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| Eleven years of research findings by the Senior Practitioner – Disability, 2007–2018 |
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Department of Health

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# Foreword

In 2006 the Victorian Parliament enacted innovative legislation, the *Disability Act 2006*, which established the role of the Senior Practitioner – a statutory body responsible for protecting the rights of people with a disability who are subject to restrictive interventions and who receive a government-funded service. It required reporting and population monitoring about the use of restrictive practices in disability services. From 2007, disability services were required to report on their use of chemical restraint, mechanical restraint, seclusion, behaviour support plans and treatment plans for those undergoing compulsory treatment. From 2011 disability services were also required to report on their use of physical restraint.

The Disability Act is unique because it also mandates research into the use of restrictive interventions, and the provision of education to services involved in supporting people with a disability. The inclusion of research and education as mandatory functions of the Senior Practitioner in the Act ensures a focus on the evidence the Senior Practitioner collects to directly inform policy and practice in disability services. Making research mandatory within a legislative framework also means it is possible to examine factors that lead to the use of restraint and seclusion on a population level and to examine the impact of behaviour support planning on the use of restraint and seclusion (Webber, Chan & French 2014). The research findings from Victoria are unique because Victoria is the only state in Australia that has collected population-level data on restrictive interventions, compulsory treatment and behaviour support plans over 11 years.

From 2007 to 2018, the Senior Practitioner undertook or commissioned 46 research projects, resulting in 24 peer-reviewed publications and 25 research reports published by the Department of Health and Human Services. The research projects cover: behaviour support plans and training; chemical restraint; mechanical restraint; seclusion and physical restraint; restraint reduction; research with people with a disability who are subject to restrictive interventions; and compulsory treatment. This document lists all research publications undertaken or commissioned by the Senior Practitioner from 2007 to 2018. The list includes all peer-reviewed publications, as well as research reports to the Senior Practitioner. It should be noted that research projects began in 2007, although they were not published until later. For example, the research reported in Webber et al. (2010) began in 2007 but was not published until 2010. This is because writing research reports, especially for peer-reviewed publications, takes time.

In 2018, I convened a panel of researchers, clinicians, disability service providers, a person with a lived experience of disability and stakeholders from the department to review this research and advise me on what they felt were the priorities for future research. The panel generated a list of potential research questions that could be pursued by the Senior Practitioner in the future. This list covers a broad range of topics that include:

* the impact of staff, environment and organisational culture the on use of restrictive interventions
* staff use of behaviour support plans and Positive Behaviour Support on restrictive interventions
* the relationship between behavioural phenotypes and forensic issues
* the prevalence of menstrual suppression being used as a chemical restraint when compared with worldwide best practice
* the use of knowledge/training/implementation of Positive Behaviour Support that puts an individual at risk of restrictive intervention
* the skills needed and how staff are equipped to support people with a disability who show behaviours of concern
* the risk factors of physical restraint use
* interventions that reduce chemical restraint
  + the relationship between adaptive behaviour and other measures of needs (for example, risk assessment).

From this list, the review panel short-listed three projects to be undertaken in the near future.

1. A project to understand the pathways to and through compulsory treatment towards a policy and service model to prevent imprisonment and reduce recidivism among offenders with a disability
2. The prevalence of menstrual suppression being used as a chemical restraint and to compare the findings to worldwide best practice
3. The critical strategies needed to implement behaviour support plans

The first two projects are currently underway; the third project has been prioritised for future funding. Over the next three years, the panel’s list will be reviewed each year to determine those projects that should be prioritised for the following year, depending on the needs of the sector and people with a disability who are subject to restrictive interventions and compulsory treatment.

I would like to thank the members of the research review panel for contributing their time and expertise in undertaking this task and advising me of research priorities for the future. The research review advisory panel included Dr Danny Sullivan, Ms Renee Dela Cruz, Dr Stella Koritsas, Professor Keith McVilly, Ms Louise Mackenzie, Ms Katie White, Mr Darren Parnell, Ms Nicole Hassall, Ms Lisa Thomson, Mr Anthony La Sala, Professor Ben Richardson and Dr Lynne Webber.

Dr Frank Lambrick

Senior Practitioner – Disability

# Behaviour support plans

| The research questions addressed | Key findings | Relevant papers |
| --- | --- | --- |
| Is the BSP-QE II tool reliable and a valid quality indicator for adults with a disability in Australia? | The BSP-QE II is a reliable and valid quality tool for use for adults with a disability in Australia. | McVilly K, Webber L, Paris M, Sharp G 2012, ‘Reliability and utility of the Behaviour Support Plan Quality Evaluation tool (BSP-QE II) for auditing and quality development in services for adults with intellectual disability and challenging behaviour’, *Journal of Intellectual Disability Research*, vol. 57, no. 8, pp. 716–727  McVilly K, Webber L, Sharp G, Paris M 2012, ‘The content validity of the Behaviour Support Plan Quality Evaluation tool (BSP-QE II) and its potential application in accommodation and day support services for adults with intellectual disability’, *Journal of Intellectual Disability Research*, vol. 57, no. 8, pp. 703–715  Webber LS, McVilly K, Fester T, Zazelis T 2011, ‘Assessing behaviour support plans for Australian adults with intellectual disability using the “Behavior Support Plan Quality Evaluation II” (BSP-QE II)’, *Journal of Intellectual and Developmental Disability*, no. 36, pp. 1–5 |
| What is the relationship between quality behaviour support plans and restrictive interventions? | A positive association between the quality of a behaviour support plan as assessed by the BSP-QE II and the use of PRN restrictive interventions was found. | Webber LS, Richardson B, Lambrick F, Fester 2012, ‘The impact of the quality of behaviour support plans on the use of restraint and seclusion in disability services’, *International Journal of Positive Behavioural Support*, vol. 2, no. 2, pp. 3–11 |

# Chemical restraint

| The research questions addressed | Key findings | Relevant papers |
| --- | --- | --- |
| What do disability support workers know about chemical restraint? | In this study, disability support workers were asked about their education and training needs around chemical restraint.  The results showed:  The majority of support workers felt they were provided with good support from their co-workers and supervisors.  However, they felt they needed more information regarding the side effects of psychotropic medication and its alternatives. | Donley M, Chan J, Webber LS 2011, ‘Disability support workers’ knowledge and education needs about psychotropic medication’, *British Journal of Learning Disabilities*, vol. 40, no. 4, pp. 1–6 |
| Who is at risk of being chemically restrained with antipsychotics? | Children are two times more likely than adults.  People with a hearing, intellectual or psychiatric disability are two times more likely than those without those disabilities.  Males, people with autism, a speech disability or a visual impairment are about one and half times more likely than people without those characteristics.  People with a physical disability or learning disability are half as likely as those without these disabilities. | Richardson B, Webber LS, Lambrick F, ‘Who is at risk of being chemically restrained with antipsychotics in disability services?’  (Paper for peer review in progress) |
| What changes were found in a five-year follow-up to the 2008 independent psychiatric review of former residents of Kew Residential Services? | The file review established that the general health recommendations made in 2008 were mostly met. For four cases there was no evidence that recommendations had been followed.  The majority of behavioural recommendations had not been implemented. | Newton D, McGillivray J 2014, *A five-year follow-up to the 2008 independent psychiatric review of former residents of Kew Residential Services.* Report to the Senior Practitioner, Melbourne |
| What chemical restraint trends are found in people over 55 years of age? | Review of medication sheets for people over the age of 55 prescribed chemical restraint on the Restrictive Intervention Data System showed:  224 older adults were subject to chemical restraint in 2012–13.  Polypharmacy rates were lower for older adults than younger.  The use of typical antipsychotic medications was most common among people aged 45 or older. | Newton D, McGillivray J 2014, *Chemical restraint among older adults with intellectual disability*. Report to the Senior Practitioner, Melbourne |
| What are the findings of an independent psychiatric review of former Kew Residential Services residents? | Many of the residents still had psychiatric diagnoses made in childhood such as ‘childhood schizophrenia’.  The majority of residents were prescribed an atypical antipsychotic medication, and typical antipsychotic medications were often prescribed for PRN.  None of the residents reviewed were linked in or had assessments by their area mental health service, even though the majority had a psychiatric diagnosis. | d’Abrera C 2008, *Independent psychiatric review of former Kew Residential Services residents conducted by the Centre for Developmental Disability Health Victoria between February and November 2008*, Monash University, Clayton |
| What does a review of disability, mental health and medication show in the Restrictive Intervention Data System? What are the implications for practice and policy? | A psychiatrist and pharmacist reviewed 201 medication reports of people administered chemical restraint.  98 per cent of people were reported as being prescribed psychotropic medication.  43 per cent of people were reported to have a current or previous mental health diagnosis.  88 per cent were determined to be in need of independent psychiatric review. | Thomas S, Corkery-Lavender K, Daffern M, Sullivan D, Lau P 2010, *Disability, mental health and medication: implications for practice and policy*, Department of General Practice, The University of Melbourne, Melbourne |
| What are the issues regarding services available in Victoria for people with dual disability? | Adults with an intellectual disability are less likely to seek help for symptoms of mental Illness.  Symptoms of mental illness often present differently in adults with an intellectual disability and can be hard to recognise.  Mental health and intellectual disability services tend to have different systems.  There is a lack of specialist knowledge and training in dual disability. | Sullivan D, Roberton T, Daffern M, Thomas S 2013, *Building capacity to assist adult dual disability clients access effective mental health services*, Monash University, Clayton |

# Mechanical restraint

| The research questions addressed | Key findings | Relevant papers |
| --- | --- | --- |
| What are the risk factors associated with the use of mechanical restraint? | Mechanical restraint Phase 1 of 4: Statewide data collected between July 2012 and June 2013 were sourced from RIDS:  Individuals with certain characteristics such as hearing, physical, neurological, communication or visual impairment, and autism, had an increased likelihood of being mechanically restrained.  Initiatives to reduce mechanical restraint should pay particular attention to the support needs of those with sensory impairments and complex communication support needs including those with autism and those with a physical impairment. | Webber LS, Richardson B, White KL, Fitzpatrick P, McVilly K, Forster S 2019, ‘Factors associated with the use of mechanical restraint in disability services’, *Journal of Intellectual & Developmental Disability*, Vol 44, no 1, pp.116-120. |
| Based on a file review, what are the needs of a sample of people subject to mechanical restraint for at least two years? | Mechanical restraint Phase 2 of 4: Examined the files of 39 people. Findings showed:  The majority of people were males.  The majority of people had cerebral palsy and/or epilepsy.  94 per cent had moderate or severe communication difficulties.  The majority of the group had moderate to profound intellectual disability.  A third of the group had a hearing impairment.  The quality of many people’s behaviour support plans showed that staff often did not appear to understand why the person used the behaviour. | Webber L, White K, Richardson B, Fitzpatrick P, Buchholtz M, McVilly K, Forster S 2014, *Phase 2 Mechanical restraint project: Results of a file audit on a sample of people subject to mechanical restraint*. Report to the Senior Practitioner, Melbourne |
| What factors prevent mechanical restraint reduction? | Mechanical restraint Phase 3 of 4: This project showed:  An apprehension from staff and parents regarding alternative interventions to mechanical restraint.  The use of mechanical restraints does not allow a behavioural intervention and does not alter a person’s behaviour in the long term.  The high support needs of the participant group highlighted the need for a multidisciplinary approach to identifying and implementing effective supports. | White K, Hayward B, McVilly K 2015, *Mechanical Restraint Project Stage Three: Intervention and investigation*. Report to the Senior Practitioner, Melbourne |
| What are the specific local factors that lead to intervention by staff for a group of people who are mechanically restrained? | Mechanical restraint Phase 4 of 4:  Four of five staff groups participated in the study (two passed away and two did not consent).  Evidence of difficulty implementing strategies to change practice. Only two houses implemented strategies, and only one house continued with the strategies over time.  Paper discusses barriers and facilitators to implementation of strategies. | Fowler S, McCann A, 2018, *Phase 4 Mechanical restraint project*. Report to the Senior Practitioner from Scope, Melbourne. |

# Seclusion

| The research questions addressed | Key findings | Relevant papers |
| --- | --- | --- |
| What are the risk factors associated with the use of seclusion? | The reported use of seclusion in disability services in Victoria was examined over a three-year period, with a focus on the characteristics of those who were secluded and the characteristics of organisations that reported seclusion. The cases were compared with others who were reported to be restrained but not secluded, showing:  Age, the presence of autism and/or a psychiatric disorder put people at risk of being secluded.  Receiving accommodation services in institutions or in the community were risk factors.  The findings are consistent with previous research but add to this literature by showing that certain organisational characteristics are also risk factors for seclusion. | Webber LS, Richardson B, Lambrick F 2014, ‘Individual and organizational factors associated with the use of seclusion in disability services’, *Journal of Intellectual and Developmental Disability*, published online, 16 July 2014 |

# Physical restraint

| The research questions addressed | Key findings | Relevant paper |
| --- | --- | --- |
| What are the current practices, contemporary concerns and future directions for using physical restraint in disability services? | A review of the literature into physical restraint found contemporary world’s best practice in support of people with a disability who exhibit behaviours of concern is informed and directed by ethical, clinical and legal imperatives to at least minimise, and in many circumstances eliminate, the use of restraint. | McVilly K 2011, *Physical restraint direction paper*. Report to the Senior Practitioner from Deakin University, Melbourne |

# Restrictive interventions (all)

| The research questions addressed | Key findings | Relevant papers |
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| What were the trends in the use of restrictive interventions in Victoria in 2007–08? | An analysis of population data sent to the Senior Practitioner in 2007–08 showed:  Most people who were reported to be subject to chemical restraint were males.  The majority of people who were mechanically restrained showed harm to self.  The majority of people who were secluded showed harm to others. | Webber LS, McVilly K, Stevenson E, Chan J 2010, ‘The use of restrictive interventions in Victoria: Australian population data for 2007–2008’, *Journal of Intellectual and Developmental Disability*, vol. 35, no. 3, pp. 199–206  Webber LS, McVilly KR, Chan J 2011, ‘Restrictive interventions for people with a disability exhibiting challenging behaviour: analysis of a population database’, *Journal of Applied Research in Intellectual Disabilities*, vol. 24, no. 6, pp. 495–593 |
| What are the characteristics of people who are subject to restrictive interventions in respite services? | Approximately 28 per cent (*n*= 578) of the total number of people with disabilities subjected to restrictive interventions were from respite services.  They were generally male, younger (average age 21 years old) and reported to have a diagnosis of autism.  The majority were subject to chemical restraint. | Chan J, Webber LS, Hayward B 2013, ‘Examining the use of restrictive interventions in respite services in an Australian jurisdiction’, *Psychiatry, Psychology and Law*, vol. 20, no. 6, pp. 921–931 |
| What is the cost for staff and clients in using restrictive interventions? | A review of the literature revealed costs included:  physical injuries to staff and clients  the cost of staff leave  the client cost of lack of trust towards staff  reputational costs to organisations that use restrictive interventions. | Chan J, Le Bel J, Webber L 2012, ‘The dollars and sense of restraints and seclusion’, *Journal of Law and Medicine*, vol. 20, no.1, pp. 73–81 |
| How do service providers compare in their use of restrictive interventions? | This report was commissioned to develop and apply a general model to facilitate comparative analysis of the practice of restrictive intervention between organisations providing services to people with an intellectual disability. | Richardson B2014, *A comparative analysis of a disability service’s use of restrictive interventions*. A joint report commissioned by a service provider and the Senior Practitioner. Report to the Senior Practitioner and service provider from Deakin University, Melbourne  (Not publicly available) |
| How do people with intellectual disabilities and their families view restrictive interventions? | Some people with disabilities:  do not know their rights  do not complain out of fear or resignation  are unseen and unheard by all but those in direct support roles  find advocates and families often have to fight for their views to be heard  find that communal settings multiply behaviours that make them feel unsafe  undergo many ‘informal restrictions’ that are never recorded but are implemented by staff to maintain overall control of a setting  find that managing private space and safety is more difficult where staff numbers are low. | Ramcharan P, Nankervis K, Strong M, Robertson A 2009,  *Experiences of restrictive practices: a view from people with disabilities and family carers*. Report to the Senior Practitioner from RMIT University, Melbourne |
| What are the hidden forms of restrictive practice in shared supported accommodation? | Tensions existed around the real capacity to promote dignity of risk in an organisational context that is perceived to prioritise duty of care.  Subtle forms of restrictive practice often took the form of omissions and oversights. For example, not being aware of client preferences or the need to offer choices and expressions of resistance (that’s not the way we/I do things), rather than overt actions. | Crinall K, Manning D, Glavas A, Feeley M 2010, *Everything effects everything else*. Report to the Senior Practitioner from Monash University and the Department of Human Services Gippsland |
| Evidence for the use of GPS devices as an intervention for elopement in people with autism and other developmental disabilities. | The literature review found very few studies that explored the practicalities of GPS device use among carers of person with developmental disabilities (most had been with carers of people with dementia).  There is little evidence to support the widespread recommendation that GPS devices are an effective intervention to prevent risk associated with elopement. | Hayward B, Ransley F, Memery R, 2016, ‘GPS devices for elopement of people with autism and other developmental disabilities: A review of the published literature’, *Journal of Policy and Practice in Intellectual Disabilities,* vol 13, no. 1, pp. 69-74. |
| What is the evidence for the use of camera surveillance in providing reliable protection for people with disabilities from abuse and neglect in their homes? | Evaluation of research evidence was subject to an integrative review, ethical analysis and application of a theory for technology adoption in practice.  The review and analysis found no evidence to support that camera surveillance reliably protects people with disabilities from abuse and neglect in their homes; camera use may indicate that possible abuse had occurred. | Hayward BA, 2017, ‘The arguments against camera and closed-circuit television surveillance in the homes of people with disabilities to protect from abuse and neglect’ *Research and Practice in Intellectual and Developmental Disabilities,* vol.4, no. 2, pp. 121-137. |

# Restraint reduction

| The research questions addressed | Key findings | Relevant papers |
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| What is the impact of Positive Behaviour Support on staff and the people they support? | Disability staff participated in a training program based on the principles of Positive Behaviour Support, which included elements of good practice as recommended in the Behavior Support Plan-Quality Evaluation II. Evaluation outcome data showed:  an improvement in behaviour support plan quality and client mental health  reductions in maladaptive behaviours and restrictive intervention use. | O’Dwyer C, McVilly KR, Webber L 2017, ‘The impact of positive behavioural support training on staff and the people they support’,[*International Journal of Positive Behavioural Support*](http://www.ingentaconnect.com/content/bild/ijpbs), vol. 7, no. 2, pp.13–23 |
| What factors impact on successful restraint reduction for people with high complex needs? | Factors that staff felt had an impact included:  understanding the person’s needs using biopsychosocial assessments including functional behavioural assessment  Positive Behaviour Support tailored to the person’s needs  senior staff providing practice leadership to all staff  staff working together across organisations  staff enabling the dignity of risk  seeing improvements in quality of life in the person with a disability. | Webber LS, Major K, Condello C, Hancox K 2017, ‘Providing positive behaviour support to improve a client’s quality of life’, *Learning Disability Practice,* vol. 20, no. 4, pp. 36–41  Webber LS, Harkness T 2016, ‘Supporting people with high complex needs in the disability sector. Cover feature—Psychology innovation in the public sector’, *InPsych*, vol. 38, no. 3,p. 9  Webber LS, Ramcharan P, McLean D 2010, ‘Minimising restraint: a case study’, *Intellectual Disability Australasia*, vol. 31, no. 1, p. 12 |
| What is the impact of training in mindfulness for staff on the use of restrictive interventions? | 12 disability support workers completed an eight-week group-based mindfulness training program.  The results showed significantly less PRN and emergency seclusions and PRN and emergency chemical restraints for the two homes than prior to training.  Mindfulness training may have helped staff to respond to clients’ challenging behaviours in a more mindful, less reactive way. | Joanne E, Brooker JE, Webber L, Julian J, Shawyer F, Graham AL, Chan J, Meadows G 2014, ‘Mindfulness-based training shows promise in assisting staff to reduce their use of restrictive interventions in residential services’, *Mindfulness,* vol. 5, no. 5, pp. 598–603 |
| Long-term use of restrictive interventions: Who is at risk and what are protective factors? | Results for people who were reported to the Senior Practitioner sometime between 2008 and 2010 were used to determine longer term outcomes in 2013 to 2015.  Three years later 74 per cent of this group were still being reported to be subject to restrictive interventions.  Two main factors were associated with long-term use of restrictive interventions:  antipsychotic medication use in 2008–2010  autism or difficulty communicating to others.  For those no longer being reported and still receiving a disability service, a survey showed:  one-third of these people were no longer reported because they were now being treated for a medical condition  64 per cent of people were no longer reported because of changes in behaviour support that the team put in place, so restrictive interventions were no longer required. | Richardson B, Webber LS, Lambrick F 2019, Factors associated with long-term use of restrictive interventions, *Journal of Intellectual & Developmental Disability*, DOI: 10.3109/13668250.2019.1639895. |
| Could a new program help services to reduce restrictive interventions in Victoria? | Upward trends in formal measurement indicating that the Roadmap is an essential ‘compass’ that can be adopted and used by organisations to create freedoms for people with a disability.  Results suggest staff were able to successfully reconceptualise what was acceptable and unacceptable behaviour. | Ramcharan R 2014, *Roadmap for the reduction of restrictive practices in Victoria: a pilot study*. Report to the Senior Practitioner from RMIT University, Melbourne |
| What is the impact of the Roadmap on the use of restrictive practices and behaviours of concern in Victoria? | The Roadmap and the National Disability Services Zero Tolerance initiative was redesigned by Paul Ramcharan and the NDS. The study used a pre-test, intervention post-test design to examine changes in the use of restrictive practices and behaviours of concern over a 12-month period. | Ramcharan P. *Roadmap for the reduction of restrictive practices in Victoria*  (Research project in progress commissioned by the Senior Practitioner and the Disability and NDIS branch. Final report from RMIT University due September 2019) |
| Can behavioural social scripts reduce restrictive interventions and behaviours of concern? | Social scripts were designed for five participants.  It was not possible to determine whether the social scripts were responsible for any changes seen.  No changes in the use of restrictive interventions were found for the five participants. | Johnson H, Iacono T, Hagiliassis N, Phillips L 2010, *Collaboration in the development of behavioural social scripts to reduce restrictive interventions for behaviours of concern*, Scope, Melbourne |
| What are the parameters for the assessment and intervention for inappropriate sexual behaviour in young people with autism and intellectual disability? | An integrative review of the research literature was undertaken to inform recommendations for service providers.  Ten recommendations were made for service provision presented within the context of an over-arching positive behaviour support framework. | Hayward, B. (2015). Inappropriate sexual behaviour in young people with autism and intellectual disability: An integrative review and recommendations for service provision. *International Journal of Positive Behavioural Support,* vol. 5, no. 1, 34-48. |

# Research with people with an intellectual disability who are subject to compulsory treatment

| The research questions addressed | Key findings | Relevant papers |
| --- | --- | --- |
| What is the risk of crime and victimisation in people with an intellectual disability? | This research aimed to estimate the prevalence of criminal histories and victimisation using a large, well-defined sample of people with an intellectual disability.  Findings showed:  People with an intellectual disability were at increased risk of having a history of criminal charges, particularly for violent and sexual offences.  Although the comparison group (without a disability) had a greater risk of criminal victimisation overall, people with an intellectual disability had a greatly increased risk of sexual and violent crime victimisation. | Fogden BC, Thomas SD, Daffern M, Ogloff JR 2016, ‘Crime and victimisation in people with intellectual disability: a case linkage study’, *BMC Psychiatry*, vol. 16, no. 1, p. 170 |
| How does the use of restrictive interventions in compulsory treatment compare with those who are not receiving a compulsory treatment service? | A comparison of people on compulsory treatment and a matched group of people subject to restrictive intervention but not compulsory treatment showed:  similar rates of chemical and mechanical restraint use  those on a compulsory treatment were more likely to experience the use of seclusion than others  compulsory treatment had higher rates of some types of medications such as anti-libidinal medications. | Webber LS, Lambrick F, Donley M, Buchholtz M, Chan J, Carracher R, Patel G 2010, ‘Restraint and seclusion of people on compulsory treatment orders in Victoria, Australia in 2008–2009’, *Psychiatry, Psychology and Law*, vol. 17, no. 4, pp. 562–573 |
| What are the criminogenic needs of youth receiving youth services? | 50 young people accessing youth services were interviewed:  One in 10 had an intellectual disability.  Two of the five young people with an intellectual disability were receiving disability services.  86 per cent had a psychiatric disorder. | Thomas S, Daffern M 2011, *Characteristics of the complex and vulnerable: intellectual disability, mental illness and criminogenic needs among youth offenders in Victoria who access youth services*, Monash University, Clayton |
| How do accommodation changes affect people with an intellectual disability under compulsory treatment? | The report reviewed client records and found:  For some people who had come from prison, they eventually returned to prison.  There were two types of service users within compulsory treatment:  a younger group with a more unstable presentation whose active offending cycle led to a higher likelihood of future imprisonment  an older group supported within shared supported accommodation whose offences were more historical and presentation more stable. | McLeod D 2014, *Accommodation changes and characteristics of people with an intellectual disability under compulsory treatment in Victoria (1997–2014)*. Report to the Senior Practitioner from The University of Melbourne  (Not publicly available) |
| How can we best assess the risk of people with an intellectual disability who engage in behaviours of concern that may be considered a criminal offence? | Developed and trialled a tool to assess the support needs of people with an intellectual disability who engage in behaviours of concern that (could) constitute a criminal offence, and consequently result in their being subject to imprisonment and other long-term restrictive practices.  A pilot instrument was field-tested: Assessment of Risk and Manageability in Intellectually Disabled IndividuaLs who Offend” [ARMIDILO].  Findings of the field testing revealed that the items in the tool were valid and reliable. | McVilly K 2009, *Development of a risk assessment & planning tool to inform services for people with ID who exhibit severe behaviours of concern*, RMIT University, Melbourne |
| What is the status of anti-libidinal medication use in people with an intellectual disability who sexually offend? | Reviewed the current state of anti-libidinal medication use in people with an intellectual disability who sexually offend and made 10 recommendations for their use. | Thomas S, Daffern M 2014, *Anti-libidinal medication use in people with intellectual disability who sexually offend*, Monash University, Clayton |

# Research with people subject to restrictive interventions

| The research questions addressed | Key findings | Relevant papers |
| --- | --- | --- |
| What impact does exposure to challenging behaviour have on support worker’s wellbeing? | Participants reported that they were generally aware of environmental factors, medical issues, communication and internal states (for example, anxiety) as triggers to challenging behaviour.  Exposure to challenging behaviour was associated with higher levels of stress and depression in staff.  Staff with higher levels of education tended to experience lower levels of depression and stress. | Koritsas S, Iacono T, Carling-Jenkins R, Chan J 2010, *Exposure to challenging behaviour and support worker/house supervisor wellbeing*, The Centre for Developmental Disability Health Victoria |
| Can the CD Scale detect changes in depressive symptoms in people with an intellectual disability who are subject to restrictive interventions? | The aim of this project was to evaluate the effectiveness of the CD Scale in detecting changes in depressive symptoms in people with an intellectual disability.  Complete data were collected for six participants.  The results indicate that the CD Scale is a useful instrument for identifying depression, measuring the severity of core and associated symptoms of depression, and tracking treatment response. | Koritsas S, Torr J, Carling-Jenkins R 2011, *Depression, behaviours of concern, and restrictive interventions,* Centre For Developmental Disability Health Victoria |
| How well is active support implemented in disability services? What factors affect its implementation? | Results of the survey showed that residents with lower support needs were engaged with little staff contact or assistance. Use of active support systems and structures was mixed. Only one organisation consistently provided good active support. | Mansell J, Beadle-Brown J, Bigby C 2013, ‘Implementation of active support in Victoria, Australia: an exploratory study’, *Journal of Intellectual and Developmental Disability*, vol. 38, no. 1, pp. 48–58 |
| What views are held by Independent Persons about the role of the Independent Person? | Independent Persons considered their role as important and the engagement with service staff was beneficial and/or constructive. However:  16 per cent said they had not seen the person’s behavior support plan.  Of those who did see the behavior support plan, 42 per cent said they were not able to communicate the plan to the person with a disability. | Audit of Independent Persons on Restrictive Interventions Data System. Completed by the Senior Practitioner team, 2014 |
| How should inclusive research with people with an intellectual disability be conceptualised? | Three approaches to inclusive research were identified: advisory, leading and controlling, and collaborative. Using the literature and the authors’ own experience, each approach is illustrated and discussed. | Bigby C, Frawley P, Ramcharan, P 2014, ‘Conceptualizing inclusive research with people with intellectual disability’, *Journal of Applied Research in Intellectual Disabilities*, vol. 27, no. 1, pp. 3–12 |
| What are the key elements of support required by clients in residential support services who show challenging behaviours? | The study examined the main elements of a reputed exemplary residential support service for adults. Five elements of the practice framework were identified (for example, communicating expectations). They inform how support staff should interact with services-users. | Clement T, Bigby C 2010, *Development and utility of a program theory: lessons from an evaluation of a reputed exemplary residential support service for adults with an intellectual disability and challenging behaviours in Victoria*, La Trobe University, Melbourne |
| How can we best embed a culture of Positive Behaviour Support in a Victorian disability organisation? | A number of key lessons were learnt from case studies:  An integrated staff team is vital for staff resilience and the creation of a Positive Behaviour Support culture.  A team that relies on restrictive practices can be supported to evolve into a Positive Behaviour Support culture through the use of Positive Behaviour Support.  The organisation should reinforce the team’s positive behaviours. | St John of God and Success Works 2010, *A way of life – embedding a culture of positive behaviour support in a Victorian disability organisation.* Report to the Senior Practitioner, Melbourne |

# Reference

Webber LS, Chan J, French P 2014, ‘Good practices in Australia in the use of restraint reduction practices for people with intellectual disabilities and autism’. In: Karim S (ed), *A human rights perspective on reducing restrictive practices in intellectual disability and autism*, British Institute of Learning Disabilities, Kidderminster,pp. 123–143.