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| Practice points for using psychotropics to manage behaviours of concern |
| For behaviour support practitioners and authorised  program officers |
| OFFICIAL |

# Purpose

This fact sheet provides information on common causes of behaviours of concern in people with developmental disability, and the withdrawal effects of commonly used medicines.

# Behaviours of concern definition

Behaviours of concern (BOCs) are defined by McVilly (2002) as ‘any behaviour that is a barrier to a person participating in and contributing to their community (including both active and passive behaviours) that undermines, directly or indirectly, a person’s rights, dignity or quality of life, and poses a risk to the health and safety of a person and those with whom they live or work’.

Those behaviours can significantly impact on quality of life and present a challenge to service providers. Any interventions to influence BOCs should be guided by an agreed behavioural support plan.

For more information on positive behavioural support, download the [Positive Practice Framework: A guide for behaviour support practitioners](https://www.dffh.vic.gov.au/positive-practice-framework-word) <www.dffh.vic.gov.au/positive-practice-framework-word>.

Restrictive practices, including chemical restraint, can only be used when their use is necessary to prevent physical harm to the person or others, and used in the least restrictive manner with a dedicated fade out plan. (Section 132 ZR of The *Disability Act 2006*).

There are some commonly missed causes of behaviours of concern in people with developmental disability.

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| Commonly missed causes of challenging behaviour in people with developmental disability:   * abuse and trauma * constipation * dental pain and gum disease * gastro-oesophageal reflux disease (GORD) and *helicobacter pylori* infection * hunger and poor nutrition * infection – consider immunisation status * medication adverse effects * poor physical activity * psychiatric disorder * sensory deterioration or loss * sleep problems * social or environmental changes, including irregular contact, or loss of contact with a trusted carer or friend (for example, change of staff or co-residents, death of a family member) * thyroid disease * unrecognised or poorly controlled neurological condition (for example, epilepsy) * unrecognised physical injury (for example, fracture).   This information was reproduced with permission from ‘Initial assessment and support for challenging behaviour in a person with developmental disability’, [Therapeutic Guidelines [digital]](https://www.tg.org.au/) <https://www.tg.org.au>, published March 2021. |

# Chemical restraint practice points

Implementing providers are encouraged to assess all potential causes and communicate the observations regularly with the client’s treating doctor(s).

The NDIS Quality and Safeguard Commission’s Regulated Restrictive Practices Guide states that a regulated restrictive practice must ‘be used only as a last resort in response to risk of harm … and after the provider has explored and applied evidence-based, person-centred and proactive strategies’.[[1]](#footnote-1)

Chemical restraint is defined, as per the *Disability Act 2006* (the Disability Act), 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, physical illness or physical condition.

The use of chemical restraint should be closely monitored (for both effectiveness and side effects) and regularly reviewed. Successful withdrawal of chemical restraint will require multidisciplinary input with the support of family and carers. The behaviour support plans should include fade out plans that outline response strategies to BOCs during the withdrawal process of chemical restraints.

Table 1. Common adverse effects of stopping or reducing the dose of an antipsychotic [NB1] [NB2] [NB3]

| Antipsychotic | Common adverse effects of stopping therapy or reducing the dose |
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| Amisulpride (Brand names: Solian®, Sulprix®) | Increased risk of unplanned pregnancy due to decrease in blood prolactin concentration |
| Aripiprazole (Brand names: Abilify®, Abyraz®, Tevaripiprazole®) | No specific adverse effects [NB2] |
| Asenapine (Brand name: Saphris ®) | No specific adverse effects [NB2] |
| Brexpiprazole (Brand name: Rexulti®) | No specific adverse effects [NB2] |
| Chlorpromazine (Brand name: Largactil®) | * Agitation because of decreased sedation [NB4] * Insomnia [NB4] * Increased risk of unplanned pregnancy due to decrease in blood prolactin concentration * Movement disorder * Cholinergic rebound syndrome |
| Clozapine (Brand names: Clozaril®, Clopine®) [NB5] | * Agitation because of decreased sedation [NB4] * Insomnia [NB4] * Cholinergic rebound syndrome |
| Flupentixol (Brand name: Fluanxol Depot®) | Increased risk of unplanned pregnancy due to decrease in blood prolactin concentration |
| Haloperidol (Brand names: Serenace®, Haldol®) | * Increased risk of unplanned pregnancy due to decrease in blood prolactin concentration * Movement disorders |
| Olanzapine (Brand names: Zyprexa®, Ozin®, Pryzex®, Zypine®) | * Agitation because of decreased sedation [NB4] * Insomnia [NB4] |
| Paliperidone (Brand name: Invega®) | Increased risk of unplanned pregnancy due to decrease in blood prolactin concentration |
| Periciazine (Brand name: Neulactil®) | * Agitation because of decreased sedation [NB4] * Insomnia [NB4] |
| Quetiapine (Brand names: Seroquel®, Kaptan®, Quetia®, Syquet®, Tevatiapine®) | * Agitation because of decreased sedation [NB4] * Insomnia [NB4] |
| Risperidone (Brand names: Risperdal®, Rispa®, Rispernia®, Rixadone®, Ozidal®) | Increased risk of unplanned pregnancy due to decrease in blood prolactin concentration |
| Ziprasidone (Brand names: Zeldox®, Ziprox®) | No specific adverse effects [NB2] |
| Zuclopenthixol (Brand name: Clopixol®) | * Agitation because of decreased sedation [NB4] * Insomnia [NB4] * Increased risk of unplanned pregnancy due to decrease in blood prolactin concentration |

NB1: The information in this table is based on a combination of reported adverse effect data and expert opinion. It is intended as a guide only and should be interpreted in the context of the patient (for example, concurrent drugs, drug history, physical health, interindividual variation in pharmacokinetics).

NB2: For all antipsychotics except clozapine, stopping therapy or reducing the dose can cause movement disorders. The above table only includes this as an adverse effect for antipsychotics that are particularly likely to cause movement disorders. Movement disorders usually settle quickly when dose reduction is slowed. If this is ineffective, seek specialist advice. Rarely, these movement disorders become chronic and the antipsychotic may require prolonged dose reduction or, in the case of psychotic disorders, a switch to clozapine.

NB3: Rapidly stopping an antipsychotic, particularly clozapine, can cause rebound psychosis, which is characterised by rapid symptom onset, pronounced positive symptoms, agitation and relative treatment resistance.

NB 4: If this problem is encountered, reduce the rate of dose reduction.

NB5: Clozapine must be stopped under psychiatrist supervision.

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1. NDIS Quality and Safeguards Commission 2020, *Regulated Restrictive Practices Guide*, Penrith, Australia. [↑](#footnote-ref-1)