Chemical restraint and working with the treating doctor (for service providers)

This Information Sheet provides practitioners, service providers and disability support workers with information and suggestions about engaging with the treating doctor of an adult who is subject to the use of chemical restraint as defined under the *Disability Services Act 2006* (the Act).

The information applies only to adults of 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.

Legislative requirements

Under the Act, the treating doctor is recognised as a critical stakeholder in the assessment of and planning for an adult where chemical restraint is proposed or in use. It is a requirement that the treating doctor be consulted and their views considered in all such cases.

The assessment and positive behaviour support plan required under the Act must show evidence that the treating doctor has been consulted throughout. In addition, where chemical restraint is recommended and agreed to, a positive behaviour plan must outline:

- the name of the medication and any available information about the medication (for example, information about possible side effects);
- the dose, route and frequency of administration and, for as needed (PRN) medication, the circumstances in which the medication may be administered — as prescribed by the adult's treating doctor;
- the date of the most recent medication review, if the adult's medication has previously been reviewed by their treating doctor;
- the name of the adult's treating doctor.

When developing the positive behaviour support plan, information must be provided to the treating doctor regarding the findings of non-medical assessments, the hypothesis for the causes, contributing factors and function/s of the behaviour that causes harm, and other strategies proposed for use, possibly in conjunction with chemical restraint.

Chemical restraint and the health assessment

Some adults with an intellectual or cognitive disability may be receiving chemical restraint medications that were prescribed many years ago and that have been in use for long periods. The original reason for the prescription may be unclear. Medications may have originally been prescribed with little or no evidence provided to the treating doctor to support this as the least restrictive approach. In many cases, the medication may be having a negative impact on the adult's quality of life.

Developing an effective, ongoing relationship with the adult's treating doctor provides a strong foundation for ensuring that chemical restraint, if used, is managed appropriately.

Service providers may develop this relationship through comprehensive health assessments for adults with an intellectual disability. They should use the Comprehensive Health Assessment Program (CHAP) to assist the treating doctor to cover all relevant health areas that may contribute to the adult's behaviour that causes harm. Service Providers in Queensland who provide support to adults with an intellectual disability can register with the Department of Communities, Disability Services and Seniors to download the CHAP on behalf of their clients. Please go to: https://eshop.uniquest.com.au/chap/

Medicare benefits (items 703, 705 and 707) allow for an extended consultation to conduct a comprehensive health assessment of people with an intellectual disability. The requirements for Medicare funded health assessments are detailed in an extract from the *Medicare Benefits Schedule* accompanying this Information Sheet. For the full Medicare benefit schedule go to www.mbsonline.gov.au

Disability service providers who support adults receiving chemical restraint should use the CHAP and the Medicare arrangements as a framework for involving treating doctors in the review of chemical restraint.

Where chemical restraint is proposed or in use, the process and responsibilities

Action	Responsibility
Clarify/confirm with the treating doctor that the medication is chemical restraint	Service provider
Schedule an extended consultation with the treating doctor as per Medicare arrangements for a comprehensive health assessment	Service provider
Collect medical and behaviour information and develop a working hypothesis (including non-medication managements and possible rationale for use of chemical restraint)	Appropriately qualified person (with input from service provider, guardian and family)
Complete a health assessment including a medication review (multiple consultations may be required) and make a recommendation about chemical restraint	Treating doctor (with input from service provider, appropriately qualified person, guardian and family)
Decide on the use of chemical restraint in context of proposed behavioural and other strategies. Resolve/note differences of opinion	Appropriately qualified person (with input from treating doctor, service provider, guardian and family)
Where chemical restraint is agreed, prescribe chemical restraint and complete with recommendations regarding the use of chemical restraint and details of dose, route, frequency and for PRN, circumstances for administration	Treating doctor
Develop a positive behaviour support plan incorporating	Service provider/s (with input

chemical restraint as prescribed	from appropriately qualified person, guardian and family)
Arrange for consent of the plan by guardian	Service provider/s
Consider providing consent to the plan and inform all parties of the outcome	Guardian
Implement the plan	Service provider/s
Monitor the plan and keep records	Service provider/s (with input from the treating doctor and appropriately qualified person)
Review the plan	Service provider (with input from treating doctor, appropriately qualified person, guardian and family).

Advice on whether medication is chemical restraint

The relevant service provider for the adult may require advice from the treating doctor about whether the medication in use is chemical restraint as defined under the Act. This will require a determination by the treating doctor as to whether the medication is used for the 'proper treatment of a diagnosed mental or physical condition' (in which case the medication is not chemical restraint) or 'for the primary purpose of controlling the person's behaviour in response to the adult's behaviour that causes harm to the adult or others' (in which case the medication is likely to be chemical restraint).

Refer to the website information *Restrictive Practices: Chemical Restraint,* which outlines the requirements under the Act (including definitions) for the use of chemical restraint. The service provider may assist in this determination by supplementing the treating doctor's records with other information from the client file and/or by involving other people in the adult's network.

Note: 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* is not chemical restraint. For example, sedating an adult before attending a dentist appointment is not chemical restraint.

Preparing information for the treating doctor

In general, under the Act, assessment and planning for the use of a chemical restraint of an adult will be coordinated by an appropriately qualified person who is working with the service provider. The treating doctor is not responsible for this coordination role.

The service provider is responsible for ensuring that the treating doctor is involved throughout the assessment/review and planning processes and that sufficient information is provided to the treating doctor to support the assessment/review. Service providers and appropriately qualified persons should support this process by providing access to all necessary information and by completing appropriate behavioural or other recordings as requested.

The type of information may include:

- history of the prescription and use of chemical restraint

- a description of the behaviour/s to be managed
- behavioural records including measures of the frequency, intensity and duration of the behaviour/s
- a hypothesis regarding the major factors contributing to the behaviour and the function of the behaviour
- record of reactions to and outcomes from the behaviour (particularly in terms of harm).
- a risk assessment
- consideration of a range of management options and if already attempted, their outcome
- possible adverse effects from the proposed interventions.

Important note: *Some adults who are receiving chemical restraint may not be actively displaying behaviour that causes harm. In such cases the service provider and the appropriately qualified person will provide as much historical data as possible to inform an assessment of whether the chemical restraint may be changed, reduced or withdrawn over time.*

Attending the consultation/s

The comprehensive assessment and/or medication review may require more than one consultation with the treating doctor.

The appropriately qualified person and a service provider representative must be involved in all consultations where the need for chemical restraint is being considered. It is highly desirable that other important stakeholders such as the adult's guardian and family members are also directly involved in these consultations.

The appropriately qualified person should take a lead role during the consultation/s in the discussion of and in resolving differences of opinion regarding the use of chemical restraint in the context of other proposed non-medical interventions. People attending the consultation should ask the appropriate questions to ensure they have a clear understanding of the treating doctor's recommendation regarding chemical restraint.

The guardian is a critical stakeholder in these discussions as ultimately this person will be considering the matter of consent to the use of chemical restraint as part of the positive behaviour support plan.

The service provider (with assistance from the appropriately qualified person) is responsible for arriving at a decision regarding the inclusion of chemical restraint in the positive behaviour support plan.

The appropriately qualified person will request that the treating doctor complete a current medication summary that includes the treating doctor's prescription regarding chemical restraint and, where the decision is made to proceed with the chemical restraint:

- other information required under the Act (dose, route, frequency, PRN circumstances)
- information required by the relevant decision maker (e.g. why a particular medication is recommended)
- information that is consistent with the Medicare schedule benefits (e.g. advising of side effects, establishing monitoring of the medication)

This information will form part of the positive behaviour support plan for the adult.
Where a medication review results in changing, reducing or withdrawing medication, the appropriately qualified person should ensure that the treating doctor provides clear and detailed instructions to the service provider. The service provider should ensure that these instructions are closely followed.

A review period and follow-up appointment should be made.

Important note: *In situations where the adult is subject to a forensic order or involuntary treatment order, consultation must be undertaken with the treating psychiatrist.*

After the consultation/s

Where the use of chemical restraint is supported, the service provider (with assistance of the appropriately qualified person) should develop the positive behaviour support plan incorporating the use of chemical restraint. The service provider will ensure all parties, including the treating doctor, are engaged in the development and finalisation of the plan to the necessary extent.

The service provider is responsible for obtaining the consent from the guardian, implementing the plan as consented and ensuring all monitoring and review activities occur, in consultation with the treating doctor as required.

Important note*: The Act (section 168) provides that if a person is accessing respite only with no PRN medication, the respite provider may use chemical restraint (fixed dose) in respite only to support an adult with an intellectual or cognitive disability if they have the consent of the relevant decision maker (either a guardian for a restrictive practice matter or the adult's informal decision maker). In this case it is the decision maker who liaises with the adult's treating doctor.*

The service provider is also responsible for ensuring that all stakeholders are involved in and informed of any changes to the chemical restraint and that the guardian provides consent to the changes as per the requirements of the Act.

The service provider is responsible for ensuring all client files and records are kept up to date.

Further Information

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

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• *Please note: The information in this document is provided as an initial guide only. It is not intended to be and is not a substitute for legal advice. Service providers should seek their own independent legal advice with reference to the implementation of the legislation.*

Attachment 1

Extract from *Medicare Benefits Schedule Book*

The full document is available at:
http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A30&qt=noteID

Health assessment for people with an intellectual disability

Items 701, 703, 705 and 707 may be used to undertake a health assessment for people with an intellectual disability.

A person is considered to have an intellectual disability if they have significantly sub-average general intellectual functioning (two standard deviations below the average intelligence quotient [IQ]) and would benefit from assistance with daily living activities. Where medical practitioners wish to confirm intellectual disability and a patient's need for assistance with activities of daily living, they may seek verification from a paediatrician registered to practice in Australia or from a government-provided or funded disability service that has assessed the patient's intellectual function.

The health assessment provides a structured clinical framework for medical practitioners to comprehensively assess the physical, psychological and social function of patients with an intellectual disability and to identify any medical intervention and preventive health care required. The health assessment must include the following items as relevant to the patient or his or her representative:

a) Check dental health (including dentition);
b) Conduct aural examination (arrange formal audiometry if audiometry has not been conducted within 5 years);
c) Assess ocular health (arrange review by an ophthalmologist or optometrist if a comprehensive eye examination has not been conducted within 5 years);
d) Assess nutritional status (including weight and height measurements) and a review of growth and development;
e) Assess bowel and bladder function (particularly for incontinence or chronic constipation);
f) Assess medications (including non-prescription medicines taken by the patient, prescriptions from other doctors, medications prescribed but not taken, interactions, side effects and review of indications);
    - Advise carers of the common side effects and interactions.
    - Consider the need for a formal medication review.
g) Check immunisation status, including influenza, tetanus, hepatitis A and B, Measles, Mumps and Rubella (MMR) and pneumococcal vaccinations;

h) Check exercise opportunities (with the aim of moderate exercise for at least 30 minutes per day);
i) Check whether the support provided for activities of daily living adequately and appropriately meets the patient's needs, and consider formal review if required;
j) Consider the need for breast examination, mammography, Papanicolaou smears, testicular examination, lipid measurement and prostate assessment as for the general population;
k) Check for dysphagia and gastro-oesophageal disease (especially for patients with cerebral palsy), and arrange for investigation or treatment as required;
l) Assess risk factors for osteoporosis (including diet, exercise, Vitamin D deficiency, hormonal status, family history, medication fracture history) and arrange for investigation or treatment as required;
m) For patients diagnosed with epilepsy, review of seizure control (including anticonvulsant drugs) and consider referral to a neurologist at appropriate intervals;
n) Check for thyroid disease at least every two years (or yearly for patients with Down syndrome);
o) For patients without a definitive aetiological diagnosis, consider referral to a genetic clinic every 5 years;
p) Assess or review treatment for co-morbid mental health issues;
q) Consider timing of puberty and management of sexual development, sexual activity and reproductive health; and
r) Consider whether there are any signs of physical, psychological or sexual abuse.

A health assessment for people with an intellectual disability may be claimed once every twelve months by an eligible patient.

Category 1 - PROFESSIONAL ATTENDANCES

701

Health assessment - brief

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to perform a brief health assessment, lasting not more than 30 minutes and, including:

a) Collection of relevant information, including taking a patient history;

b) A basic physical examination;

c) Initiating interventions and referrals as indicated; and

d) Providing the patient with preventive health care advice and information.

703

Health assessment - standard

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including:

a) Detailed information collection, including taking a patient history;

b) An extensive physical examination;

c) Initiating interventions and referrals as indicated; and

d) Providing a preventive health care strategy for the patient.

705

Health assessment - long

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including:

a) Comprehensive information collection, including taking a patient history;

b) An extensive examination of the patient's medical condition and physical function;

c) Initiating interventions and referrals as indicated; and

d) Providing a basic preventive health care management plan for the patient.

707

Health assessment - prolonged

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to perform a prolonged health assessment, lasting at least 60 minutes, including:

a) Comprehensive information collection, including taking a patient history;

b) An extensive examination of the patient's medical condition, and physical, psychological and social function.

c) Initiating interventions and referrals as indicated; and

d) Providing a comprehensive preventive health care management plan for the patient.