



Discussion Paper

Restrictive Interventions in Victoria's Disability Sector Issues for Discussion and Reform

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Introduction

This discussion paper presents some of the key issues surrounding the use of restrictive interventions for people with a cognitive impairment or mental illness. The paper provides the legislative context for the use of restrictive interventions in Victoria, reviews the factors associated with their use and raises three key areas for reform.

In this paper, restrictive interventions are defined as the deliberate or unconscious use of coercive power to restrain or limit an individual's freedom of action or movement. These include chemical, environmental, mechanical and physical restraint, and seclusion (see appendix 1 for definitions).

Background

The Office of the Public Advocate (OPA) is an independent statutory body with legislative powers under Victoria's *Guardianship and Administration Act 1986*. OPA is dedicated to upholding the rights and interests of Victorians with a cognitive impairment or mental illness, and works to eliminate abuse, neglect and exploitation. OPA addresses this mission through a variety of advocacy, guardianship and investigation services. OPA also undertakes research and policy work that aims to improve the lives of people with disabilities.

OPA's Advocate/Guardian Program provides guardianship, investigation and individual advocacy services to people with a cognitive impairment or mental illness. Guardianship orders and referrals for investigation are made by the Victorian Civil and Administrative Tribunal (VCAT) under the *Guardianship and Administration Act 1986*. The advocacy component of the Advocate/Guardian program derives its authority from the powers given to the Public Advocate under the same Act. Restrictive interventions are a key issue facing OPA Advocate/Guardians.

Victorian legislation surrounding the use of restrictive interventions

As a signatory to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the Optional Protocol to the Convention Against Torture and Other Forums of Inhuman and Degrading Treatment or Punishment (OPCAT), Australia is required to take effective legislative and other measures to prevent acts of torture and other inhuman treatment. The key aim of OPCAT is to prevent the mistreatment of people in detention, which includes people in mental health and disability settings.

In Victoria, the *Victorian Charter of Human Rights Act 2006* (the charter) provides protection from torture and cruel, inhuman or degrading treatment (s.10). The charter requires all public authorities to act in a way that is compatible with human rights and any new legislation that goes through Parliament requires a statement of compatibility with the charter.

Victoria has explicit legislative protections that prescribe how and when restrictive interventions can be used in mental health facilities and disability services. By definition, restraint is a limitation of a person's autonomy and freedom of movement. As such, where legislation allows the use of restraint, it is only in specific circumstances in the context of harm prevention and only where it is used as a last resort. In any other circumstances, the use of restrictive interventions is illegal.

Both the *Mental Health Act 1986*, the *Disability Act 2006* allow the use of restrictive interventions only in specific circumstances, namely when there are no less restrictive options available and only to prevent harm to the person and/or harm to others. The Mental Health Act and the Disability Act differ according to how restrictive interventions are defined, the conditions surrounding their use and the amount of procedural reporting and monitoring associated with their use by service providers. Chemical restraint is only addressed in the Disability Act.

The *Aged Care Act 1997* and the *Accreditation Standards for Residential Aged Care* do not explicitly address restrictive interventions. While the legislation is not explicit, the improper use of restrictive interventions would nonetheless be considered a breach of human rights.

The Mental Health Act 1986

Sections 81 and 82 of the *Mental Health Act 1986* outline the requirements surrounding the use of restraint and seclusion for people with a mental illness who are receiving treatment in a mental health service. Under this Act, restrictive interventions refer to:

- mechanical restraint - applying a device such as a belt, harness, manacles, sheets and straps to a person's body, and
- seclusion - the sole confinement of the person with a mental illness in a locked room.

The *Mental Health Act 1986* stipulates that mechanical restraint and seclusion can only be used if they have been approved by the authorised psychiatrist of the service or, in the case of emergencies, by the senior registered nurse. The authorised psychiatrist is expected to review the use of restraint or seclusion at the end of each month. Any person subject to mechanical restraint must be under continuous observation by a registered nurse or registered medical practitioner, and any person subject to seclusion must be clinically reviewed at intervals of no more than 15 minutes by a registered nurse.

It is expected that the Victorian Mental Health Bill, to be introduced into Parliament in 2013, will incorporate additional safeguards around the use of seclusion and restraint in mental health facilities.

The Disability Act 2006

Victoria was the first jurisdiction in Australia to provide guidelines and safeguards for the use of restrictive interventions within its disability specific legislation. Part 7 of the *Disability Act 2006* outlines

a series of procedural safeguards for the inclusion and use of restrictive interventions in disability services.¹ The core safeguards include:

- the appointment of an Authorised Program Officer who ensures that the use of restrictive interventions comply with the Act (s.139),
- the use of a behaviour management plan (more commonly referred to as a behaviour support plan) that outlines the circumstances where restraint or seclusion will be used and the benefit of their use as the least restrictive option (s.141),
- the inclusion of an independent person in the process who must be made available to the person with a disability to explain the inclusion of restrictive interventions in their behaviour support plan and the person's right to review before VCAT (s.143),
- the appointment of the Senior Practitioner who monitors the use of restraint or seclusion by disability service providers (s.148).

In the 2010-2011 financial year, 1,911 people were reported to the Office of the Senior Practitioner as being subject to restrictive interventions. The majority of people reported were subjected to chemical restraint (approximately 96 percent) (Office of the Senior Practitioner, 2011).

Disability Act 2012 Amendment

On 29 February 2012 the Parliament of Victoria introduced the *Disability Act 2006 Amendment Bill*. The Amendment Bill came into operation on 1 July 2012, and repealed parts of s.143 and substituted new provisions that limit the use and involvement of an independent person. Under the changes, the Authorised Program Officer must make an independent person available to explain the inclusion of restrictive interventions *only* if the service provider intends to use a more restrictive form of intervention than is currently included in the person's behaviour support plan. Additionally, the amendments included a provision for the independent person to report to the Senior Practitioner as an alternative to reporting to the Public Advocate.

The Aged Care Act 1997 and the Accreditation Standards for Residential Aged Care

The Aged Care Act dictates that residential aged care facilities must satisfy the *Accreditation Standards for Residential Aged Care*. The Accreditation Standards provide some limited implications for the use of restraint. Standard 4.4, 'physical environment and safe systems', states that an expected outcome of accredited residential aged care facilities is 'Management of the residential care service is actively working to provide a safe and comfortable environment consistent with residents' care needs'. While this outcome does not directly refer to restraint, it holds implications for the use of restraints such as bed rails, keypad-locking systems and so on.

¹ Legislative requirement outlined under the *Disability Act 2006* only apply to disability service providers, they do not apply in the home.

The Quality of Care principles made pursuant to s.96-1(1) of the Aged Care Act do not explicitly address the issue of restraint minimisation. However, the User Rights Principles provide for the rights of people in receipt of residential aged care. These rights include:

- full and effective use of his or her personal, civil, legal and consumer rights
- to quality care appropriate to his or her needs
- to full information about his or her own state of health and about available treatments
- to be treated with dignity and respect, and to live without exploitation, abuse or neglect
- to move freely both within and outside the residential care service without undue restriction
- to the promotion and achievement of optimum mental and physical health in partnership with their health care team.

OPA is concerned about the uneven and inadequate regulation of restrictive interventions in the disability, mental health and aged care fields.

Issues surrounding the use of restrictive interventions

Where the behaviour of a person with a cognitive impairment or a mental illness in residential care poses a threat to their own or other people's safety, the person may be described as having 'behaviours of concern' or 'challenging behaviours'. In certain circumstances, behaviours of concern need to be addressed or managed. However, the use of restrictive interventions to address or manage challenging behaviours of people with a disability or mental illness is contentious.

The following three issues have been raised as reasons why service providers should reconsider the use of restrictive interventions for managing challenging behaviour:

1. Behaviours of concern may act as a form of communication for some individuals with a cognitive impairment.
2. Behaviours of concern may be unintended or result from poor understanding of the rules.
3. There are serious negative consequences associated with the use of restrictive interventions to manage behaviours of concern.

Behaviours of concern may act as a form of communication

Behaviours of concern have the potential to cause serious harm to both the person with a cognitive impairment and those in their immediate surroundings (for example, staff, carers, family and friends). For this reason, when a person with a cognitive impairment displays concerning behaviour, they typically elicit an immediate and often significant response from staff. There is potential, therefore, for behaviours of concern to act as a form of communication for some individuals with a cognitive impairment or mental illness.

As Weiss and Knoster (2008) acknowledge, service providers and governments must recognise that in some cases, what appears as a behaviour of concern may actually be an attempt of a person with a cognitive impairment to draw immediate attention to their frustration about their situation or environment.

Behaviours of concern may be unintended or result from poor understanding of rules

Some researchers have drawn attention to the experiences of restrictive interventions for people with a cognitive impairment or mental illness. Several have focused on how people who have very limited cognitive capacity may either not understand the impact of their original actions or behaviours, or not understand the reasons behind the use of restrictive interventions as a response. For example, Ramcharan, Nankervis, Strong and Robertson (2009) explain that some individuals with a cognitive impairment who have very limited capacity may act without intention of harm. For these individuals, the use of restrictive interventions to address their behaviour is confusing, scary, and may even constitute torture.

In a similar vein, Gumber, Gangavati and Bhaumik (2011) explain that one of the key factors contributing to inappropriate sexual behaviour in people with learning disability is their lack of understanding of social or legal rules, not an intent to cause harm. These researchers explain that there are a number of societal and environmental factors that may contribute to this poor understanding, including: gender segregation and restrictions in the living environment of people with a disability, and a lack of psychosexual education for this population. Together, the work of these researchers highlights the need for service providers and governments to consider both the appropriateness of restrictive interventions as a response to unintended behaviours of concern, and the potential for other targeted responses (such as educational programs, or situational role-playing) to reduce challenging behaviours without the need for restraint.

Serious negative consequences

The use of restrictive interventions for a person with a cognitive impairment or mental illness is a serious matter. It can have significant impact on the person's physical and mental wellbeing. For example, several researchers have discussed how mechanical restraints can cause pain, pressure sores and loss of circulation to people's limbs (see for example: Kahng, et al. 2008; Bredthauer et al. 2005; and Tovino 2007). Chemical restraints have been associated with infertility, gynaecomastia, changes in bone density and metabolic changes (see for example, Murray 1987, Hayes 1991, Rohit, Gangavati and Bhaumik 2011).

The use of seclusion and physical or environmental restraints have each been linked to individuals feeling unsafe, vulnerable or powerless. For example, Holmes, Kennedy and Perron's (2004) study of the use of seclusion from patients' perspectives revealed how the key negative experience for these individuals was not the fact that they were secluded, but rather that they felt abandoned or rejected

because they had little-to-no contact with staff. The study noted that patients' feelings of abandonment and rejection often resulted in further psychological distress.

Given the deleterious nature of restrictive interventions and their potential impact on individuals with a cognitive impairment or mental illness, it is commonly accepted that restrictive interventions should not be used unless there is no less restrictive alternatives. The question therefore becomes, which factors influence service providers' decision to use restrictive interventions?

Factors influencing the use of restrictive interventions

The literature indicates that service providers are more likely to use restrictive interventions when either of the following two groups of factors are present:

1. Factors relating to the culture of a service provider, such as staff resources, knowledge and orientation.
2. Factors relating to the person with the impairment or illness, such as disability type and sex.

Factors relating to service provider culture

Commonly identified factors relating to service provider culture include staff resources, knowledge and orientation. For example, Moore and Haralambous (2007) found that staff at aged care facilities were more likely to rely on mechanical and chemical restraints if they lacked the time or resources to perform their role efficiently. Similarly, Banerjee (2009) found that staff at aged care facilities were more likely to rely on chemical restraints for people with dementia if they had not received appropriate training in managing the needs and behaviours of people with dementia.

Zwijzen and colleagues (2011) also indicate that staff understanding of restraint may affect its use. Their study of restraint in nursing home practice indicated that nurses perceived restraint only in terms of the discomfort that it caused to the individual. Accordingly, while staff may hesitate to impose interventions that caused discomfort to patients, they were more willing to impose other forms of intervention without further consideration. For example, several nursing home staff commented that using bedrails and movement sensors in the care of people with dementia did not constitute restraint because people with dementia were often unaware or unbothered by the use of these instruments.

Similar results have been found in relation to Victorian disability services. For example, Webber and colleagues (2011) demonstrated how the quality of behaviour support planning and staff understanding of its functions can affect the use of restrictive interventions in disability services.

A behaviour support plan specifies a broad range of strategies used in supporting the needs of a person with a disability who shows behaviours of concern and is subject to restrictive interventions. The plan includes proactive strategies that build on the person's strengths, and supports the learning

of skills such as general life skills, coping skills and effective communication. Behaviour support plans must be reviewed and submitted to the Office of the Senior Practitioner at least once every 12 months. Webber and colleagues found that higher quality behaviour support plans resulted in less restrictive interventions.

Singh and colleagues (2009) also acknowledged the important role of staff knowledge in disability services. These researchers explored how and why alternative approaches to behaviour management could decrease the use of physical restraints. Their study indicates that mindfulness training could decrease the use of restraints in service. This decrease may be related to the ways that staff interact with people with an intellectual disability after training. Specifically, the study suggested that staff who underwent mindfulness training were less likely to have interactions with consumers that prompted aggressive outbursts, and as a result, the need to use restrictive interventions was decreased.

Factors associated with the person with the impairment or illness

Factors associated with the person with the impairment or illness further influence the use of restrictive interventions. The disability, aged care and mental health literature have each traced connection between specific characteristics or behaviours of people with a cognitive impairment or mental illness, and the use of restrictive interventions. For example, Webber and colleagues (2010) noted that people with an intellectual disability were more likely to be subject to restrictive interventions if they were male, aged between 25 and 44 years of age and had an additional disability.

Webber, McVilly and Chan (2011) also noted an association between the type of restrictive intervention used by a service provider and the reasons for its use. These researchers showed that restrictive interventions such as seclusion were more likely to be used in situations where the person with a disability posed a risk of harm to others, whereas chemical and mechanical restraints were more likely to be used in situations where the person with a disability posed a risk of self-harm.

The literature on aged care indicates that the level of mobility of the person can also affect decision by service providers to use restrictive interventions. For example, Bredthauer and colleagues (2005) found that aged care consumers with dementia who required help with their mobility were more likely to be subjected to a form of mechanical restraint than consumers with unaffected mobility.

The aged care literature further indicates that issues of safety, including staff and patient safety, are associated with the use of restrictive interventions. However, the way that safety is constructed and considered in relation to other factors may vary between groups. For example, Hantikainen and Kappeli (2000) found that nursing staff may prioritise environmental factors or their beliefs about the rights of nursing staff over their concern for the safety or wellbeing of the person who is subjected to restraint.

Finally, a recent Finish study (Keski-Valkama et al., 2010) found the use of restraint and seclusion in psychiatric inpatient care was gendered. Women were more likely to receive intervention in cases of actual violence, whereas intervention with men was associated with agitation or disorientation. The study further found that for both genders, restraint and seclusion were used interchangeably as a form of intervention.

Key areas for reform

In light of the issues raised by this discussion paper, OPA would like to draw attention to the following three key areas for reform.

Auditing the use of chemical restraint

OPA is particularly concerned about the use of chemical restraints. Chemical restraint is the most common form of restrictive intervention used by disability service providers in Victoria. This form of restraint was included in 96 percent of the behaviour support plans reported to the Office of the Senior Practitioner in the 2010-2011 financial year.

OPA believes that increased auditing of chemical restraint usage is essential. Such auditing should include on-site and unannounced pharmacological reviews by well-resourced clinically-trained staff. OPA believes this auditing function could be performed by the Office of the Senior Practitioner or another agency with the requisite expertise. OPA further believes that this auditing should apply to all government funded and supported accommodation settings (including supported residential services and aged-care facilities).

[Recommendation 1: that the Office of the Senior Practitioner undertakes increased auditing of chemical restraint usage in government funded and supported accommodation settings.](#)

Consistent legislative protections for people with a disability or mental illness

As previously noted, OPA is concerned about the uneven and inadequate regulation of restrictive interventions. OPA believes that the use of restrictive interventions in all government funded and supported accommodation now needs clear, uniform legislative controls and reporting requirements, which could be modelled on Part 7 of the Disability Act. This includes both federal and state funded and supported accommodation, including aged-care facilities, and should include the auditing of chemical restraint.

[Recommendation 2: that the Victorian Law Reform Commission undertake an inquiry into the legislative controls and reporting requirements for using restrictive interventions across the disability, mental health and aged care sectors providing key recommendations for reform.](#)

The role of the independent person as a legislative safeguard

OPA has two concerns about the role of the independent person as a legislative safeguard. First, the *Disability Act 2006* outlines that an independent person will be made available to a person with a disability to explain the inclusion of restrictive interventions in their behaviour support plan. Since the passage of the *Disability Act 2006*, OPA has argued that *explaining* the inclusion of restrictive interventions is not equivalent to assisting the person with the disability *understand* their use. OPA believes it is the duty of the Authorised Program Officer to explain why the use of restraint or seclusion was proposed in relation to the person's behaviour, and that it is the role of the independent person to assist the person to:

- understand the Behaviour Support Plan,
- understand their right to review from VCAT, and
- initiate consideration to a review of the decision if necessary by report to the Public Advocate.

Second, the *Disability Act 2006* stipulates that if the independent person is concerned that the person with a disability does not understand the inclusion of restrictive interventions, or that the service provider does not meet some of the other requirements under the Act, the independent person may report the matter to the Public Advocate or to the Senior Practitioner as the 2012 amendments provide. OPA is concerned about the effectiveness of this safeguard.

In the six years since the implementation of the Disability Act, the Public Advocate has not received any reports from independent persons about these matters. However, OPA's Advice Service and Legal Team have both received a handful of queries from disability service providers seeking advice about who constitutes an appropriate independent person, and how to locate them in the community. OPA therefore believes that programmatic support and training is required for both disability service providers and independent persons if the function of the independent person's role is to be an effective right's safeguard.

Recommendation 3: that the Department of Human Services provides disability service providers and independent persons with greater programmatic support and training in relation to the functions and purpose of the independent person's role.

Appendix Definition of Restrictive Interventions

Restrictive interventions are the deliberate or unconscious use of coercive power to restrain or limit an individual's freedom of action or movement. There are five main forms of restrictive interventions: chemical, environmental, mechanical, and physical restraint, and seclusion.

Chemical restraint

Involves using pharmaceuticals to change or affect a person's behaviour. For example, a service provider may have a doctor prescribe anti-libidinal medication to a person with an intellectual disability who displays 'problematic sexual behaviour', such as public masturbation or voyeurism.

In Victoria, chemical restraint is the most common form of restrictive intervention used by disability service providers, with 'psychotropic' pharmaceuticals - medication that affects perception, emotion or behaviour - being the most common chemical restraint (Office of the Senior Practitioner, 2008). Chemical restraints are administered either to subdue an individual at a single point in time, or to manage persistent behaviours of concern over the long-term. Chemical restraints are distinguished from the treatment of a mental or physical illness or medical condition.

Environmental restraint

Refers to restricting a person's actions or movements through changes to their environment. For example, an aged care facility may include keypad-locking devices on the facility's door in order to stop patients with dementia from exiting the premises unaccompanied. Similarly, a residential service for people with cognitive impairments may restrict a resident's access to rooms such as the kitchen in order to manage their impulsive behaviour within the facility.

Mechanical restraint

Refers to devices for the purpose of behavioural control such as strapping a person's wrists, chest or other parts of the body in order to stop them from hurting themselves or others. This form of restraint may be used in situations such as a mental health facility when there is a concern that a patient will self-harm.

Physical restraint

Refers to using a person's physical body to restrict the movement of another. This form of restraint is most likely to occur in response to the immediate actions of an individual, such as when an involuntary patient at a mental health facility tries to leave the premises by force.

Seclusion

Refers to confining an individual in a room where they are unable to leave or interact with other individuals. This form of restraint is typically used in mental health facilities when a patient receives

too much stimulation from other patients or their environment and their behaviour becomes agitated, aggressive or erratic.

References

- Banerjee, S. (2009) *The Use of Antipsychotic Medication for People with Dementia: Time for Action*. A Report for the Minister of State for Care Services. Department of Health, Crown UK.
- Bredthauer, D., Becker, C., Eichner, B., Koczy P and Nikolaus, T., (2005) 'Factors Relating to the Use of Physical Restraints in Psychogeriatric Care: A Paradigm for Elder Abuse' *Zeitschrift fur Gerontologie und Geriatrie*, 38:10-18.
- Emerson, E. (2001) *Challenging behaviour: Analysis and Intervention in People with Severe Intellectual Disabilities*. Cambridge University Press.
- Gumber, R., Gangavati, S. and Bhaumik, S. (2011) 'Antilbidinals – cure or curse? Long-term use of Antilbidinal Medication in Adult Patients with Learning Disability', *The British Journal of Developmental Disabilities*, 57 (112): 81-90.
- Hantikainen, V. and Kappeli, S. (2000) 'Using Restraint with Nursing Home Residents: a Qualitative Study of Nursing Staff Perceptions and Decision-making' *Journal of Advanced Nursing*, 32(5): 1196-1205.
- Hayes, S. (1991) 'Sex Offenders' *Australian and New Zealand Journal of Developmental Disabilities*, 17(2): 221-227.
- Holmes, D., Kennedy, S., and Perron, A. (2004) 'The Mentally Ill and Social Exclusion: A Critical Examination of the use of Seclusion from the Patient's Perspective', *Issues in Mental Health Nursing*, 25: 559-578.
- Kahng, S., Leak, J., Vu, C., and Mishler, B. (2008) 'Mechanical Restraints as Positive Reinforcers for Aggression' *Behavioural Interventions*, 23: 137-142.
- Keski-Valkama, A., Sailas, E., Eronen, M., Koivisto, A., Lonnqvist, J. and Kaltiala-heino, R. (2010) 'The Reasons for Using Restraint and Seclusion in Psychiatric Inpatient Care: A nationwide 15-year study', *Nordic Journal of Psychiatry*, 64:136-144.
- Moore, K. and Haralambous, B. (2007) "Barriers to Reducing the use of Restraints in Residential Elder Care Facilities' *Journal of Advance Nursing*, 58(6): 532-540.
- Murray, J. (1987) 'Psychopharmacological Therapy of Deviant Sexual Behaviour' *Journal of General Psychology*, 115(1): 101-110.
- Office of the Public Advocate (2011) *Position Statement on Restrictive Interventions*. Office of the Public Advocate: Melbourne
- Office of the Senior Practitioner (2008) 'Chemical Restraint: What Every Disability Support Worker Needs to Know', *Positive Solutions in Practice*. Office of the Senior Practitioner: Melbourne.
- Office of the Senior Practitioner (2011) *Senior Practitioner Report 2010-11*. Office of the Senior Practitioner: Melbourne.
- Ramcharan, P., Nankervis, K., Strong, M. and Robertson, A. (2009) *Experiences of Restrictive Practices: A View from People with Disabilities and Family Carers*. A Final Research Report to the Office of the Senior Practitioner. Victorian Government Printer: Melbourne.

- Rohit, G., Gangavati, S., and Bhaumik, S. (2011) 'Antilipidals – Cure or Curse? Long-term Use of Antilipidinal Medication in Adult Patients with Learning Disability' *The British Journal of Developmental Disabilities*, 57(112), 81-90.
- Singh, N., Lancioni, G., Winton, A., Singh, A., Adkins, A. and Singh, J. (2009) "Mindful Staff Can Reduce the Use of Physical Restraint When Providing Care to Individuals with Intellectual Disabilities" *Journal of Applied Research in Intellectual Disabilities*, 22: 194-202
- Tovino, S. (2007) 'Psychiatric Restraint and Seclusion: Resisting legislative Solution', *Santa Clara Law Review*, 47.
- Webber, L., McVilly, K., and Chan, J. (2011) 'Restrictive Interventions for People with a Disability Exhibiting Challenging Behaviours: Analysis of a Population Database', *Journal of Applied Research in Intellectual Disabilities*, 24: 495-507
- Webber, L., McVilly, K., Fester, T., and Chan, J. (2011) 'Factors Influencing Quality of Behaviour Support Plans and the Impact of Plan Quality on Restrictive Intervention Use', *International Journal of Positive Behavioural Support*, 1(1): 24-31.
- Webber, L., McVilly, K., Stevenson, E., and Chan, J. (2010) 'The Use of Restrictive Interventions in Victoria, Australia: Population Data for 2007-2008' *Journal of Intellectual and Developmental Disability*, 35(3): 199-206
- Weiss, N. and Knoster, T. (2008) 'It May be Nonaversive, But is it a Positive Approach? Relevant Questions to ask Throughout the Process of Behavioural Assessment and Intervention' *Journal of Positive Behaviour Interventions*, 10(1): 72-78.
- Zwijzen, S., Depla, M., Niemeijer, A., Francke, A. and Hertogh, C. (2011) 'The Concept of Restraint in Nursing Home Practice: A Mixed-methods Study in Nursing Homes for People with Dementia' *International Psychogeriatrics* 23(5): 826-834.