Use of chemical restraint (restrictive practices) in residential aged care

Summary

- **Many people living with dementia in residential aged care have changed behaviours**
- **Chemical restraint is not an appropriate response for most changed behaviours**
- **The short and long-term impacts of chemical restraint can be harmful and should be an *intervention of last resort***
- **Psychosocial interventions support well-being and are more effective in responding to most changed behaviours**
- **Quality dementia care education for the aged care workforce is central to reducing the use of chemical restraint and promoting psychosocial interventions**
- **Dementia Australia strongly supports minimising the use of chemical restraint to address changed behaviour in people living with dementia in residential aged care**

Background

It is estimated that more than two thirds of people living in Australian residential aged care have a diagnosis of dementia with moderate to severe cognitive impairment. Changed behaviours are commonly associated with various forms of dementia, particularly in the later stages of the condition. Chemical restraint - now classified as a *restrictive practice* under the revised definition in the *Aged Care Act 1997* - has been and by many reports continues to be used to manage changed behaviour in residential aged care settings.

Chemical restraint is the administration of medication to control a person's movement or decision-making capacity. This includes but is not limited to psychotropic medication, most commonly anti-depressants, anxiolytic/hypnotic agents (primarily benzodiazepines) and antipsychotic medications. The misuse or overuse of psychotropic medication was a central concern in the recent Royal Commission into Aged Care Quality and Safety and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.[i]

Issue

Leading researchers in the quality dementia care field suggest changed behaviour needs to be understood as a response to the person's environment and a form of communication about an unmet need. This unmet need might be physical (for example pain, fatigue or sensory burden) and/or psychological and emotional (grief, loneliness or depression). Research has shown that most changed behaviours will reduce spontaneously within six months therefore interventions should target the cause(s) of the behaviour – the unmet needs (for example pain) - rather than the resultant behaviour itself. [ii]

> **'We've got to rule out all these medical reasons (for changed behaviour) and then we've got to go with non-pharmacological approaches...'** Carer

Psychosocial approaches and other interventions are effective in responding to most changed behaviour and include but are not limited to pain relief, music therapy, massage, aromatherapy, physical activities, life story work, reminiscence therapy, cognitive stimulation and animal assisted therapy. [iii]

Despite consistent evidence of their limited efficacy and a high associated risk of adverse effects, psychotropic medications are still widely prescribed for people living with dementia. Recent research suggests up to 44% of people living in residential care are receiving antipsychotic medication and only 10% of anti-psychotic medication is prescribed appropriately for people living with dementia.[iv]

The adverse psychological and physical effects of chemical restraint are well documented and include physical injury and psychological distress, increased confusion, functional decline, an increased risk of stroke and in some cases death.

> **For some people with dementia, it (anti-psychotic medication) is not the answer. We have to be looking at the behaviour. We have to be looking at what is wrong…are we in their world?'** Person living with dementia.

Dementia Australia's position

Dementia Australia strongly supports minimising the use of chemical restraint to address changed behaviour in people living with dementia in residential aged care.

Timely and accurate clinical and other assessments should be undertaken to identify the basis of physical and psychological unmet needs and changed behaviour. Unrecognised and untreated pain is a significant unmet need and cause of changed behaviour in this context. Psychosocial interventions can assist in addressing unmet needs, modifying changed behaviours and promoting quality of life for people living with dementia. *These non-pharmacological interventions should always be the first response to changed behaviour* and developed, implemented and evaluated in a person-centred way.

In line with recent changes to the *Aged Care Act 1997*, the use of medication to modify changed behaviours should only be considered as a *last resort*, recognising the likely impact, and after all other therapeutic interventions and approaches have been attempted and proven to be ineffective.

If a psychotropic medication is prescribed for changed behaviour, a rigorous informed consent, monitoring and review process must be in place consistent with the *Aged Care Act 1997* and the relevant health professional guidelines. In an emergency situation, the use of medication may be an appropriate intervention. In any situation where psychotropic medication is prescribed, a behaviour support plan, careful monitoring for adverse effects and regular evaluation and review involving the individual, their restrictive practice substitute or supported decision maker, a pharmacist and/or medical practitioner must be part of the process.

Dementia Australia believes that a well-educated and supported aged care workforce is crucial to ensuring high quality, person-centred dementia care into the future. Providing all levels of the aged care workforce with the skills and knowledge to identify unmet needs and respond appropriately to changed behaviours with individualised, psychosocial interventions will be critical to minimising the use of chemical restraint in residential aged care. Education and support for medical practitioners on appropriate prescribing of psychotropic medication will play an equally significant role in achieving this objective.

> **'Most importantly the staff, nurses and carers, have the best possible up to date training and understanding in managing aged care residents needs over and above the use of medication.'** Former carer

Related Dementia Australia Position Statements

- Mandatory dementia education and the aged care workforce

[i] Royal Commission into Aged Care Quality and Safety, 2019; Royal Commission into Safety and Violence, Abuse, Neglect and Exploitation of People with Disability (2021 -).
[ii] Macfarlane, S and Cunningham, C., 'Limiting antipsychotic drugs in dementia'', Australian Prescriber, Volume 44, Number 1, February 2021, p. 8
[iii] Johnston, B., Narayanasamy, M. Exploring psychosocial interventions for people with dementia that enhance personhood and relate to legacy - an integrative review. *BMC Geriatric* 16, 77 (2016). https://doi.org/10.1186/s12877-016-0250-1
[iv] MacFarlane and Cunningham, 2021, p.8