Chemical restraint

This Information Sheet provides practitioners, service providers and disability support workers with information about the authorisation and use of chemical restraint as applied to adults (18 years or older) who:

- have an intellectual or cognitive disability; and
- are receiving services provided by Disability Services, or services prescribed by regulation and funded under a NDIS participant plan; and
- behave in a way that causes physical harm or a serious risk of physical harm to themselves or others.

The intent of Part 6 of the Disability Services Act 2006 is to promote positive behaviour support approaches; support the elimination or reduction of the use of restrictive practices; and to reinforce that, if restrictive practices are used, they are the least restrictive way of ensuring the safety of the adult or others.

What is chemical restraint?

Chemical restraint of an adult with an intellectual or cognitive disability means the use of medication for the primary purpose of controlling the adult’s behaviour in response to the adult’s behaviour that causes harm to the adult or others. This includes both fixed daily dose and medication given as required.

However under the Act, the following are not chemical restraint:

- The use of medication for the proper treatment of a diagnosed mental illness or physical condition.
- The use of medication, for example a sedative, prescribed by a medical practitioner to facilitate or enable the adult to receive a single instance of health care under the Guardianship and Administration Act 2000. For example, sedating an adult before attending a dentist appointment is not chemical restraint.

Examples of chemical restraint

Chemical Restraint (fixed dose)

Veronica is 50 years of age and has been taking a pill to make her calmer for 10 years. This pill was given to Veronica by a psychiatrist but the psychiatrist has not said Veronica has a mental health or other health problem. The reason he has given her this pill is due to her behaviour of pushing people near her and sometimes hitting others. The psychiatrist has told her brother to give the pill to Veronica every morning with her breakfast.

Veronica lives with her brother who has provided full care for his sister without using any disability services. However her brother has just asked for respite care for his sister.

The respite service must write down the name of the pill, information on the pill, the correct way and time to give Veronica the pill and the psychiatrist’s name and contact details. Staff
providing respite support must have this information and follow what it says. The respite service must also have written consent from Veronica’s brother.

Chemical Restraint (PRN)
Jeremy is 21 years of age and lives with one other man in a rented unit. The two men are supported by a service provider. Jeremy has just started to hit and grab staff when they are driving in the car. Staff have thought about what is happening and checked Jeremy’s health and whether there are any other problems. To try and reduce this behaviour, Jeremy’s activity level has been increased and staff now let him know where he is going and why. The amount and length of car trips have been shortened. However, Jeremy still needs to travel in the car to attend regular doctor’s appointments, visit his mother and go to the movies - something he really enjoys. Staff have requested that Jeremy be given something to calm him down prior to travelling by car.

Jeremy already has a guardian for restrictive practice. Staff have sometimes physically restrained him from self injury since he started living in the house when he turned 18 years.

When considering using medication to stop Jeremy from hitting, the service provider must give a statement in the approved form to Jeremy, his family members and others in his support network about the use of this medication. The statement must include why the service provider is considering using medication; how Jeremy, his family or others in his support network can be involved and express their views in relation to the use of this medication; who decides whether the medication will be used; and how Jeremy, his family or others in his support network can make a complaint about, or seek review of, the use of the medication. The statement must be explained in a way that Jeremy is most likely to understand and is appropriate to his age, culture, disability and communication skills.

The service must find an appropriately qualified person to organise an assessment of the behaviour and work out why Jeremy is hitting and grabbing staff when driving. The staff must talk with Jeremy, his family, guardian for restrictive practice and other staff to determine what other changes may make life better for Jeremy. If taking medication before going for a drive is thought to be the best way to keep Jeremy from hurting others, his treating doctor must be consulted and their views considered. The treating doctor should complete a health assessment, a medication review, and must make a recommendation about chemical restraint including details of dose, route, and frequency and for PRN, circumstances for administration.

A new positive behaviour support plan which includes the use of this medication must be written and sent to the guardian for restrictive practice (general) matter for authorisation/approval. The service must have authorisation for the new plan to use the medication before or prior to going on drives.

Chemical restraint should only be used as part of a planned response to an adult’s behaviour that causes harm and where it has been demonstrated that such responses are the least restrictive way.

* This description of the authorisation process is only for this example as the process will change depending on the disability service provided and whether this is the only restrictive practice.
Chemical restraint should be used only to address the risks presented by an adult’s behaviour that causes harm. As such, chemical restraint does not include using medication for the proper treatment of a diagnosed mental illness or physical condition. ‘Diagnosed’ means a doctor has confirmed that the adult has the illness or condition. Chemical restraint does not include the use of medication as an adjunct to medical treatment, for example, when a medical practitioner prescribes a sedative prior to performing a medical procedure.

The difference between medications (pills/tablets, needles, liquids) to make someone healthy again and chemical restraint depends on why the doctor gave the medication. Medications given to stop or control behaviour are a form of restraint.

When should restrictive practices be considered?
Chemical restraint as a form of restrictive practice may be considered for use by relevant service providers in the following circumstances:

- as part of a positive behaviour support plan that promotes positive outcomes for the adult and supports the reduction or elimination of restrictive practices.
- as the least restrictive way to prevent the adult’s behaviour causing harm to themselves or others
- as a time-limited response where there is a need to safeguard the adult and others from significant harm.

Considerations for the use of chemical restraint
A number of factors must be considered with regard to the use of chemical restraint in relation to an adult with an intellectual or cognitive disability:

- The relevant service provider must give a statement in the approved form about the use of chemical restraint to the adult, their family members and others in the adult’s support network
- A positive behaviour support plan must have been developed which details the use of the restrictive practice in the context of a proactive framework.
- The positive effects of chemical restraint on the adult must outweigh the possible negative effects and the risk involved if the restrictive practice is not used.
- Evidence that less restrictive alternatives have been considered and found to be inappropriate or ineffective.
- An appropriately qualified person has been involved in undertaking a comprehensive assessment of the adult.
- The adult’s treating medical practitioner must be consulted and a current medication summary should be provided by the treating doctor.
- Support staff and others have been trained in the use of the practice and assessed as competent.
- Systems have been put in place to allow the ongoing monitoring and review of the use of the practice.
- The practice must be reviewed within established time frames.
- The adult, their family and relevant others must be involved and consulted at all stages of the process, including assessment, plan design, implementation and review.
- The adult’s unique attributes must be considered, including their communication support needs as well as their cultural, linguistic and social background.
- Authorisation (consent) has been obtained from the relevant decision maker prior to implementation.
Chemical restraint must not be used in specific circumstances, including:

- when the use is unplanned or ad hoc.
- when a relevant professional has assessed and identified contraindications to the use of chemical restraint.
- when the use of chemical restraint is a form of punishment or for organisational convenience.

Who can authorise the use of chemical restraint?

In all cases where chemical restraint is used or proposed, the adult’s treating doctor must be involved at all stages of the decision-making process. For further information on the treating doctor’s involvement and roles and responsibilities in involving the treating doctor refer to the Fact Sheet, *Chemical restraint — working with the treating doctor*.

Where chemical restraint is used in combination with containment or seclusion, the authorisation requirements for containment and seclusion apply. For further information, refer to the Fact Sheet, *Authorising Restrictive Practices*.

If the service provider is using or proposing to use chemical restraint only or in combination with mechanical or physical restraint, then the use of chemical restraint as written in the person’s positive behaviour support plan can only be authorised by a guardian for a restrictive practice (general) matter appointed by the Queensland Civil and Administrative Tribunal (QCAT).

For a respite or community access services, consent to use chemical restraint as written in the person’s respite/community access plan is required from a guardian for a restrictive practice (respite) matter. The exception to this is where a person is only accessing respite and there is no PRN medication or any other type of restrictive practice being used or proposed. This is known as chemical restraint respite (fixed dose) only.

Chemical restraint respite (fixed dose) only

In a respite setting only, supporting a person to take regular, fixed-dose medication is an extension of the decision made by the family and their doctor. As such, the respite service provider has little or no involvement in this process other than to support the person to take their medication as prescribed. The Act recognises this and does not require the development of a respite/community access plan.

The Act (section 168) provides that a service provider may use chemical restraint (fixed dose) in respite only to support an adult with an intellectual or cognitive disability if they have consent from the relevant decision maker (either a QCAT appointed guardian for a restrictive practice matter or the adult’s informal decision maker).

Further Information

For more information, contact the Positive Behaviour Support and Restrictive Practices team on 1800 902 006 or enquiries_DSA_RP@communities.qld.gov.au.

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