Fact Sheet: Information for the legal community on restrictive practices in residential aged care in Victoria

# Chemical Restraint

## Introduction

Aged Care Justice (ACJ) supports older Australians receiving aged care services, in residential and home care, by providing rights information, legal referral services, and promoting reform.

The use and application of restrictive practices is a significant issue in aged care. ACJ is creating Fact Sheets on restrictive practices with the aim of reducing serious incidences of restrictive practices in aged care settings through legal education and access to legal support. This project received funding through the Victorian Legal Services Board Grants Program.

The collection of Fact Sheets are designed to support the aged care community and include dedicated Fact Sheets for the legal community. They will contain information on chemical, environmental, physical and mechanical restraint and seclusion, in residential care and home care.

Restrictive practices are regulated both by the laws of the Commonwealth and the State and Territories. The Fact Sheets apply to Victorian residential aged care services, delivered under the Commonwealth *Aged Care Act 1997* (Cth). The use of restrictive practices in aged care settings is complex, involving issues of decision-making capacity, substitute decision making and restriction of freedom.

## Background

The Royal Commission into Aged Care Quality and Safety in their Final Report released in March 2021, warned 'inappropriate use of unsafe and inhumane restrictive practices can result in serious physical and psychological harm and, in some cases, death' and required 'immediate attention'. In response, the Commonwealth Government made significant amendments to the *Quality of Care Principles 2014*[1] (**the Principles**), including that restrictive practices are only to be used as a last resort to prevent harm, after alternative strategies are explored, and requiring informed consent from the Resident or a substitute decision maker, with exceptions for emergency situations.

The use of a restrictive practice relies not only Commonwealth legislation, but State and Territory laws, with respect to defining a resident's capacity to consent to a restrictive practice and the appointment of a substitute decision maker, if it is determined that the Resident does not have decision making capacity. As the current laws in Victoria, are unclear on who can be a substitute decision maker, the Commonwealth has legislated a hierarchy

[1] *Quality of Care Amendment (Restrictive Practices) Principles 2022*, sched 3.

of 'restrictive practice substitute decision-makers' (**RPSDMs**), effective until 1 December 2024 to allow States and Territories to make their own arrangements.

On 15 October 2024, the Victorian Government introduced a Bill to Parliament containing a new consent model for restrictive practices to be enacted by 1 July 2025, and announced on the Department of Health website that 'transitional arrangements for valid nominations made under Commonwealth legislation will apply to provide continuity'.[2]

## CHEMICAL RESTRAINT

This fact sheet applies to residential aged care services delivered by Victorian aged care providers (**Providers**) under the Commonwealth *Aged Care Act 1997* (Cth).[3]

### 1.0 What is chemical restraint?

Chemical restraint is defined, as a 'practice or intervention that involves the use of medication or a 'chemical substance' for the primary purpose of influencing a care recipient's behaviour.[4] It is categorised as a 'restrictive practice' because its use restricts a person's rights or freedom of movement.[5] Medications that are considered chemical restraint do not include medication for diagnosed mental or physical conditions and illnesses, or end of life care. Chemical restraint is where medication is used in response to a change in the behaviour of the Resident who has been assessed as posing a risk of harm to themselves or someone else.

### 2.0 Chemical restraint and provider obligations

Providers considering using chemical restraint must abide by the requirements set out in the Quality of Care Principles 2014 (Cth), which include that chemical restraint;

a) is used as a last resort to prevent harm to the Resident or other persons, and after consideration of the likely impact on the Resident;[6]

b) cannot be used unless alternative strategies are considered and used to the extent possible, and documented in the Resident's Behaviour Support Plan;[7]

c) is used to the extent that it is necessary and in proportion to the risk of harm to the Resident or other persons; is in the least restrictive form, and for the shortest time necessary to prevent harm;[8] and

d) complies with the Resident's Behaviour Support Plan, the Aged Care Quality Standards, and is not inconsistent with the Charter of Aged Care Rights.[9]

---

[2] *Aged Care Restrictive Practices (Substitute Decision-maker) Act 2024* (Vic); 'Department of Health Victoria', *Substitute decision making and restrictive practices in aged care* (Web page) https://www.health.vic.gov.au/residential-aged-care/substitute-decision-making-and-restrictive-practices-in-aged-care

[3] *Aged Care Act 1997* (Cth) s 41-3; *Quality of Care Principles 2014* (Cth) s 15DA.

[4] *Quality of Care Principles 2014* (Cth) s 15E(2).

[5] *Aged Care Act 1997* (Cth) s 54-9.

[6] *Quality of Care Principles 2014* (Cth) s 15FA(1)(a).

[7] Ibid s 15FA(1)(c).

[8] Ibid s 15A(1)(e).

[9] Ibid ss 15A(g)-(i).

To use chemical restraint the Provider must be satisfied that a medical practitioner[9] or nurse practitioner[10] has:

a) assessed the Resident as posing a risk of harm to themselves or any other person;[11]

b) assessed that the use of the chemical restraint is necessary;[12]

c) prescribed medication for the purpose of restraint;[13] and

d) obtained informed consent for the prescribed medication.[14]

## 3.0 Informed consent for chemical restraint

A decision to use chemical restraint requires informed consent by the individual receiving the restraint, or if they lack capacity, by a substitute decision-maker.[15] Consent is to be given by someone with capacity to understand and communicate their informed consent.[16]

### 3.1 How is capacity determined?

Capacity is determined by State and Territory law. All persons over 18 years are presumed to have capacity. Anyone alleging incapacity has the onus of proving it. At common law, the test is whether the person understands the 'nature and effect' of the transaction.[17] Courts have accepted that capacity (or incapacity) may not be absolute and may not be permanent. The Law Council of Australia (LCA) describes the task of determining capacity as 'task, time and content specific'. This indicates that in the early stages of mental decline, it may be difficult to identify with precision whether a Resident has capacity to consent to the use of restrictive practices. Some jurisdictions provide a 'Capacity Toolkit' or guidelines for assessing capacity. In Victoria, a guide is available for legal practitioners to purchase. The LCA, offers a 'Best Practice Guide for Legal Practitioners on Assessing Mental Capacity, 2023'. If determining capacity is an issue in relation to chemical restraint, either an appropriately qualified medical practitioner or a determination by VCAT can determine if the Resident has capacity to make their own decisions.

### 3.2 Who can be a restrictive practices substitute decision maker?

In Victoria, it is uncertain if a person who has been appointed to make decisions on health or personal matters can make decisions regarding restrictive practices. An application can be made for a substitute decision maker, or an enduring guardian, to be appointed by VCAT to make decisions on restrictive practices for a person who does not have capacity. To avoid confusion, whilst the States and Territories consider developing legislation, the Commonwealth has implemented a temporary hierarchy of Restrictive Practices Substitute Decision Makers. Victoria has introduced the *Aged Care Restrictive Practices (Substitute Decisionmaker) Bill 2024* (Vic), providing a hierarchy of decision makers, anticipated to commence on 1 July 2025. The transitional arrangements are that the Commonwealth hierarchy contained in the Principles will apply as follows:[18]

1. A Restrictive Practices Nominee who has been previously nominated by the Resident.
2. A partner, who has a close continuing relationship with the Resident.
3. A relative or friend who was the unpaid carer of the Resident immediately prior to entering care, who has a personal interest in the welfare of the Resident and a close continuing relationship.

---

[9] *Health Practitioner Regulation National Law (Victoria) Act 2009* s 5.
[10] Ibid s 95.
[11] *Quality of Care Principles 2014* (Cth) s 15FC(1)(i).
[12] Ibid s 15FC(1)(ii).
[13] Ibid s 15FC(1)(iii).
[14] Ibid s 15FC(1)(iv).
[15] *Aged Care Act 1997* (Cth) s 54-10(f).
[16] *Quality of Care Principles 2014* (Cth) s 5A(c).
[17] *Gibbons v Wright* (1954) 91 CLR 423.
[18] *Quality of Care Principles 2014* (Cth) s 5B(2).

4. A relative or friend who was not the carer but has a personal interest in the welfare of the Resident and a close continuing relationship.
5. A Medical Treatment Authority – an individual or body appointed in writing that can give informed consent to the provision of medical treatment (however described).

### 3.3 What is informed consent for chemical restraint?

Informed consent is required for each authorised restrictive practice, by the resident or the substituted decision maker. Informed consent requires the decision maker to be provided information on the reasons for the medication, the alternative options available, the type of medication, and the risk and benefits of the restrictive practice.[19]

As a matter of general law, consent to the restrictive practice must be informed, voluntary, current and specific in relation to each proposed use of a chemical restraint.

## 4.0 How is chemical restraint used in an emergency?

Chemical restraint can be used in an emergency as necessary, such as in a dangerous event that is unanticipated and requires immediate action. It does not require informed consent. The chemical restraint must be in the least restrictive form, for the shortest period possible and documented. The Provider must inform the restrictive practices substitute decision maker as soon as practicable after the event, and document the Resident's behaviour, information on alternatives considered or used, why the restraint was necessary, and the care provided.[20]

## 5.0 Chemical restraint and provider documentation

The Provider must document the following in the Resident's Behaviour Support Plan:[21]

a) The Resident's behaviour and assessments relevant to the use of chemical restraint, and the alternative strategies that have been considered or used.

b) The practitioner's decision to use the chemical restraint and their reasons.

c) Information provided to the practitioner that informed the decision to prescribe the medication.

d) That the practitioner obtained informed consent.

e) Details of the prescribed medication, including its name, dosage and when it may be used.

f) Details of any engagement with persons other than the practitioner in relation to the use or assessment of the chemical restraint (for example, dementia support specialists).

## 6.0 Provider duties when using chemical restraint

a) The Provider is required to monitor and review the use, effectiveness and impact of the medication on the Resident, and document reviews in the Resident's Behaviour Support Plan.[23]

---

[19] Ibid 15FA(f).
[20] s 15GB.
[21] *Quality of Care Principles 2014* (Cth) s 15FC(b).
[22] Ibid s 15GA.

b) Observe the Resident for signs of distress or harm, side effects, changes in mood or behaviour, such as ability to engage in activities of daily living, and changes in the ability to maintain independent function (to the extent possible).

c) Consider whether an alternative strategy can be used, and restrictive practice reduced or stopped.

d) Provide information about the effects and use of chemical restraint to the prescribing practitioner.

## 7.0 Health Legislation

In Victoria, the *Health Practitioner Regulation National Law (Victoria) Act 2009*, s 15FA(1)(j), may also apply with respect to the regulation of health professionals.

## 8.0 Unlawful Use of Chemical Restraint

The *Aged Care Act 1997* (Cth) provides that if the restrictive practice is used in accordance with the Principles, Providers and individuals are not subject to any criminal or civil liability in relation to the restrictive practice.[24] Non-compliance with Restrictive Practices, is a reportable incident, by the Provider.[25] Unauthorised use of chemical restraint may give rise to civil or criminal actions for assault or false imprisonment in severe cases.

The affected person may seek an injunction from the courts to prevent the restraint from happening or continuing. The Aged Care Quality and Safety Commission (ACQSC) has powers to deal with unauthorised use of restrictive practices including, suspension and banning orders against Providers.[26]

## 9.0 Unlawful use of Chemical Restraint

If a chemical restraint has been applied unlawfully, what can a person do?

- Make a complaint to the Provider, referencing the Principles which outline the requirements of applying restrictive practices.
- Make a complaint to the ACQSC.
- Contact ACJ for a free legal consultation.

---

[24] *Aged Care Act 1997* (Cth) s 54-11.
[25] *Quality of Care Principles 2014* (Cth) Part 4A, s 15NB(2)
[26] *Aged Care Quality and Safety Commission Act*, *2018* (Cth) ss 63R, 7B and 74GB.

**Contact Aged Care Justice if you would like a free legal consultation:**

Email: info@agedcarejustice.org.au

Phone: (03) 9016 3248

Website: **www.agedcarejustice.org.au**