the forums. Key themes that have arisen over the course of the year have included access to mental health services, the role of specialist services, implementation of supervised treatment orders, skill deficits in assessment and behaviour support plan development and how to better support children and adolescents with autism. In the most recent round of PPS forums, individualised data reports were provided to regions with a focus on particular themes emerging from the data.

Two initiatives arising from regional action plans are of particular note. Barwon South Western region has established a best practice forum as a part of its CSO engagement strategy. The forum on 10 June highlighted and shared best practice initiatives across the region. Loddon-Mallee region developed a consultation service with area mental health services to provide monthly consultation from a senior psychiatric nurse to disability accommodation services clients and staff. A behaviour intervention support team advanced practitioner also attends these consultations to enhance skills, provide disability-specific perspectives and facilitate referral pathways.

The way forward

The Statewide PPS forum was convened for a second time on 28 January of this year and was scheduled to meet again on 5 August. The action plan developed from this forum has a particular focus on progressing access to mental health services, consistency of support and information

sharing to CSOs and sharing of information across regions and CSOs.

The focus for the coming year will be on the development of individualised data reporting approaches for regions and CSOs to not only highlight and address individual practice issues but also to inform systemic strategy development.

North-Western Metropolitan region (NWMR) and Grampians region – joint report on regional practice leadership

What we did

The roles of regional senior practice leader (Grampians) and regional senior practice advisor (RSPA) (NWMR) were created to support practice improvement within the Regions and the objectives of the office.

The key activities were to:

- provide strategic advice and direction in delivering service to people who may be exhibiting behaviours of concern,
- lead or consult in client/service reviews,
- deliver training/mentoring in positive behaviour support,
- develop, participate within or lead communities of practice,
- actively assist services in meeting the requirements of the Disability Act – particularly parts 7 and 8,
- actively assist services in implementing systemic change.

What we found

The office undertook a ‘2009 Regional Practice Leader/Advisor Stakeholder Survey’, eliciting the following positive comments:

- client-focused – 86.5 per cent,
- providing the same support to the CSO services and DHS – 60 per cent,

- informing/making aware the sector of the need to protect the rights of people with a disability who are subject to restrictive practices – 82 per cent,
- influencing my practice about protecting the rights of people with a disability who are subject to RI – 69 per cent,
- acting as a facilitator assists me to achieve better outcomes for my clients – 82 per cent,
- providing strong, clinical expertise and practice advice – 72 per cent,
- willingly provides assistance when needed – 86 per cent,
- provides relevant education and information – 82 per cent,
- service/information/training material is relevant to my work – 90 per cent,
- promotes problem-solving that results in increased learning for practitioners – 73 per cent,
- provides practical support needed to get job done better – 74 per cent,
- is making positive, systemic change in the region – 77 per cent,
- collaborative – 59.6 per cent,
- effective communicator – 57.7 per cent.

The way forward

Continue to co-fund the current positions and expand trial of the positions to two rural regions (Loddon-Mallee and Hume).

Learning and development: putting research into practice

What we did

All learning and development provided by the Office of the Senior Practitioner is directly informed by a careful evaluation of the information provided to the RIDS and in behaviour support plans and treatment plans that are sent into the office. Based on this evaluation and on feedback provided to the office from past participants, the office offered

four workshops and two seminars and an on-going series of eight advancing behaviour support practice forums in 2009.

By 30 June 2009, four workshops had been run and included:

1. *Designing behaviour support plans that work* (11 workshops to 291 participants; six scheduled for July-December 2009),
2. *Ins and outs of risk assessment* (one workshop to 20 participants; three scheduled for July-December 2009),
3. *Trauma, attachment and psychotherapeutic interventions* (four workshops provided to 93 people; five scheduled for July-December 2009),
4. *Information to Community Visitors about the Office of the Senior Practitioner* (two workshops to 50 people; one more scheduled for 2009).

By 30 June 2009, two seminars had been run:

1. *The role of the authorised program officer, making a difference and legal obligations* (two workshops to 45 people; two scheduled for July-December 2009),
2. *Chemical restraint* (one seminar to 29 people; five scheduled for July-December 2009).

There have been a total of 40 requests for workshops and seminars from seven regions in 2009. Most requests have been made for the new workshop: *Designing behaviour support plans that work*. All workshops and seminars are hosted by DHS and CSOs; 22 of the workshops and seminars have been hosted by the department alone, 10 have been hosted by CSOs alone and they have shared the hosting in the other eight.

Advancing behaviour support forums

A series of eight monthly forums (March-October) have been offered again in 2009 after a successful pilot in 2008. Thirty disability professionals from the department and CSOs meet with practice leaders and advisors from the office to share best practice in behaviour support and hear about alternatives to restrictive interventions, as well as network with other disability professionals.

What we found

All participants were asked to tell us how satisfied they were by rating their satisfaction on a scale from 1 (extremely dissatisfied) to 10 (extremely satisfied). We also asked the participants to comment about what they liked best and to provide suggestions for changes.

Workshops and Seminars

Overall, on average, participants were very satisfied with all of the sessions. Average satisfaction scores ranged from 7.5 to 9. On average, participants were most satisfied with the presenters (8.5), the sessions overall (8.0), the content (8.0), and least satisfied with the venues (7.5).

The majority of participants commented about the presenters, who they described as 'excellent', 'informative', and felt they presented the information in an engaging and interesting way. Many participants commented that the information was very useful and could be easily applied to their work. For example, one person commented that they felt they had learnt a lot about 'changing the environment and learning about behavioural functions and to focus on the positives'. Some participants commented that the information helped them understand the things they could do to improve the quality of support to people with behaviours of concern. For example, one person commented that 'Knowing the client's position and using the information to improve the client's quality of life with effective planning' was useful.

Advancing behaviour support forums

The majority of participants in the 2008 cohort said they felt they had acquired the following skills from their participation in the forums:

- behaviour support skills to better support individuals with disabilities,
- networking skills, especially between DHS and CSOs,
- alternative strategies to restrictive interventions,
- self-confidence.

The 2008 group wanted to be kept on a mailing list and receive new research articles to keep

informed. Updates of research are sent out on a regular basis to all on the mailing list and feedback shows that recipients appreciate being kept up to date.

The 2009 group has completed four of the eight forums and has also rated the forums highly. Many stated they particularly liked the ability to network with others and hear from others in field. While the majority of the group feel they have a lot of knowledge about restrictive interventions, they feel they need more assistance in the areas of finding alternatives to restrictive interventions and skills around least restrictive interventions and positive behaviour support planning. The final forums will focus on skill-building.

The way forward

Participant feedback is used by the office in an ongoing way so that future presentations,

workshops and forums can respond to the needs of participants in a dynamic way. The office continues to work with the DHS' Workforce Development and Learning Unit to design material that is relevant to the needs of disability support professionals throughout Victoria. To date, training has been delivered to individuals and while individual participants' feedback is very positive, it is clear that the individuals need ongoing support from teams to do their work well. In the future, the office will work closely with professional bodies to help build the capacity of teams by implementing a train-the-trainer mentoring model.

Information on research partnerships can be found in Appendix 4.

Section 5

Stakeholder feedback

What we did

The Office of the Senior Practitioner conducted a stakeholder survey in June 2009. The survey was also conducted in 2008, the aim being to obtain stakeholder feedback to inform the office's existing and future strategies.

The survey was customised in consultation with the office and included questions about the role of the office, the support and skills of office staff, service provided and office systems. Stakeholders were asked to respond to questions against an agreement scale and an importance scale (from 1-strongly disagree – 5-strongly disagree) and were also asked to provide comments.

Surveys were sent to approximately 800 stakeholders across a range of groups, including CSOs, DHS' central office, the department's regional disability services and external stakeholders. A number of family members and individuals with a disability were also invited to complete the survey. In all, 418 responses were received, which translates to a return rate of approximately 53 per cent. The majority of these came from CSOs (44.5 per cent), the department's central office (22 per cent) and the department's regional disability services (20.6 per cent). Of the contact with the office, 56 per cent of queries were requests for information/advice, 54 per cent were regarding RIDS, 53 per cent were about Behaviour Support Plans and 43 per cent were about training.

What we found

Overall, the stakeholder feedback was very positive. Responses in the 2009 survey were highly consistent with the 2008 survey responses. Key highlights were:

- The emphasis on positive solutions and a planned reduction in seclusion and restrictive orders is a positive step forward (95 per cent favourable),
- The office promotes the rights of people with disabilities (94 per cent favourable),
- The office influences practices that support people to achieve dignity without restraint (82 per cent favourable),
- I believe the office is an organisation with great potential (82 per cent favourable),
- The staff who work in the office conduct themselves in a professional manner (81 per cent favourable),
- The office has a strong emphasis on delivering a quality service (78 per cent favourable),
- The office willingly provides assistance when needed (74 per cent favourable).

Other key strengths identified by stakeholders were:

- client focus
- staff skills and knowledge
- leadership

- professional staff.

Stakeholders identified a few areas that we can do better (scores in brackets):

- The office gives me the practical support I need to get my job done better (3.52),
- RIDS provides the most effective way to capture business information needs as they relate to the use of restrictive interventions (3.53),
- I receive consistent messages from the office (3.53).

The way forward

The office will continue to capitalise on strengths identified by stakeholders and to recognise and communicate the positive feedback to disability service providers.

Specific opportunities for the office include:

- considering ways to enhance practical support and advice,
- reviewing communication systems to ensure consistent messages are delivered and received across stakeholder groups,
- reviewing the methods and systems for capturing information, needs and stakeholder views, in particular the use of RIDS and other alternatives.

“A breath of fresh air – has cut through and begun to resolve issues that a few years ago seemed intractable.”

“Their collaborative work process provides organisations with the skills and knowledge to decrease the use of restrictive interventions.”

“I believe that the office would have a greater influence in making an even bigger

difference if the feedback is provided in such a way that it recognises some of the deficits and challenges within which we may be working. Sometimes there is a sense of moral high ground about the comments provided.”

“One of the strengths of the office is that it offers practice advice while also strengthening the capacity of organisations to become more accountable for their roles in assisting clients to achieve positive outcomes rather than the office being responsible for managing the day to day interaction with clients.”

“I would like to see the OSP practitioners spend a few weeks/days in each office ... the office did not provide appropriate or enough training.”

“The office has influenced practitioners to re-examine practise in restrictive behaviours, has provided good evidence for new approaches and we are starting to see better outcomes for some clients. They are well led, organised and methodical.”

Section 6

Appendices

Appendix 1

About the office

Our role

Victoria's Senior Practitioner is a new position created through the *Disability Act 2006*. Effective from 1 July 2007, the Act established the role to ensure the rights of people with a disability who are subject to restrictive interventions and compulsory treatments are protected and that treatment standards are complied with. The functions of the Senior Practitioner, as listed in the Act, are to:

- develop guidelines and standards,
- provide education about the rights of people with a disability,
- provide advice to disability service providers to improve practice
- give directions to disability service providers in relation to behavioural management plans and treatment plans,
- develop links and access to professionals, professional bodies and academic institutions for the purpose of facilitating knowledge and training in clinical practice,
- undertake research in the area of restrictive interventions and compulsory treatments,
- evaluate and monitor the use of restrictive interventions across disability services,
- recommend improvements in practice to the Minister and Secretary.

Our vision

An inclusive and safe community that supports people to achieve dignity without restraints.

Our principles

Our work is also guided by the underlying principles from the *Charter of Human Rights and Responsibilities Act 2006*, *A Fairer Victoria 2005* and the *Victorian State Disability Plan 2002-2012*. These principles include:

- human rights and citizenship,
- quality of life and wellbeing,
- community inclusion,
- positive lifestyle and behaviour support,
- building relationships,
- collaborating with key partners to enable change and support dignity.

Our values

The office meets DHS' organisational values in the following ways:

Being person-focused Protecting the rights of people with a disability subject to restrictive interventions and compulsory treatment.	Preserving quality Implementing and maintaining a culture and practice of continuous improvement.
Developing collaborative relationships Engaging and working with all stakeholders to achieve required results.	Maintaining responsibility Being accountable for the actions of the Office of the Senior Practitioner.

The Senior Practitioner is generally responsible for ensuring the rights of persons who are subject to restrictive interventions and compulsory treatment are protected and that appropriate standards in relation to restrictive interventions and compulsory treatment are complied with.

Disability Act 2006, s.23 (2) (a)

To do this we develop guidelines and standards, provide education and information relating to restrictive interventions and compulsory treatment to DSPs, people with a disability and their carers. Another important aspect of this role is to provide advice to DSPs to improve practice and give directions in relation to restrictive interventions and compulsory treatment, behaviour support plans and treatment plans.

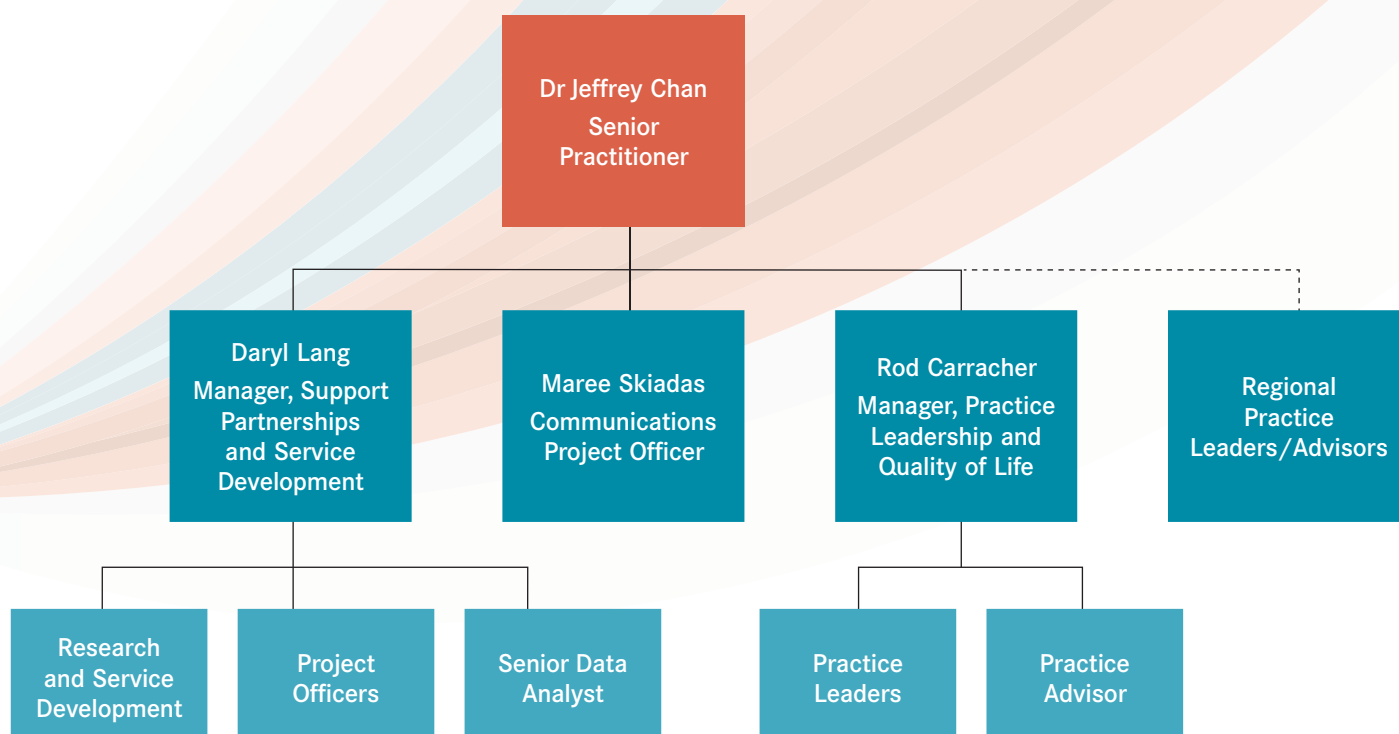
Finally, a significant part of what we do is to develop links and access to professionals, professional bodies and academic institutions to facilitate knowledge and training in clinical practice for people working with people with a disability. This includes undertaking research into restrictive interventions and compulsory treatment and providing information on practice options to disability service providers.

Who we support

The office is responsible for ensuring that:

- the rights of people who are subject to restrictive interventions and compulsory treatment are protected,
- appropriate standards in relation to restrictive interventions and compulsory treatment are complied with.

Office of the Senior Practitioner – structure organisation chart



Appendix 2

Raw data

Table 1: Number of reported episodes of restraint and/or seclusion 2008/09

Administration type	Episodes
Routine	19 897
PRN	7199
Emergency	5018
Total	32 114

Table 2: Number of people reported by activity type and organisation type 2008/09

Activity type	Total people	DHS	CSO	Attends both CSO and DHS
Shared supported accommodation	1231	768	468	5
Day program	129	0	129	0
Respite	578	331	298	51
Congregate care	132	117	15	0
Criminal justice services	20	18	2	0
Other	121	2	119	0
Total¹	2036	1228	957	149

Table 3: Number of authorised program officers, registered disability services providers and registered service type outlets, by organisation type at 30 June 2009

	DHS	CSO	Total
Authorised program officers	17	132	149
Disability service providers	8	109	117
Service Type Outlets	587	801	1388

Table 4: Number of people reported to be receiving restraint and/or seclusion by primary disability 2008/09

Primary disability	Total people	%	Type of restraint administered		
			Routine	PRN	Emergency
Intellectual disability	1881	92%	1703	423	523
Acquired brain injury	41	2%	40	5	8
Physical	47	2%	42	5	11
Neurological	34	2%	28	9	11
Sensory	11	1%	7	1	8
Not stated	22	1%	17	5	19

Table 5: Number of people reported by combinations of restraint received during 2008/09

Restrictive intervention combination	Total people	%
Single restraint type		
• Chemical (only)	1806	89%
• Mechanical (only)	59	3%
• Seclusion (only)	14	1%
Combined restraint types		
• Chemical + mechanical	64	3%
• Chemical + seclusion	80	4%
• Mechanical + seclusion	6	0%
• Chemical + mechanical + seclusion	7	0%
Total	2036	100%

Table 6: Number of people reported by gender and age group

Age group (as at 30 June 2009)	Males	Females	Males %	Females %
05–14 years	166	50	12%	8%
15–24 years	293	122	21%	18%
25–34 years	262	105	19%	16%
35–44 years	258	153	19%	23%
45–54 years	245	133	18%	20%
55–64 years	129	70	9%	11%
65 years and over	22	28	2%	4%
Total	1375	661	100%	100%

Table 7: Number of people reported by region and organisation type

Region ¹	Total people	DHS	CSO	Subgroup who attend both CSO and DHS
Eastern Metropolitan	386	154	260	28
North and West Metropolitan	513	352	194	33
Southern Metropolitan	377	174	244	41
Barwon South Western	234	145	93	4
Gippsland	126	100	31	5
Grampians	153	117	54	18
Hume	131	87	54	10
Loddon Mallee	135	99	37	1
Total	2036	1228	957	149

¹ Neither region nor organisation type are mutually exclusive as individuals may receive services from more than one organisation and/or region. Individuals are counted once within each applicable organisation type and/or region and once in each applicable total.

Table 8: Number of people and number of reported restraint episodes by intervention type and administration type 2008/09

Intervention type ¹	Routine		PRN		Emergency	
	Total people	Episodes	Total people	Episodes	Total people	Episodes
Chemical	1782	19 001	400	4465	505	4064
Mechanical	92	967	30	1543	57	424
Seclusion	31	171	54	1259	69	612
Total	1837	19 897	448	7199	580	5018

1 Intervention type is not mutually exclusive as episodes may contain multiple types of restraint. Similarly, individuals may receive multiple types of restraint (in the same or separate restraint episodes) during the course of a year.

Table 9: Number of people and number of reported restraint episodes by region and intervention type 2008/09

Region ¹	Total people	Chemical episodes	Total people	Mechanical episodes	Total people	Seclusion episodes	Total people	Total ² episodes
Eastern Metropolitan	367	4700	29	809	16	80	386	5 525
North and West Metropolitan	503	6749	21	1428	23	282	513	8 420
Southern Metropolitan	344	4751	53	421	31	413	377	5 469
Barwon South Western	223	3131	13	154	8	103	234	3 385
Gippsland	125	1627	7	37	0	0	126	1 644
Grampians	147	2577	6	23	14	769	153	3 284
Hume	129	2113	3	22	1	8	131	2 137
Loddon Mallee	135	1882	5	40	14	387	135	2 250
Total	1957	27 530	136	2934	107	2042	2036	32 114

1 Neither region nor organisation type are mutually exclusive as individuals may receive services from more than one organisation and/or region. Individuals are counted once within each applicable organisation type and/or region and once in each applicable total.

2 Restraint type is not mutually exclusive as individuals may receive more than one type of restraint in an episode and/or over the course of the year.

Table 10: Number of people and number of reported restraint episodes by region, intervention type and organisation type 2008/09

Region ¹	Intervention type ¹	DHS ¹		CSO ¹	
		People	Episodes	People	Episodes
Eastern Metropolitan	Chemical	150	1650	241	3050
	Mechanical	5	32	26	777
	Seclusion	11	65	6	15
	Total	154	1708	260	3817
North and West Metropolitan	Chemical	349	4734	186	2015
	Mechanical	11	1324	11	104
	Seclusion	14	203	10	79
	Total	352	6227	194	2193
Southern Metropolitan	Chemical	160	2070	216	2681
	Mechanical	21	159	34	262
	Seclusion	4	17	27	396
	Total	174	2180	244	3289
Barwon South Western	Chemical	137	2042	90	1089
	Mechanical	10	126	3	28
	Seclusion	7	100	1	3
	Total	145	2265	93	1120
Gippsland	Chemical	99	1270	31	357
	Mechanical	5	26	2	11
	Seclusion	0	0	0	0
	Total	100	1276	31	368
Grampians	Chemical	112	1885	52	692
	Mechanical	4	19	2	4
	Seclusion	12	667	4	102
	Total	117	2509	54	775
Hume	Chemical	85	1524	54	589
	Mechanical	1	8	2	14
	Seclusion	1	8		0
	Total	87	1540	54	597
Loddon Mallee	Chemical	99	1486	37	396
	Mechanical	1	1	4	39
	Seclusion	14	387		0
	Total	99	1840	37	410
Total	Chemical	1191	16 661	898	10 869
	Mechanical	58	1695	84	1239
	Seclusion	63	1447	48	595
	Total	1228	19 545	957	12 569

¹ Neither region, intervention type nor organisation type are mutually exclusive as individuals may receive more than one type of restraint at a time and/or they may be reported by more than one organisation and/or region. Individuals are counted once within each applicable organisation type, restraint type and/or region and once in each applicable total.

Appendix 3

Research

Office of the Senior Practitioner – research grants and commissioned projects

Title	Purpose of grant project	Name of organisation	Partner organisations
Intellectual disability, victimisation and criminal offending during a period of deinstitutionalisation: a data linkage study 2008 Research Partnership Grants	To explore the impact of deinstitutionalisation on a cohort of people with a disability receiving disability services in the 1970s, 1980s and 1990s by examining their health- and justice-related outcomes over a period of up to 35 years. The project will consider the effectiveness of social inclusion policies in the short-, medium- and long-term.	Centre for Behavioural Science, School of Psychology, Psychiatry and Psychological Medicine, Monash University	Victoria Police,
A protocol to guide a collaborative medication review for adults with behaviours of concern 2008 Research Partnership Grants	Develop and evaluate a collaborative medication review protocol that will result in meeting the criteria for the use of medication according to the .	Centre for Developmental Disability Health Victoria, Monash University	Jewish Care Victoria and Nadrasca
Depression, behaviours of concern, and restrictive interventions 2009 Research Partnership Grants	Restrictive interventions may be used inappropriately to control behaviours that are in fact symptoms of undiagnosed and untreated depression. The aim of this research is to evaluate how well a screening tool for depression can detect changes in behavioural symptoms following treatment for depression. The aim is to also explore changes in behaviours of concern and restrictive interventions in people diagnosed and treated for depression.	Centre for Developmental Disability Health Victoria, Monash University	Villa Maria Gateway
Characterising the complex and vulnerable: intellectual disability, mental illness, and criminogenic needs among youth offenders in Victoria 2009 Research Partnership Grants	This study aims to characterise the broad spectrum of needs of youth offenders with a specific focus on intellectual ability, mental well being and criminogenic need. Improved identification of disability, illness and need should result in more comprehensive service provision, treatment and preventative interventions for young people.	Centre for Forensic Behavioural Science Monash University	Forensicare, Jesuit Social Services and Brosnan Youth Services
Everything affects everything else: power, perception and hidden forms of restrictive practice in shared supported accommodation 2009 Research Partnership Grants	The project aims to improve the quality of life and dignity of people with a disability subject to restrictive restrictions living in shared supported accommodation. The project will adopt a partnership approach to redress the use of covert or invisible forms of restrictive practices by engaging staff in defining, identifying and developing strategies for challenging the inappropriate exercise of power which occurs at interpersonal and systemic levels	School of Humanities, Communications and Social Sciences Monash University	DHS Gippsland Region

Title	Purpose of grant project	Name of organisation	Partner organisations
Disability, mental health and medication: implications for practice and policy	To examine the need for independent psychiatric reviews of people with a disability prescribed psychotropic medications and develop practice guidelines for GPs and psychiatrists.	Centre for Forensic Behavioural Science, Monash University	
The effect of individual and organisational factors on restraint use in people with intellectual disabilities.	To examine relationships between restraint use, the individual and organisational factors in a bid to determine which factors are the best predictors of restraint use. Interventions targeting such predictors may then be used to reduce restraints.	Centre for Developmental Disability Health Victoria, Monash University	Yooralla and Positive Behaviour Support Services (Gary Radler)
Exposure to challenging behaviour and support worker/house supervisor well-being Faculty of Medicine Industry Grant	To explore attitudes towards challenging behaviour and the use of restrictive interventions by disability support professionals. To explore the link between exposure to challenging behaviours and burnout, depression, anxiety, stress and organisational factors.	Centre for Developmental Disability Health Victoria, Monash University	Senior Practitioner (industry support)
Experiences of restrictive practices: a view from people with disabilities and family carers	Bring the voices of people with a disability and their family carers onto the agenda and to establish the contextual, environmental and systems factors that produce or affect people's behaviour	RMIT University	
A literature review of physical restraint	Review the literature on the definition, use and policy context for regulation of the use of physical restraint.	RMIT University	
Development of a risk assessment and planning tool to inform services for people with intellectual disabilities who exhibit severe behaviours of concern 2008 Research Partnership Grants	Develop a tool to assess the support needs of people with an intellectual disability who engage in behaviours of concern that could constitute a criminal offence and consequently result in their being subject to imprisonment and other long-term restrictive practices.	RMIT University	University of Waikato and Department of Justice
Understanding organisational factors that impact on person-centred practice and quality of life outcomes for residents with complex needs 2009 Research Partnership Grants	This study will provide a greater understanding of the staff and organisational factors that support the implementation of active support and a person-centred approach by staff, which leads to improved engagement and participation in meaningful activities by people with complex needs living in group homes, reduced levels of challenging behaviour and the reduced risk of restrictive practices.	La Trobe University	Tizard Centre (UK), Jewish Care, Annecto, Yooralla, Golden City Support Services, St John of God Accord, DHS Eastern Region

Title	Purpose of grant project	Name of organisation	Partner organisations
Self advocacy and inclusion: what can be learned from speaking up	To examine the significance of self-advocacy in building individual, social and political inclusion of people with an intellectual disability.	La Trobe University	ARC, Office of the Senior Practitioner, Reinforce, Jewish Care Victoria, St John of God Services Victoria, Office of the Public Advocate and Annecto
Evaluating a reputed exemplary residential support service for people with severe intellectual disability and challenging behaviour 2008 Research Partnership Grants	Evaluate a reputed exemplary service for people with challenging behaviour and describe the elements of a good practice model.	La Trobe University	Golden City Support Services
It's a way of life: a case study of embedding a culture of positive behaviour support in a Victorian disability organisation 2008 Research Partnership Grants	The pilot project will explore the crucial contextual and organisational factors that compliment staff training to lead to positive behaviour support becoming part of a disability organisation's culture.	St John of God	RMIT University and Reinforce
Collaboration in the development of behavioural social stories to reduce behaviours of concern and restrictive practice 2008 Research Partnership Grants	Determine the extent to which behaviour support plans for adults subject to restrictive interventions are implemented, factors influencing implementation and the effectiveness of behavioural social stories to reduce behaviours of concern and restrictive practices.	Scope	Monash University
Developing organisational readiness resource encouraging person-centred service responses 2009 Research Partnership Grants	The development of a practical guide for disability service providers to enable successful implementation of Person-Centred Active Support (PCAS) and positive behaviour supports for people with extensive support needs.	Jewish Care (Victoria) Inc	RMIT University
Mindfulness Project	To conduct a formal demonstration project to replicate the mindfulness approach in two shared supported accommodation services to support people with significant behaviours of concern.	Yooralla	School of Psychology, Psychiatry and Psychological Medicine, Monash University
Building foundations for effective communication and decision-making for Victorians with behaviours of concern	This project proposes to create a foundation for effective communication assessment and everyday communication practice, to build a capability to implement supported decision-making and to build best practice in behaviour support.	Scope	Monash University, Deakin University, Villamanta Disability Legal Service

Title	Purpose of grant project	Name of organisation	Partner organisations
Safeguarding Rights Project	To design and develop a communication strategy to support people with a disability subject to restrictive interventions being made aware of their rights. Production of a pilot training package.	VALID	
The Implementation of supervised treatment orders (STOs): what is the balance between restrictive interventions, therapeutic outcomes and human rights for people detained under the Disability Act 2006	In order to inform a revision of current policies, practices used to interpret and apply the Disability Act, and the act itself, in particular regarding the rights of people subject to STOs, research will be done focusing on risk, benefit and treatment using a human rights and therapeutic jurisprudence framework to examine the application of provisions for detention and compulsory treatment under the Disability Act 2006.	Office of the Public Advocate	VCAT

Appendix 4

Office of the Senior Practitioner – publications and presentations for 2008–09

OSP Publications

Update newsletter: *Issue No. 5*, July 2008.

Positive solutions in practice: *Chemical restraint: What every disability support worker needs to know*, August 2008.

Positive solutions in practice: *Attachment and trauma in people with an intellectual disability*, October 2008.

Medications and the Restrictive Intervention Database System (RIDS), things to consider, November 2008.

Information sheet – *Introducing the Senior Practitioner – for disability services*, November 2008.

Active Preventions: Children & young persons, pilot project, November 2008.

Independent Person Toolkit: Information for the independent person, people with a disability and disability service providers, December 2008.

Independent psychiatric review of former Kew Residential Services residents conducted by the Centre for Developmental Disability Health Victoria between 27 February and 30 November 2008, December 2008.

Report on the use of restrictive interventions, behaviour support plans and supervised treatment orders for the period 1 July 2008–31 December 2008, 17 March 2009.

Senior Practitioner Grants Initiative summary report. Promoting research and working in partnerships to better support people with disabilities subject to restrictive interventions, May 2009.

Plain English publications

Office of the Senior Practitioner, Annual Report 2007–2008 Plain English, July 2008.

What is the Office of the Senior Practitioner?, October 2008.

What is a behaviour support plan?, November 2008.

Independent Person Toolkit, December 2008.

What is the Office of the Senior Practitioner and who is the Senior Practitioner?, February 2009.

What people with disabilities think about restraint and seclusion, May 2009.

Research publications

Chan, J. (2008). A profile of respite Service providers in New South Wales, *International Journal of Disability, Development and Education*, 55 (4) 289–302.

Riches, V.C., Parmenter, T.R., Llewellyn, G., Hindmarsh, G., & Chan, J. (2009). I-CAN: A new instrument to classify support needs for people with disability: Part I, *Journal of Applied Research in Intellectual Disabilities*, 22, 326–339.

Riches, V.C., Parmenter, T.R., Llewellyn, G., Hindmarsh, G., & Chan, J. (2009). The reliability, validity and practical utility of measuring supports using the I-CAN instrument: Part II. *Journal of Applied Research in Intellectual Disabilities*, 22, 340–353.

French, P., Chan, J., & Carracher, R. (second review). Realising human rights in clinical practice and service delivery to persons with a cognitive impairment who engage in behaviours of concern, *Psychiatry, Psychology & Law*, paper submitted for publication consideration.

Webber, L., Chan, J., & McVilly, K. (2009). Beyond seclusion and restraint in disability services: The Victorian perspective. Finding better ways to support the inclusion of people with behaviours of concern, *Journal of Policy and Practice in Intellectual Disabilities*, 6, (2), 157. Abstracts from the 2nd IASSID Asia Pacific Regional Conference, June 24 – 27, Singapore.

Palermo, J., Webber, L., Smith, K., & Khor, A. (2009). *Factors that predict work ability: Incorporating a measure of organisational values towards ageing*, Ilmarinen, J (Ed). Promotion of work ability towards a productive ageing, Japan: International Committee on Occupational Health.

Other publications

Butler, J., Burbidge, M., Tracy, J., & Donley, M. (2009). *Supporting women – a guide for Victorian general practitioners supporting women with intellectual disabilities to manage their menstruation.*

Ramcharan, P., Nankervis, K., Strong, M., & Robertson, A. (2009). *Experiences of restrictive practices: A view from people with disabilities and family carers. A final research report to the Office of the Senior Practitioner.*

McVilly, K. (2009). *Physical restraint in disability services: Current practices, contemporary concerns, and future directions.*

Conference presentations

Chan, J. (2008) “All I did was growl a little.” *Reflections on the Victorian experience in protecting the rights of people with disabilities subject to restrictive interventions*, Western Australia State Conference, Australasian Society for the Study of Intellectual Disability (ASSID), Fremantle (13 August).

French, P., Chan, J., & Carracher, R. (2008). *Enlivening rights: applying human rights standards to restrictive practices and compulsory assistance*, Risks Vs Rights, 28th Annual Congress, Australian and New Zealand Association of Psychiatry, Psychology and Law (ANZAPPL), Sydney (23–26 October).

Webber, L., Chan, J., & McVilly, K. 2008, *Restraint and seclusion: past practices and future directions*, Australasian Society for the Study of Intellectual Disability (ASSID) conference, Melbourne (24–26 November).

Webber, L., Carracher, R., Chaffey, D., & Chan, J. (2008). *Behaviour support plans: Planning for success*, 8th Annual Conference for Disability Support Workers, Australasian Society for the Study of Intellectual Disability (ASSID), Melbourne (27–28 November).

Chan, J. (2009). *Justice and dignity for people with disability who present with behaviours of concern: We can do better than imposing restrictive interventions.* 2nd Australian Association for the Scientific Study of Intellectual Disability, South Australia, Adelaide (20 May).

Webber, L., Chan, J., & McVilly, K. (2009). *Beyond seclusion and restraint in disability services: The Victorian (Australian) perspective*, 2nd Asia Pacific Regional Congress, International Association of the Scientific Study of Intellectual Disability (IASSID), Singapore (24–27 June).

Lambrick, F., Carracher, R., Webber, L., & Chan, J. (2009). *Managing risk and dignity of risk in offenders with intellectual disability.* 4th Forensic Disabilities Conference, Melbourne, (16–17 July).

Webber, L., Donley, M., Buchholtz, M., Chan, J., & Patel, G. (2009). *Implications of human rights on the practice of chemical restraint in people subject to supervised treatment orders.* 4th Forensic Disabilities Conference, Melbourne, (16–17 July).

Chan, J., & French, P. 2009, *Protecting human dignity & rights – a professional responsibility*, 5th Annual Disability Professionals Victoria Conference, Melbourne (23–24 April).

Dignity seminars

Ramcharan, P. (2009). *Experiences of restrictive practices: A view from people with disabilities and family carers. A final research report to the Office of the Senior Practitioner*, Office of the Senior Practitioner Dignity Seminar, Melbourne (31 July).

Martin, R. (2009). *Mr Robert Martin, Internationally Recognised Self Advocacy Leader, Council of Inclusion International and Chairperson of the International Self Advocacy Committee and the International Disability Alliance and the expert panel for the United Nations Standard Rules for Persons with a Disability*, Office of the Senior Practitioner Dignity Seminar, Melbourne (2 February).

Other presentations

Chan, J. (2008). *Locked doors, locked refrigerators: food for thought on human rights*, Disability Services and Victorian Charter of Human Rights and Responsibilities, Melbourne (16 July).

Chan, J. (2008). *The Disability Act – Progressing Change Locally*, Barwon South-Western Region, Geelong (23 July).

Chan, J. (2008). *The evidence informing practice improvement*, Gippsland Disability Chief Executive Officer (CEO) and DHS Partnership Forum, Traralgon (6 August).

- Chan, J. (2008). *About the Senior Practitioner*, Victorian Advocacy League for Individuals with Disability (VALID), Client Network Meeting, Melbourne (3 October).
- Chan, J. (2008). *People with acquired brain injury subject to restrictive interventions*, Victorian Coalition Acquired Brain Injury Service Providers (VCASP), Melbourne (7 November).
- Chan, J. (2008). *How do we protect the dignity of people with disability subject to restrictive interventions and compulsory treatment*, Office of the Public Advocate (OPA) Community Visitors Disability Services Regional Convenors, Melbourne (19 November).
- Chan, J. (2008). *"Above all else, don't wobble": Reflection on practice leadership in human services*, DHS Strategic Thinking Club, Melbourne (9 December).
- Chan, J. (2009). *Counting dignity: Is there a role for Certified Practising Accountants?* DHS CPAS Group, Melbourne (23 March).
- Chan, J. (2009). *Liberation theology, Zen and Dale Carnegie: What motivates you to promote the dignity of the person with a disability?* Gippsland Disability Services, DHS Staff Forum, Traralgon (1 April).
- Chan, J. (2009). *Towards a restraint-free environment: Can we do it?* Yooralla, Individualised Services Planning Workshop, St Kilda (8 May).
- Chan, J. (2009). *Safeguarding rights, new mechanisms and the role of advocacy*, Disability Advocacy Resource Unit (DARU) and Victorian Disability Advocacy Network (VDAN) Forum, Melbourne (10 March).
- Lang, D., & Webber, L. (2009). *Introduction to the role and functions of the Senior Practitioner*, Community Visitor Seminars, Office of the Senior Practitioner and the Office of the Public Advocate, Melbourne (3 March, 4 April and 29 June).