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| Chemical restraint |
| Information for prescribers |
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# Purpose

This fact sheet informs prescribers of the legislative context in the regulation of restrictive practices under the *Disability Act 2006* (the Disability Act) and the relevant clinical considerations.

# Chemical restraint definition

Section 3 of the Disability Act defines chemical restraint as ‘the use of medication or chemical substance for the primary purpose of influencing a person’s behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable the treatment of, a diagnosed mental disorder, a physical illness or a physical condition’.

# Role of the Victorian Senior Practitioner

The Victorian Senior Practitioner is responsible for ensuring that:

* the rights of the persons who are subject to restrictive practices and compulsory treatment are protected
* appropriate standards in relation to restrictive practices and compulsory treatment are complied with under Section 23 of the Disability Act.

This includes working with all stakeholders in the sector to reduce restrictive practices where possible, and where restrictive practices are necessary, to ensure that the benefit continues to outweigh the potential harm.

# Role of authorised program officers and behaviour support practitioners

Authorised program officers (APOs) from the implementing providers are responsible for determining whether a medication is considered chemical restraint under the Disability Act.

APOs and behaviour support practitioners need to work with prescribers and service providers to reduce the use of chemical restraint where possible, and to implement positive behaviour support strategies.

# Medication purpose form

APOs and behaviour support practitioners may seek information from you as the prescriber, regarding the purpose of medication(s), to assist them with fulfilling their responsibilities under the Disability Act. This is particularly important in helping APOs to identify medication(s) used primarily to influence behaviour(s) as chemical restraint.

You may be requested to complete a medication purpose form, or alternatively, you can provide this information in a letter or in medical notes.

# Behaviour support plan

The Disability Act defines a behaviour support plan as a plan developed for a person with a disability that specifies a range of strategies to be used in supporting the person who shows behaviours of concern, including proactive strategies to build on the person’s strengths and increase their life skills.

Positive behaviour support strategies can:

* improve a person’s quality of life
* offer recommendations to make changes to the environment that are based on the person’s preferences
* support the person to learn skills that meet the same need as the behaviours of concern
* use targeted positive strategies based on the function of the behaviour, which can result in reduced need for restrictive practices, including medications.

# Clinical implications

It is important to note that if a medication is prescribed primarily to manage behaviour(s) of concern, it would be considered chemical restraint, regardless of the person’s medical diagnoses.

A particular focus should be placed on medications that have psychoactive properties with significant side effect profiles (for example, antipsychotics). The substantial risks associated with those medications warrant additional oversight to prevent harm.

The National Institute of Health and Care Excellence (NICE) 2015 guidelines on ‘Challenging behaviour and learning disabilities: Prevention and interventions for people with learning disabilities whose behaviour challenges’ makes the following recommendations:

* Consider antipsychotic medication to manage behaviour that challenges, only if:
	+ psychological or other interventions alone do not produce change within an agreed time, or
	+ treatment for any coexisting mental or physical health problem has not led to a reduction in the behaviour, or
	+ the risk to the person or others is very severe.
* Only offer antipsychotic medication in combination with psychological or other interventions.
* Antipsychotic medication should initially be prescribed and monitored by a specialist (an adult or child psychiatrist) who should:
	+ identify the target behaviour
	+ decide on a measure to monitor effectiveness (for example, direct observations), including frequency and severity of the behaviour, and impact on functioning
	+ start with a low dose and use the minimum effective dose needed
	+ only prescribe a single medication
	+ monitor side effects (including regular blood levels, serum cholesterol and lipids, and weights)
	+ review the effectiveness and any side effects of the medication after 3 to 4 weeks
	+ stop the medication if there is no indication of a response at 6 weeks, reassess the behaviour that challenges, and consider further psychological or environmental interventions.

The Victorian Senior Practitioner also recommends that the long-term goals of medications are clearly communicated to all stakeholders involved in the person’s care, and that regular attempts are made to reduce or cease medication where appropriate.

For further information:

* visit the [Department of Developmental Disability Neuropsychiatry (3DN – UNSW)](https://dhhsvicgovau-my.sharepoint.com/personal/peter_o%27brien_dffh_vic_gov_au/Documents/00%20BRANDPUB%20JOBS%20PETE/2209322_Chemical%20restraint%20resources/Working/Edited%20docs%20from%20Bridget/Department%20of%20Developmental%20Disability%20Neuropsychiatry%20%283DN%20%E2%80%93%20UNSW%29) <https://www.3dn.unsw.edu.au/>
* download the ‘[Medication Review Guide for GPs – A guide for GPs on the use of psychoactive medications for adults with intellectual disability who present with behaviours of concern](https://www.cddh.monashhealth.org/wp-content/uploads/2016/11/2015-medication-review-guide-for-gps.pdf)’ <https://www.cddh.monashhealth.org/wp-content/uploads/2016/11/2015-medication-review-guide-for-gps.pdf>, published by the Centre for Developmental Disability Health Victoria.

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