Key points

✓ If the person uses behaviours of concern, a functional behavioural assessment must be completed, regardless of whether chemical restraint is used.

✓ If a medication is not right, it should be reviewed by a psychiatrist or other specialist.

✓ If the person has difficulty communicating, then a communication assessment will help find strategies the person could use to communicate their issues.

✓ If you are not sure whether use of a medication is chemical restraint or not, seek advice.

Introduction to chemical restraint

A chemical restraint is a restrictive practice that involves the use of a medication or chemical substance, often referred to as psychotropic medications, for the primary purpose of influencing a person’s behaviour. It excludes the use of medication prescribed by a medical practitioner for the treatment, or to enable treatment, of a diagnosed mental disorder, physical illness or condition.

Behaviours of concern, such as aggression and self-injury in people with intellectual disability, for example, have led to high rates of antipsychotic medications being prescribed. Reports suggest that 20-45% of people with an intellectual disability are taking psychotropic medications and, of those, 14-30% are taking medications to manage behaviours of concern.

There is evidence supporting some medications, such as risperidone and lithium to manage some behaviours of concern. In general, however, the evidence for using medication to treat behaviours of concern, such as aggression in people with intellectual disability, is not strong, has potential for long-term side effects, and many medications are not licensed for this purpose.


A restrictive practice is an intervention which has the effect of restricting the rights, freedom of movement, or access of a person with a disability who is displaying a behaviour of concern. Restrictive practices should be used only in limited circumstances as a last resort and not as a first response to behaviours of concern, or as a substitute for adequate supervision. We are working towards the reduction and elimination of the use of restrictive practices.

Restrictive practices include:

- Seclusion
- Physical Restraint
- Mechanical Restraint
- Chemical Restraint
- Environmental Restraint.

The NSW Government oversees authorisation of restrictive practices by registered NDIS providers. The NDIS Quality and Safeguards Commission provides leadership in behaviour support and in the reduction and elimination of restrictive practices.
Does the definition of chemical restraint include all medications that affect behaviour?

Use of a medication that affects behaviour is not always a chemical restraint that requires authorisation. The key point is the purpose for prescribing of the medication, whether it is on a routine or PRN basis.

Some medications might, or might not, be a chemical restraint depending on why they are being used.

Two examples of medications and when they do, or do not, require authorisation as a chemical restraint are discussed below.

Diazepam prescribed (other than for a diagnosed anxiety disorder) to help a person to remain calm through the day to minimise likelihood of target behaviours is for the primary purpose of addressing behaviours of concern and is a chemical restraint. Authorisation is required.

Diazepam prescribed and used as muscle relaxant after seizure activity is for the primary purpose of treating a physical illness and is not a chemical restraint. Authorisation is not required.

Sodium valproate prescribed to stabilise a person’s mood to decrease likelihood of target behaviours is for the primary purpose of influencing the person’s behaviour and is a chemical restraint. Authorisation is required.

Sodium valproate prescribed to treat or minimise seizure activity is for the primary purpose of treating a neurological condition and is not a chemical restraint. Authorisation is not required.

What issues do I need to consider for participants when using chemical restraint?

Chemical restraint should not be used without consent. For consent to be valid it must be voluntary, informed, specific and current. Where possible, consent should be obtained from the person if they are an adult or young person (16-18 years). Consent may also be given by other people, such as an advocate, solicitor, carer, or next of kin, as well as a person appointed by the Guardianship Division of the NSW Civil and Administrative Tribunal.

Consent for the use of a regulated restrictive practice for a child should be obtained from a parent or guardian, or the person with parental responsibility (e.g. the Minister for Family and Community Services).

High doses of psychotropic medications can cause side effects, such as drowsiness, tardive dyskinesia (e.g. tongue protrusion, tremor and restless legs), and toxicity. A medical practitioner should regularly review medications to reduce doses where possible.

Taking a mix of different medications, e.g. benzodiazepines, antipsychotics, and antidepressants, can increase risks of side effects and toxicity. Although people with a disability are often prescribed a combination of medications, this should be avoided where possible.

Some prescribed medications may not help the person to feel calmer and 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.
What types of medications are commonly used to alter behaviour?

There are five major categories of medications that may be used to alter behaviour: antipsychotics, benzodiazepines, mood stabilisers, antidepressants, and hormonal medications.

Antipsychotic medications such as Olanzapine or Risperidone are used to treat psychosis. They can reduce or eliminate delusions, hallucinations and thought disorders.

Benzodiazepines such as Diazepam and Nitrazepam have a calming effect by depressing the central nervous system. They can have a sedative or sleep-inducing effect. They are sometimes used to manage side effects of other medications and seizures, or to manage short term anxiety or sleep disturbance.

Mood stabilisers are sometimes described as anticonvulsants. Mood stabilisers such as Clonazepam and Lithium carbonate are used to treat mood disorders such as bi-polar illness and depression, as well as to treat seizures and epilepsy.

Antidepressants such as Fluoxetine and Sertraline hydrochloride can be used to treat depression, or to manage anxiety or obsessive compulsive disorder. Sometimes these medications are used to reduce sexual arousal in men.

Hormonal medications have different purposes and effects for women and men. Women take hormonal medications such as Mestranol for contraception, for gynaecological issues, or to suppress menstruation. Men may take hormonal medications such as Cyproterone acetate to deliberately reduce sexual arousal.

What less restrictive alternatives to chemical restraint should I consider?

With appropriate environmental, personal and social support, a substantial proportion of people taking antipsychotic medications for behavioural control can have their medications withdrawn completely or reduced to a minimum.

Using medication to manage behaviours of concern should never be the only behaviour support strategy. Behaviour support plans need to include positive behaviour management strategies. These may include environmental adjustments, functional skill replacement strategies for destructive, self-injurious, stereotypic and inappropriate social behaviour. Changes to interpersonal settings may also assist the person to manage behaviours of concern, such as developing predictable routines, using low-arousal techniques, modifying triggers, or changing the setting entirely.

Behaviour support interventions that are consistent with functional assessment are more effective in managing behaviours of concern. For example, some people who are distressed when routines change can benefit from help to prepare for changes of plan so that they are less distressed. All behaviour support plans need to be based on a functional behaviour assessment so that strategies can address the purpose of the behaviour.
What duty of care issues should I consider when using chemical restraint?

Anyone who is prescribed chemical restraint should have a functional behavioural assessment\(^x\) to identify the purpose of the behaviour so that appropriate environmental, personal and social supports can be provided.

Psychotropic medications should be reviewed at least every six months by a medical practitioner and at least every twelve months by a psychiatrist. Recommendations from medical practitioners should be documented in the behaviour support plan and implemented.

Many medications associated with chemical restraint have side-effects that may be unpleasant, such as sleepiness or weight gain.\(^i\) Strategies for managing side-effects should be considered in the person’s plan.

People who have complex communication needs should be assessed by a speech pathologist and supported to communicate the effects and side effects of medications.

Using a medication for long term treatment can introduce new issues such as tolerance, dependence and addiction (especially for benzodiazepines). These issues, and appropriate fade-out or replacement strategies, should be assessed regularly by a medical practitioner.

Sometimes behaviours of concern have physical causes, such as an illness like gastro-oesophageal reflux or untreated fractures, which may result in the person feeling sad, angry or aggressive. Prior to behaviour support, a medical practitioner needs to conduct a thorough health assessment.

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.

Further reading


