Positive Solutions in Practice

Office of the Senior Practitioner

Chemical Restraint: What every Disability Support Worker needs to know | August 2008

It is estimated that 10-15% of people with a disability will show behaviours of concern which may be dangerous to themselves or others.[1] The majority of people who show behaviours of concern will be administered some form of chemical restraint[2] (the most commonly used form of restraint). According to the Disability Act (2006) any medication that is prescribed in Victoria for behavioural control is a form of *chemical restraint*. It is estimated that between 44 and 80% of people who show behaviours of concern are prescribed chemical restraint.[3]

The most commonly used form of chemical restraint are "psychotropics" which are medications that affect the mind, emotions and behaviour.[4] It should be noted that approximately 32.2% of people with an intellectual disability have some kind of mental illness, psychiatric disorder or emotional difficulty that requires treatment and psychotropics are often used in the treatment.[5] Unfortunately, misdiagnosis often occurs for people with an intellectual disability, because it is often difficult to diagnose mental illness and emotional problems in people who have severe communication difficulties. Misdiagnosis of psychiatric illness will usually result in inappropriate medical treatment.[6]

There are positives and negatives about the use of chemical restraint. On the positive side, chemical restraint may be effective in calming a person who is highly agitated. On the negative side, chemical restraint may result in adverse side effects (e.g. dry mouth, restless legs, headache, constipation, weight gain, sexual dysfunction & low blood pressure). In addition, the person may never be taught to learn coping strategies such as anger management or receive important counselling to help cope with past trauma. According to the practice guidelines accepted by the American Psychiatric Association and other international sources, ***medication should never be used as a substitute for meaningful psychosocial services***.[7]

In this issue we try to answer five most frequently asked questions about chemical restraint.

---

[1] *Emerson, E. (2001).Challenging behaviour: Analysis and intervention in people with severe intellectual disabilities. Cambridge University Press.*

[2] *Disability Act (2006). Act No. 23/2006*

[3] *Lowe, K., Allen, D., Brophy, S., & Moore, K. (2005). The management and treatment of challenging behaviours* Learning Disability Review, 10 *(2), 34-37.*

[4] *http://www.amfar.org*

[5] *Kwok ,H.,&Cheung,P.W.H.(2007).Co-morbidity of Psychiatric Disorder and Mental Illness in People with Intellectual Disabilities,*Curr Opin Psychiatry 20,443-449.

[6] *Khan,A.Y., & Shaikh,M.R. (2008). Challenging the Established Diagnosis in Psychiatric Practice:Is It Worth It?,*J.Psychiatric Practice 14(1),67-72.

[7] *Huang, W, et al., (2007). Multidisciplinary approach to optimizing pharmacological and behavioural interventions for persons with developmental disabilities who are on Psychotropic Medications.* J. Dev Phys Disabil 19*, 237-250.*

Supporting people to achieve dignity without restraints

A Victorian Government initiative

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

The answer to this is it 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 does 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 should be reported. ***In Victoria, disability service providers who administer medication for behavioural control must report such administration monthly through Restrictive Intervention Data System.***[8]

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

- 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.***[9]
- 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.***[9]
- The medications prescribed may not be useful in helping the person feel more calm, 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.

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

The answer to 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[10] 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.[11] Although both risperidone and haloperidol were found to be effective in reducing aggressive challenging behaviour, 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.***

---

[8] *www.dhs.vic.gov.au/ds/osp*

[9] *Huang, W, et al., (2007). Multidisciplinary approach to optimizing pharmacological and behavioural interventions for persons with developmental disabilities who are on Psychotropic Medications.* J. Dev Phys Disabil 19*, 237-250.*

[10] *Capone, G.T., Goyal, P., Grados, M., Smith, B., & Kammann, H. (2008). Risperidone use in children with Down Syndrome, severe intellectual disability and comorbid Autistic Spectrum Disorders: A naturalistic study.* Journal of Developmental Behavioural Pediatrics, 29*, 1-11.*

[11] *Tyrer, P., et al. (2008). Risperidone, haloperidol and placebo in the treatment of aggressive challenging behaviour in patients with intellectual disability: a randomised controlled trial.* The Lancet, 371*, 57-63.*

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

Armed and his colleagues[12] 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.

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

Unfortunately, it is estimated that only 2-20% of people like Gill will be provided with personal and social interventions.[13] 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.***[14]

5. 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[15], to determine how best to support the person, environmentally, personally and socially.

b) 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.

c) 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.

d) Menstrual suppression (without informed consent of the person) is a form of chemical restraint and should be reported to the Office of the Senior Practitioner as such.

e) Some people in Victoria are still being given Aldazine (also known as Melleril), although Aldazine was withdrawn from the market in 2001 because of its negative side effects. All people who are currently on Aldazine should be reviewed by a psychiatrist.

f) 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.

g) 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.

---

[12] *Armed, Z, et al., (2000). Reducing antipsychotic medication in people with a learning disability.* British Journal of Psychiatry, 176*, 42-46.*

[13] *Lowe, K., Allen, D., Brophy, S., & Moore, K. (2005). The management and treatment of challenging behaviours* Learning Disability Review, 10 (2)*, 34-37.*

[14] *Huang, W, et al., (2007). Multidisciplinary approach to optimizing pharmacological and behavioural interventions for persons with developmental disabilities who are on Psychotropic Medications.* J. Dev Phys Disabil 19*, 237-250.*

[15] *See Getting it right from the start: the value of good assessment, Positive Solutions in Practice, Issue 3, 2008. (www.dhs.vic.gov.au/ds/osp)*

The Bottom Line

1. If you are not sure whether it is chemical restraint or not, then you can contact the Office of the Senior Practitioner or visit our website, www.dhs.vic.gov.au/ds/osp.

2. If you think the medication is not right, then it should be reviewed by a psychiatrist or other specialist (e.g., neurologist).

3. If the person shows behaviours of concern, a functional behaviour assessment should be completed, regardless of whether they are administered chemical restraint.

4. If the person has difficulty communicating, then a communication assessment will help find out if there are alternative and augmentative communication stategies the person could use to communicate their issues.

Other reading

Brylewski, J. & Duggan, L. (2007). Antipsychotic medication for challenging behaviour in people with learning disability (Review), *The Cochrane Library*, 2. 1-26.

Matson, J, L, Bamburg, J, W, Mayville, E, A, Pinkston, J, Bielecki, J, Kuhn, D, Smalls, Y. & Logan, J, R. (2000). Psychopharmacology and Mental Retardation: a 10 year review 1990-1999, *Research in developmental Disabilities*, 21, 263-296.

Prepared by Lynne Webber, Mandy Donley and Hellen Tzanakis from the Office of the Senior Practitioner.

© Department of Human Services, Victoria 2008.
Authorised by the Victorian Government 50 Lonsdale St, Melbourne.

If you would like to receive this publication in an accessible format, please phone 03 9096 8427 using the National Relay Service 13 36 77 if required, or email seniorpractitioner@dhs.vic.gov.au
This document is also available in PDF format on the Internet at www.dhs.vic.gov.au/ds/osp

State Government Victoria | Department of Human Services