Misuse of Chemical Restraint in Residential Aged Care Facilities: Current Framework, Issues and Solutions

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Chemical restraint is the most common type of restraint used[1] and its wide use in the context of Residential Aged Care Facilities ('RACFs') has been a topic of concern in Australia[2] since its classification as a human rights issue.[3] Chemical restraint is generally known as the 'use of medication or chemical substance for the purpose of influencing a person's behaviour' and does not include treatment.[4] The investigations of the Oakedin Older Persons Mental Health Service[5] and the Earle Haven RACF at Nerang[6] highlighted the misuse of chemical restraint and demonstrated that the current regulatory structure fails to safeguard individuals. **This paper will support the argument that the deficiencies in the current framework fail to protect the elderly by sustaining customs that facilitate the misuse of chemical restraint in RACFs. This misuse infringes on critical human rights and potential solutions will be considered.**

Current Framework: An Overview

The implementation of the *National Disability Insurance Scheme Act 2013* (Cth) ('NDIS') and the *NDIS (RPs & Behaviour Support) Rules 2018* (Cth) reformed the disability sector by establishing a scheme for participants and providing guidance on the use of restrictive practices ('RP') in the disability domain. The NDIS is applicable to anyone who has registered before the age of 65,[7] meaning that a portion of residents in RACFs interact simultaneously with the NDIS and the aged care sector. This paper's focus does not include specifics for that portion and instead assesses the aged care sector in isolation of the NDIS.

The current framework relating to aged care is exceedingly and unnecessarily complex.[8] The *Aged Care Act 1997* (Cth) ('ACA') is the primary instrument for RACFs and has been criticised as being an ineffective structure for regulating RPs due to its ambiguity.[9] As such,

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[1] Victorian Office of the Senior Practitioner, *Chemical Restraint: What Every Disability Support Worker Needs to Know* (Department of Human Services, August 2008) 1.
[2] Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (Final Report No 124, August 2014) 244 ('ALRC, Final Report'); Human Rights Watch*, "Fading Away" How Aged Care Facilities in Australia Chemically Restrain Older People with Dementia* (Report, October 20) ('Human Rights Watch, Report').
[3] Australian Law Reform Commission, Office of the Public Advocate of Queensland, *Legal Frameworks for the use of Restrictive Practices in Residential Aged Care: An Analysis of Australia and International Jurisdictions* (Paper, June 2017); Human Rights Watch, Report (n 2).
[4] *Royal Commission in Aged Care Quality and Safety: Regulation of Physical and Chemical Restraint* (Regulatory Bulletin, August 2019) ('Regulatory Bulletin').
[5] South Australia Department for Health and Ageing, *The Oakden Report* (Report, 2017) ('The Oakden Report').
[6] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Investigation of the Closure of the Earle Haven Residential Aged Care Facility of Nerang* (*Inquiry into Aged Care, End-of-Life and Palliative Care and Voluntary Assisted Dying*) (Report No 30, November 2019) 46.
[7] *National Disability Insurance Scheme Act 2013* (Cth) s 22 ('NDIS').
[8] Michael Williams, John Chesterman and Richard Laufer 'Consent Versus Scrutiny: Restricting Liberties in Post-Bournewood Victoria' (2014) 21(3*) Journal of Law and Medicine* 641, 641.
[9] Office of the Public Advocate of Queensland, *Legal Frameworks for the use of RPs in RACFs: An Analysis of Australia and International Jurisdictions* (Paper, June 2017) 3.

there is currently no primary legislation in Australia regulating RP in the context of RACFs.[10] However, a multitude of documents exist to accompany the ACA. It is expected that service providers comply with the *Aged Care Quality Standards* and the *Quality of Care Principles 2014* (Cth) ('*Quality of Care Principles*') which set out expected outcomes advocating for a safe environment. Further, the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (Cth) encompassed chemical restraint, but the principles are no longer in force due to human rights concerns raised by the Standing Committee on Regulations and Ordinances.[11] The Principles were criticised for significantly lowering the threshold for the legitimised use of medication.[12] Similarly, the *Quality of Care Amendment (Reviewing Restraints Principles) Principles 2019* (Cth) are also no longer in force.

Until recently, the *Decision-Making Tool: Supporting a Restraint Free Environment in Residential Care* ('Decision-Making Tool') was the only express RP document.[13] However, as of August 2019, the Royal Commission into Aged Care Quality and Safety ('the Commission') has introduced a Regulatory Bulletin that establishes additional responsibilities of service providers in their use of chemical restraint in relation to the *Quality of Care Principles*.[14] More recently, in February 2020, the Commission released an information sheet focusing on the different types of psychotropic medication.[15] Despite what should be a sufficient combination, these documents fail to provide a clear and rigid process that addresses the issues inherent in the application of chemical restraint in RACFs. Due to its inadequacy, the current framework fails to protect the rights of residents and exposes them to continued misuse of chemical restraint.

The misuse of medication is a serious concern because it can constitute as elder abuse and infringe on basic human rights, such as liberty and dignity.[16] The inadequacies of the current framework offer little guidance in preventing the occurrence of this infringement. The consideration of Australia's vital international obligations is pertinent when scrutinising

[10] Ibid 4.
[11] Standing Committee on Regulations and Ordinances, Commonwealth of Australia (Monitor 9 of 2019, 27 November 2019).
[12] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Inquiry into Aged Care, End-of-Life and Palliative Care and Voluntary Assisted Dying* (Report No 30, November 2019) 46.
[13] Department of Health and Ageing, *Decision-Making Tool: Supporting a Restraint Free Environment in Residential Care* (Commonwealth of Australia, 2012) ('Decision-Making Tool').
[14] Regulatory Bulletin (n 4)
[15] *Royal Commission into Aged Care Quality and Safety: Psychotropic Medications Used in Australia* (Information for Aged Care, February 2020) <https://www.agedcarequality.gov.au/sites/default/files/media/acqsc_psychotropic_medications_v11.pdf>.
[16] Australian Law Reform Commission, *Elder Abuse: A National Response* (Report 131, 2017) 251.

chemical restraint. The *Convention on the Rights of Persons with Disabilities* ('CRPD') extends to individuals in RACFs,[17] and is one of the many international human rights treaties that has been ratified by Australia. In 2013, it was recommended by the United Nations Committee on Rights of Persons with Disabilities that Australia take action to end chemical restraint in multiple environments.[18] A study conducted in 2014 for the National Mental Health Commission, concluded that 80% of respondents (consisting of consumers, carers and mental health professionals) think that chemical restraint infringes on human rights.[19] The alarming frequency at which chemical restraint is used does not reflect the perception that it severely hinders human rights. The repercussions experienced by residents in RACFs due to this discrepancy triggers the need of an analysis of the issues that serve as barriers to the harmonisation of legal obligations and the reality of practice.

Issues with the Current Framework

The inadequacies of the current framework facilitate reliance on customs by service providers in absence of a clear scheme providing guidance on and protection against the use of chemical restraint. These 'entrenched ideas about using restraints' are a barrier to reducing their use.[20] Various alarming myths about elder restraint have been identified[21] and those specific to chemical restraint are of no exception. The four main issues with the current framework will be discussed in relation to the misguided belief that each issue perpetuates in practice.

Inconsistent Interpretations

The Commission has recognised that the aged care sector has inconsistent thresholds as to what actions or interventions constitute as a RP.[22] The Australian Commission on Safety and Quality in Health Care has highlighted that this inconsistency is due to a conflict of

[17] *United Nations Convention on the Rights of Persons with Disabilities,* opened for signature on 30 March 2007 (entered into force on 3 May 2008) Art 1 ('CRPD').
[18] Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia*, UN Doc CRPD/C/AUS/CO/1 (21 October 2013) [35]-[36].
[19] Melbourne Social Equity Institute, *Seclusion and Restraint Project: Report* (Report prepared for the National Mental Health Commission, University of Melbourne, August 2014) <http://socialequity.unimelb.edu.au/__data/assets/pdf_file/0017/2004722/Seclusion-and-Restraint-report.PDF>.
[20] Kirsten Moore and Betty Haralambous, 'Barriers to Reducing the Use of Restraints in Residential Elder Care Facilities' (2007) 58(6) *Journal of Advanced Nursing*, 532, 535.
[21] See, eg, Lois K Evans and Neville E Strumpf, 'Myths About Elder Restraint' (1990) 22(2) *Image: Journal of Nursing Scholarship* 124.
[22] *Royal Commission into Aged Care Quality and Safety* (Interim Report, October 2019) vol 1, 195 ('Interim Report').

perspectives that rely on the clinician's motivation to either control an individual's behaviour or appropriately treat their symptoms.[23] This causes difficulty in categorising an action or intervention as either chemical restraint or treatment. The inconsistent thresholds promote the misguided belief that the categorisation of treatment escapes the connotation of chemical restraint. The practice of incorrectly categorising chemical restraint as treatment is evident in the current patterns of drug administration in RACFs. The medications most frequently relied on for chemical restraint in RACFs are antipsychotics and benzodiazeptines.[24] Both are frequently prescribed as treatment by doctors unfamiliar to patient at the request of nurses caring for them.[25] This process can easily disguise an intention to chemically restrain an individual as treatment supported by what appears on the surface to be a valid opinion of a medical professional. The opinion's validity may be impaired depending on the weight given to the service provider's input and intentions.

The avenues for prescription combined with the lack of a unified interpretation can inflate the frequency that chemical restraint is misrepresented as treatment. Statistics as recent as 2019 have revealed that in some RACFs, up to 71% of residents receive psychotropic medication.[26] This high frequency of use would likely not be achievable if the intention to either treat symptoms or to control behaviour was continuously considered in the prescription process. Of course, there are circumstances where these aims can overlap. However, research has demonstrated that the use of prescription antipsychotic medication in RACFs is considerably disproportionate to the reasonably anticipated medical needs of residents.[27] This discrepancy suggests that not all drug administration is solely to treat symptoms and that a portion is intended to control an individual's behaviour. Residents are not protected in these circumstances and the 'treatment' has the potential to restrict the individuals beyond what is necessary.[28]

It has been suggested by clinicians that when the purpose of medication as chemical restraint or treatment is blurred, the focus should be on the appropriate use of the medication which is

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[23] Ibid citing National Safety and Quality Health Service Standards, *Guide for Multi-Purpose Services and Small Hospitals* (Australian Commission on Safety and Quality in Health Care, 2017) 172, <https://www.safetyandquality.gov.au/sites/default/ files/migrated/National-Safety-and-Quality-Health-Service-Standards-Guide-for-Multi-Purpose-Services-and-SmallHospitals.pdf>

[24] Ibid.

[25] Human Rights Watch, Report (n 2) 22.

[26] Interim Report (n 22) 193; Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Inquiry into Aged Care, End-of-Life and Palliative Care and Voluntary Assisted Dying* (Report No 30, November 2019) 47.

[27] Interim Report (n 22) 198.

[28] Interim Report (n 22) 193.

in alignment with 'professional or government guidelines and publications.'[29] This suggestion is impractical as the guidelines for chemical restraint promote the use of medications that offer minimal benefit compared to their severe side effects. The Australian Government Department of Health has acknowledged that guidelines require non-pharmacological therapies to be relied on first, but that risperidone (an antipsychotic medication) constitutes as a first line of therapy.[30] The categorisation of this drug as a first line of therapy is concerning for many reasons, including its side effect of increased risk of death and stroke when administered to seniors with dementia.[31] Equally concerning is the consequence that this approval can have in practice. The classification of risperidone as a first line of therapy may indicate acceptance of using similar antipsychotic medications, constituting their use as treatment despite their affiliation as a method of chemical restraint. The inconsistent thresholds create leniency in disguising chemical restraint as treatment and can explain the high use of medication in RACFs. Further, the categorisation of an antipsychotic medication as a first line of therapy is an issue in itself as it may be a factor contributing to the reliance on chemical restraint as a first response.

Chemical Restraint as A First Response

The Decision-Making Tool advocates that restraint free options should be attempted prior to implementing RP.[32] Similarly, the Australian Commission on Safety and Quality in Healthcare has highlighted that preference should be given to non-pharmacological methods, which corresponds with policy guidance provided by the Australian Department of Health.[33] In the event alternatives fail, the least restrictive method of RP should be relied on.[34] Despite the theme of prioritising alternatives to RP, there is no clear process on how to rely on alternatives in a variety of circumstances, including emergencies. Similarly, there is no authoritative instrument outlining which specific alternatives to chemical restraint should be regarded.

[29] Interim Report (n 22) 195 quoting Exhibit 3-61, Sydney Hearing, Statement of Dr Juanita Westbury (now Breen), 29 April 2019, WIT.0117.0001.0001 at 0018 [27].
[30] Human Rights Watch, Report (n 2) 20.
[31] Therapeutic Goods Administration 'Apo-Risperidone (Risperidone) Tablets', *Australian Product Information* (Web Page, 12 August 2019) 4 <https://www.ebs.tga.gov.au/ebs/picmi/picmirepository.nsf/pdf?OpenAgent&id=CP-2010-PI-07033-3>.
[32] Decision-Making Tool (n 13) 28.
[33] Interim Report (n 22) 204.
[34] Decision-Making Tool (n 13) 28.

The absence of a definitive preliminary process requiring alternative methods perpetuates the misconception that there are no adequate alternatives. This belief is a factor in explaining why the approach in practice conflicts with the aim of limiting the use of RP to a last resort. It is common that 'restraints are used as a first-line response to manage behaviours that are challenging for staff and others in RACFs, contrary to available guidance and evidence'.[35] Service providers are likely not actively disregarding available guidance, but are instead subject to a level of automatism that is inherent in a first-line response. Various stakeholders, who may or may not be advocating for the best interests of the individual, have provided input outlining what the first response should be. One suggestion is that the first approach should be a 'person-centred, psychosocial, multidisciplinary treatment plan'.[36] While other agents promote antipsychotics as a 'quick fix' resulting in a mentally of 'set and forget'.[37] Restraints have been described as a 'routine management tool', which certainly does not reflect the meaning of 'last resort'.[38] The lack of binding legislation requiring specific alternatives condones the routine of relying on chemical restraint in place of alternatives, which solidifies the misconception that it is the most appropriate response.

Although it has been repealed, the language in the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (Cth) alluded to the fallacy that sufficient alternatives are unavailable. The Principles stated that in the event chemical restraint was applied, the provider must document the alternatives used, 'if any'.[39] The drafting of this section to include 'if any' set a standard that service providers are not expected to have attempted an alternative to RP in all circumstances. Although the principles have been repealed, it is concerning that this language was originally enacted.

The need for a strategic first response to urgent situations is dire. Unlike some states[40], SA has no guidance for emergency situations. As such, they are frequently met with chemical restraint.[41] A unfavourable staff to patient ratio can cause urgency and hinder staff's motivation to commit time and resources to attempting alternatives. A large and demanding caseload may advance the belief that alternatives equally as effective as chemical restraint do

[35] Interim Report (n 22) 193.
[36] The Royal Australian and New Zealand College of Psychiatrists*, Antipsychotic Medications as a Treatment of Behavioural and Psychological Symptoms of Dementia* (Professional Practice Guideline 10, August 2016) 1.
[37] Kate Carnell and Ron Paterson, Review of National Aged Care Quality Regulatory Processes (Report, October 2017) 118.
[38] The Oakden Report (n 5) 109.
[39] *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (Cth) s 15G (2)(b)(ii).
[40] Tasmania Government, 'Consent to Medical and Dental Treatment', Guardianship and Administration Board (Web Page, 21 September 2017) <https://www.guardianship.tas.gov.au/consent_for_treatment>
[41] Melbourne Social Equity Institute, *Seclusion and Restraint Project: Report* (Report prepared for the National Mental Health Commission, University of Melbourne, August 2014) 6.45.

not exist in the circumstances.[42] The dependency on chemical restraint in place of alternatives invalidates the seriousness of the potential side effects, which may go unrecognised if they are presented collectively by the high portion of residents being chemically restrained. It has been noted that nurses often do not possess knowledge of side effects and incorrectly ascribe falling or drowsiness to characteristics of old age,[43] although both are correlated with the use of antipsychotics and benzodiazeptines.[44] Service providers need to be equipped with a range of research-based alternatives that are adept at responding to urgent situations while imposing minimal infringement on the rights of the recipient. Alternative approaches to management must become the standard in RACFs.[45] Reliance on chemical restraint as a first response not only disregards guidelines and possible alternatives, but escapes other vital elements required for justifying the use of chemical restraint, such as obtaining consent.

Disregard of Consent

Informed consent for medical treatment is required by the CRPD.[46] It has been expressed by the CRPD committee that medical treatment in absence of consent violates various human rights including the right to freedom from torture and the right to personal integrity.[47] The Committee confirmed that the obligation to require consent extends to emergencies.[48] As such, consent is an essential component of the right to health.[49]

Despite the importance of consent, its role is overlooked in some circumstances. In a study of individuals subject to psychotropic medication in RACFs that did not have capacity to provide informed consent, only one in thirteen people had documented consent from a legal representative.[50] Another investigation verified that medication was typically prescribed

[42] Evans and Strumpf (n 21) 126.
[43] Interim Report (n 22) 206.
[44] For antipsychotics see: Yin Bing Yip and Robert G Cumming, 'The Association Between Medications and Falls in Australian Nursing-Home Residents' (1994) 160(1)*The Medical Journal of Australia*14; Purushottam B Thapa,Patricia Gideon, Terry WCost,Amanda B Milam and Wayne A Ray, 'Antidepressants and the Risk of Falls Among Nursing Home Residents'(1998) 339(13) *New England Journal of Medicine*875. For benzodiazeptines see: Westbury, Juanita L, Peter Gee, Tristan Lang, Donnamay T Brown, Katherine H Franks, Ivan Bindoff, Aidan Bindoff, Gregory M Peterson, 'RedUSe: Reducing Antipsychotic and Benzodiazepine Prescribing in RACFs Facilities' (2018) 208(9*) Medical Journal of Australia* 398; Anita K Wagner, Fang Zhang, Stephen B Soumerai,Alexander M Walker, Jerry H Gurwitz,Robert J Glynn, and Dennis Ross-Degnan, 'Benzodiazepine Use and Hip Fractures in the Elderly: Who is at Greatest Risk?'(2004)164(14) *Archives of Internal Medicine*1567.
[45] Carnell and Paterson (n 37) 114.
[46] CRPD (n 17) Art 25.
[47] UN Committee on the Rights of Persons with Disabilities, General Comment No 1 (31 March – 11 April 2014) [42], citing CRPD arts 15-17.
[48] Ibid.
[49] See, generally, UN Human Rights Council, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc A/HRC/35/21 (28 March 2017) <https://www.refworld.org/docid/593947e14.html>.
[50] Interim Report (n 22) 208 citing Exhibit 3-80, Sydney Hearing, Statement of Professor Henry Brodaty, 16 May 2019, [50].

without consent of a power of attorney.[51] Evidently, these findings are not unique in Australia's RACFs and are concerning because non-consensual chemical restraint contravenes the basic human rights of liberty and dignity.[52]

In permitting the unjustified use of chemical restraint without consent, the current framework encourages the belief that the requirements for proper administration of chemical restraint are flexible. The over-reliance on chemical restraint to such a degree that the need for consent can be minimised demonstrates a lack of regard to guidelines.[53] If consent is not sought from the individual or power of attorney then whoever is making the choice may be bias or have misconceptions about chemical restraint. It is often understood by staff that medications improve the quality of a resident's life by providing comfort.[54] Chemical restraint does not guarantee comfort but does put the individual at risk of experiencing side effects, some of which would likely diminish quality of life (ie. Drowsiness). In the context of physical restraint, it was found that staff genuinely possess the belief that the restraint is for the individual's safety and that they would rather the individual be subject to restraint than suffer harm.[55] This risk assessment can extend to chemical restraint as staff must evaluate a variety of factors when choosing to administer medication. The risks may be inadequately assessed in a way that negates the severity of potential side effects and complications of drug administration. Overall, this concern gives rise to a fourth issue because there are minimal repercussions when chemical restraint is used as a first response or is applied without consent.

Lack of Sanctions

The use of RPs is rarely challenged, and there are no known prosecution or civil suits relating to chemical restraint.[56] However, the obiter in *Saitta Pty Ltd v Secretary, Department of Health and Ageing*[57] revealed that the misuse of RPs can breach the *Quality of Care Principles 2014* (Cth). This breach was not explored further because it was not the primary issue in the case. The Senate Community Affairs References Committee has noted that 'there do not appear to be any penalties for the overuse of medication, or incentives for providers to

[51] Human Rights Watch, Report (n 2) 22.
[52] Australian Law Reform Commission, *Elder Abuse: A National Response* (Report 131, 2017).
[53] Carnell and Paterson (n 37) 118.
[54] Interim Report (n 22) 206.
[55] Stumpf and Evans (n 21) 135.
[56] Human Rights Watch, Report (n 2) 65.
[57] (2008) 105 ALD 55.

minimise the use of restraint.'[58] The lack of penalties for the misuse of chemical restraint suggests that the concern of misuse is a lower priority than maintaining a safe and functional environment**.** The lack of consequences perpetuates the misconception that failure to restrain when necessary may expose individuals and facilities to criticism.[59]

In maintaining responsibility of residents' safety, any substantial events involving injuries or dangerous circumstances resulting from challenging behaviour can attract attention from family members, the media, advocacy groups and the Government.[60] As discussed above, chemical restraint can be recategorised as treatment. Assigning treatment for challenging behaviour may be a means to an end in cultivating a functional environment for residents. Due to the lack of consequences for the misuse of chemical restraint, service providers may perceive a higher risk of consequences associated with failing to administer medication as a preventative measure against risk or harm. However, harmonisation between the goal of safety and goals pertaining to reducing the use of chemical restraint must be achieved.[61] Any reform should illustrate that the misuse of chemical restraint will result in consequences.

Solutions

When considered in isolation, the issues discussed above each result in misconceptions in practice. When considered together, these issues are dependent on one another in the dangerous cycle of continued misuse of chemical restraint in RACFs. The misguided categorisation of chemical restraint as treatment leads to non-compliance with the guidelines which depict chemical restraint as a last resort that is to be accompanied by consent if and when applied. This lack of compliance is met with no binding sanctions. The connectivity of the issues rationalises a comprehensive approach to considering solutions that address the issues in their entirety.

Training

Legislative reform in isolation of other initiatives is not guaranteed to reverse the customs developed in practice. It is arguable that it must be accompanied by advanced staff training

[58] Senate Community Affairs References Committee, Parliament of Australia, *Care and Management of Younger and Older Australians Living with Dementia and Behavioural and Psychiatric Symptoms of Dementia (BPSD)* (Report, March 2014) 82.
[59] Evans and Strumpf (n 21).
[60] Sarah H Johnson, 'The Fear of Liability and the Use of Restraints in Nursing Homes' (1990) 18(3) *Law, Medicine and Health Care* 263, 264.
[61] Ibid 263.

to ensure clarity on how to implement the law in practice in place of current customs.[62] Evidence presented to the Commission confirmed that there is a 'lack of knowledge about restraints and their impacts, alternatives to their use and the safe and appropriate management of the behavioural and psychological symptoms of dementia.'[63] As such, aged care staff and general practitioners should be required to complete training in all of these aspects.[64] The implementation of education and training structures in aged care may be equally effective as legislative reform in reducing chemical restraint in RACFs, especially when combined with appropriate staffing.[65]

Intervention

Studies have demonstrated that the combination of staff training in targeting crisis management and intervention is effective in reducing the use of restraints.[66] An example of an intervention within Australia is 'RedUSE' (also known as Reducing Use of Sedatives) which was created for the purpose of advancing the proper use of medications within RACFs, including antipsychotics and benzodiazepines.[67] Staff education is the second of three steps in the intervention.[68] The first is auditing and feedback, and the last is interdisciplinary review.[69] The use of this specific intervention resulted in 39% of prescriptions either being reduced or discontinued over a six month period.[70] This significant percentage demonstrates the effectiveness of this method, and it is highly recommended that the RedUSe intervention be applied in all RACFs to achieve reduction consistent with guidelines.[71]

Legislative Models

A national approach to RP was recommended by the ALRC in relation to disability and aged care.[72] This approach could be achieved by primary legislation or regulations. Although the

[62] Dean Fixsen, Vicky Scott, Karen Blase, Sandra Naoom, and Lori Wagar, 'When Evidence is Not Enough: The Challenge of Implementing Fall Prevention Strategies' (2011) 42(6) *Journal of Safety Research* 419, 421.
[63] Interim Report (n 22) 205.
[64] Ibid 210.
[65] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Inquiry into Aged Care, End-of-Life and Palliative Care and Voluntary Assisted Dying* (Report No 30, November 2019) 46.
[66]John Ellis Agens 'Chemical and Physical Restraint Use in the Older Person' (2010) 3(1) *British Journal of Medical Practitioners* 302, 305.
[67]Juanita L Westbury, Peter Gee, Tristan Lang, Donnamay T Brown, Katherine H Franks, Ivan Bindoff, Aidan Bindoff, Gregory M Peterson, 'RedUSe: Reducing Antipsychotic and Benzodiazepine Prescribing in RACFs Facilities' (2018) 208(9*) Medical Journal of Australia* 398, 398
[68] Juanita Westbury, Shane Jackson, Peter Gee, Gregory Peterson, 'An Effective Approach to Decrease Antipsychotic and Benzodiazepine Use in Nursing Homes: The RedUSe Project' (2010) 22(1) *International Psychogeriatrics*, 26.
[69] Ibid.
[70] Westbury et al, 'RedUSe: Reducing Antipsychotic and Benzodiazepine Prescribing in RACFs Facilities' (n 67) 401.
[71] Ibid 402.
[72] Interim Report (n 22).

recent Regulatory Bulletin initiates advancement in this dire area, additional enactment of an legally binding instrument would be beneficial as rigid regulation is typically sufficient in assuring voluntary compliance.[73] A strict legislative structure reaffirming the content of the Regulatory Bulletin while including more details addressing the issues outlined above is integral to creating clear, legally binding requirements.

The Standing Committee on Regulations and Ordinances asserts that there is little merit in regulating chemical restraint in RACFs by delegated legislation as opposed to primary legislation.[74] The argument that delegated legislation would bare consistency with the current framework is an insufficient justification of assigning matters pertaining to personal rights and liberties to delegated legislation.[75] Introducing this regulation in primary legislation would be beneficial because of the essential scrutiny embedded in the process of enactment.[76] This scrutiny would account for all the information to date and achieve a suitable approach. Closely examining the subject in preparation for enactment would avoid history repeating itself with a failure parallel to that of the *Quality of Care Amendment (Reviewing Restraints Principles) Principles 2019* (Cth). The criticisms revealed in the repeal of these principles can contribute to the preparation of primary legislation for the regulation of chemical restraint in RACFs. Any legislative reforms must be accompanied by training that addresses the unsuitability of the current customs and misconceptions in practice that have been the unfortunate consequence of inadequacies of the current framework.

Conclusion

The current framework not only fails replace the entrenched beliefs in practice but has proven to be incompetent in discouraging them. The severity of the situation has been recognised at both a national and state level. At the national level, the Commission is expected to provide their final report by 12 November 2020 which will advance discussion of a potential regulatory framework and other measures of reform.[77] Meanwhile, in South Australia, an inter-departmental RPs Task Group was created by the Social Affairs Committee of Cabinet for the purposes of investigating the use of RP in all relevant domains, including aged care.

[73] Mary Ivec and Valerie Braithwaite, *Applications of Responsive Regulatory Theory in Australia and Overseas: Update* (Occasional Paper 23, March 2015) 14.
[74] Standing Committee on Regulations and Ordinances, Commonwealth of Australia (Monitor 9 of 2019, 27 November 2019) 2.
[75] Ibid 2.
[76] Ibid 3.
[77] Interim Report (n 22) 215.

Overall, there is merit in introducing a multifaceted approach that encompasses increased staff training, intervention and legislative reform. The many credible organisations referenced throughout this paper have committed significant efforts to this area of deficiency which confirms that change is vital and is coming.

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