FACTSHEET - OFFICE OF THE SENIOR PRACTITIONER

Chemical Restraint: Frequently Asked Questions

Background

This fact sheet has been developed to highlight some of the issues with the use of chemical restraint and assist service providers understand what is and what isn't a chemical restraint in preparation for the new reporting requirements of the NDIS Quality and Safeguards Commission.

The current definition of Restrictive Intervention in the Tasmanian *Disability Services Act (2011)* (DSA) has two categories which are subject to authorisation – these are: environmental restrictions and personal restrictions.

From July 2019 the National Disability Insurance Scheme (NDIS) will be introducing its Quality and Safeguarding Framework (QSF) into Tasmania. The QSF will bring a nationally consistent approach to the reduction and elimination of the use of restrictive practices including a set of definitions for seclusion, physical restraint, mechanical restraint, environmental restraint and chemical restraint.

Authorisation of these restrictive practices under the definitions contained in the DSA will apply to environmental restraint (under environmental restrictions) and physical restraint, seclusion and mechanical restraint (under personal restrictions).

Under the DSA however, the use of chemical restraint does not need to be authorised but there is a legal requirement for the 'person responsible' to consent to the 'administration of a restricted substance primarily to control the conduct of a person to whom it is given' (Guardianship and Administration Regulation 12).

The NDIS Quality and Safeguards Commission (the Commission) has defined chemical restraint as:

> *'the use of medication or chemical substance for the primary purpose of influencing a person's behaviour or movement. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment, of a diagnosed mental disorder, a physical illness or physical condition.'*[1]

[1] NDIS (Restrictive Practices and Behaviour Support) Rules 2018

The Commission will require registered service providers to report to them any use of a regulated restrictive practice. The service provider will also need to arrange for a behaviour support plan to be developed for the person being subject to a restrictive practice. As mentioned above, because Chemical Restraint is not defined in the Tasmanian Disability Services Act 2011 there is no requirement for providers to seek authorisation from the Senior Practitioner.

The Disability Services Medication Management Framework provides general guidance on use of medications and administration. This guide provides the following guidance in relation to chemical restraint:

- *'Decisions relating to medication selection and administration should only result in the restriction of freedom of decision and action of the individual, if at all, to the smallest extent that is practicable in the circumstances. Restrictive interventions involving the use of medication (chemical restraint) are supported by a transparent, easily understood and evidence-based Behaviour Management Plan developed in consultation with the individual, or a person nominated by the individual, persons who have expertise in the carrying out of the proposed restrictive intervention, the prescriber and the Senior Practitioner. This plan should indicate a process for review of restrictive practices.'*

Why is monitoring the use of chemical restraint important?

People with an intellectual disability (ID) are one of the highest medicated groups in society and there is strong evidence that the use of psychotropic medication, for example, is too high within this population (Matson et al, 2003). Psychotropic medication is defined as any medication that alters the mental state or mood of an individual.

One factor explaining this is that although the prevalence of ID in the Australian community is only 1-3% (ABS 2007), approximately 30-40% of people with ID will experience some kind of mental illness, psychiatric disorder or emotional difficulty that requires treatment (Thomas et al, 2011). This equates to a higher risk than the general population. Unfortunately, people with an ID are often misdiagnosed with mental illness. This is partly due to the difficulty in diagnosing mental illness in people who have severe communications difficulties. Misdiagnosis will usually result in inappropriate medical treatment.

Another issue is that between 7-15% of people with ID will show behaviours of concern. Although there are many factors which might contribute to their occurrence, and there are a large range of options for de-escalation and strategies addressing the underlying factors, the most common response to manage behaviours of concern is to use medication (McGillivray & McCabe, 2006). Indeed it is estimated that 44-88% of people who show behaviours of concern are prescribed some form of medication, usually a psychotropic (Thomas et al 2011)

Psychotropic medications are not licensed for use in reducing behaviours of concern and there is no evidence the consumption of these medications are in any way helping the individuals involved. They can in fact worsen the problem. Despite the limited evidence into the

effectiveness of psychotropic medication on behaviours of concern, studies have consistently illustrated the highest predictor of a prescription of this drug class is not mental illness but behaviours of concern (Matson & Neal, 2009).

People with ID often have an array of physical and neurological health issues which are usually managed with drug therapy. This coupled with medication aimed at reducing behaviours of concern, can lead to polypharmacy (the prescription of two or more medications to an individual), having the potential to interact and exacerbate physical, mental, neurological and behavioural issues (McGillivray & McCabe, 2006).

Psychotropic medications also have a range of potential side effects which can actually increase the behaviours of concern they are trying to control. If people with ID cannot express themselves verbally, they may 'act out' in order to try to communicate distress, or more simply may act upon their side effects, for example by over eating due to feeling constantly hungry (Mason et al, 2003).

The issues discussed above were all highlighted in a study carried out in 2010 by psychiatrists and pharmacists from the Centre for Forensic Behavioural Science (Monash University) that found that out of 201 participants who were subject to the use of chemical restraint, 88% needed an independent psychiatric review due to potential for adverse effects including additive side effects (Thomas et al 2011).

Frequently asked questions about chemical restraint

Q. Is it chemical restraint if the person has a diagnosis of a mental illness?

A. This depends on whether the person is also prescribed medication for behavioural control over and above what would be prescribed for the mental illness. For example, someone may be prescribed olanzapine (also known as Zyprexa) for schizophrenia, but also PRN valium for when they become angry. In this case olanzapine would not need to be reported because it is treating schizophrenia; however, PRN valium is chemical restraint because it is prescribed to control the person's behaviour rather than treat schizophrenia and thus would need be reported.

The NDIS will require disability service providers who administer medication for behavioural control to report such administration monthly to the Q&S Commission.

Q. What are the main issues I should be aware of for people who are prescribed chemical restraints?

A. The inappropriate prescribing of psychotropic medications at high doses. High doses can result in side effects, such as drowsiness & ultimately tardive dyskinesia (motor difficulties such as tongue protrusion, tremor and restless legs). ***Periodic checks by medical practitioners for possible dose reduction should be obtained.***

Often people with a disability are prescribed a combination of medications (also known as poly-pharmacy) (e.g. benzodiazepines, anti-psychotics, anti-convulsants and anti-depressants).

Taking a number of different medications can result in increased side effects and toxicity. ***Poly-pharmacy should be avoided unless the necessity is clearly demonstrated.***

The medications prescribed may not be useful in helping the person feel calmer, but in fact may make the situation worse by making them feel more agitated.

People who are administered chemical restraint should be reviewed regularly by a medical practitioner, so that any of the above issues can be dealt with promptly so the person is given the best care possible.

Q. Are antipsychotic medications useful or beneficial for people with an intellectual disability for behavioural control?

A. This is not clear, because there is evidence to suggest that low doses of antipsychotic medications may be useful for certain people in the short term; however there is also other evidence suggesting medication does not make a difference. Evidence showing that medications have an impact comes from the work of Capone and his colleagues (2008) who found that the use of low doses of risperidone resulted in improvements in hyperactivity, stereotypy, lethargy, irritability and sleep with children with Down Syndrome and comorbid Autistic Spectrum Disorder. However, it also resulted in significant weight gain over the three months for most children.

Unfortunately Capone and colleagues did not use a comparison group and so they do not know whether risperidone was any better than a pill that looks and tastes similar, but contains no medication. Another study found that two types of commonly used psychotropic medications for people with aggressive behaviour were no better than a pretend pill (Tyrer, 2008). Although both risperidone and haloperidol were found to be effective in reducing aggressive behaviours of concern, the pretend pill was found to be the most effective in reducing aggression!

Taken together these findings suggest that the effects of medication should be monitored by staff and reviewed regularly by a medical practitioner.

Q. What other kinds of support are effective in reducing behaviours of concern that could be used to replace the need for chemical restraint?

A. Armed (2000) found that a substantial proportion of people taking antipsychotic medications for behavioural control were able to have their medications withdrawn completely or reduced to minimum when supported with appropriate environmental, personal and social support. Below is an example how one person was supported to withdraw from medications.

Example: Jill has been diagnosed with Fragile X. For many years Jill had been taking many medications for her behaviours of concern. About 18 months ago Jill was seen by a specialist who recommended that people with Fragile X should not be taking any psychotropic medications; Jill's medication was slowly reduced to no medication at all. Initially there was an escalation in Jill's behaviours of concern, but staff agreed to find other ways to support Jill (e.g., positive behavioural support such as, teaching Jill to solve problems and to cope with frustrations). Now Jill continues to be medication free and staff who have supported her over the years say she is a different woman, happier, more relaxed and a pleasure to be with. Teaching Jill ways to cope has been much more effective than the medication was in improving Jill's quality of life.

Unfortunately, it is estimated that only 2-20% of people like Jill will be provided with personal and social interventions. In addition, where behaviour support plans do exist, they are often mostly no more than a list of reactive strategies (e.g. distraction).

Psychotropic medication should only ever be used within a behaviour support plan where the person is supported with personal, social and or environmental interventions as well.

Q. Is it chemical restraint if medication is used for Menstrual Suppression or Contraception?

A. The use of medication to achieve menstrual suppression (without informed consent of the person) is a form of chemical restraint and will need to be reported to the NDIS Q&S Commission. Alternative approaches to solving issues such as fear of blood, smearing, hygiene problems and/or pain need to be trialed first such as, education, relaxation, exercise and positive support staff behaviours.

The use of medication to prevent pregnancy (without informed consent of the person) is a form of chemical restraint and will need to be reported to the NDIS Q&S Commission. It would be important to provide education around sexual relationships and safe sex as a first step.

Q. Are there any duty of care issues I need to be aware of?

A.

- Anyone who is prescribed chemical restraint should have a functional behavioural assessment, to determine how best to support the person, environmentally, personally and socially.
- All psychotropic medications should be reviewed on a regular basis by a medical practitioner (every six months) and by a psychiatrist annually. Any recommendations that are made by medical practitioners should be documented in the behaviour support plan and followed up and implemented.

- People who have complex communication needs should be assessed by a speech pathologist for an appropriate augmentative communication system so that they can communicate, where possible, any side effects of medications.
- Sometimes behaviours of concern are the result of physical illnesses such as gastro-oesophageal reflux. Symptoms include vomiting and/or regurgitation of food, and may result in the person feeling sad, angry or aggressive. Any such symptoms should be checked by a medical practitioner promptly because gastro-oesophageal reflux can result in choking.
- Misdiagnosis is possible especially for people who have limited communication skills, therefore if you feel the person you support should have a second opinion, get one.

Some additional points

- If you think the medication is not right, then it should be reviewed by a psychiatrist or other specialist (e.g. neurologist).
- If the person shows behaviours of concern, a functional behaviour assessment should be completed, regardless of whether or not the person is administered chemical restraint.
- If the person has difficulty communicating, then a communication assessment will help find out if there are alternative and augmentative communication strategies the person could use to communicate their issues.

How do I contact the Tasmanian Senior Practitioner?

The Senior Practitioner is available to discuss any issues or concerns relating to the use or potential use of a personal restriction on the contact details listed below.

Telephone: (03) 6166 3567 Mobile: 0428 197 474

Email: seniorpractitionerdisability@communities.tas.gov.au

Web: www.communities.tas.gov.au/disability/office-of-the-senior-practitioner

Further information about Restrictive Interventions can be found on the RISET Tas link below.

Access practice resources and restrictive intervention information via RISET-TAS online: RISET-Tas Link