CHEMICAL RESTRAINT

POSITIVE BEHAVIOUR SUPPORT & RESTRICTIVE PRACTICES

The Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (the department) draws on its SOLID values (Strengths based, Open, Loyal, Innovative and Dedicated) to commit itself to supporting people with a disability to thrive.

As such, the department is dedicated to ensuring that adults with intellectual or cognitive disability are supported in appropriate ways which ensure personal safety while actively considering the adult's rights and needs. Furthermore, the department is committed to respecting, protecting and promoting human rights. Under the *Human Rights Act 2019*, the department, as a public entity, has an obligation to act and make decisions in a way compatible with human rights and, when making a decision, to give proper consideration to human rights.

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

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

The purpose of Part 6 of the *Disability Services Act 2006* is to protect the rights of adults with an intellectual or cognitive disability by:

- promoting principles to guide service providers supporting adults with behaviour that causes harm to themselves or others
- regulating the use of restrictive practices.

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 which might otherwise cause harm to the adult or others. This includes both fixed dose, and medication given 'as required' (often referred to as PRN medication).

Under the Act, the following are not chemical restraint:

- The use of medication for the proper treatment of a diagnosed mental illness, as defined in the *Mental Health Act 2016*, or a physical condition.
- The use of medication such as 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, providing a sedative to 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 medication to calm her for 10 years. This medication was prescribed by a psychiatrist but the psychiatrist has not said Veronica has a mental health or other health diagnosis. Veronica does not take any other regular medications. The reason he has given her this medication is due to her behaviour of pushing people who are near her, and sometimes hitting others. The psychiatrist has told her brother to give the medication to Veronica every morning with her breakfast. Veronica lives with her brother who has provided primary care and support for his sister in the family home for many years without using any funded disability service providers. However, her brother has requested respite care for his sister. The respite service provider must record:

- *the name of the medication*
- *information about the medication*
- *the correct way and time to give Veronica the medication*
- *the psychiatrist's name and contact details.*

Staff providing respite support must have this information. The respite service must also have written consent from Veronica's brother to give her the medication[1].

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 an NDIS registered 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 to 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 considering using medication in response to Jeremy hitting others, 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 treating doctor should complete a health assessment and a medication review. This should include a risk assessment about the potential adverse side effects and look for any reasons the medication should not be used (contra-indication) when psychotropic medications are being considered. Where the treating doctor makes a recommendation about chemical restraint, a clarification of purpose of medication form should be completed including details of dose, route, and frequency, and for PRN, the circumstances for administration. As Jeremy's service provider does not currently have an approval for the use of chemical restraint, a Short-Term Approval application must to be made to the department. This approval means so that the service provider has approval to administer this medication while Jeremy's Positive Behaviour Support Plan is updated and consent from the guardian for restrictive practice is obtained.

The service must use an appropriately qualified person[2] to do 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 least restrictive means of preventing Jeremy from hurting others, his treating doctor must again be consulted and their views considered[3].

Chemical restraint must only be used as part of a planned response to an adult's behaviour that causes physical harm, and where it has been demonstrated that such responses are the least restrictive way to ensure the safety of the adult or others.

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[1] 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

[2] For assessing an adult with an intellectual or cognitive disability, a person is appropriately qualified if the person has the qualifications or experience appropriate to conduct the assessment. Examples of who might be appropriately qualified persons— behaviour analysts, medical practitioners, psychologists, psychiatrists, speech and language pathologists, occupational therapists, registered nurses, social workers (*DSA 2006, s149).*

[3.] ibid 1 page 2

Chemical restraint must only be used 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 addition 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.

How to determine whether a medication is chemical restraint?

Service providers should use the department's Clarification of Purpose of Medication Form (COPM) that assists the treating doctor or specialist to specify the primary reason for the prescription of a medication. The COPM meets the requirements of the Act and defines mental illness in accordance with the *Mental Health Act 2016*.

The COPM form should be used when a client is prescribed a medication, no matter what the medication is (including topical medications) and will include all medications prescribed.

Service providers should request the treating doctor to complete the COPM to clarify the reason for the medication prescription. The COPM asks for the name of the medication, dose, route, frequency, identify whether it is Fixed Dose or PRN, the reason for the medication, and to specify the treating condition if not prescribed for the purpose of controlling behaviour.

The service provider should keep the completed and signed COPM/s on file. If a medication is prescribed for the control of behaviour, the service provider must apply for a short term approval for the use of the restrictive practice in accordance with the Act. If a service provide is unsure about a restrictive practice matter, they should contact their regional delegate or enquiries_dsa_rp@dsdsatsip.qld.gov.au.

When can chemical restraint 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 about to the use of chemical restraint in relation to an adult with an intellectual or cognitive disability including:

- 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 be developed which details the use of the restrictive practice in the context of a proactive framework.
- A risk assessment in relation to adverse side effects and contra-indications is undertaken[4]. 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

[4] Office of the Public Advocate (QLD), 2016, Upholding the right to life and health: A review of the deaths in care of people with a disability in Queensland. A systemic advocacy report.

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 by the service provider.
- Systems are in place to allow the ongoing monitoring and review of the use of the practice.
- The practice must be reviewed within established time frames. When psychotropic medications are used, regular (e.g. three monthly) reviews of medication should occur[4].
- Where the adult is administered multiple medications, these should be regularly reviewed by a specialist pharmacist or psychiatrist[4].
- 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 appropriate decision maker prior to implementation.
- It is strongly recommended as clinical best practice that where a prescribed medication is in place, all medication and its primary purpose is documented on a COPM form.

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 (for example, when a staffing shortage occurs).

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 or restricting access, 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.

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4. ibid 4 page 3

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 adult's relevant decision maker 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 (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). The development of a positive behaviour support plan is not a state requirement.

In all cases, the relevant service provider is required to seek initial approval for the use of chemical restraint (and other restrictive practices as required) through a short-term approval application to the appropriate decision-making body.

Further Information

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

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Restrictive practice requirements

Restrictive practice		Assessment	Plan	Approval / Consent	Plan implementation	Monitoring	Review
Containment or seclusion	**General***	Multidisciplinary assessment (Disability Services)	Positive Behaviour Support Plan (Disability Services)	Queensland Civil and Administrative Tribunal	Relevant service provider (support from Disability Services)	Relevant service provider (support from Disability Services)	Queensland Civil and Administrative Tribunal
	Respite or community access service only	Risk assessment (relevant service provider)	Respite/community access plan (relevant service provider)	Guardian for a restrictive practice (respite) matter	Relevant service provider	Relevant service provider	Guardian for a restrictive practice (respite) matter
	Short term approval	—	—	Short term approval (public guardian)	Relevant service provider	Relevant service provider	—
Physical restraint or mechanical restraint	**General***	Assessment (appropriately qualified person)****	Positive Behaviour Support Plan (relevant service provider)	Guardian for a restrictive practice (general) matter	Relevant service provider	Relevant service provider	Guardian for a restrictive practice (general) matter
	Respite or community access service only	Risk assessment (relevant service provider)	Respite/community access plan (relevant service provider)	Relevant decision-maker (respite)	Relevant service provider	Relevant service provider	Relevant decision-maker (respite)
	Short term approval	—	—	Short term approval (Chief Executive delegate, Disability Services)	Relevant service provider	Relevant service provider	—
Chemical restraint	**General***	Assessment (appropriately qualified person)****	Positive Behaviour Support Plan (relevant service provider, with information from the treating doctor)	Guardian for a restrictive practice (general) matter	Relevant service provider	Relevant service provider	Guardian for a restrictive practice (general) matter
	Respite (fixed dose) Only**	—	—	Relevant decision-maker (respite)	—	—	—
	Community access services (fixed dose) only	Risk assessment (relevant service provider)	Respite/community access plan (relevant service provider with information from the treating doctor)	Guardian for a restrictive practice (respite) matter	Relevant service provider	Relevant service provider	Guardian for a restrictive practice (respite) matter
	Respite or community access service (PRN)	Risk assessment (relevant service provider)	Respite/community access plan (relevant service provider with information from the treating doctor)	Guardian for a restrictive practice (respite) matter	Relevant service provider	Relevant service provider	Guardian for a restrictive practice (respite) matter
	Short term approval	—	—	Short term approval (Chief Executive delegate, Disability Services)	Relevant service provider	Relevant service provider	—
Restricting access	**General***	Assessment (relevant service provider)	Positive Behaviour Support Plan (relevant service provider)	Relevant decision-maker	Relevant service provider	Relevant service provider	Relevant decision-maker
	Respite or community access service only	Risk assessment (relevant service provider)	Respite/community access plan (relevant service provider)	Relevant decision-maker (respite)	Relevant service provider	Relevant service provider	Relevant decision-maker (respite)
	Short term approval	—	—	Short term approval (Chief Executive delegate, Disability Services)	Relevant service provider	Relevant service provider	—

* Where the adult in is receipt of a funded accommodation support package and also has additional respite/community access services, the general rule applies.

** Plan implementation, monitoring and review not required for Chemical Restraint Respite (fixed dose) only.

*** For definitions used in this table please see the Glossary.

**** For assessing an adult with an intellectual or cognitive disability, a person is appropriately qualified if the person has the qualifications or experience appropriate to conduct the assessment. Examples of who might be appropriately qualified persons: behaviour analysts, medical practitioners, psychologists, psychiatrists, speech and language pathologists, occupational therapists, registered nurses, social workers (*DSA 2006, s149).*