Office of the Senior Practitioner
Annual report 2007–08

Supporting people to achieve dignity without restraints
Office of the Senior Practitioner

Annual report 2007–08

October 2008
Contacts
Office of the Senior Practitioner
Department of Human Services
Level 7, 50 Lonsdale Street
Melbourne Victoria 3000
Phone: 9096 8427
Email: seniorpractitioner@dhs.vic.gov.au

If you would like to receive this publication in an accessible format, please phone 03 9096 8427 using the National Relay Service 13 36 77 if required, or email seniorpractitioner@dhs.vic.gov.au
This document is also available in PDF format on the Internet at www.dhs.vic.gov.au/ds/osp
Contents

4 Abbreviations used in this report
6 A message from the Senior Practitioner
9 A year of new beginnings
10 Dignity without restraints
12 Behaviour support plans
16 Reporting the use of restraints and seclusion
25 New orders under the Disability Act 2006
28 A year of refinements
29 Stakeholder survey
31 A year of initiatives
32 Introducing RIDS
34 Revisiting the psychiatric diagnoses of former KRS residents
36 Active prevention strategy
38 The Mindfulness Project
39 Partnerships for Positive Solutions
41 Reducing chemical restraint
43 OSP awards 24 grants to fund research
47 High-needs, high-risk clients
49 Focusing on professional development
51 Advancing behaviour support practice forums
52 A year in review
53 Reflections – Rod Carracher
54 Reflections – Frank Lambrick
55 Reflections – Lynne Webber
56 Reflections – Mandy Donley
57 Reflections – Daryl Lang
58 Reflections – Janice Rouhan
59 Reflections – Simon Wardale
60 Appendices
61 Appendix 1: Office of the Senior Practitioner – structure
62 Appendix 2: Publications and presentations
65 Appendix 3: Summary of achievements
Abbreviations used in this report

APO  authorised program officer
BSP  behaviour support plan
CDDHV  Centre for Developmental Disability Health Victoria
CIS  Community and Individual Support
CSO  community service organisation
DAS  disability accommodation services
DSP  disability service provider
FBA  functional behaviour assessment
GP  general practitioner
IDRP  Intellectual Disability Review Panel
OSP  Office of the Senior Practitioner
PRN  pro re nata (as required)
PPS  Partnerships for Positive Solutions
QSD  Quality and Sector Development
RIDS  Restrictive Interventions Data System
VCAT  Victorian Civil and Administrative Tribunal

Note that all percentages in this report have been rounded to the nearest whole number.
Dear Minister,

In accordance with section 24 (2) of the Disability Act 2006, I have great pleasure in submitting the inaugural Senior Practitioner annual report. This document reports on the functions and activities of my office for the period 1 July 2007 to 30 June 2008.

As you are aware, the role of the Senior Practitioner is established by the Disability Act 2006 to protect the rights of persons with a disability subject to restrictive interventions and compulsory treatment, and that appropriate standards in relation to restrictive interventions and compulsory treatment are complied with.

I am pleased to inform you that this annual report demonstrates that the objectives of the role of the Senior Practitioner have been met.

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

Yours sincerely

Jeffrey Chan
Senior Practitioner
September 2008
A message from the Senior Practitioner

It is with great pleasure and privilege that I present the inaugural Senior Practitioner annual report for 2007–08.

The role of the Senior Practitioner was established by the Disability Act 2006 (the Act) to protect the rights of people with disabilities subject to restrictive intervention and compulsory treatment. It is unique in the disability sector internationally as it combines a legislative role with a strong practice improvement focus and a capacity to initiate research within a human rights framework. Safeguarding the rights of people with disabilities who present with behaviours of concern is a significant commitment of the state government’s strategy of building an inclusive Victorian community.

When I first started to develop a Senior Practitioner strategy, I indicated that behaviours of concern do not occur in a vacuum. The behaviours occur in a context of the person’s experience, environment and community. Any intervention that primarily focuses on the person alone will not effect positive sustainable change. The intervention needs to include the systems\(^1\) that are required to support the person. To bring about change for the person we also need to bring about change in the system. The Senior Practitioner strategy is not simply about reducing restrictive interventions or compulsory treatment, or working towards a ‘restraint-free’ environment and culture; it is about ensuring there is measurable positive change in each person’s quality of life.

Change in practice and culture cannot occur overnight. Hence while there is an important legislative compliance role, the Senior Practitioner strategy is focused on partnering for change, improvement, learning and incremental success in the systems that support the person. At the same time the strategy aims to achieve positive solutions for each person.

So what did we achieve in our first year?

Establishing the office for its first year in operation was, of course, a key focus of our work. In addition, three strategies were identified following extensive statewide consultation. These are:

- advancing disability support practice
- building partnerships
- creating leaders.

These strategies are aimed at achieving long-term sustainable change that is also guided by the Charter of Human of Human Rights and Responsibilities 2006. These strategies and their achievements are further outlined in the appendices section of this report.

You will read in the report what we have achieved this year. In summary, we

- conducted 1,521 detailed reviews of 2,349 behaviour support plans received (defined in the Act as ‘behaviour management plans’) and made recommendations in two published reports
- analysed an average of 2,544 restrictive intervention episodes each month (including PRN, emergency and routine medication)
- analysed and reviewed 36 initial treatment plans for interim supervised treatment orders (we continue to monitor the progress of 30 treatment plans)

\(^1\) Systems are defined here as practice, policy, workforce and organisational culture and services designed to support a person. It also includes other government departments (such as primary and mental health or education) and other professional associations.
• reviewed over 300 people subject to chemical restraints
• reviewed 47 cases of people who were from the former Kew Residential Services and recommended that 76 people be independently reviewed by a psychiatrist
• reviewed and monitored 16 people identified as high needs and high risk
• developed and trialled implementation of an active prevention strategy for 15 people in three rural regions
• coordinated, delivered and produced more than 80 workshops, seminars, conference presentations, information sessions and publications
• developed and implemented a clinical and practice coaching eight-month intensive workshop to 25 staff members from departmental and community service organisations (CSOs) (four sessions were held this year)
• implemented the Restrictive Intervention Database System (RIDS) across the state, conducting about 53 regional training sessions and responding to around 1,200 online queries
• established the Partnership for Positive Solutions, a practice improvement strategy across eight departmental regions
• funded six Senior Practitioner Research Partnerships grants totalling about $291,000 and 18 Promoting Dignity grants to disability support professionals at approximately $24,000
• undertook a stakeholder survey evaluation of the Office of Senior Practitioner’s (OSP’s) performance, in excess of 500 surveys were distributed with 317 completed returns received.

This report does not merely focus on the activities of the OSP or the findings of our analysis of restrictive interventions and behaviour support plans over the past 12 months. The report also highlights some of the things that we have learned over the past year. It is therefore intended that disability service providers use what we have learned to inform the planning of service delivery, resource allocation, policy development and to improve their practice. There are many things this report tells us about what we can do differently to improve the lives of people with a disability who are subject to restrictive interventions and compulsory treatment. Some of these initiatives are not resource intensive while others do require investment in resources in order to achieve significant benefits in return.
I expect over the next two years there may be an increase in the number of recorded restrictive intervention episodes. The increase will be a result of better reporting by disability service providers and not a reflection that the number of people being restricted is increasing. Currently there is still under-reporting of people subject to restrictive interventions and episodes of restrictive interventions. The strategy of the OSP is to track progress for each person over time so that we can accurately identify whether there is an actual increase or decrease in restrictive interventions and in the number of people subject to restrictive intervention.

This report also intends to reflect and share with you some good news stories about the lives of people that we have had some involvement with over the past year. By working with disability service providers the OSP aims to be part of the solution to effect positive change for people. I hope that by reading these stories you will have an appreciation that practice change can occur. These stories affirm that the OSP’s creation by government is definitely a positive step forward in supporting the dignity and rights of people presenting with behaviours of concern.

Thank you.

Jeffrey Chan
Senior Practitioner
September 2008
A year of new beginnings
...implementing the Disability Act
Dignity without restraints

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 treatment 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 and information to disability service providers
• provide information 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 behaviour 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 and collaborating with key partners to enable change and dignity of risk.

Our values
The OSP meets the Department of Human Services organisational values in the following ways.

<table>
<thead>
<tr>
<th>Being person focused</th>
<th>Preserving quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protecting the rights of people with a disability subject to restrictive interventions and compulsory treatment.</td>
<td>Implementing and maintaining a culture and practice of continuous improvement.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Developing collaborative relationships</th>
<th>Maintaining responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaging and working with all stakeholders to achieve required results.</td>
<td>Being accountable for the actions of the Office of the Senior Practitioner.</td>
</tr>
</tbody>
</table>
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)

Who we support

The OSP is responsible for ensuring that the rights of people 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. 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.
Sections 140 and 141 of the *Disability Act 2006* 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 on a regular basis (at least every 12 months) and the Senior Practitioner is responsible for monitoring and reviewing the BSP to ensure that the rights of the person are protected.

### What we did

The OSP conducted an initial analysis of 2,349 BSPs submitted in July 2007. We looked for common themes and other common issues of concern, directly contacting disability service providers where concerns warranted follow-up.

A random sample of 1,521 plans were examined in detail based on requirements of the Act and other best practice assessment criteria. Only one plan was analysed in detail for each person; two or more plans were received for 179 people and the one closest in date to July 2007 was examined in detail.

The majority of these plans were prepared under the *Intellectually Disabled Person’s Services Act 1986* (repealed) and implemented under the transitional provisions section 223 of the *Disability Act 2006*.

### What we learned

Of the 1,521 BSPs reviewed in detail, 65 per cent were for males with an average age of 36 years. The remaining 35 per cent were for females with an average age of 41 years. All related to people aged between six and 82, although not all birth dates were provided.

Fifteen per cent of the plans included disability-specific information about the person, these included mental illness (n=163) and/or a neurological disorder (n=113). An Autistic spectrum disorder was reported for 88 people and a physical disability, for example cerebral palsy, was reported for 48 among other impairments and disorders.

Thirty-seven per cent (n=560) of plans were received from the Department of Human Services, 60 per cent (n=900) from a CSO and 3 per cent did not specify.

The majority of plans were developed by shared supported accommodation facilities (58 per cent), 15 per cent by respite services and 11 per cent by day programs. The remainder did not record services from which the plan was developed.

### The role of the APO and independent person

The legislative requirement is that all BSPs need to be approved and signed by an authorised program officer (APO). Twenty-two per cent had been signed by an APO, 163 of these originated from a CSO and 167 from DHS.

Plans signed by an APO were more likely to be complete and include a wider range of information such as positive behaviour strategies and active support.

---

2. Five people coded the data and achieved agreement of between 80 and 100 per cent for the majority of the questions (82 per cent or 67 of the questions we asked about plans). 71–79 per cent agreement was obtained for 13 questions and 65 per cent and 67 per cent agreement were obtained for two questions; data from both of these latter questions were not used in the analyses in this report due to the low inter-rater reliability obtained. SPSS was used to analyse all data presented in this report.

3. Disability service providers have reported that a record of APO signoff may not have been submitted to the OSP. The OSP has developed a strategy to ensure a record of APO signoff is submitted.
The Act also requires that an ‘independent person’ is available to explain the BSP to the person with a disability. Only 12 per cent of plans (n=175) identified this taking place. Disability service providers have reported that a record of independent person involvement may have taken place but not identified in the plan. The OSP has developed a strategy to ensure a record of independent person involvement is reported.

**Consultation**

Just over half of the plans (53 per cent) reported that the person with a disability was consulted in its development and almost 40 per cent reported that a member of the person’s family had been consulted. About 18 per cent of the plans reported that another significant person had been consulted although 2.7 per cent said that person was a legal guardian. Twenty-five per cent (n=380) of plans did not report consultation with anyone.

**Assessments**

Just over half of the BSPs analysed in detail (52 per cent) did not include details of any assessments. It is possible that assessments were completed, but not documented. Twenty one per cent of plans (n=320) stated that formal assessments such as published tests and evaluations had been completed while 37 per cent (n=559) reported that informal assessments had been completed. Ten per cent (n=156) reported that both a formal and informal assessment had been completed.

In 334 cases (22 per cent) functional behaviour assessments (FBA) (assessments about possible reasons for behaviours of concern) had been completed. These plans were somewhat more likely to base their positive behaviour strategies on the results of the FBA. This was especially true for a minority of plans (17) that had reported both a formal and informal functional behaviour assessment. Sixteen of these 17 plans also provided evidence that the positive behaviour strategies were based on the findings of the FBA. This finding suggests that those plans that had obtained both formal and informal FBAs were more likely to develop appropriate interventions that directly targeted behaviours of concern.

**Behaviours of concern**

The most common behaviours of concern reported were physical aggression (52 per cent), self-injurious behaviour (31 per cent) and 26 per cent was behaviour that may harm themselves or others as a result of property damage. Other findings included disruptive behaviour (24 per cent) and verbal aggression (23 per cent). Inappropriate sexual behaviour was reported less frequently (6 per cent).

Assessments about the person’s behaviours of concern provide valuable information about the possible reasons for the behaviours and are an important first step towards designing appropriate interventions. These aspects would include an assessment by a psychiatrist if the person has a mental health concern or a neuropsychological assessment if the person has an acquired brain injury. All people who show behaviours of concern should at least undergo an FBA to identify possible reasons for the behaviours of concern. The results of the FBA should be linked directly to the positive behaviour support strategies. The need for appropriate assessments is a recurrent theme in all analyses conducted by the OSP. It is a concern that many people have not been appropriately assessed.
The analysis showed that most plans (75 per cent) included positive behaviour support and 66 per cent were worded positively. Forty-four per cent showed evidence that steps were in place to teach or maintain daily skills and approximately one-third (32 per cent) provided evidence that social skills were being taught. Eighteen per cent mentioned using active support methods and 9 per cent of people were receiving some form of therapeutic interventions such as counselling, art or speech pathology interventions.

Many people who are subject to a restrictive intervention show behaviours of concern that may result in injury to the person themselves or others. Best practice suggests that restrictive interventions should never be used alone or as the first intervention and the person should always be supported using personal, social and or appropriate environmental interventions; for example, active support and counselling.

Positive behaviour supports include helping the person to learn skills like coping strategies that may replace the expression of behaviours of concern. For example, someone who hits their head when angry could be supported to learn other anger management strategies such as problem solving or another way of communicating their anger. Positive behaviour supports have been shown to lead to developing new skills and improvements in a person’s quality of life.

Although the majority of interventions were worded positively, most were not actively addressing behaviours of concern. Of particular concern were a minority of plans (12 per cent) that did not provide any details of any kind of positive support.

Restrictive interventions

The use of restrictive interventions should be reviewed regularly and reduced over time. The majority of plans (78 per cent) indicated chemical restraint would be used, 7 per cent identified using mechanical restraint and 9 per cent reported that seclusion would be used. Of the plans reviewed in detail, 12 per cent described using more than one restrictive intervention, 122 of which stated that chemical restraint and seclusion would be used and 56 saying that chemical and mechanical restraints would both be used.

A minority of plans (9 per cent) described a strategy to reduce the restrictive interventions and very few of these identified a timeline within which to reduce the restrictive interventions. Most plans that included restrictive interventions also provided information about positive support; however, 323 plans (21 per cent) only provided information about restrictive practices and no information about how the person would be supported using positive strategies. This suggests that some people may not be provided with the necessary support to develop new skills.

Twenty-two per cent (n=329) of plans stated that ‘other’ restrictive interventions would be used, most of which were either a type of time-out or locked doors and or cupboards. Many of the time-out interventions appeared to use a type of social restraint (such as direction to stay on one side of black tape on the floor) or physical restraint (such as physically escorting a person to their room). Others appeared to be a form of seclusion (such as the person would be contained in house).

Eight per cent of plans reported they would use strategies of behaviour control that they define as teaching consequences of the person’s behaviour; for example, if the person bit their hand, they would not be allowed to go to the movies that week. However, these strategies may not be appropriate. For example, teaching consequences where the behaviour was responded to by the removal or denial of certain activities.7

---

7 It is important to reiterate that activities such as social outings or food treats are not privileges that should be withdrawn from or denied to the person as a part of a behaviour support plan, particularly: (a) when the person is unable to make any connection between the withdrawal/denial of the activity with the behaviour, (b) when there is no learning or outcome achieved by the person and (c) the definition of a “food treat” or “social outing privilege” is open to varied interpretations, both ethical and legal.
Constant reviewing of the effect of all interventions is important to find out what works and what needs to change. Only a few plans provided information about when and how the interventions would be reviewed.

**Positive aspects**

Most BSPs provided evidence of:

- how the person would be supported by using positive behaviour support strategies
- the details of restrictive interventions and the circumstances in which they were used
- when reactive strategies were used (they were clearly described)
- a clear understanding of the person’s needs (that is, taking into account informative and practical assessment reports written by Department of Human Services specialist services, external professionals and specialist service providers such as CDDHV)
- specific assessment reports (such as attached mental health reviews).

**The way forward**

Over the next 12 months, the OSP will review BSPs to identify good practice standards in terms of intent and practice. We need to find out the extent to what is proposed within the plans is actually implemented and whether it delivers the desired outcomes to reduce the use of restrictive interventions. Because our review is based entirely on what was included in the written plans submitted it is possible that certain information was available and used by the service provider, but not included in the plan (such as the authorised program officer’s name and signature).

All BSPs must contain full details of legislative compliance requirements (such as providing evidence that the APO has approved the plan and involvement of an independent person) as well as evidence that anyone who exhibits behaviours of concern is supported so that restrictive interventions will be reduced over time. This should include:

- describing and assessing every behaviour of concern and identifying possible causes and interventions
- writing down all planned interventions (if it is not written down in a BSP, it probably won’t be acted on)
- reviewing and updating interventions if they are clearly not working
- a speech pathologist assessing for people with communication difficulties
- reviewing (annually) anyone who is prescribed a psychotropic medication (especially those on the older (typical) psychotropic medication because they have some side effects that may be detrimental to the person)
- reporting menstrual suppression as a chemical restraint if the medication is being prescribed for behaviours of concern and not a medical condition (anyone receiving medications to suppress their menstrual cycle should be reviewed by a gynaecologist)
- planning graded responses to behaviours of concern beginning with positive solutions and moving along on the least restrictive continuum.

During the year the OSP ran several workshops and seminars that focused on targeted aspects of planning support for people who show behaviours of concern. The OSP will call for expressions of interest from regions for more workshops and seminars in 2008–09.
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 OSP via RIDS.

The Disability Act 2006 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; or
(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; or
(b) in any room in the premises where disability services are being provided of which the doors and windows are locked from the outside; or
(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, 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

The OSP undertook an analysis of restrictive intervention RIDS data to identify trends and issues in the use of restraint and seclusion. All analysis was based on RIDS data received between 1 July 2007 and 31 July 2008.

What we learned

Services

As at 1 July 2007 there were 152 approved service providers, eight regional Department of Human Services providers and 144 CSOs reporting on the use of restrictive interventions to the Senior Practitioner.

The majority of services that were approved to administer restraint and seclusion were departmental and CSO shared supported accommodation services (department: n=531; CSOs: n=406). Most of the day programs, respite and other programs that were approved to administer restraint and seclusion were CSO facilities, while most of the congregate care and criminal justice services were departmental facilities.
Restraint types

While a total of 2,096 people were reported to have been restrained and/or secluded for one or more months during the year, 516 people were reported to be restrained and/or secluded for each month of the 12 months and 201 people were reported to be restrained and/or secluded only once during the year.

The majority of people were reported to be administered routine restraint and seclusion. Between July 2007 and June 2008, 571 people were reported to have been restrained and/or secluded as a PRN response and 471 were reported as emergency response.

Gender and age

More than twice as many males 65 per cent (n=1,357) than females 35 per cent (n=738) were reported to be restrained and/or secluded. Younger males (younger than 34 years of age) were the highest reported percentage at 36 per cent to be restrained and/or secluded compared to older males (older than 35 years of age) at 35 per cent and females of all ages at 29 per cent.

Type of restraint

The majority of people who were reported via RIDS 94 per cent (n=1,964) were subject to routine restraint. Of these 97 per cent (n=1,906) were subjected to some form of routine chemical restraint. Of these 97 per cent (n=154) were subjected some form of mechanical restraint (including socks, gloves, splints, harnesses, helmets). 6 per cent (n=126) of people were subjected to seclusion.

The use of chemical restraints

Figure 1. Total incidences of people who were subjected to chemical restraint, 2007–08

Source: RIDS

8 These percentages do not add to 100 per cent because some people with a disability were subjected to more than one type of restraint and/or seclusion.
Figure 1 shows the number of people reported to have been subjected to chemical restraint decreased slightly between July to November followed by an increase in December with a subsequent decrease in January.

In sum, variability in reporting appears to account for the spike in December and lower reporting rates for October, November, January and February in routine chemical restraint, this will be further investigated by the OSP. It is anticipated that a longitudinal analysis in subsequent years will lead to a more thorough understanding of variability across months.

Common medications used

The 20 most commonly used medications for chemical restraint included one of six types of medications as shown in Figure 2.

Figure 2. Medications used for chemical restraint, 2007–08

Two issues of concern are raised by the above list of medications are the use of ‘typical’ antipsychotics which have more severe side effects than the more recent ‘atypical’ antipsychotics and the use of thioridazine hydrochloride (mellerill).
Poly-prescribing

A total of 1,906 people with a disability were subject to routine chemical restraint. Of these 61 per cent (n=1,157) were reported to be administered more than one type of chemical restraint (poly-prescribing). Of these 51 per cent (n=975) were reported as having been poly-prescribed by a GP, 17 per cent (n=324) were reported to have been poly-prescribed by a Psychiatrist and approximately 5 per cent (n=89) by other registered medical practitioners. It should be noted that this data is compounded by the fact that a person may be prescribed medication by more than one registered medical practitioner (e.g. GP and Psychiatrist). Hence total percentages do not sum to 100 per cent. The number of people on poly-prescribing peaked in July 2007 and again in December 2007. Seventy-six more people were reported to be administered poly-prescribing in December than November. As discussed earlier this is most likely due to inconsistent reporting in October, November and January and February.

People administered more than five chemical restraints

An examination of the youngest people with a disability on the highest poly-prescribing showed that three young male adolescents aged 12 (n=2) and 16 years of age were administered up to five chemical restraints for at least one month during the year. The three adolescents had autism and two of the adolescents also had other disabilities such as neurological and speech impairments. A GP, and more recently a paediatrician, had prescribed the medications for one adolescent. Psychiatrists had prescribed medication for the other two adolescents. The medications included a combination of atypical antipsychotics, benzodiazepines, mood stabilisers and psychostimulants.

Five people aged 19 years and older (four were aged between 26 and 37 and one was 57) were administered between five and eight medications for chemical restraint for at least one month during the year. Three of the five people also had autism and two of those had other disabilities (for example, psychiatric illness, neurological and speech difficulties). Psychiatrists had prescribed medication for two of the five people, the other three had been prescribed medication by GPs. The five people were prescribed a combination of atypical antipsychotics, typical antipsychotics, mood stabilisers, benzodiazepines.

Mechanical restraint

The number of people reported to have been subject to mechanical restraint fluctuated between 53 (August) and 72 (April and June) throughout the year with an average of 65 per month. Over the 12 months there were twice as many males (n=110) than females (n=53) who were mechanically restrained. Males aged between 15 and 24 had the highest risk of mechanical restraint and the most common forms of mechanical restraint used included: gloves (1,203 episodes), splints (934), harnesses (464), belts (294) and bodysuits (161).

As can be seen in Figure 3 on the following page, some form of self-harm was the main reason reported for the use of mechanical restraint.

Two young men both in their twenties experienced the highest rates of mechanical restraint, spending most of each day in restraint to prevent them from harming themselves. The OSP is working with the service providers to find alternatives to mechanical restraint for both these young men.

---

9 The term poly-prescribing in this report is used to describe the prescribing of more than one medication for a particular indication, in this case behaviours of concern.

10 Some instances of mechanical restraint that were reported include the use of seatbelt buckles in vehicles which would not be considered mechanical restraint by the definition used in the Disability Act 2006.
Seclusion

Between 34 and 47 people were reported to be secluded each month in 2007-08 at an average rate of 41 per month. Again, twice as many males than females were reported to be subjected to seclusion (86 males and 40 females) for one or more months during the year. Males between the ages of 15 and 34 years of age were at greatest risk of seclusion. According to information provided from BSPs, the location for seclusion ranged from the person’s bedroom, the backyard, another room in the house (such as a lounge room) or a specific seclusion room.

Examining the number of episodes of routine restraints and seclusion is problematic as reporting of routine episodes varies according to service type. A Shared Supported Accommodation (SSA) will report one episode a month per person; respite may report the number of times a person is provided a service; and a day service may not report at all because the SSA has reported. This means the number of episodes of routine restraint across services is inconsistent. However, it is possible to examine the number of episodes of PRN and emergency restraint and seclusion because these are reported by all types of service providers in the same way.

PRN and emergency episodes of restraint and seclusion

Figure 4 shows that during 2007–08 between 118 and 196 people were reported to be restrained and/or secluded as needed.
During the year between 19 and 136 people were reported to be restrained and/or secluded in an emergency between one and 60 times per month. Both the number of people and the number of episodes shows a marked increase in the first half of 2008.

Source: RIDS
Taken together figures 4 and 5 show that the total number of people reported to have been administered PRN restraint and/or seclusion decreased slightly over the year while the total number of people who were restrained or secluded for emergency use increased significantly from 1 January to 30 June 2008. One explanation for this is that, with increased knowledge of the Disability Act 2006, some service providers learned that if the person did not have a current BSP they should be reporting the restraint and seclusion as emergency.

The following gender and age differences were found for PRN and emergency restraint and seclusion:

- More males than females were reported to be subjected to all forms of PRN and emergency restraint and seclusion.
  - Chemical restraint: females=25 per cent; males=75 per cent
  - Mechanical restraint: females=12 per cent; males=88 per cent
  - Seclusion: females=18 per cent; males=82 per cent.

- The majority of the people who were subjected to PRN and emergency restraint and seclusion were younger than 36 years of age.
  - Chemical restraint: 75 per cent aged younger than 35 years of age
  - Mechanical restraint: 74 per cent aged between 15 and 34 years of age
  - Seclusion: 82 per cent aged between 15 and 34 years of age

These results suggest that males aged between 15 and 34 years of age were most at risk of PRN and emergency restraint and seclusion.

All people who were reported to be subjected to restrictive interventions had more than one disability type:

- 95 per cent had an intellectual disability as well as other disabilities (such as autism, speech impairments, neurological, and mental illness)
- 5 per cent had an acquired brain injury, a neurological impairment, or a physical or sensory disability with other disabilities.

Figure 6. Number of people with a disability and type of secondary disability as reported
As can be seen in Figure 6 the majority of people who are subject to restrictive interventions have autism, speech, neurological, psychiatric and/or physical disabilities. It appears that there is a higher proportion of people with autism (n=663) in this group when compared with the current prevalence rates in the population of people with an intellectual disability. It should be noted that the above picture is likely to be a conservative estimate of the physical and mental health needs of this particular group because many health-related conditions are currently under-diagnosed in people with an intellectual disability. This includes the prevalence of autism in adolescents with an intellectual disability. People who are subjected to restraint or seclusion are, on the whole, people who have high and complex health needs.

Multiple restraints

Although most people were subjected to one type of restraint and/or seclusion (n=2,000), 96 were subjected to more than one type of restrictive intervention:

- Fifty-one people were reported to be subjected to chemical and mechanical restraint. The majority of the group had some combination of the following diagnoses: autism (n=23), speech impairments (n=14), psychiatric illness (n=12), an acquired brain injury (n=6). Please note some people have dual diagnoses.
- Thirty-eight were subjected to chemical restraint and seclusion.
- Three were subjected to mechanical restraint and seclusion.
- Four people were reported to be chemically and mechanically restrained and secluded for one month only.
- One person was reported to be chemically and mechanically restrained and secluded for 10 months.

Type of restraint and effectiveness

Each time a disability service provider enters data about restrictive interventions they are also asked to provide a judgment about the level of effectiveness of the restrictive practice used. Specifically, they are required to choose whether the restrictive practice resulted in either:

- ‘full change’ in the behaviour of concern
- ‘partial change’ in the behaviour of concern
- ‘no change’ in the behaviour of concern.

Correlations were used to examine any significant relationships between type of restraint and its effectiveness as reported by the service provider. These analyses revealed the following significant relationships:

- The use of chemical restraint was found to be most highly associated (r=0.7) with producing ‘partial change’, but was also associated but not highly with ‘no change’ (r=0.2) as reported by disability service providers.
- The use of mechanical restraint was extremely highly associated with ‘full change’ (r=0.9) as reported by disability service providers.
- The use of seclusion was most highly associated with producing ‘no change’ (r=0.7), but also associated with producing ‘partial change’ (r=0.5) as reported by staff.

\[11\] Correlations measure relationships between variables and range from \(r=0\) (no relationship) to \(r=1\) (perfect relationship). The closer \(r\) is to 1, the stronger the relationship.
The way forward

Finding better ways to support young people

It appears that younger people, especially young males, are most commonly subjected to restraint and seclusion. Approximately half of the people who were reported to be restrained were under 35 years old and the majority of people (72 per cent) were under 45 years old. People with autism and those with multiple disabilities are more likely to be restrained and secluded than other people and have the highest rates of PRN and emergency restraint and seclusion. This finding suggests disability service providers need to find better ways to support young people with a disability who show behaviours of concern especially young people with autism and multiple disabilities.

Finding positive alternatives to restraint and seclusion

The effectiveness of restraint and seclusion can be measured in two ways. First, the results of staff judgments about effectiveness and second whether restraint and seclusion use declines, increases or remains the same over a number of months. The results of staff judgment of effectiveness suggest that, for the most part, chemical restraint was judged as only partially effective in reducing behaviours of concern. On the other hand, mechanical restraint was viewed by staff as highly effective. Perhaps this is not surprising, given that mechanical restraint by its very nature totally prevents a behaviour occurring. However, the use of mechanical restraint did not decline over the six months from July to December 2007, so it is therefore not effective in reducing behaviours of concern in the long term.

Seclusion was judged to be least effective in producing a change in behaviours of concern. Seclusion is more likely to be used for people with autism and more likely to be judged to be less effective for people with autism. Taken together the results suggest that restraint and seclusion are not effective in decreasing behaviours of concern and other positive interventions (such as anger management skills) should be taught for long-term change in behaviours of concern.

Reporting of restraint and seclusion

There may be substantial under-reporting of restraint and seclusion. While it is difficult to measure under-reporting, evidence for it comes from at least three sources of information:

- Intellectual Disability Review Panel (IDRP) data for 2004–2006 reports much higher rates than reported through RIDS and IDRP also claimed there was under-reporting.

- The results from two small OSP projects also suggest there is under-reporting:
  - The Senior Practitioner update: Chemical restraint six-month update (May 2008). In this study 157 people showed 20 per cent under-reporting of chemical restraint.
  - The Senior Practitioner report and recommendations on the review of psychiatric diagnoses of former and current residents of Kew Residential Services (May 2008) found that 3 per cent of 47 people were not reported on the RIDS system.

In 2008–09, the OSP will continue to support services to report accurately through face-to-face help, phone advice and the seminar/workshop series.
New orders under the *Disability Act 2006*

**Supervised treatment orders and assessment orders**

Under the *Disability Act 2006* a supervised treatment order (STO) is a civil order issued by the Victorian Civil and Administrative Tribunal (VCAT). STOs provide a legal framework to protect the rights of a small number of people with an intellectual disability who are being detained for the purpose of treatment, because of the significant risk of harm they may pose to others.

The Act states:

1. A disability service provider who proposes to use supervised treatment in the provision of a disability service must apply to the Secretary for approval.
2. An application for approval must include—
   a. the prescribed details; and
   b. a request for approval of the title and rank of any position and the name of the holder of the position to be appointed as an authorised program officer for the disability service provider.
3. The Secretary may grant an application for approval subject to any conditions that the Secretary considers appropriate.
4. In the case of a disability service in respect of which the disability service provider is the Secretary, the Secretary—
   a. is to be taken to be approved to use supervised treatment; and
   b. must ensure that an authorised program officer is appointed for the disability service; and
   c. must approve the title and rank of any position and the name of the holder of the position to be appointed as the authorised program officer.

An APO may apply to VCAT for an STO to be made in respect of a person:

1. who has an intellectual disability
2. who is receiving residential services
3. in respect of whom the disability service provider has prepared a treatment plan approved by the Senior Practitioner
4. who meets the criteria specified in section 191 (6) of the Act (to prevent a significant risk of serious harm to another person without an STO applying).

The treatment plan must be approved by the Senior Practitioner before APOs apply to VCAT for consideration of an STO.

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.

**What we did**

In July 2007, when the *Disability Act 2006* came into effect, there were 27 treatment plans submitted to the Senior Practitioner for approval. This number increased to 36 over the first 12 months of the Act. At the end of this financial year (30 June 2008), there were 24 people on STOs and six people on interim STOs. Of the 36 people for whom applications were made to VCAT, 35 were males who presented as significant risk to others because of alleged physical violence or sexually offending behaviour.

Two applications have been submitted to the Senior Practitioner for assessment orders. One resulted in an application for an STO, the other person was returned home to be supported by family.
The initial 27 treatment plans were reviewed by OSP practice leaders. The treatment plans were approved for periods of time ranging from two months to the full 12 months. Approvals were granted based on the quality of the treatment plans prepared and the assessments that informed the treatment proposed.

Other treatment plan reviews throughout the year provided the opportunity for the OSP to provide further direction to DSPs on assessing, collecting and analysing data. Some resulted in issuing mandatory assessments and ongoing reviews for particular people.

VCAT revoked orders or dismissed applications for six orders in 2007–08 because it was not satisfied that either:
- the person was able or willing to consent to voluntarily comply with a treatment plan
- it was necessary to continue detaining the person to ensure compliance with the treatment plan
- there was a significant risk of harm to another person that could not be substantially reduced by using less restrictive means.

Submissions from APOs, guardians or the person’s legal representative also influenced these decisions.

What we learned

The people subjected to STOs during 2007–08 were mostly aged 20–40 years with mild intellectual disability. Within this group there was a range of other diagnoses including mental illness, epilepsy and autism. Dual disability (intellectual disability and mental illness) accounted for more than a third of the people who applied for supervised treatment orders.

Of the 15 people diagnosed with mental illness, eight people had a single diagnosis of schizophrenia (2), bipolar affective disorder (1), anxiety disorder (1), shared psychotic disorder (1), atypical psychosis (1) and depression (2). Seven people had more than one diagnosed mental illness, for example schizophrenia, anxiety disorder and depression.

Other diagnoses included tourette syndrome, foetal alcohol syndrome, mild adjustment disorder, paraphilia and paedophilia, borderline personality disorder, impulse control disorder, post traumatic stress disorder and conversion disorder. There were six people who had autism, five with epilepsy, and two with substance abuse issues. Five people had no diagnosed condition other than intellectual disability.

The risk of physical violence towards others was the predominant reason that 11 treatment plans were submitted. This group tended to have issues associated with mental illness, be diagnosed with autism and were placed in care at a young age.

Twenty-five plans were submitted predominantly because of a risk of sexually offending behaviour. Similarities in this group included allegedly being subjected to sexual assault as a child (13 cases), experiencing domestic violence at an early age (associated with drug and alcohol dependence of one or both parents), having a disrupted and sometimes transient life during early years and being placed in care or with other relatives at a young age.

The concept of developing treatment plans for people was new to some DSPs and many struggled with the initial development. The area of most concern to the Senior Practitioner was the number of treatment plans submitted in June 2007 that were developed either without assessments, based on outdated assessments or developed without fully considering the recommendations made in an assessment. The Senior Practitioner’s expectations regarding assessment were made clear in the initial treatment plan certificates issued to approve the plans. Those that were submitted based on outdated or no assessments were approved based on this work being completed within a designated timeframe.

At the end of the reporting period (30 June 2008) all approved treatment plans were developed with an assessment completed either in 2007 or 2008. This has improved the way treatment plans have been developed and full implementation of the plans should lead to positive life changes for these people.
The way forward

In reflecting on the supervised treatment orders issued during 2007–08, it’s difficult not to wonder ‘what if’. The right support or intervention provided at the right point may have made a dramatic difference in these people’s lives. Although we can’t change history, we must learn from the events of the past and there are many lessons to be learned both from a systemic point and from the service system being challenged in supporting this group of people.

The Act sets out the criteria for applying supervised treatment and the key to moving forward is developing and implementing a treatment plan that meets the person’s needs. There is a need for ongoing assessment and ongoing evaluation of treatment strategies to ensure that progress is made and that the person’s human rights are not limited unnecessarily.
A year of refinements
...asking stakeholders to rate our performance
Stakeholder survey

What we did

In June 2008 we sent out over 500 surveys to a variety of stakeholders including disability service providers, advocacy groups and training participants. We wanted stakeholder feedback to help inform both our existing and future strategies. We engaged an external provider, Full Circle Feedback, to conduct the survey to ensure independence and to reassure stakeholders about the confidentiality of the process.

We structured the survey into six sections that asked for responses about:

1. the parameters of our role
2. the support and skills we provide to stakeholders
3. our level of service
4. the quality and efficacy of our systems
5. the calibre and conduct of our staff
6. to what extent we successfully fulfil our role.

The survey contained aspirational statements requiring responses against an ‘agreement’ scale (1 = strongly disagree to 5 = strongly agree), questions about key strengths and opportunities and questions that required ‘free text’ responses. In total, 317 responses were received, with the majority coming from CSOs (182) and the Department of Human Services - regional disability services (81).

For the OSP, the importance of research extends much further than just to inform the practice of our stakeholders. It’s also important to learn what we need to do to improve as well. It is important to not only seek the views of stakeholders, but also act on them.

What we learned

The overall feedback from stakeholders was very positive. The average agreement score for the survey was 3.93 (agree). Sixty-seven per cent of responses were favourable (agree or strongly agree); 4 per cent were unfavourable (disagree or strongly disagree). Twenty-nine per cent of responses were either neutral or don’t know, which was relatively high and seems to reflect the new role of the OSP. It also highlights a range of areas where stakeholders were yet to develop a strong opinion. The highest scoring survey statements tended to have very low levels of neutral or don’t know scores whereas the lowest scoring survey statements tended to have very high levels of neutral or don’t know scores.

Stakeholders selected client focus, leadership and professional staff among the highest strengths of the OSP. The emphasis on positive solutions and a planned reduction in seclusion and restrictive orders was considered a positive step forward. The problem solving approach was considered better than a compliance model. The OSP was perceived to have a strong focus on protecting the rights of people with a disability and promoting the human rights of people with disabilities. The values demonstrated by the OSP were considered consistent with the objective of protecting the rights of people with a disability.

Stakeholders believe the OSP is an organisation with great potential. We were perceived to be influencing practices that support people to achieve dignity without restraint. The highest scoring statements had very high levels of agreement (90–95 per cent) and very low levels of disagreement (0–4 per cent).

Stakeholders selected communication, collaboration and strategic advice among the opportunities for improvement. However, it is important to note that the lowest scoring survey questions tended to have very high levels of neutral or don’t know responses. This suggested that many stakeholders may have had limited exposure to some areas of OSP services and were yet to make up their minds.
Example of free-text feedback include:

There seems to be a real commitment to working together to support community inclusiveness and work practices based on the human rights model.

I wish that I had more support, training, and contact with them. The training I have had with them has been excellent.

The office’s expectations are unreasonable/unachievably high in regards to having assessments/psychiatrist consultations.

On the occasions I have called the OSP I have received great advice and there has always been a follow up email.

There is strong leadership and a common vision shared by all at OSP.

The burden of compliance has increased markedly since introduction of the Act. The concern here is about the lack of funding to support that change.

One of the things that excites me about the OSP is the solution-focused nature of what it does and its not just about pouring in more [money] its about looking at the way we do things.

They have developed some great tools for organisations to use and I think the OSP is challenging the way people operate.

Much more work [is] required to assist direct support staff to get an understanding of what is required of them and why.

I think the office is unaware of the huge impost of this on CSOs who are struggling with the mounting compliance costs from new legislation which is designed to monitor CSOs more than provide safeguards for people.

The PD sessions have been brilliant. They encouraged us rather than deterred us.

The way forward

The evaluation feedback will inform our practice and planning of future initiatives. We will target training to groups of professionals that can help us implement the Disability Act 2006. We will communicate better to DSPs maintaining our focus of protecting rights and dignity.
A year of initiatives
...implementing new strategies and projects
Introducing RIDS

For the first time ever Victoria has an accurate measure of the use of restrictive interventions for people with a disability showing behaviours of concern.

Part 7 of the Disability Act 2006 requires all disability service providers to report to the OSP on their use of restrictive interventions. To help DSPs fulfil this obligation, the OSP developed the Restrictive Intervention Data System (RIDS).

RIDS is a web-based system, a first in the disability sector. For DSPs to access it, the OSP must first register users and issue a password. All information is housed on a secure server located within the Department of Human Services. No information is stored on individual computers. RIDS allows staff to enter information, submit a monthly report to the Senior Practitioner and extract information. The Senior Practitioner and his delegates are the only ones who can view and extract information for all DSPs.

RIDS is easy to use. For example, medication names have been made easy to enter using a recognition scheme so that the user can type in part of the medication name and the correct spelling will be provided. These features also help decrease regulatory burden by reducing the workload of DSPs while still meeting legislative reporting requirements.

What we did

The OSP developed RIDS following extensive consultation with the disability sector. It was made available to all DSPs on 1 July 2007.

A staged introduction of the system allowed DSPs time to adjust from the former paper-based Intellectual Disability Review Panel (IDRP) monthly reporting regime to an online system. Providers were permitted to report restrictive intervention use through a paper-based version of RIDS up until the end of 2007.

Throughout this transition period, the OSP actively trained DSP management and staff to use the electronic version.

Features of RIDS

DSPs and the Senior Practitioner can view the information as reported by the DSP’s APO at any time. This information has been used to inform the Senior Practitioner’s quarterly reports and occasional reviews of services provided to DSP clients.

RIDS has a number of system alerts that advise nominated users both within DSPs and the Senior Practitioner when preset triggers have been activated. These automatic alerts include:

- an email to the APO advising that a BSP is due to expire in two months’ time
- an alert advice to the APO when an intervention has not been reported.

Other alerts can be programmed within RIDS as identified by any stakeholder and may include an alert to the Senior Practitioner when seclusion has been reported, a young person is subject to an intervention or when a combination of restraints are used.

The information entry fields within RIDS are mostly selectable from dropdown menus to save time and reduce the potential for error. RIDS can also identify patterns and trends in the use and form of restrictive interventions, such as in the types of medications selected by prescribers.

Under the Disability Act 2006, DSPs that propose to use restrictive interventions must be approved by the Secretary of the Department of Human Services. RIDS was upgraded on 1 July 2008 to facilitate this application process, significantly reducing the regulatory burden and improving data accuracy.
What we learned

The transition period from paper-based to the electronic version of RIDS not only assisted DSPs to adjust, but helped us as well. We discovered a number of system limitations including how spelling errors or missing information for medications, addresses and names impacted on the quality of the data and our ability to analyse it. We realised that missing BSP dates meant that we weren’t able to quickly identify if the intervention was supported by a current BSP.

The way forward

Feedback from DSPs has indicated a high level of acceptance of RIDS as a reporting mechanism. The information has been used to inform existing practice and will shape future planning. Interest has also been shown by researchers in using this information to review and inform policy and practice.

The Senior Practitioner is now developing self-reporting modules for DSPs. The objective of the project is to work with all DSPs to identify their information needs and to produce custom reports, enabling DSPs to access information that better meets their individual needs. For example, some DSPs have expressed a need for reports to identify PRN and emergency intervention use for a specific period. This data can then be used to inform their performance reporting requirements.

The integration of an online process to generate BSPs and to report on restrictive interventions is scheduled for 2008–09. Currently, RIDS collects information about the use of restrictive interventions. In the future RIDS will not be limited to just what happened, but rather link in with the BSP to enable a comparison between actual use and planned use as detailed in the BSP.
Revisiting the psychiatric diagnoses of former KRS residents

When we looked at the medical treatment of many former Kew Residential Services (KRS) residents we found a disproportionate number on high doses and/or multiple medications without a clear rationale. In 2007 a review by the IDRP (now decommissioned) found that about 20 per cent of 440 former KRS residents were diagnosed as having a psychiatric illness. The most common psychiatric illness was ‘psychotic disorder NOS’ (not otherwise specified). Not only was the rate of this unspecified diagnosis too high, many of these residents had not received an independent psychiatric review as recommended by the IDRP.

Before its decommissioning, the IDRP recommended that 82 former KRS residents receive an independent psychiatric review with follow-up treatment. The Senior Practitioner was asked to see that the reviews were conducted and that any medication prescribed for the primary purpose of behavioural control was reported as chemical restraint.

What we did

We began this process by identifying those former KRS residents who had a diagnosis of ‘psychotic disorder NOS’, no diagnosis or a diagnosis of pica (an appetite for non-nutritive or unusual foods such as chalk, paper etc). We specified that information be provided on prescribed psychotropic medication including details of the drug’s name and date of first prescription. Details of the first psychiatric diagnosis (including the name of the psychiatrist consulted) were also requested.

Of the 82 former KRS residents referred by the IDRP, 47 had diagnosed with psychotic disorder NOS. Of the remaining 35, three had passed away and the other residents had been diagnosed with a more specific psychiatric disorder such as bipolar disorder, trichotillomania (an impulse control disorder characterised by the repeated urge to pull out scalp hair), anxiety disorder or obsessive-compulsive personality disorder.

We understand that many people with a disability may exhibit behaviours of concern, the causes of which are sometimes difficult to distinguish between mental illness and other factors. Communication difficulties may further impede how behaviours of concern are interpreted. Either way, using medication to control behaviour in a person with a disability may have severe side effects; the risks of which need to be carefully weighed against the benefits.

The prevalence of gastro-oesophageal reflux (GERD) among people with a physical and intellectual disability has been estimated at 10–15 per cent. For those prescribed anticonvulsants, anti-psychotics or benzodiazepines, the rate of reflux oesophagitis may be as high as 50 per cent, greatly increasing the risk of oesophageal stricture, Barrett’s oesophagus and oesophageal cancer.

What we learned

Twenty-nine of the 47 former KRS residents were first prescribed psychotropic medication during the same year they were diagnosed, another 12 were prescribed before receiving their first psychiatric diagnosis, the longest being 43 years prior.

We received first-diagnoses dates for 40 former KRS residents. Thirty-five of those were conducted by one psychiatrist.

We also found that two former KRS residents with no psychiatric diagnosis and a diagnosis of pica were administered chemical restraint that was not reported on RIDS as required by the Disability Act 2006.
The way forward

The Office of the Senior Practitioner is recommending that any former KRS resident identified by the IDRP with severe communication difficulties be reviewed by a speech pathologist or an augmentative and alternative communication specialist (if such a review has not been conducted previously) prior to any psychiatric review.

We are further recommending that any former KRS resident with symptoms of GERD should be referred to their GP for further assessment and management.

The Senior Practitioner is funding the independent psychiatric review of the remaining 76 former KRS residents to be reviewed by an independent psychiatrist. Forty-four of these former residents have been diagnosed with ‘psychotic disorder NOS’ or no psychiatric diagnosis and 32 have a range of other potentially out-of-date diagnoses. These reviews will be conducted through the Centre for Developmental Disability Health Victoria.

Twenty-three reviews have so far been submitted to the Senior Practitioner. Seven former residents were found to no longer display symptoms consistent with a psychiatric illness and another eight were diagnosed with autism. The remaining reviews will be submitted to the Senior Practitioner by November 2008.

The Senior Practitioner is also recommending that all people who have a psychiatric diagnosis or are prescribed psychotropic medication be reviewed annually by a psychiatrist.

John's story

John is a 49-year-old man who lived in an institution from the age of 16, having never attended school. In 2000 he was relocated to a community residential unit.

John has a profound intellectual disability, does not communicate with speech, is quadriplegic, asthmatic and epileptic. John’s complex physical needs were compounded when he needed a gastrostomy tube inserted in 2007 to control aspiration.

During a visit from the OSP’s practice leader of Integrated Health Care Practice it was recommended that his medication be reviewed. John was prescribed antidepressant medication about eight years ago although the reason for it is unknown. When staff approached his GP to cease the antidepressant medication he was reluctant to do so, as he felt that John appeared well and contented.

This was not the view of the staff who supported John on a daily basis; therefore, staff approached the GP a month later explaining that they required written documentation stating why John was prescribed the medication. The GP would not write a letter justifying the prescription of the medication, so he decided to trial ceasing the medication. In the event that John showed signs of distress, the GP would re-prescribe the antidepressant medication and write a report to the OSP.

The antidepressant medication was ceased in May 2008. Within three days staff could see an improvement in his demeanour, the district nursing service who sees John twice daily also reported an improvement. The staff at the day service John attends did not recognise him as the same person. Staff noticed that he was a lot more bright and attentive. John could communicate his wants and needs more effectively. It was also noticed that there was a great improvement in his sleeping pattern. John used to wake and moan at least three times a week around midnight pointing to his abdomen area. Staff later wondered if he was suffering from nausea – a side effect of the medication.

Staff, and others who know John well, feel his whole life has changed and he is now more sociable, approachable and above all, happy.
Active prevention strategy

The OSP’s *Active prevention strategy* assists service providers – including direct support workers and supervisors – to find positive and proactive alternatives to restrictive interventions and practices. This exploring of intervention options and support may also involve other professionals, the person with a disability and families in developing intervention plans.

What we did

The OSP’s practice improvement advisor, Jenny Butler, has visited service providers, day placements and community residential units and taken a hands-on approach to implementing the strategy. She has worked proactively with support workers and people with disabilities and their families on developing and implementing intervention strategies and plans. She has also conducted assessments, staff training sessions, provided additional advice and made recommendations to progress supports that enable a person with a disability to lead a better quality of life using less restrictive interventions.

The *Active prevention strategy* has implemented a range of strategies, interventions and reviews for 15 people across three departmental regions resulting in an improved quality of life for the individuals concerned and greater staff understanding of alternatives to restrictive interventions. This has included:

- improving staff knowledge about specific issues such as sexuality
- providing information and resources on a variety of topics
- developing alternative options for managing behaviours of concern
- formal assessments when required and providing ongoing support for staff, carers and people with a disability.

In all instances using less restrictive approaches designed to improve the quality of life for people with a disability have been of paramount importance.

What we learned

Feedback so far indicates that the staff, service providers and people with an intellectual disability who have been involved with the *Active prevention strategy* have all been highly satisfied with the outcomes and the service that have been provided. Feedback has included the following.

‘I would like to say on behalf of the client involved and the staff team that we were extremely pleased at the way this difficult subject was approached by Jenny Butler. It was dealt with in a very timely and professional manner and at all times the client was treated with dignity and respect.’ (House supervisor)

‘What I think is you have done a good job helping us write the rules. I reckon you did a good job explaining what you were talking about. You are a nice person.’ (Person with an intellectual disability)

‘It was great. You made the staff feel comfortable, you encouraged all staff to contribute and made them feel valued’. (Support worker)

The way forward

Active prevention is an important practical strategy to assist direct disability support professionals and people who are subject to restrictive intervention. The strategy helps to prevent the behaviour from escalating to high risk. The OSP is considering also implementing the strategy for children and adolescents who are subject to restrictive intervention.
Jarrod is a 36-year-old man with a rare genetic multi-system disorder complicated by a severe intellectual disability, epilepsy and significant problems communicating. He is non-verbal but uses a series of vocalisations and mannerisms to communicate. He dislikes crowds and prefers only one person working with him at a time.

Jarrod has a long history of engaging in a number of behaviours of concern. These include property destruction, harming others, verbal aggression such as roaring at others to intimidate them and self-injurious behaviour including hand biting and head slapping. These outbursts of behaviour occur approximately every three months often without any discernable indicators or triggers beforehand. When these incidents occur Jarrod is secluded or physically restrained to stop him from harming himself or others. Jarrod is on high doses of antipsychotic medication to ‘curb’ his behaviour.

Following a referral from the Office of the Senior Practitioner and recommendations from the Active Prevention practice advisor, the staff where Jarrod lives, have shown considerable insight, initiative and creativity in their efforts to improve Jarrod’s quality of life. Staff have built an accessible sand pit in his garden area, refurbished the trampoline and provided him with a garden swing seat. A selection of ‘squeaky’ toys and other items has been set up in his lounge area. They have also hung pictures on the walls and his sister, who is an artist, painted a mural of a lion for his bedroom depicting the qualities she saw in her brother. Every Wednesday he has one-on-one time with staff.

Jarrod has been booked in for a comprehensive health assessment with his GP and staff are investigating the feasibility of both communication and neurological reviews.

Staff generally feel very proud of what they have achieved with Jarrod. They believe that while the interventions have not necessarily had an immediate impact on Jarrod’s behaviour, reporting little to no change, it has altered how they perceive themselves as a staff group. They feel more confident, expressed feelings of improved self-worth as direct care staff and said that they felt far more motivated towards positive practice improvement than they had in the past. The family were delighted with the project, with his sister finding new focus in her relationship with her brother and his mother feeling a new connectedness with her son.
A fundamental aim of the Office of the Senior Practitioner is to promote positive behaviour support practices that reduce the need for restrictive interventions. One method we looked at during 2007–08 was ‘mindfulness’. And it’s producing results.

What we did

The OSP began working in partnership with Dr Nirbhay Singh and his team at the ONE Research Institute in the United States to implement the Mindfulness Project – an initiative that aims to explore the effectiveness of training people with disabilities to use mindfulness (a form of meditation) to better manage anger and aggression.

Dr Singh’s team trained the first group of Victorian clinicians in November 2007 and they became certified in April 2008. They are now qualified to train clients and staff in a mindfulness technique called Soles of the feet (SoF).

A second group of clinicians and support workers were trained in April 2008 and are currently practising the technique with clients.

What we learned

To evaluate the effectiveness of the technique, we spoke with staff and clients about how using SoF had helped their state of mind. Many commented on how enjoyable it is, saying they look forward to the mindfulness meditation sessions each week. The sessions have, they say, helped them to calm down when they are angry and to cope better with pain.

We have also learned that people who practice SoF can remain calm for some time after their session, even when usual triggers occur directly after practising the technique. For example, one client reported that using SoF when he is out in the community helps him calm down if he becomes upset. Another told us that it has helped her to relax when she becomes stressed and anxious when travelling home from work in a taxi. Staff say they now feel negative emotions less intensively and feel they are more able to respond to stressful events in a calm way.

The way forward

The OSP is now working with staff and residents from the department’s Barwon South West region. By the end of 2008, the Barwon South West region will have several staff trained in using SoF.
Partnerships for Positive Solutions

One of the things that really struck us when we went out and spoke with disability service providers about using restrictive interventions was the lack of information sharing. We found that many DSPs resorted to restrictive measures to manage behaviours of concern for no other reason than they simply weren’t aware of the alternatives. The lack of up-to-date professional diagnoses didn’t help matters either.

Under the Disability Act 2006 the Senior Practitioner is required to provide education, information and advice with respect to restrictive interventions and compulsory treatment. We understand this is a legislative requirement, but in our first year have taken a collaborative approach to fulfilling it.

What we did

The OSP has developed Partnerships for Positive Solutions (PPS) – as a practice improvement strategy that incorporates this reporting role. We have initiated PPS forums to proactively feed back issues arising from RIDS and BSP data analysis reports, as well as providing the opportunity for DSPs to develop action plans to address identified service system and individual client issues.

We have set down a number of core requirements relating to the forums:

- Within the context of this data analysis, discussion must centre around clients on compulsory treatment orders, high-needs, high-risk clients and associated behaviour support practices surrounding this client group.
- The specialist services manager or equivalent must be a member and sit equally at the forum with other representatives.
- There must be an independent member appointed to the forum to ensure transparency and to give the process credibility.
- Where identified, action plans will be developed to address issues arising from RIDS/BSP data analysis reports.

The PPS forums began in late February 2008 and have run quarterly with each Disability Services region. Seven regions have since convened a second quarterly forum and in this process have developed regional action plans; all regions are developing strategies to include CSOs with their regional PPS framework. A PPS forum has also been established with the Disability Services division executive to examine statewide trends and issues arising from the regional forums. Like the regional forums, this forum has independent representatives as part of its membership. The divisional forum meets every six months and had its first meeting in July 2008. The forums will be offered to larger CSOs over 2008–09.

What we learned

A number of common issues have arisen from the action plans:

- Audits have revealed a lack of quality reporting both in relation to BSPs and restrictive interventions on RIDS.
- APO networks need developing.
- The use of chemical restraint can be further reduced.
- Pathways for more effective engagement with CSOs need to be created.
- More training is required for staff in BSP development, functional behaviour analysis and positive behaviour support.
- The interface between disability accommodation services, disability client services and specialist services needs improving.

12 Southern region is in the process of developing and incorporating their PPS action plan into their annual business plan.
• Systems to review and monitor high-needs, high-risk clients need to be implemented.
• There is not enough access to mental health services.
• Access to GPs in rural areas is an issue.
• There is a need for region-specific practice development strategies.
• For individual clients, clear actions and those responsible for implementing them must be identified.

The way forward

These themes and the initiatives developed to address them are documented in individual action plans, which will be monitored and evaluated in subsequent PPS forums at both a regional and head office level. Individual items in the action plans will not be finalised until agreed outcomes have been achieved and PPS forum members agree that the particular issue has been addressed.
Reducing chemical restraint

Any time a drug is used to control behaviour rather than to treat medical/psychiatric symptoms it is considered chemical restraint. To address this, the Senior Practitioner implemented a chemical restraint reduction strategy in August 2007. The strategy is about helping service providers to consider less restrictive alternatives where possible.

Under the Disability Act 2006, the Senior Practitioner is responsible for monitoring seclusion, chemical restraint and mechanical restraint. All incidents of these restrictive interventions must be included in BSPs, a copy of which must be provided to the Senior Practitioner.

What we did

To ensure the strategy was implemented, we established a new role – Practice Leader, Integrated Health Care Practice. We wanted someone exclusively available to assist people with disabilities, their families, direct support workers and supervisors to find alternatives to chemical restraint.

We started by working with the department’s disability accommodation services (DAS) in August 2007 and continued with CSOs in March 2008. As a first step, disability service providers were asked to nominate people with a disability who, having been prescribed chemical restraints, may particularly benefit from an informal consultation, review or further advice about alternative treatments.

Between August 2007 and June 2008, the practice leader visited 99 community residential units (CRUs) across all eight departmental regions. She reviewed 326 person’s and developed 99 ‘action plans’ (a list of recommendations) for house supervisors. These plans pertained to individual people with disabilities and were followed up within six weeks.

What we learned

Systemic issues

Staff support

Staff need support to:

• identify medications that people with a disability are prescribed
• link the process of assessment, planning, implementation and evaluation
• make sense of the recommendations from assessments by medical practitioners
• follow-up and implement recommendations identified by assessment reports
• address complex needs.

Medication

• Product information for medications was not available to staff or staff were unaware of product information.
• The majority of staff were unaware of the purpose of psychotropic medication.
• Treatment sheets do not list anticholinergic (for side effects) medication.

Psychiatric diagnoses

• Very few psychiatric reviews had been carried out for people prescribed psychotropic medications on a regular basis or annually by a psychiatrist.
• Most psychiatric diagnoses were made by GPs.
Other

- There is little evidence to link BSPs with the behaviour of concern they supposedly address, in particular by using chemical restraints.
- People with complex communication appear to be more vulnerable, as many do not have current and appropriate augmentative communication system and vocabulary to address their needs, for example, in order to express side effects of medication.
- Menstrual suppression continues to be practiced for women with a disability.

Issues specific to disability accommodation services

Several issues were common across all eight departmental regions.

- Prior to October 2007, there were still 91 people prescribed Aldazine. Aldazine was withdrawn from the market in 2001. In June 2008, there were still approximately nine people prescribed Aldazine.
- Many clients who were prescribed antipsychotic medications were also on poly-prescribing.
- Before the strategy was implemented staff were not aware or completely clear about the division’s new format health plans.

Issues specific to CSOs

- Some CSOs have not reported anyone on RIDs.
- It is common for CSOs to think only PRN medications are classified as chemical restraint.
- Day services have not been reporting routine medications administered for people living at home.

Other issues identified

- Midazolam is prescribed for many individuals for seizure management. In one region, midazolam is used as a sedative prior to medical appointments – 35 of 36 cases prescribed in the same region alone. In a few cases, midazolam is prescribed to manage a behaviour of concern.
- Further discussions need to be had with GPs regarding the safety and wellbeing of people subject to chemical restraints.
- Not all incidents of chemical restraint were reported on RIDS.
- A more effective interface with mental health and medical specialists is needed.

The way forward

As of 20 June 2008, 47 (67 per cent) action plans were completed for DAS. The OSP is awaiting responses from CSOs and will continue to work with services and organisations for the outstanding plans.

Many of the systems issues identified were similar to other reviews undertaken by the Senior Practitioner (such as ex-KRS residents). Region-specific issues have been discussed the relevant regions and will be reiterated in the PPS strategy.

The practice leader (IHCP) will work with staff on the Aldazine issue.

The department’s Disability Services Division (Quality Sector & Development Branch) has initiated several strategies to address many of the concerns.
OSP awards 24 grants to fund research

Improving the way we provide our services to the community relies on having thorough, up-to-date knowledge about the needs of the people we support. And the only way to do this is through research.

What we did

During our first year, the OSP established the Research Reference Panel to provide advice and feedback about sector research priorities and to disseminate OSP-funded research. Through this panel we offered two major funding initiatives to promote research in the sector:

1. The Senior Practitioner Partnership Grants. Six grants totaling more than $291,000 were awarded to collaborations between disability service organisations and researchers in partnership with the Senior Practitioner. Having practitioners work directly with researchers will mean new knowledge is more rapidly turned into practice.

2. The Promoting Dignity grants encourage disability support workers to try new ways to support people with a disability who are subject to restraints and seclusion through 18 grants totaling $24,184.

The grants were presented by the Senior Practitioner and Health and Community Services Union State Secretary Lloyd Williams at an event held in July.

At the presentation, Lloyd Williams made clear HACSU’s support for the grants initiative saying they recognise the day-to-day work of disability support professionals in bringing about practice change, supporting alternate ideas that can make a difference to people’s lives and supporting evidence-based practice.

It is crucial, he said, ‘that we support, encourage and challenge disability support professionals to be innovative and brave with new ideas, that they are tested to see what works, what makes a difference and that we then celebrate and support the implementation of those ideas and outcomes’. Mr Williams also made the point that service providers need to support staff when ideas and opinions are offered.

Research partnership grants

The six major research partnership grants were awarded to:

- **Dr Stuart Thomas and Dr Michael Daffern** from the Monash University School of Psychology, Psychiatry and Psychological Medicine Centre for Behavioural Science for *Intellectual disability, victimisation and criminal offending during a period of deinstitutionalisation: a data linkage study.*

- **Associate Professor Christine Bigby, Dr Tim Clement and Ian McLean**, a partnership project of La Trobe University and Golden City Support Services, for *Evaluating a reputed exemplary residential support service for people with severe intellectual disability and challenging behaviour.*

- **Dr Teresa Iacono, Dr Robert Davis, Stella Koritsas, Daniel Leighton and Betty Hamilton**, a partnership project of Monash University, Jewish Care Victoria and Nadrasca for *A protocol to guide a collaborative medication review for adults with behaviours of concern.*

- **Dr Anton Mischewski, Dr Nancy Salton, Dr Keith McVilly and Reinforce**, a partnership project of St John of God, RMIT University and Reinforce for *It’s a way of life: a case study of embedding a culture of positive behaviour support in a Victorian disability organisation.*

- **Hilary Johnson, Dr Teresa Iacono and Nick Hagiliassissi**, a partnership project of Scope and Monash University for *Collaboration in the development of behavioural social stories to reduce behaviours of concern and restrictive practice.*

- **Dr Keith McVilly, Dr Douglas Boer, Dr Frank Lambrick, Peter Persson and Dr Barry Waterman**, a partnership project of RMIT University, University of Waikato and Department of Justice for *Development of a risk assessment and planning tool to inform services for people with intellectual disabilities who exhibit severe behaviours of concern.*
Promoting Dignity grants

The 18 Promoting Dignity grants went to:

- **Traceylee Barr and Glenauburn Road team**, North and West Metropolitan Region Disability Accommodation Services for an *individualised sensory room*.

- **Traceylee Barr and Glenauburn Road team**, North and West Metropolitan Region Disability Accommodation Services for *literacy and numeracy resources*.

- **Marita Brady**, Skills Connection for *raised garden beds at the Day Program at Pound Road*.

- **Simone Brennan**, Central Access Limited for *implementation of Advancing Practice in Behaviour Support*.

- **Deb Sturt and James McDougall and Finn Street team**, Loddon Mallee Region Sandhurst Centre for *sensory and relaxation materials*.

- **Brooke Andrews**, the Onemda Association for *the appointment of a Behaviour Support Coordinator*.

- **Lisa Lewis and James Street team**, Southern Metropolitan Region Disability Accommodation Services for *a communication assessment and Person Centred Active Support training*.

- **Leeanne Carleton and Hamilton Street team**, Southern Metropolitan Region Disability Accommodation Services for *educational activities*.

- **Donna Melder and James Street team**, Southern Metropolitan Region Disability Accommodation Services for *sensory assessments and equipment for the residents of James Street*.

- **Janet Wilson**, Community Learning and Living Service Yooralla for *the development of a training module and a training kit for mealtime assistance to people with disabilities who have dysphagia*.

- **Christopher Spiteri and River Drive team**, North and West Metropolitan Region Disability Accommodation Services for *the development of a sensory program*.

- **Caroline Chown and Batesford team**, Barwon South Western Region Disability Accommodation Services for *yoga and meditation for the residents of the Batesford community residential unit*.
• **Jason Vorstenbosch and Mair Street staff**, EW Tipping Foundation for *The establishment of a sensory room for residents of Mair Street.*

• **Alby Adams**, Gippsland Region Disability Accommodation Services for *A literature review on lock free environments.*

• **Lorna Richardson and Gray Street team**, Gippsland Region Disability Accommodation Services for *The creation of a sensory garden for residents of Gray Street.*

• **Donna McKay**, Disability Services Jewish Care for *The development of a photo-voice strategy to reduce the use of restrictive interventions.*

• **Jodie Colclough**, Knoxbrooke Adult Training Support Services for *The development of a sensory room.*

• **Andrea Squire and Bright Street team**, Loddon Mallee Region Disability Accommodation Services for *Equipment to use in an activities room for the residents of Bright Street.*

What we learned

We identified that staff were keen to learn and put into practice alternative positive support solutions in their work with people with a disability. This was expressed by Mr Daniel Leighton, Disability Services Manager, Jewish Care in his speech at the Senior Practitioner Grants Awards ceremony on 29 July 2008, where he stated that "creating positive environments and supporting people to live meaningful lifestyles is not just the mantra from the Victorian state disability plan – it should be the primary obligation of all service providers if they are to promote developing positive behaviours. In 2004 at Jewish Care Victoria, for example, staff adopted a ‘whole-of-person’ approach to respond to behaviours of concern that considers the adult, their support needs, their home environment and their overall quality of life. They implemented active support along with staff training, a refocus on resident needs and re-rostering of staff. Within six months, we were beginning to see results, and by 2006 the number of physical assaults had dropped to a third of the 2004 levels. Today, it is not unusual for a month to pass without any use of seclusion."

Research can and should occur everywhere. As a sector we have a much greater need to focus on evidence-based practice. Therefore, it is particularly rewarding to see direct support staff and team leaders engaging, encouraging and entering into debate and a search for alternatives at a grass-roots level.
The way forward

There is a lot of interest from disability service providers and research centres in working together and increasing communication and the sharing of ideas relevant to their work. Mr. Leighton also emphasised this in his speech by stating 'as a service provider, the OSP is keen to work in partnership with other service providers to the benefit of the people we support. We are extremely proud of the achievements of disability sector staff who continue to work in challenging roles to deliver the best outcomes, often within stretched resources.'

Service providers and staff appreciated the recognition and stimulus to their work with people with a disability provided by funding grants. Mr. Leighton stated that 'by providing a modest funding partnership grant, the hope is that practitioners and researchers will be able take their work further into bigger grant applications in the future.

We look forward to the positive outcomes of this first round of grants coming to fruition in 2008–09.
High-needs, high-risk clients

The Department of Human Services (DHS) Disability Services Division, in some instances, provides additional funding to departmental regions for clients with needs beyond the scope of existing funding. The Office of the Senior Practitioner analysed and reviewed these clients for both funding allocation and management.

What we did

In September–October 2007, the OSP reviewed 10 high-needs, high-risk clients who were funded as part of this program during 2006–07. The clients were mostly male and ranged in age from 12 to 60; four were adolescents.

What we learned

Poly-prescribing was evident in seven cases with typical antipsychotic medications commonly prescribed. Psychotropics were prescribed in cases where there was no formal psychiatric diagnosis and many others had questionable diagnoses. Nine were on psychoactive medications and they came from a mix of accommodation types.

We found that support plans need to be more comprehensive in order to reflect the clients’ high-needs, high-risk profile and funding allocations.

There tended to be a major emphasis on residential supervision and supervised community access and little emphasis on reducing these measures. Physical restraint was identified in four cases and seclusion was used as a regular strategy in three. Three cases were not recorded on RIDS nor had a BSP. All had a lack of comprehensive assessment and comprehensive BSP.

There was minimal evidence of any reduction of restrictive practices and minimal to no progress in monitoring. In all cases staff had not been properly trained to implement plans.

The way forward

The OSP made a number of recommendations for future referrals and funding applications for high-needs, high-risk clients:

1. All referrals should have a current and comprehensive biopsychosocial assessment. Any psychological assessment must include a functional analysis of the individual's presentation and behaviours of concern. Any psychiatric assessment must contain details surrounding diagnosis and subsequent reasons for specific medication prescription. Regular review dates related to all assessments completed should also be specified. The assessments must be conducted by suitably qualified and experienced professionals, reflecting the priority that the individual poses for the region.

2. A BSP based on recent assessment recommendations must be provided. It must contain clear guidelines for reducing restrictive interventions and using positive or alternative behaviour support strategies across all settings.

3. The restrictive interventions outlined in the BSP need to be reflected in RIDS.

4. BSPs and treatment plans need to provide evidence of the effectiveness of both proactive and restrictive interventions. Evidence of reduced restrictive intervention or why this was not possible must also be provided.

5. Ongoing funding applications need to clearly reflect regular reviews of the assessment(s), preferably by the same professional.
To support these recommendations, the OSP has instigated the following:

• The Partnership for Positive Solutions (PPS) forum: In partnership with service providers, we have established and co-lead regular practice monitoring and evaluation forums. These forums review data arising from RIDS and BSP reviews. High-needs, high-risk clients and any associated behaviour support practices are discussed in the context of this data analysis.

• Review of high-needs, high-risk clients: The OSP will undertake a six-monthly review process (in consultation with CISB and QSD) to identify other high-needs, high-risk clients. So far, we have only reviewed cases where additional funding has been requested, only capturing a small percentage of clients who would meet the profile. Other clients will be identified through tracking Category 1 incident reports and via direct referral to OSP.

• Active prevention strategy: The OSP is developing a pilot project to target clients at risk of escalating to a high-needs, high-risk status. These clients will be primarily identified through RIDS and BSP data evaluation processes and also through existing individual client referrals made to OSP. The pilot comprises an experienced clinician who works with these clients and their support services to develop a comprehensive assessment, intervention planning and implementation approach in collaboration with the services supporting the client.

Mark's story

Mark is an adolescent male with a progressively deteriorating brain disease. He was subject to poly-prescribing, including anticonvulsant medications, treatments for his brain disease, anxiolytics and a routine antipsychotic with additional PRN antipsychotic. Mark frequently requested PRN medication in the hope it would help him calm down.

Mark was first placed in emergency accommodation and then into residential care. He has displayed a number of behaviours of concern including threatening suicide, self-harm, property damage, hitting others with his fist and implements, threatening to injure others with weapons and leaving his accommodation during the night without informing staff. Mark spent most of his day in his room by himself. He had not been to school for a number of months due to his behaviour. He couldn’t exercise because overheating would instigate seizures and he put on a lot of weight.

When the OSP were asked to conduct a review assessment of Mark it became clear that because his placement had evolved out of an emergency, direct support staff were not adequately briefed about his history and behaviours. There was an obvious lack of awareness of Mark’s acquired brain injury, which together with the brain disease’s deteriorating neurological and cognitive deficits and his sadness over his life circumstances, had led to a number of behaviours of concern.

As a result of the OSP assessment recommendations, Mark was transitioned to an established CSO accommodation service that did not restrict his movement. Staff instituted ‘talk time’ with Mark every day and he started attending a specialist educational environment for two hours a week with a plan to increase these hours. Mark’s house supervisor arranged for Mark to commence paid work experience at a local supermarket. His case manager has purchased an ice vest that allows him to exercise without overheating and he plans to play in some local sporting teams. An ABI consultant has also been engaged to provide training and behavioural support strategies to direct care staff, Mark’s family and Mark. Mark’s behaviours of concern have gradually decreased. There have been no incidences of property damage or assaults and he is only requesting PRN chemical restraint twice a month.
Focusing on professional development

Ongoing education is an important part of any service profession. Expanding our skills and knowledge means that the service we provide is in line with the latest national and international practices and ideas. It’s important because it not only benefits our clients but means that our staff are more challenged, stimulated and rewarded.

What we did

The Office of the Senior Practitioner delivered three industry workshops and two seminars over 14 sessions in 2008. We visited four locations around Victoria (Melbourne, Ararat, Shepparton and Traralgon) and worked with 443 people including disability support workers, behaviour intervention support team (BIST) practitioners, house supervisors, community service organisations (including disability support workers and senior management) and a number of consultants from the private sector.

We offered the following sessions:
1. Getting it right from the start (the value of good functional behaviour assessment) – 3 workshops, 70 participants
2. Trauma, attachment and psychotherapeutic interventions – 3 workshops, 53 participants
3. The ins and outs of risk assessment – 2 workshop, 41 participants
4. Risk assessment (OSP-sponsored workshop by Dr Doug Boer) – 1 workshop, 16 participants
5. What is chemical restraint? – 4 sessions, 162 participants
6. Role of the APO – 4 sessions, 141 participants

What we learned

Continuous improvement is not only about improving the way our staff work, but the way we all work as well. So, we asked workshop and seminar participants to rate their satisfaction on a scale from 1 (extremely dissatisfied) to 10 (extremely satisfied), to comment about what they liked best and to give their suggestions for future events.

Average satisfaction levels for the workshops and seminars are presented on the following table.

<table>
<thead>
<tr>
<th>Workshop/seminar</th>
<th>Session overall</th>
<th>Content</th>
<th>Presenters</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting it right from the start (3)</td>
<td>8.7</td>
<td>8.7</td>
<td>8.7</td>
<td>8.0</td>
</tr>
<tr>
<td>What is chemical restraint? (2)</td>
<td>8.0</td>
<td>8.0</td>
<td>8.5</td>
<td>8.5</td>
</tr>
<tr>
<td>The role of the APO (3)</td>
<td>7.3</td>
<td>7.3</td>
<td>7.7</td>
<td>7.7</td>
</tr>
<tr>
<td>Trauma attachment and psychotherapy (3)</td>
<td>9.1</td>
<td>9.1</td>
<td>9.3</td>
<td>9.0</td>
</tr>
<tr>
<td>The ins and outs of risk assessment (2)</td>
<td>8.0</td>
<td>7.9</td>
<td>8.8</td>
<td>8.8</td>
</tr>
<tr>
<td>Risk assessment (1)</td>
<td>9.2</td>
<td>9.2</td>
<td>9.4</td>
<td>7.7</td>
</tr>
<tr>
<td>Overall averages</td>
<td>8.4</td>
<td>8.4</td>
<td>8.7</td>
<td>8.3</td>
</tr>
</tbody>
</table>

In this study of 157 people, four main themes emerged from participant feedback about the things they liked best about the sessions they attended.
1. They were informative and delivered in an engaging and interesting way.
   ‘Mandy was very impressive in her knowledge and Kylie was able to give great examples enabling [clear] delivery of information. Brilliant seminar!’ (What is chemical restraint? Shepparton, 6 May).

2. They provided skills and resources participants could really use.
   ‘Presenters were excellent, information was easy to understand and relevant to our work place.’ (Getting it right, 16 April).

3. They delivered the right mix of information and applied activities.
   ‘Overall session was really good – loved the activities, they really helped absorb the information and give it more context.’ (Trauma attachment, 29 April)

4. They helped participants understand the things they could do to improve quality of support.
   ‘Clearly identified need for addressing resources to improve and implement quality improvement responses.’ (Role of APO, 14 March)

Participants agreed there were five areas to build on.

1. More specific examples and suggestions about restrictive practices, guidelines and positive ways to address the behaviour/underlying issues could be included.
   ‘Thought there might be more information on restrictive practices and current guidelines. Workshop was still good.’ (Getting it right, 16 April)

2. Additional resources are needed to make some of the changes suggested in the sessions.
   ‘Where are the resources going to come from? We are all in favour of the changes but how can we physically do them?’ (Role of APO, 14 March)

3. The workshops and seminars should be available to a wider audience.
   ‘I appreciate that a small training group may be appropriate for this subject matter, but I feel so many people (including clients) would benefit so much from the content of this session and it should be made available to a broader audience.’ (Trauma attachment, 29 April)

4. Sessions could be offered in a broader selection of locations.
   ‘Please provide seminars and presentations at the other end of the region on occasions.’ (What is chemical restraint? 6 May)

5. More time is needed to cover the topics in depth.
   ‘Session appeared hurried – need more time to go over topics.’ (What is chemical restraint? 18 June)

The way forward

All the workshops and seminars conducted in 2007–08 (except Getting it right from the start) will be offered on an invitation basis from the regions in 2009. A new workshop on creating dynamic behaviour support plans will also be offered in 2009.

A training package on introduction to communication and positive behaviour support (including functional behaviour assessment) is being developed by Workforce Development and Learning as part of their professional development for staff working in disability accommodation services.
Networking with sector colleagues is one of the most valuable ways to share information. To facilitate this, the OSP devised a series of eight-monthly forums where behaviour practitioners and other disability professionals could meet in small groups to share best practice in supporting people who show behaviours of concern.

The *Advancing behaviour support* forums cover all aspects of behaviour support for people who show behaviours of concern with a focus on:

- assessment, interventions, monitoring and reviewing interventions
- concepts of risk, quality of life and clinical disability-specific information such as chemical restraint and behavioural phenotypes
- guest presenters (Dr Gordon Lyons on Quality of Life and Jeffrey Chan on other restrictive practices).

Twenty-nine practitioners attended the forums with representation from all regions in the state. Seventeen were from departmental facilities and 12 practitioners represented CSOs.

By the end of June 2008 four of the eight forums had been conducted at the Department of Human Services head office.

**What we did**

To better understand the value of these networking opportunities for staff, we asked participants to rate their satisfaction on a scale from 1 to 10, where 1 meant *extremely dissatisfied* and 10 equated to *extremely satisfied*. We asked about overall satisfaction with the forums, content of the forums, quality of the forums and the venue for the forums.

**What we learned**

On average, most people rated their satisfaction as very high with the forums overall (8/10), the content (8/10), quality of the forums (8/10) and the venues provided (9/10).

They commented that the forums provided a good opportunity to learn about new ideas to apply to the workplace, offered useful opportunities for networking and sharing information with others and allowed them to better keep up with research on best practice.

That said, participants also mentioned they would prefer if the sessions were more structured and had more input from the OSP regarding key topics. They also wanted to hear more from guest presenters.

**The way forward**

Based on participant feedback, all future forums will now feature a guest presenter. These will be:

- **August**: Jenny Butler – *Sexuality and disability*
- **September**: Rod Carracher – *Feedback on behaviour support plans: best practice*
- **October**: Bianca Wiederman – *BART*
- **November**: Simone Riley – *Drawing it all together*; Lynne Webber, Hellen Tzanakis, Frank Lambrick, Kylie Saunders, Mandy Donley – *Where to from here?*

The sessions will also feature more discussion about networking – specifically how participants could form a network within their regions as part of a network of practitioners and how they could be linked into existing regional networks/communities of practice.
A year in review ...reflections from staff
Practice Leader, Quality of Life

I joined the Office of the Senior Practitioner in March 2007, with all the anticipation of what the position of the Senior Practitioner could achieve. The approach and priorities set out for the first year of operation was ambitious, challenging and well considered. A partnership approach was firmly entrenched in the team and I was definitely on board.

In reflecting on behaviour support practice under previous legislation, I believe that an emphasis on a restrictive intervention being lawful and managing the behaviour of a person had become the predominant focus, instead of a more holistic approach that was initially intended. I was therefore very supportive of the Senior Practitioner’s view to change the term ‘behaviour management plan’ to ‘behaviour support plan’. This is more reflective of the direction that the OSP is promoting for supporting people who present with behaviours of concern.

My work during the first year has focused on the areas of BSPs and treatment plans. Prior to July 2007 there was notable anxiety from disability service providers about submitting BSPs to the Senior Practitioner. To alleviate the anxiety, we asked for plans to be submitted in whatever format they were in, the good, the not so good and, yes, that is what we received.

We analysed the BSPs with the aim to scope the immediate areas of concern and to provide directions for the longer term. The BSPs were reviewed based on a set of key questions around the requirements of the Act and good clinical practice. This has provided the OSP with substantial information on how behaviour support was considered prior to 1 July 2007. This work has shaped our focus and I would like to thank Jemma Barber and the committed group of staff who undertook this significant piece of work.

Practice guides for BSP and behaviour support for people using respite services were developed based on knowledge from the review work and through consultation with disability service providers. It has been very pleasing to see the move towards key elements being incorporated into more recent BSPs submitted to the OSP. It has also pleasing to have the support of APOs who have accepted the challenges in this area.

The challenge ahead is to continue to build on the quality of behaviour support and where appropriate, treatment. When a plan is developed and implemented from a holistic perspective, based on good assessments and ongoing review, is when we have seen the best results for improving a person’s quality of life. Therefore, this will continue to be a significant focus of the OSP and I look forward to this work.
The build-up to 1 July 2007 began with considerable apprehension about how the new Act would roll out. As it happened the build-up and stress was unfounded and we are now well into the business of implementing the Act, working with real practice examples. In the beginning we were nervous about giving out advice, as each situation was new. We made it a point to consult with each other and use the skills and expertise of our team before giving out advice, a practice we continue to use when new situations challenge us.

As the practice leader overseeing the Practice Improvement area, I have had involvement in almost all areas of OSP work over the year. Ideas for practice improvement can only come from evidence-based practice and research, so it has only been relatively recently that some ideas have started to emerge about potential directions that could be taken. The data coming from RIDS and from BSP audits is now starting to give us direction and a sense of the enormous potential of our work.

In the meantime there have been a number of highlights in my area over the past 12 months. A number of reviews were undertaken of high-needs, high-risk people with an intellectual disability (or ‘complex clients’), all of whom were subject to restrictive interventions, such as the use of poly-prescribing or chemical restraints, seclusion, and the use of locked doors and windows. There have been a number of cases that have resulted in improvements to quality of life despite the periods of review occurring over a relatively short period. There is one specific case study in this report (‘Mark’) that highlights this. I would like to thank practice advisor Kylie Saunders in particular, who has done great work in this area among many other activities over the past 12 months.

Another highlight was the ‘active prevention’ pilot program. This program assists service providers including direct support workers and supervisors to seek positive and proactive alternatives to restrictive interventions and practices. It has a strong emphasis on assisting staff to implement the recommended interventions. The program provides the opportunity for quick and effective intervention to occur in particular cases identified in the course of our work. There is one specific case study in this report (Jarrod) that highlights this program. I would like to thank practice advisor Jenny Butler for the great work that she has done in implementing this strategy since its inception in February 2008.
It goes without saying that you need to hit the ground running with any new job and this one was no exception. Although the OSP’s vision was clear, the means of achieving that vision needed a lot of work; there was a new Disability Act 2006 to interpret, new relationships to be made, practice guides to be written, workshops and forums to be run and research projects to get underway and this all had to be achieved in the space of a few months. Luckily, I was part of a great team of people with just the right mix of skills to get this all done.

Our colleagues in the regions were keen to know what they had to do to comply with the new legislation and our workshops on treatment plans and BSPs were so well attended the rooms were filled to capacity. Disability stakeholders were also keen to participate in having a say to change the way people are supported and a statewide forum on ‘Creating positive solutions for all’ received feedback from all stakeholder groups.

November saw another flurry of activity with a quick study tour with Fred Wright to New Zealand to examine policy and practice for offenders with a disability. The five-day study tour took in five services in Wellington and Auckland. Of particular interest for me was participation in Auckland Prison’s Te Piriti’s weekly therapeutic community – a therapeutic session with 60 offenders and their staff (approximately 10 staff). Never before had I been part of therapy on such a grand scale! But it worked and showed that it is possible to deliver therapy to many at once.

In the New Year there were workshops, seminars and practice forums to coordinate and deliver. These have all been evaluated very positively and the wonderful coordination by Hellen Tzanakis must be acknowledged. At the same time, there were data to be interpreted for the Senior Practitioner reports and Danielle Chaffey’s assistance was invaluable.

One of the issues to be solved in the new year was how to link practice, research and policy. Much interest was received from most stakeholder groups that we decided to appoint a research reference panel. The work of the research panel is invaluable in creating the link between practice, research and policy.

The first year with the OSP has been a tremendously busy one, with so much achieved and never a dull moment, but none of these achievements would have been possible without the support of a wonderful team of colleagues both inside the office and within the regions.
When I first joined the OSP I assumed the transition from forensic psychiatric nursing was going to be a challenging one. At my first case conference for a lady with dual disability who had committed an offence, I knew that my background and experience in mental health would be an asset in my new role. This position allows me to both work at a policy level trying to influence people within the department’s Disability Services division as well as primary care and mental health services, and at a local level talking to families and carers who are trying to navigate a very complicated system to get the best outcome possible for the people they support.

As soon as I started to visit service providers I realised staff needed help to make sense of the new Disability Act 2006 and its implications, especially regarding chemical restraint. There was varied knowledge regarding medications and their side effects with few people exploring why someone had been prescribed these medications, for how long, and when would they be reviewed.

Obviously it is not support staff who are prescribing these medications, but everyone has their role in the process that leads to the prescribing of chemical restraint. I felt incredibly satisfied when a cluster manager rang to say she had visited a GP to question why a young man had been prescribed sedation when this was not warranted; the medication was then removed from the treatment sheet. The manager said I had given her the confidence and access to information and to reasonably debate the issue.

In each region I visit staff tell me stories of medications being reduced or ceased because staff are now not seeing medication as the only answer for dealing with behaviours of concern, and they hardly recognise the person they are now supporting. Many lively debates have taken place in doctors’ offices and, all across the region, service providers are questioning the need for antipsychotic medication being prescribed for people who do not have a mental illness.

Over the past year I have seen champions emerge among staff who have wanted to see change in the way people with a disability are treated for some time. These people now have a vehicle to question service providers regarding restrictive interventions – the Disability Act 2006, and an ally to advocate for the rights of people with a disability – the Office of the Senior Practitioner.
Manager, Office of the Senior Practitioner

Throughout my time in OSP I have been impressed with the dedication and real commitment of some support providers and all of our OSP staff. A highlight has been the opportunity to view the differing governance structures that exist within both the department and non-government disability support services and the variation in outcomes for people with a disability.

RIDS has provided us with an opportunity to work closely with DSP staff as they fulfil their reporting obligations under the Act. During these interactions I have found a real compassion and commitment by some staff at house level who understand the benefits of the role performed by the Senior Practitioner. There is an increasing awareness of the rights of people with a disability and a general improvement in the understanding of what constitutes restrictive interventions by DSP personnel.

I was interested to see how the recent round of Promoting Dignity grants involved simple yet effective measures that will see an improvement in the lives of people with a disability. These grants demonstrate the commitment by the Senior Practitioner to work together with staff to protect the rights of people and the willingness of disability support professionals to make a difference.

Highlights for me over the past 12 months have included a better understanding of the disability sector and an appreciation of the issues that often result in staff resorting to the use of restrictive interventions to manage behaviours of concern.

I see RIDS as a significant achievement for the Senior Practitioner. Finally, planners and policymakers will have access to accurate information about restrictive interventions.

Another significant event has been the development of the resource information kits by Philip French. The material will ensure that the work of the OSP is well founded on the basic building blocks of human rights that provide a fundamental underpinning to the work of the OSP and that of our stakeholders.

Lastly, the requirement for service providers to formally document their BSPs and have them reviewed by the Senior Practitioner is also a significant milestone. There is finally a capacity (by the Senior Practitioner) to review these plans with the objective of reducing and possibly eliminating the use of restrictive practices.
Grampians Disability Services has welcomed and embraced the role of the Office of the Senior Practitioner. As a means of enhancing the work of the OSP and embedding its role and function into everyday work practice within the region’s disability sector, a joint initiative was undertaken to appointment of a senior practice leader, who commenced work in the region in March 2008. The senior practice leader’s work supports the objectives of the office and is available to all Grampians DSPs.

The senior practice leader role has best practice, educational and clinical leadership responsibility. A key focus of the initiative is systemic improvement in disability support services, promoting positive organisational culture, promoting learning and development, promoting positive behaviour support and guidance for reducing the use of restrictive interventions. All these measures aim to promote quality of life and wellbeing for people with disability, their families and carers.

In Grampians, through this initiative, we have conducted secondary/tertiary consultations, facilitated case conferences and reviews, assisted clients to access area mental health services and provided clinical/practice leadership.

All this has been achieved through engaging and consulting with CSOs (via the CSO Chief Executive Group), Disability Services executive (including the Partnerships for Positive Solutions Working Group), DAS, Disability Client Services and the Grampians Community Care/Disability Services Interface Committee.

We are proud to have initiated some major activities during 2007–08 including: developing clinical pathways to accessing area mental health services; providing ongoing education and training in behaviour support planning; and conducting regional practice forums.
North and West metropolitan region (N&WMR) has become the first Department of Human Services region to appoint a practice advisor to help reduce the use of restrictive interventions on people with a disability. The appointment was made in February 2008 in partnership with the Office of the Senior Practitioner.

N&WMR have been working towards this objective for some time through providing training, workshops, information sessions and direct client or service consultation about using restrictive interventions. The region has provided BSP training to more than 160 first-line managers, with a further 20 mid-level managers receiving training in positive behaviour support leadership and supervision. This work has formed the basis of the PBS Good Practice Series, which will be a feature within the region over the coming year.

In July N&WMR hosted its inaugural forum for APOs. The forum was facilitated in partnership with the OSP and St John of God Accord. APOs who attended this forum highlighted the unique needs of professionals entrusted with this role and established a draft framework for future peer support, lobbying and information dissemination.

N&WMR’s senior practice advisor has also been busy meeting with 14 people with a disability and their families or professional supports. Five of these people continue to receive support via case coordination or practice review.

The five months from February to July 2008 have highlighted N&WMR’s ongoing commitment to supporting people in the least restrictive and intrusive way.
Appendices
Appendix 1: Office of the Senior Practitioner – structure

The teams

Quality of Life
The Quality of Life team provides advice, direction and promotes quality of life for people subject to restrictive interventions and compulsory treatment orders. It monitors service provider and practitioner compliance and is responsible for collecting and analysing data on the use of restrictive interventions and compulsory treatment and also developing a restrictive interventions reduction strategy.

Practice Improvement
This area is focused on providing advice and direction to enhance practice. It is also responsible for conducting individual or service reviews, particularly for people with intensive behaviours of concern.

Research and Service Development
This role advances disability support practice in the area of behaviours of concern by facilitating partnerships with a range of stakeholders. The role also provides information on evidence-based practice that focuses on positive solutions rather using restrictive interventions.

Integrated Health Care Practice
This role examines how medication is used for people with a disability and its impact on health and assists service providers and practitioners to monitor chemical restraint use.

Supporting the work of the OSP is a management team consisting of a manager, senior data analyst, executive assistant and three senior project officers who provide advice on governance and conducting client reviews.
Appendix 2: Publications and presentations

OSP publications

- Practice advice – Authorised program officers, April 2007.
- Practice guide – Behaviour support plans, August 2007
- Practice advice – Important information about medications prescribed for the primary purpose of the behavioural control on a person with a disability, March 2008.
- Practice guide – Behaviour support for people using respite services, June 2008.

Research publications

OSP seminars
- Carracher R, Lambrick F 2008, The role of the authorised program officer, making a difference and the legal obligations, Melbourne (14 March), Ararat (9 April), Shepparton (6 May) and Traralgon (18 June).
- Donley M, Barber J 2008, What is chemical restraint? Melbourne, Ararat, Shepparton and Traralgon; March 14, April 9, May 6 and June 18.
- Riches V C 2007, International Classification of Functioning, Disability and Health (ICF), CDDS and The University of Sydney, DHS Forum.

OSP workshops
- Lambrick F, Saunders K 2008, Trauma, attachment and psychotherapeutic interventions, Melbourne (29 April) and Traralgon (5 June).
- Tzanakis H 2008, Getting it right from the start – the value of good assessment, Melbourne (18 March), Ararat (16 April), Shepparton (27 May) and Traralgon (27 May), (co-authored by Chan J).

Conference presentations
- Chan J 2007, Where we were, where we are now and where we need to get to with the person, ‘It’s All About the Person’ EMR joint Day and Accommodation Service Annual Conference 2007, Department of Human Services Eastern metropolitan region, Ivanhoe (8 August).
Other presentations

• Chan J 2007, *Supporting people with disability to achieve dignity without restraints*, Presentation to the Strategic Projects Branch, Department of Human Services, Melbourne (4 December).
• Chan J 2007, *Supporting people with disability to achieve dignity without restraints*, Western Region Disability Network, North and Western metropolitan region, Melbourne (4 December).
• Chan J 2007, *Supporting the dignity of people with an intellectual disability*, Department of Human Services and CSO Information Forums, Barwon-South Western Region, Geelong, Colac and Warrnambool (15 November).
• Chan J 2007, *The role of the Senior Practitioner*, Planning Conference, Department of Human Services North and Western metropolitan region Disability Services Executive, Melbourne (14 August).
• Chan J 2008, *Simply the best: The only way we know how to provide support services for persons with a disability who have behaviours of concern*, Support staff training day, SCOPE Barwon-South West and Grampians (7 May).
• Lambrick F 2007, *Assessment of offenders with an intellectual disability*. Department of Criminology, The University of Melbourne (3 April).
• Lambrick F 2007, *Clinical issues surrounding the development of case plans for offenders with intellectual disability*. Division of Disability Studies, RMIT University (3 October).
• Lambrick F 2007, *Staff and environment factors relevant to the management of offenders with intellectual disability*. Division of Disability Studies, RMIT University (17 October).
• Lambrick F 2007, *Treatment of offenders with intellectual disability*. Division of Disability Studies, RMIT University (10 October).
### Functions of the Senior Practitioner (Section 24.1)

<table>
<thead>
<tr>
<th>Functions of the Senior Practitioner (Section 24.1)</th>
<th>OSP business plan strategy</th>
<th>How will we achieve it?</th>
<th>What have we achieved?</th>
</tr>
</thead>
</table>
| (a) To develop guidelines and standards with respect to restrictive interventions and compulsory treatment | Advancing disability support practice | Develop and implement practice advice and practice guides | The OSP produced the following publications in 2007–08. **Implementation guides:**  
- Disability Act 2006 – Restrictive intervention  
- Disability Act 2006 – Supervised treatment orders  
- Disability Act 2006 – Residential treatment facilities  

**Practice guides:**  
- Behaviour support plans  
- Behaviour support for people using respite services  

**Practice advice:**  
- Authorised program officer  
- Independent person  
- Important information about medications prescribed for the primary purpose of the behavioural control of a person with a disability  

**Toolkits:**  
- Independent person |
### Functions of the Senior Practitioner (Section 24.1)

<table>
<thead>
<tr>
<th>OSP business plan strategy</th>
<th>How will we achieve it?</th>
<th>What have we achieved?</th>
</tr>
</thead>
</table>
| **(b) To provide education and information with respect to restrictive interventions and compulsory treatment to disability service providers** | Advancing disability support practice | Initiate and develop education for disability service providers and practitioners so they have increased knowledge of evidence-based practice and apply this knowledge to how people with a disability are supported | **Seminars:**  
- The role of the authorised program officer, making a difference and the legal obligations – targeted at disability support professionals (for 400 people); sessions held in Melbourne, Ararat, Traralgon and Shepparton over March, April, May and June (2008)  
- *What is chemical restraint?* – targeted for disability support professionals (for 400 people); sessions in Melbourne, Ararat, Traralgon and Shepparton over March, April, May and June (2008)  
- **Workshops:**  
  - *Getting it right from the start, the value of good assessment* – targeted for disability support professionals (for 400 people) sessions in Melbourne, Ararat and Traralgon over March, April, May and a session scheduled in Shepparton in September (2008)  
  - *Trauma attachment and psychotherapy interventions* – targeted for disability support professionals (for 400 people) sessions in Melbourne, Ararat and Traralgon over April, July, June and a session scheduled in Shepparton in August (2008)  
  - *The ins and outs of risk assessment* – targeted for disability support professionals (for 400 people) a session in Melbourne in June and scheduled sessions in Ararat, Traralgon and Shepparton over August, September and October (2008)  
  - *A convergent approach to risk assessment* – targeted for regional and CSO psychologists required to conduct offender risk assessments conducted in April (2008)  
- **Conferences:**  
  - Presented an introduction to assessment processes at the ASSID 7th Annual Conference for disability support professionals  
  - **Training:**  
    - Mindfulness accreditation and training for 22 clinicians and disability support workers in residential and forensic services  
    - Extensive training and support to community service organisations to use the online version of RIDS, including 1,252 training sessions with 60 of these at sites of disability service providers  
- **Presentations:**  
  - *The role of the Office of the Senior Practitioner* – presented to all regions and two departmental Client Services induction sessions, June and July 2008  
- **Case conferences:**  
  - Five sessions on supervised treatment orders; relating to 12 people with a disability on an STO (September 2007 to March 2008) for disability accommodation services and Public Health branch  
- **Positive Solutions in Practice:**  
  - Leading practice change, the Office of the Senior Practitioner has released a series of plain-English reviews of the latest innovative research in best practice to support people with a disability:  
    - Issue 2 – *From seclusion to solutions*, September 2007  
    - Issue 3 – *Getting it right from the start: the value of good assessment*, April 2008 |
<table>
<thead>
<tr>
<th>Functions of the Senior Practitioner (Section 24.1)</th>
<th>OSP business plan strategy</th>
<th>How will we achieve it?</th>
<th>What have we achieved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(b) To provide education and information with respect to restrictive interventions and compulsory treatment to disability service providers</td>
<td>Building partnerships</td>
<td>Establish a research collaboration strategy to work with academic institutions, professional bodies and disability service providers</td>
<td>• Leading the research agenda through the implementation of the Senior Practitioner Research Reference Panel.</td>
</tr>
</tbody>
</table>
|  | Creating leaders | Build expertise within the industry and the initiation of practice development to better support people with behaviours of concern | **Advancing behaviour support practice:**  
• Advancing behaviour support practice is a series of intensive workshops for eight months for 20–25 clinicians and practitioners. Advancing behaviour support practice is a clinical leadership program. |
| (c) To provide information with respect to the rights of persons with a disability who may be subject to the use of restrictive interventions or compulsory treatment | Advancing disability support practice | Initiate and implement communication strategy with various stakeholder groups | **Communication strategy:**  
The communication objectives are to:  
• inform audiences of the Office of the Senior Practitioner’s role  
• inform disability service providers how they can comply with components of the Act that are monitored by the Office of the Senior Practitioner  

The communication strategy established the vision and mission of the OSP:  
• Vision – An inclusive and safe community that supports people to achieve dignity without restraints  
• Mission – To work with services to safeguard the rights of people with a disability and to influence practices that support people to achieve dignity without restraints  

**Newsletters:**  
• Bi-monthly newsletter  

|  | Building partnerships | Collaborative relationships with stakeholders that facilitate both the vision and intent of the Disability Act 2006 | **Projects:**  
• Engaging with people with an intellectual disability and their carers and/or families as per s24.1 (c) |
### Functions of the Senior Practitioner (Section 24.1)

- **Advancing disability support and service practice in restrictive and compulsory treatment:** Provide advice to disability service providers to improve practice in relation to restrictive interventions and compulsory treatment.
- **Chemical restraint review strategy:** Conduct individual service reviews, where appropriate, and make recommendations that ensure the rights of people with a disability are protected and there is an improvement in their quality of life. Service providers and practitioners have increased knowledge of evidence-based best practice and apply this knowledge in the support of people with a disability.
- **OSP business plan strategy:** Improve links with area mental health services, providing psychiatric nursing to support behaviour support plans with people with dual disabilities (ILM).
- **Creating leaders:** Initiate and provide advice, mentoring and grants to facilitate the development of expertise and practice improvement within the sector.
- **.assertive management of violence and aggression (IMV):** Provide advice to disability service providers to improve practice in relation to restrictive interventions and compulsory treatment.
- **Individual service reviews:** Where appropriate conduct reviews for 326 services where people with a disability are subject to chemical restraint and review people from shared supported accommodation services operated by community service organisations and departmental DAS.
- **Practitioner development strategies:** A total of 326 people reviewed 226 from all departmental regional services and 100 people from community service organisations.

#### How will we achieve it?

- **Individual service reviews:**
  - Reviews conducted for 326 services where people with a disability are subject to chemical restraint.
  - A total of 326 people reviewed 226 from all departmental regional services and 100 people from community service organisations.

#### What have we achieved?

- **Building partnerships:** Establish collaborative relationships with disability service providers and departmental regions.
- **Creating leaders:** Mentoring and grants to facilitate the development of expertise and practice improvement within the sector.

#### Practice improvement strategy:

- **OPC business plan strategy:** A collaborative practice improvement strategy in partnership with disability service providers and departmental regions.
- **Senior Practitioner report (first quarter 2007–08):**
  - Developed practice improvement guide: Partnerships for positive solutions.
  - Eight regional forums conducted.
  - Creating leaders: Initiating and providing advice, mentoring and grants to facilitate the development of expertise and practice improvement within the sector.

#### Grants:

- **Senior Practitioner Partnership Research grant:** An initiative by the Senior Practitioner to develop high-quality research and evaluation that supports practice and policy development in supporting people with a disability who may be subject to restrictive interventions. The office received 11 applications and awarded six project grants to the value of $291,602.
- **Senior Practitioner Promoting Dignity grant:** An initiative by the Senior Practitioner that provides opportunities for disability support workers to develop and implement creative, practical and alternative solutions for people with a disability who are subject to restrictive interventions. The Office received 24 applications and awarded 18 project grants to the value of $24,184.
<table>
<thead>
<tr>
<th>Functions of the Senior Practitioner (Section 24.1)</th>
<th>OSP business plan strategy</th>
<th>How will we achieve it?</th>
<th>What have we achieved?</th>
</tr>
</thead>
</table>
| (e) To give directions to disability service providers in relation to restrictive interventions and compulsory treatment and behaviour management plans and treatment plans | Advancing disability support practice | Service providers and practitioners have increased knowledge of evidence-based best practice and apply this knowledge in the support of people with a disability Conduct individual service reviews where appropriate, and make recommendations that ensure the rights of people with a disability are protected and there is an improvement in their quality of life | Reviews of people with a disability with high-needs, high-risk:  
• Review of 16 people with a disability with high-needs, high-risk (HNHR). Reviews resulted in recommendations to regions and improved referral process for departmental regions seeking Disability Services Division funds for people with HNHR  
• Provision of professional development for practitioners for HNHR people with a disability  
• Individual client and service audit tools developed – trials conducted with two people with a disability and one SSA  
Active prevention strategy:  
• The active prevention strategy is a pilot program established to assist disability service providers to seek positive and proactive alternatives to restrictive interventions and practices. Reviews implemented for 15 people across three departmental regions resulting in an improved quality of life for the individuals concerned and greater staff understanding of alternatives to restrictive interventions |
| (f) To develop links and access to professionals, professional bodies and academic institutions for the purpose of facilitating knowledge and training in clinical practice for persons working with persons with a disability | Advancing disability support practice | Establish a research collaboration strategy to work with academic institutions, professional bodies and disability service providers | Research collaboration projects:  
• Staff (disability support staff) understanding of restrictive interventions. A project conducted by an undergrad honours student from the RMIT, Division of Disability Studies  
• Examining stress related to behaviours of concern and what staff could have done to defuse behaviours of concern. A project conducted in partnership by Monash University, the Centre for Developmental Disability Health Victoria (CDDHV) and the Senior Practitioner  
Research agenda:  
• A practice, research and policy forum was held on 29 March 2008 to seek advice from stakeholders to look at appropriate research and clinical practice support model for disability practice development  
Research panel:  
• The Senior Practitioner Research Reference Panel established – a group of representatives from academics, disability service providers and advocates |
<table>
<thead>
<tr>
<th>Functions of the Senior Practitioner (Section 24.1)</th>
<th>OSP business plan strategy</th>
<th>How will we achieve it?</th>
<th>What have we achieved?</th>
</tr>
</thead>
</table>
| (g) To undertake research into restrictive interventions and compulsory treatment and provide information on practice options to disability service providers | Advancing disability support practice | Establish a research collaboration strategy to work with academic institutions, professional bodies and disability service providers to conduct research activities and partnerships that the resulting outputs are incorporated into practice | Research projects:  
  - Physical Restraint Literature Review – a research project conducted by Royal Melbourne Institute of Technology (RMIT), Division of Disability Studies to advise the Senior Practitioner on best practice in monitoring the use of physical restraint  
  - Restrictive Interventions: A View from People with a Disability – a research project conducted by Royal Melbourne Institute of Technology (RMIT), Division of Disability Studies to advise the Senior Practitioner on the views and experiences of people with a disability subject to restrictive interventions  
  - ARMADILLO, The Development of Clinical Risk Assessment and Development Tool for People with a Disability – an international partnership research project involving Australia, New Zealand and Canada  
  - The Effectiveness of Mindfulness – a Senior Practitioner research project to evaluate the use of mindfulness as an behaviour support method as a less restrictive option to restrictive interventions |
| (h) To evaluate and monitor the use of restrictive interventions across disability services and to recommend improvements in practice to the Minister and the Secretary | Advancing disability support practice | Monitor the implementation of evidence-based research through behaviour management and treatment plans, to measure the impact of practice changes on quality of life  
  Analyse data to monitor and evaluate the use of restrictive interventions and compulsory treatments:  
  - measure compliance with the legislation  
  - monitor the implementation of OSP recommendations to improve practice | Papers:  
  - Proposition paper – Creating positive solutions for all  
  - Sample of BSPs submitted to the OSP reviewed against positive behaviour support and clinical best practice criteria – the data is being presented to regions via the PPS sessions  
  - Senior Practitioner report – Report and recommendations on restrictive interventions and behaviour support plans for the period 1 July–30 September 2007 completed  
  - Report of the review of people with disabilities subject to restrictive interventions post-redevelopment of Kew Residential Services  
  - Chemical restraint reduction report – initial update  
  User guides:  
  - RIDS paper-based version user guide  
  - RIDS electronic version user guide |
<table>
<thead>
<tr>
<th>Functions of the Senior Practitioner (Section 24.1)</th>
<th>OSP business plan strategy</th>
<th>How will we achieve it?</th>
<th>What have we achieved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) To undertake any other function relating to persons with a disability as may be directed in writing by the Secretary</td>
<td>Advancing disability support practice</td>
<td>• Provided advice to Grampians region regarding the use and reporting of physical restraints (resulting from a review of a death of a person with a disability in Grampians region)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Building partnerships</td>
<td>Collaborative relationships with stakeholders that facilitate both the vision and intent of the Disability Act 2006.</td>
<td>• Communication strategy implemented</td>
</tr>
<tr>
<td></td>
<td>Creating leaders</td>
<td>Provide advice, mentoring and grants to facilitate the development of expertise and leadership experience within all regions Engage in a 360-degree survey to assess the performance of the OSP against the roles and functions defined within the Disability Act 2006 and the OSP business plan</td>
<td>• Survey of stakeholders commenced on 23 June 2008. It was conducted as an online survey by Full Circle Feedback Ltd and was completed in July 2008.</td>
</tr>
</tbody>
</table>