Australian Federation of Disability Organisations

The Aged Care Bill 2024 and the rights, needs and interests of people with disability

Submission to the Senate Community Affairs Legislation Committee

October 2024

Report author & contact:

Matthew Hall
National Manager - Systemic Advocacy & Policy
matthew.hall@afdo.org.au

Reviewed & approved by:

Ross Joyce
Chief Executive Officer

Contents

Australian Federation of Disability Organisations (AFDO) Ltd is registered as a charity with the Australian Charities and Not for profit Commission. It is also a Public Benevolent Institution, endorsed by the Australian Taxation Office as a Deductible Gift Recipient. A donation of $2.00 or more is tax deductible.

Australian Federation of Disability Organisations (AFDO) consents to the publication of this submission, including the names and contact details of AFDO staff. The relevant AFDO staff also give that consent.

Acknowledgements

Australian Federation of Disability Organisations (AFDO) acknowledges Aboriginal and Torres Strait Islander people as the traditional custodians of the land on which we stand. We recognise their continuing connection to land, waters, and community. From our offices in and where we work across Australia, we pay our respects to the peoples of the lands on which we operate and to their Elders past, present, and emerging. We also pay our respects to the traditional owners of all lands on which we operate or meet around the country.

AFDO acknowledges people with disability, particularly those individuals that have experienced or are continuing to experience violence, abuse, neglect, or exploitation. We also acknowledge their families, supporters, and representative organisations and express our thanks for the continuing work we all do in their support.

AFDO also acknowledges and thanks our colleagues at the Older Persons Advocacy Network (OPAN), whom we recently partnered with to author a joint discussion paper on access to supports for older people with disability, and members of the National Assistive Technology Alliance (NATA), whom we worked with in 2023 on a joint submission on the Department's proposed framework for a new assistive technology and home modifications program for in-home care. We have drawn on this work to inform this submission.

Language used in this document

AFDO uses person-first language, like "people with disability," not identity-first language. This is a deliberate choice made by AFDO. This aligns with the UN Convention on the Rights of Persons with Disabilities. It also matches the language used by all levels of government in Australia. Most other peak bodies in the Australian disability sector also use person-first language.

AFDO chooses to use this language because it puts the person before the disability. It values the individual by seeing them as a person, not a condition.

Consistent with this position, AFDO uses person-first language in this document.

We know many people with disability prefer identity-first language. Disability is a part of their identity. This language shows a connection to the disability community and pride in their disability. It also says society is what disables them.

Views on language use reflect people's identities, experiences of disability, and community attitudes. It is a matter of individual choice and agency. AFDO respects everyone's right to choose how to describe their identity and experiences.

"People with disability," means anyone who is d/Deaf (including people who identify as culturally Deaf), or who has a learning disability, or a sensory, physical, hidden, or mental health condition.

About AFDO

Since 2003, the Australian Federation of Disability Organisations (AFDO) has been the peak body in the disability sector. We are a Disabled Peoples Organisation (DPO) and a funded

Disability Representative Organisation (DRO). AFDO's mission is to champion the rights of people with disability in Australia and support them to take part fully in Australian life.

Our member organisations represent disability-specific and cross-disability communities. We have a combined reach of over 4 million Australians.

AFDO is a strong, trusted voice for the disability sector. We advocate on national policy, inquiries, and initiatives with the Federal and State/Territory governments.

We work to build a community where people with disability can take part in all aspects of social, economic, political, and cultural life. This means:

- real participation in community life
- building respectful, valued relationships
- social and economic participation, and
- contributing as valued citizens.

Our vision

All people with disability can take part equally in all aspects of social, economic, political and cultural life.

Our mission

Using the strength of our member organisations to harness the collective power of uniting people with disability to change society into a community where everyone is equal.

Our strategic objectives

- To represent the interests and united voice of our members and people with disability at a national and international level in all relevant forums.
- To build the capacity, profile, reputation, and sustainability of AFDO through the strength of our member organisations.
- To enhance the connection and influence in international disability initiatives by policy, advocacy, and engagement, focused on the Asia Pacific region.

Our members

AFDO's member organisations contribute to the national policy agenda and address issues that impact the lives of people with disability in Australia. We understand that disability specific organisations play a key role in the provision of information and peer support to people with disability and their families. This role keeps them closely connected to their grass roots communities. Each community has its peak organisation that uses its voice to advocate on issues.

Information about AFDO's members can be found on AFDO's website.

1. Acronyms and abbreviations

AFDO	Australian Federation of Disability Organisations
Aged Care Royal Commission	Royal Commission into Aged Care Quality and Safety
AHRC	Australian Human Rights Commission
ALRC	Australian Law Reform Commission
Bill	Aged Care Bill 2024
Committee	Senate Community Affairs Legislation Committee
CRPD	United Nations Convention on the Rights of Persons with Disabilities
DDA	Disability Discrimination Act 1992 (Cth)
Department	Department of Health and Aged Care
Disability Royal Commission or DRC	Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
ICESCR	International Covenant on Economic, Social and Cultural Rights
NDIS	National Disability Insurance Scheme
Scrutiny Committee	Senate Standing Committee for the Scrutiny of Bills
UN	United Nations

2. Executive summary

This submission focuses on the extent to which the Aged Care Bill 2024 (Bill) adequately deals with and reflects the rights, needs and interests of people with disability in the aged care system.

Due to the significant time constraints for submissions, we highlight some key, high-level issues that the Bill must address, namely:

1. Better alignment of the objects of the Bill with obligations under international law, the rights of older people under the law, and the rights identified by identified by the Aged Care Royal Commission (**section 3**)
2. Elimination of a medical model of age infirmity and "sickness" (**section 4**)
3. Recognising, strengthening, and protecting the rights of older people in the aged care system (**section 5**)
4. Improving the principles of the aged care system (**section 6**)
5. Recognising that restrictive practices are not aligned with community expectations and are a significant violation of rights and liberties (**section 7**)
6. Removing uncertainty and improving community consultation in determining funded supports (**section 8**), and
7. Strengthening the duty of care providers owe older people who access their aged care services (**section 9**).

We have not had time to seek the views of, or input from, our members on the Bill, or this submission. We note the Committee is generally accepting submissions received after 30 September 2024, and that all material received will inform the Committee's deliberations and its final report (however, that it is unlikely anyone who submits after the deadline will be considered as a witness for hearings). Once we have had time to consult our members and receive their input into the Bill, and this submission, we may submit an amended, or supplementary, submission.

This submission builds on our submission to the Department in response to its September 2023 consultation paper seeking input to inform the development of a new Commonwealth Aged Care Act.

In summary, the Bill will deliver a significantly improved, more equitable and more accessible aged care system that reflects the rights, and meets the needs and interests of, older people, including older people with disability if the following changes are made:

Objects of the Bill - section 3

1. Clause 5(a) includes express references to:

   (a) the relevant articles of the ICESCR, including article 11 (right to an adequate standard of living) and article 12 (right to the highest attainable standard of physical and mental health),

   (b) the relevant articles of the CRPD, including articles 3 (general principles), 8

(awareness raising), 9 (accessibility), 12 (equal recognition before the law), 19 (independent living), 20 (personal mobility) 25 (right to health services,) and 26 (habitation), and

(c) the "United Nations Principles for Older Persons".

2. The objects of the Bill and paragraph 25(2)(c) must:

(a) uphold the rights of older people under the law

(b) expressly acknowledge the universal right to high quality, safe and timely support and care and rights of social participation accessible to members of society generally identified by the Aged Care Royal Commission

3. To meet the object stated in clause 5(c), the Bill must:

(a) provide a supported decision-making framework that is:

(i) an effective and accessible means for all people with disability to make their own decisions on matters that affect their lives and to have those decisions respected and honoured

(ii) consistent with the Commonwealth decision-making model and "National Decision-Making Principles" recommended by the ALRC, and

(iii) consistent with the best practice principles and best practice elements identified by La Trobe University's Living with Disability Research Centre

(b) require all persons subject to the Bill to implement or follow the processes of the framework, and impose penalties for non-compliance, and

(c) acknowledge that the framework is a key component of the recognition and implementation of the rights under articles 5, 9 and 11 of the CRPD.

"Sickness" - section 4

4. The concept of "sickness" is removed from the Bill.

Statement of rights - section 5

5. Clause 23 is amended:

(a) to include equitable access to funded aged care services as an express right

(b) in paragraph (2)(a) as follows:

"(ii) accessible for the individual; and

(iii) suitable for individuals living with dementia or other cognitive impairment".

(c) to provide that the right to person-centred communication is a right to

"(a) be informed, in a way the individual **has requested and** understands, about the funded aged care services the individual accesses; and"

6. The Bill makes it clear that an individual is "seeking to access" funded aged care services, and therefore has a right to accessibility suitable to the individual and a right to be informed in a way the individual has requested and understands, when:

   (a) making an application under clause 56

   (b) making an election under paragraph 58(c)(i), or

   (c) being informed of any other services that may be available to meet the care needs of the individual under paragraph 58(c)(ii).

7. Any "approved form" is accessible or can be modified in any way necessary to ensure that it is accessible, having regard to each individual's needs.

8. Clause 24(2) is deleted, as it does not put the rights of older people first, which is a paramount principle of the aged care system identified by the Aged Care Royal Commission.

9. If clause 24(2) remains in the Bill, the Committee reviews all the rights provided in clause 23 and identifies those fundamental rights that must never be subject to limitations (for example, the right to "safe, fair, equitable and non-discriminatory treatment") and any lesser rights that may need to be limited in the circumstances identified in clause 24.

10. Clause 24(2) is amended, so that is limited to only the specific, limited, lesser rights the Committee identifies.

Statement of principles – section 6

11. Clause 26(2) is amended to exclude from its operation clause 25(1) and paragraph 25(2)(a).

12. Clause 25 is amended to include principles that:

   (a) aged care services and the funding model for aged care services, are consistent with Recommendation 125 of the Aged Care Royal Commission

   (b) older people with disability can access supports on an equitable basis with participants of the NDIS.

   (c) the aged care system:

      (i) prioritises responsiveness and acknowledges the importance of early intervention.

      (ii) recognises the potential for rapidly changing support needs (e.g., in the case of older people with progressive conditions) and responds accordingly, and

      (iii) is delivered through a flexible, integrated approach to service delivery across service systems, and

   (d) entrusted persons and registered providers are committed to measuring and being accountable for timely approval processes and service delivery standards, consistent with the aspirations of the NDIS Participant Service Guarantee.

Restrictive practices - section 7

13. Clause 17(1) is amended to make it clear that a restrictive practice is any practice or intervention that has the effect of restricting any rights the individual has at law, including, but not limited to, the rights in clause 23.

14. In the absence in the aged care sector of a framework similar to the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector in place to reduce and eliminate restrictive practices, we urge the Committee to ensure that the Bill, and the Government's approach to restrictive practices in the aged care system, is consistent with the Framework.

15. If the provisions dealing with restrictive practices remain in the Bill (which is not AFDO's preferred position), then:

(a) the Bill must include provisions that implement in full:

- all of the existing safeguards in the Quality-of-Care Principles
- the recommendations of the Aged Care Royal Commission in relation to the use of restrictive practices, and
- recommendation 6.35 from the Disability Royal Commission, and

(b) all the requirements and limitations for their use must be included in the Bill, and not in delegated legislative instruments.

16. What constitutes "informed consent" must be specified in the Bill.

17. The information necessary for any consent to be "informed" must be provided in a manner that is accessible for the individual, in a way the individual has requested and understands, and given, and informed consent sought, prior to the use of the restrictive practice.

18. A clear capacity standard for the giving of informed consent is specified in the Bill.

19. Capacity must only be assessed at the time at which consent is needed.

20. Assessment of capacity must not be 'status' based or based on a medical model.

21. An assessment of capacity must consider any available decision-making assistance and supports that are available or should reasonably be made available (having regard to the Statement of Rights, and including the supported decision-making framework discussed in **item 3(a)** above).

22. The considerations and safeguards that apply when identifying persons and bodies who may consent to restrictive practices are included in the Bill.

23. A record of the information provided to the individual, and the terms of any consent given by the individual, must be kept by the person seeking consent, and included in the personal information of the individual held by that person, for at least seven years after the death of the individual.

24. If any requirements for using a restrictive practice are lifted in an emergency (which is not AFDO's preferred position) the Bill must:

    (a) clearly specify what constitutes an emergency.

(b) prevent a determination of an emergency being made after a restrictive practice has been applied to an individual.

(c) identify who determines that an emergency is occurring or is about to occur, and

(d) expressly exclude from clause 18(3) the requirements that a restrictive practice must be used as a last resort, in the least restrictive form and for the shortest time.

25. Clause 163 must be redrafted to align it with the Government's stated intention in the Explanatory Memorandum, to limit immunity so that an aged care recipient has no claim based on a lack of consent only, when consent is given by another person in accordance the frame work in the Bill, and exclude immunity for negligent and, indeed, reckless, wilful, and malicious) acts other than in relation to the issue of consent.

Funded supports - section 8

26. Foundational supports must include funding to care for the needs of people in the aged care system who are not eligible to participate in the NDIS.

27. The NDIS must fund the disability support needs of its participants who need residential care in the aged care system.

28. High and low-cost assistive technology and home modifications are included in the list of funded supports.

29. In any assessment of an individual, the individual can identify as a person with disability and the system captures all relevant disability-related support needs of the individual, as appropriate.

30. The Department must consult widely with the various communities with an interest in the aged care system, including people with disability and their representative organisations, in developing the service list.

31. There is a mechanism in the Bill to ensure legislative oversight of the development of the service list.

Duty of care - section 9

32. A statutory duty of care for aged care providers consistent with the recommendations of the Aged Care Royal Commission is included in the Bill, with civil and criminal liability provisions.

3. Objects of the Bill

3.1 Obligations under international law

It is an express object of the Bill:

> in conjunction with other laws, give effect to Australia's obligations under the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of Persons with Disabilities[1]

As, no doubt, the Committee is aware, the ICESCR does not contain any direct references to older persons. Nevertheless, because the Covenant's provisions apply fully to all members of

society, it is clear older persons are entitled to enjoy the full range of rights recognised in the ICESCR. Further, in so far as respect for the rights of older persons requires special measures to be taken, States parties are required by the Covenant to do so to the maximum of their available resources.[2]

'Older persons' are expressly referred to in the CRPD[3]. Other articles refer to 'age-appropriate accommodations'[4] and 'age-sensitive assistance'[5]. Other articles in the CRPD that are directly relevant to the Bill are articles 5 (equality and non-discrimination), 9 (accessibility), 19 (independent living), 20 (personal mobility) and 26 (habitation).

The most relevant international human rights document in relation to older people is the "United Nations Principles for Older Persons"[6]. As an Assembly resolution this is not legally binding on Australia. However, the resolution lists principles in five areas which governments are encouraged to include in national policies: namely independence, participation, care, self-fulfillment, and dignity. These principles are directly relevant to the Bill and are consistent with the Bill's stated objects and principles.

ADFO believes that the Bill, and the objects of the Bill in particular, will be improved by amending clause 5(a) to include express references to:

1. the relevant articles of the ICESCR, including article 11 (right to an adequate standard of living) and article 12 (right to the highest attainable standard of physical and mental health),
2. the relevant articles of the CRPD, including articles 3 (general principles), 8 (awareness raising), 9 (accessibility), 12 (equal recognition before the law), 19 (independent living), 20 (personal mobility) 25 (right to health services,) and 26 (habitation), and
3. the "United Nations Principles for Older Persons".

3.2 Universal right to care

It is also an express object of the Bill to provide a forward-looking aged care system that is designed to:

> (i) uphold the rights of individuals under the Statement of Rights; and
>
> (ii) assist individuals accessing funded aged care services to live active, self-determined and meaningful lives; and
>
> (iii) ensure equitable access to, and flexible delivery of, funded aged care services that put older people first and take into account the needs of individuals, regardless of their location, background and life experience; and
>
> (iv) support individuals accessing funded aged care services to effectively participate in society on an equal basis with others, thereby promoting positive community attitudes to ageing; and …[7]

AFDO agrees that these are important objects of the Bill. However, the objects of the Bill (and the Principles)[8] should also uphold the rights of older people under the law.

Further, paragraph (b)(ii) does not properly reflect the recommendation of the Aged Care Royal Commission that:

> The objects of the new Act should be to:

> (a) provide a system of aged care based on a universal right to high quality, safe and timely support and care to:
>
> (i) assist older people to live an active, self-determined and meaningful life, … (and)
>
> (b) to continue to **enjoy rights of social participation** accessible to members of society generally (emphasis added) [9]

It is important that the Bill recognises that older people are entitled to pursue (and to be supported in pursuing) physical, social, emotional and intellectual development and to be active and engaged members of the community, regardless of their age or level of physical or cognitive capability, and that the aged care system must be based on, support, and expressly acknowledge the rights identified by the Aged Care Royal Commission.

3.3 Exercise of choice and control

For the Bill to meet the object of enabling

> individuals accessing funded aged care services to exercise choice and control in the planning and delivery of those services[10]

and to uphold the rights of an individual to

> exercise choice and make decisions that affect the individual's life[11]

it is essential that the Bill provides a supported decision-making framework that is an effective and accessible means for all older people (including older people with disability) to make their own decisions on matters that affect their lives and to have those decisions respected.

In 2014, the Australian Law Reform Commission undertook a comprehensive review of equality, capacity and disability in Commonwealth laws. The ALRC's final report[12] made 55 recommendations for reform that will better provide people with disability equal recognition before the law - in particular, in relation to the right to make decisions that affect their lives and to have those decisions respected.

"National Decision-Making Principles"[13], developed by the ALRC to guide reform at a national level, are at the heart of the recommended reforms that shift the focus away from 'best interests' decision-making to a focus on 'wills, preferences and rights'.

A key recommendation was to establish a new Commonwealth decision-making model that will encourage the adoption of supported decision-making at a national level. The recommended model would introduce mechanisms for the appointment of 'supporters' for adults who may require decision-making support, and provisions relating to 'representatives' to address circumstances in which a person may desire, or require, someone else to make decisions for them. This framework is critical for aged care participants if they are to have true exercise of choice and control.

This framework will also go help fulfill Australia's human rights obligations under article 5 (equality and non-discrimination), article 9 (accessibility) and article 12 (equal recognition before the law) of the CRPD.

In 2023, La Trobe University's Living with Disability Research Centre published a report for the Disability Royal Commission "Diversity, dignity, equity and best practice: a framework for supported decision-making"[14]. This report includes nine best practice principles and eight best practice elements that should underpin a national supported decision-making framework for Australia.

To meet the object stated in clause 5(c), the Bill must:

1. provide a supported decision-making framework that is an effective and accessible means for all people with disability to make their own decisions on matters that affect their lives and to have those decisions respected and honoured
2. require all persons subject to the Act to implement or follow the processes of the framework, and impose penalties for non-compliance, and
3. acknowledge that the framework is a key component of the recognition and implementation of the rights under articles 5, 9 and 11 of the CRPD.

The design and implementation of the Framework must be consistent with:

- the model framework recommended by AHRC, and
- the best practice principles and best practice elements identified in La Trobe University's Living with Disability Research Centre report "Diversity, dignity, equity and best practice: a framework for supported decision-making".

4. "Sickness"

The Minister must ensure that funded aged care services in a service type that is specified as a service type that is delivered in a residential care home for the purposes of clause 8(1)(f) of the Bill are:

> (a) services for the care of persons who are experiencing **sickness**;
>
> (b) services incidental or conducive to the care of persons who are experiencing **sickness**.[15] (emphasis added)

"Sickness" is defined[16] as meaning "an infirmity, illness, disease, incapacity or impairment".

Insofar as residential care home services are to be provided to residents of residential care homes who are people with disability, ADFO is very concerned with this significant shift in language, to return to a medical model of disability, within the paradigms of disability as a medical deficit, or condition requiring a medical 'cure'.

The medical model of disability says people are disabled by their impairments or differences and looks at what is 'wrong' with the person, not what the person needs. We believe that the medical model of disability creates low expectations and leads to people losing independence, choice, and control in their lives.

The social model helps us recognise barriers that make life harder for people with disability. Removing these barriers creates equality and offers people with disability more independence, choice, and control.

The definition of "sickness" in the Bill is a backward step for people with disability and is an

approach, and attitude, that is inconsistent with the stated objects, rights, and principles, of the Bill.

5. Statement of rights

5.1 No right to equitable access to funded aged care services

It is an object of the Bill to "provide a forward-looking aged care system that is designed to … ensure **equitable access to**, and flexible delivery of, funded aged care services"[17] (emphasis added). However, none of the rights given in the Statement of Rights and none of the Principles in the Bill ensure that this object will be met. As the Bill is drafted, there is no right to equitable access to funded aged care services.

Clause 23 gives only a right to:

1 equitable access to:

(a) have the individual's need for funded aged care services assessed, or reassessed, in a manner which is:

(i) culturally safe, culturally appropriate, trauma-aware and healing-informed; and

(ii) accessible and suitable for individuals living with dementia or other cognitive impairment[18]

2 safe, fair, **equitable** and non-discriminatory **treatment**[19]

3 funded aged care services being delivered to the individual:

(a) in a way that is culturally safe, culturally appropriate, trauma-aware and healing-informed; and

(b) in an **accessible manner**[20] (emphasis added).

AFDO agrees that each of these rights is important. However, none of these rights, and the combination of these rights when taken together do not, amount to any right to equitable access to funded aged care services. If it is truly an object of the Bill to ensure equitable access to funded aged care services, then this must be an express right that is included in clause 23.

5.2 Right to access and services that are accessible

It is not clear from the way paragraph 23(2)(a)(ii) is drafted if it provides only a right to accessibility for individuals living with dementia or other cognitive impairment, or if it provides a right to the assessment in a manner that is accessible for the individual, **and that is suitable** for individuals living with dementia or other cognitive impairment.

Further, it is not clear whether the Bill intends for the concept of accessibility to be determined objectively, or subjectively having regard to the specific needs and requirements of the individual.

To ensure greater clarity, AFDO suggests paragraph 23 (2)(a) is redrafted to provide as follows:

"(ii) accessible **for the individual**; and

(iii) suitable for individuals living with dementia or other cognitive impairment".

Similarly, AFDO suggests the right to person-centred communication[21] is amended to provide as follows:

"(a) be informed, in a way the individual **has requested and** understands, about the funded aged care services the individual accesses; and"

5.3 When do the rights arise?

An individual is entitled to the rights specified in clause 23 when "accessing, or seeking to access,"[22] funded aged care services. It is not clear whether an individual is "seeking to access" funded aged care services (and, therefore, is entitled to the rights in clause 23) when:

1. making an application under clause 56
2. making an election under paragraph 58(c)(i), or
3. being informed of any other services that may be available to meet the care needs of the individual under paragraph 58(c)(ii).

This must be clarified.

It is AFDO's position that an individual is "seeking to access" to funded aged care services at each of these points, and therefore has a right to accessibility suitable to the individual and a right to be informed in a way the individual has requested and understands.

This also means that any "approved form" is accessible or is able to be modified in any way necessary to ensure that it is accessible, having regard to each individual's needs.

5.4 Limitation of rights

Clause 24(2) sets out the intention of the Parliament that the rights granted in clause 23 are subject to, and may be limited by, the balancing of

(a) competing or conflicting rights;

(b) the rights and freedoms of other individuals, including aged care workers of the registered provider and other individuals accessing funded aged care services;

(c) compliance with other laws of the Commonwealth, or of a State or Territory, including the *Work Health and Safety Act 2011*.[23]

AFDO understands that there can be circumstances where rights of different people may compete or conflict. However, many of the rights provided in clause 23 are fundamental and inalienable human rights. For example, there are no circumstances that should entitle anyone to deny a person accessing aged care services the right to "safe, fair, equitable and non-discriminatory treatment".

Further, if the result of balancing the rights of older people against the rights of others is a restriction or lessening of the rights of older people, this does not put the rights of older people first. Putting the rights of older people first was identified by the Aged Care Royal Commission as a paramount principle of the aged care system (see **section 6.1** below).

Consistent with the paramountcy of that principle, clause 24(2) must be deleted.

If clause 24(2) remains in the Bill, we urge the Committee to review carefully all of the rights provided in clause 23, to identify the limited number of rights that may need to be balanced. We also urge the Committee to amend clause 24(2) so that is limited to only those specific, limited rights the Committee identifies.

6. Statement of principles

AFDO is very pleased to see that the Department accepted our recommendation to amend the note included as part of clause 25(4) to expressly include people with disability, with mental ill health, who are neurodivergent, and who are deaf, deafblind, vision impaired or hard of hearing.

However, our other concerns with the Principles have not been addressed.

6.1 Some principles must be mandatory

The Aged Care Royal Commission identified two principles of an aged care system that are paramount:

- ensuring safety, health and wellbeing of aged care recipients, and
- putting older people first.[24]

We acknowledge these principles are reflected in the Statement of Principles[25]. However, the effect of clause 26(2) means that these principles are not paramount, and do not align with the views of the Aged Care Royal Commission.

Clause 26(2) must be amended to exclude from its operation clause 25(1) and paragraph 25(2)(a).

6.2 Expectation to meet some of the costs

Individuals accessing funded aged care services are expected to meet some of the costs of those services if those individuals have the financial means to do so[26].

We refer to recommendation 125 from the Aged Care Royal Commission which requires:

> Individuals who are assessed as needing social supports, assistive technologies and home modifications, or care at home should not be required to contribute to the costs of that support.[27]

This is in keeping with recommendations put forward by the Special Rapporteur on the Rights of Persons with Disabilities in 2017, which require states parties to:

> ensure that social protection systems include the provision of access to different forms of support for persons with disabilities, including the provision of free access to essential assistive technologies, as part of the State's health coverage and social protection schemes.[28]

While we understand there will be a limited budget for the new aged care system, it is critical that older people with higher support needs are not financially disadvantaged under these arrangements. As an example, an individual with higher support needs will be significantly disadvantaged if the new system requires a co-payment for each individual service required.

The Bill, and the funding model for aged care services, must be consistent with Recommendation 125 of the Aged Care Royal Commission, noting the obligation to ensure older people with disability are able to access supports on an equitable basis with participants of the NDIS.

AFDO recommends an additional principle is added to prioritise timely access to support, noting that the new aged care system must:

- prioritise responsiveness and acknowledge the importance of early intervention
- recognise the potential for rapidly changing support needs (e.g., in the case of older people with progressive conditions) and respond to these accordingly, and
- specify timeframes for decision making around approval processes and service delivery, consistent with the aspirations of the NDIS Participant Service Guarantee.

6.3 "Inappropriate" use to address service gaps

It is a further principle of the Bill that the aged care system should not be used "inappropriately" to address service gaps in other care and support sectors[29].

Older people with disability are fearful that this principle will be used to prevent them from accessing the support they need from the aged care system into the future. What is needed is an integrated, "no wrong door" approach to prevent people with disability from continuing to fall through the cracks. The Bill must also be based on a principle that the aged care system is delivered through a flexible, integrated approach to service delivery across service systems.

AFDO also questions whether it is possible that the system could ever be used "appropriately" to address service gaps in other care and support sectors.

7. Restrictive practices

The Bill defines "restrictive practice" in relation to an individual as

> any practice or intervention that has the effect of restricting the **rights** or freedom of movement of that individual.[30] (emphasis added)

It is not clear from this drafting whether the reference to "rights" is limited to a reference to the Statement of rights in clause 23 (see **section 5** above). This clause must not be interpreted so narrowly. To avoid doubt, paragraph 17(1)(a) must make it clear that a restrictive practice is any practice or intervention that has the effect of restricting any rights the individual has at law, including, but not limited to, rights in clause 23.

Rules under the Bill will define specific, restrictive practices. [31] When specifying restrictive practices, the rules must require they are used only as a last resort to prevent harm to the individual or others, and after consideration of the likely impact of the practice on the individual.[32]

Rules must also include several other safeguards identified in the Bill[33]. The rules may name who can consent to a restrictive practice on an individual who cannot consent[34]. They may also exclude the rules in an emergency if using a restrictive practice is necessary.[35]

The rules must require that informed consent is given to the use of a restrictive practice.[36]

The rules may also make provision for the persons or bodies who may give informed consent to the use of a restrictive practice if the individual lacks capacity to give consent.[37] Persons who use a restrictive practice are granted immunity from civil or criminal liability if informed consent is given by a person prescribed by the rules.[38]

Aged care providers must, as a condition of registration, follow the rules on using restrictive practices.[39]

The identification of restrictive practices in the rules is justified by the Government as allowing

> for responsiveness in relation to the regulation of restrictive practices in aged care … it is appropriate that the legislation relating to restrictive practices can be adapted and modified in a timely manner in response to emerging concerns … Allowing some flexibility to promptly respond to these unforeseen risks, concerns and omissions aligns with community expectations …[40]

7.1 No alignment with community expectations

The use of restrictive practices is normalised and legitimised in law, policy and practice under the guise of 'behaviour modification' or for 'therapeutic' reasons. Governments tend to focus on service silos in regulating restrictive practices rather than applying a human rights approach. A need for use of restrictive practices is viewed as a service provision issue rather than a violation of human rights that is pervasive across multiple sectors.

The prohibition of torture (under the CRPD, as well as Article 7 of the International Covenant on Civil and Political Rights and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment) is one of the most fundamental principles of international human rights law. It is an absolute and universal norm, as such, the ban on torture cannot be derogated under any circumstances whatsoever, not even in a state of war or public emergency. Further, States are not only obligated to refrain from using or condoning torture. They are also required to take positive measures to prevent its occurrence, protect and support victims, investigate any allegations of torture, and prosecute those responsible.

And yet, many restrictive practices in use are a form of torture.

The National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector[41] (Framework) was endorsed by Commonwealth, State and Territory Disability Ministers at the Disability Reform Council meeting on 21 March 2014.

The Framework outlines key principles and core strategies to reduce the use of restrictive practices in the disability service sector.

The Framework also is supposed to enable all Australian Governments to have a consistent approach to reducing and eliminating restrictive practices.

Research undertaken for the Disability Royal Commission in 2023[42] found that:

1. restrictive practices are at odds with international human rights, including the absolute non-derogable prohibition on torture and cruel, inhuman, or degrading treatment or punishment[43], the prohibition of discrimination against people with disability and rights to protection from violence[44] under the CRPD
2. restrictive practices strip people with disability of dignity. They cause trauma, pain, and harm. They generate feelings of violation, abandonment, neglect, and fear. They are

disempowering, humiliating, and dehumanising, that cause lifelong trauma and life-altering effects. They are cruel and punishing treatment

3. restrictive practices occur within an ecological system of violence, coercion and control, and

4. current approaches to restrictive practices have limited or inconclusive effects. Positive behaviour support has a mixed and inconclusive evidence-base with distinct limitations, that focuses on staff training or on the quality of plans, which prove to be poor quality, and mixed and inconclusive results about the overall effectiveness of PBS.

That research also recommended eight steps to eliminating restrictive practices, directed to society, institutions, relationships, and individuals. Importantly, the first step is to prohibit restrictive practices, and end legal authorisation for their use, which AFDO endorses.

If the provisions authorising the use of restricted practices remain in the Bill, (which is contrary to AFDO's position), then as an absolute minimum, and in the absence of a similar framework in place to reduce and eliminate restrictive practices in the aged care sector, we urge the Committee to ensure that the Bill, and the Government's approach to restrictive practices in the aged care system is consistent with the Framework.

7.2 Recommendations from Royal Commissions

The Aged Care Royal Commission recommended[45] that restrictive practices should only be used when recommended by an independent expert, and where alternative strategies have been unsuccessful. In response, the Government amended the Quality-of-Care Principles[46] to require aged care providers to satisfy several conditions before and during the use of any restrictive practice outside of emergency situations. Many of those conditions are not included in the Bill, for example:

1. monitoring the person for signs of distress or harm, side effects, adverse events, and changes in wellbeing, independent functions, or ability to undertake activities of daily living,[47] and

2. to the extent possible, changing the environment to reduce or remove the need for the use of the restrictive practice.[48]

The Aged Care Royal Commission also recommended that restrictive practices should only be used in accordance with relevant State or Territory laws and that the giving of informed consent be documented.[49].[50] Whilst the Bill includes the same or similar requirements in relation to the giving of consent, the Bill does not require that consent is documented.

The Bill is taking several steps backwards from the conditions and safeguards currently in place.

Further, we urge the Committee to recommend amendments to the Bill to better align with the recommendations of the Disability Royal Commission in relation to the use of restrictive practices. Recommendation 6.35 of the Disability Royal Commission[51] deals directly with the use of restrictive practices, and the legal frameworks needed to ensure the rights of people are protected, and safeguards for care recipients are effective.

We appreciate that recommendation 6.35 is not within an area of Commonwealth responsibility. It is a recommendation that was only addressed to the States and Territories.

However, we also note that the Government has adopted some of the requirements of the recommendation in the drafting of the restrictive use provisions in the Bill.

In recommendation 6.35, the DRC identifies the required features the legal frameworks for the use of restrictive practices must have. They are (appropriately adapted to sector-specific contexts) as follows:

- restrictive practices should only be used:
    - as a last resort, in response to a serious risk of harm to a person with disability or others, and only after other strategies, including supported decision-making, have been explored and applied **[which maps against paragraph 18(1)(a) and (b) of the Bill]**
    - as the least restrictive response possible to ensure the safety of the person with disability or others **[which maps against paragraph 18(1)(e) of the Bill]**
    - to the extent necessary to reduce the risk of harm and proportionate to the potential negative consequences from the use of restrictive practices, and for the shortest time possible **[which maps against paragraph 18(1)(d) of the Bill]**
- decisions to authorise restrictive practices should be subject to independent review [**not included in the Bill**], and
- the use of restrictive practices should be subject to independent oversight and monitoring, [**not included in the Bill**].

In addition, the legal frameworks must set out the powers and functions of a Senior Practitioner for restrictive practices in disability service provision (or equivalent authority). These powers and functions need to include:

- promoting the reduction and elimination of the use of restrictive practices
- protecting and promoting the rights of people with disability subjected to restrictive practices
- developing and providing information, education and advice on restrictive practices to people with disability, their families and supporters, and the broader community
- considering applications to use restrictive practices in disability service settings and authorising their use according to procedures consistent with the Draft Principles for Consistent Authorisation
- developing guidelines and standards, and providing expert advice, on restrictive practices and behaviour support planning
- receiving complaints about the use of restrictive practices and the quality of behaviour support planning
- investigating the use of restrictive practices and the quality of behaviour support planning, either in response to complaints or of its own motion, and
- acting in response to complaints and investigations where appropriate.[52]

The Bill does not deal with any of the recommendations in relation to a Senior Practitioner.

If the Government is willing to accept and implement recommendations from a Royal Commission, it cannot do so half-heartedly, or cherry-pick bits out of those recommendations. If the provisions authorising the use of restricted practices remain in the Bill, (which is not AFDO's preferred position), then the Bill must include provisions that implement in full:

(a) all of the existing safeguards in the Quality-of-Care Principles
(b) the recommendations of the Aged Care Royal Commission in relation to the use of restrictive practices, and
(c) recommendation 6.35 from the Disability Royal Commission.

7.3 Such significant elements must not be left to delegated legislation

A legislative instrument (such as the rules under the Bill) is not subject to the same level of parliamentary scrutiny as amendments to primary legislation.

The Scrutiny Committee's very strong view is that;

> significant matters, such as when restrictive practices can be used in aged care settings, should be contained on the face of the primary legislation unless a sound justification for the use of delegated legislation is provided.[53]

Further, a desire for administrative flexibility is not sufficient justification for leaving significant elements of a legislative scheme to be delegated legislation, especially given

> the potentially significant impact of the inappropriate use of restrictive practices and the vulnerability of the persons to whom they may be applied.[54]

If the provisions dealing with restrictive practices remain in the Bill (which is not AFDO's preferred position), then, in accordance with the views of the Scrutiny Committee, all the requirements and limitations for their use must be included "on the face" of the Bill.

7.4 Informed consent

Informed consent is an essential requirement for the use of any restrictive practice. It is also essential requirement for immunity from civil or criminal liability for the use of a restrictive practice.

We deal with the issue of immunity in **section 7.6** below.

There is no guidance in the Bill as to what constitutes "informed consent". There is no requirement for the information necessary for any consent to be "informed" to be provided in a manner that is accessible for the individual, or in a way the individual has requested and understands. There is no requirement for the necessary informed consent to be sought, and given, prior to the use of the restrictive practice.

Further, it is not clear whether the reference in clause 18(2) to "capacity" of the individual is a reference to "legal capacity" or "mental capacity". There is also no indication of the required capacity standard, nor of the point in time at which capacity is assessed.

Is the capacity standard required under the clause:

(a) testamentary capacity

(b) the ability to make reasonable judgments or understand the nature and effect of a document[55]

(c) the individual is capable of managing his or her person[56],

(d) understanding the nature and significance of the restrictive practice on the individual's rights or freedom of movement?

Any assessment of "capacity" must only be judged at the time at which consent is needed. The assessment must not be 'status' based, nor based on a medical model. The existence of a "cognitive impairment" must not be used to automatically permit a limitation on the exercise of agency by the individual, nor automatically be considered as a limitation on the recognition of legal capacity.

When assessing "capacity", there is no consideration given in the Bill to any decision-making assistance and supports that are available or should reasonably be made available (having regard to the Statement of Rights) in determining whether the individual has the necessary capacity to provide informed consent. (See **section 3.3** above).

Further, if the Bill is to allow another person to consent to use of restrictive practices on an individual, as proposed it is essential that (as the Scrutiny Committee has noted)

> at a minimum, guidance should have been included on the face of the bill as to the considerations and safeguards that apply when identifying persons and bodies who may consent to restrictive practices in recognition of the significant trespass on rights and liberties that these practices represent.[57]

There are no provisions in the Bill that require the person who uses restrictive practices to make, and keep, any record of:

1. the restrictive practice, and specific details of its use
2. where the individual does not have capacity to consent, the identity of the person who gave informed consent, their relationship to the individual and their contact details
3. the information provided to the person providing informed consent that establishes the person was properly informed before consent was given
4. any capacity assessment made of the individual concerned, including the timing and all other circumstances relevant to that assessment
5. details of any decision-making assistance and supports available to the individual concerned at the time of consent, or any capacity assessment, and
6. the terms of the consent given, and the place, date and time at which consent was given.

All of these records must be created, kept by the person who is seeking consent, or who uses a restricted practice and included in the personal information of the individual on whom the restricted practice was used, for at least seven years after the death of the individual concerned.

7.5 Use in an "emergency"

Clause 18(3) gives the Minister a broad discretion to determine, in delegated legislation, when the requirements for using a restrictive practice no longer apply. This clause should be removed from the Bill.

However, if the clause remains in the Bill, we note there is no guidance in the Bill as to what constitutes an emergency. There is nothing that prevents a determination of an emergency after the use of a restrictive practice has been applied to an individual. There is also no guidance as to who determines that an emergency is occurring or has occurred. There is no limitation on the requirements that are excluded by the Minister's determination. For example, there can be no justification in any emergency for removing the requirement that a restrictive practice must be used:

(a) as a last resort[58], or

(b) in the least restrictive form and for the shortest time.[59]

The Scrutiny Committee has significant scrutiny concerns in relation to the ability to override any of the statutory requirements in circumstances when there is no guidance on the face of the Bill as to what may be considered an emergency.[60]

7.6 Civil and criminal immunity

The Bill grants civil and criminal immunity for "protected entities" who use restrictive practices if informed consent was given by a person or body as prescribed by the rules (where the individual concerned lacks capacity to consent) and the practice was used in accordance with these requirements.[61]

Clause 163(2) is in the following terms:

> A protected entity is not subject to **any civil or criminal liability** for, or in relation to, **the use of the restrictive practice** in relation to the individual if:
>
> (a) informed consent to the use of the restrictive practice was given by a person or body prescribed by the rules made for the purposes of this paragraph; and
>
> (b) the restrictive practice was used in accordance with any requirements prescribed by rules made for the purposes of section 162.
>
> Note: This means a protected entity **does not have immunity** from liability if the restrictive practice was **not used in accordance with** the requirements prescribed by the **rule**s.

According to the Explanatory Memorandum, clause 163 is necessary;

> because the proposed consent arrangements may result in a registered provider, or relevant individual, relying on consent by a person who is authorised to give that consent under the Commonwealth's aged care laws, but who may not have the requisite authority under the relevant State or Territory laws.[62]

There is no similar concern with consent given when the relevant individual has capacity, notwithstanding the different capacity standards in different States and Territories (and, as we have noted in **section 7.4**, above, there is currently no relevant capacity standard under the Bill). In Victoria, for example, the Senior Practitioner Model is an administrative authorisation model for the use of restrictive practices. It does not operate as a substitute decision maker for the consent of restrictive practices. The Senior Practitioner authorises all

restrictive practices irrespective of person's ability to provide consent.[63]

This means that, under the Bill, the Senior Practitioner consent to the use of restrictive practices on an aged care resident in Victoria who, at the time, did not have capacity to give consent, has complete immunity. However, an aged care resident in Victoria who, at the time, did have capacity to give consent but, nevertheless, did not consent, will have a claim, and the Senior Practitioner does not have the blanket immunity under the Bill.

The Explanatory Memorandum further states that clause 163 gives

> additional protection to individuals receiving funded aged care services and … is **not intended to provide a broad immunity to negligence in respect of the use of a restrictive practice**. It is **only intended to permit** registered providers and those involved in the use of restrictive practices **to rely on consent** from a restrictive practices substitute decision maker as prescribed by the rules.[64] (emphasis added)

The Explanatory Memorandum does not include any similar statement that there is no intention to provide a broad immunity for criminal conduct in respect of a restrictive practice. However, we assume this is also the Government's intention.

The position stated in the Explanatory Memorandum (that the immunity provision is limited to permit those involved in the use of restrictive practices to rely on the consent given, without being exposed to liability) is simply not true. If this is the true intention of the Bill, clause 163 must be redrafted.

8. Funded supports

For those who are not NDIS participants, the current negotiations with the States and Territories on foundational supports must include funding to care for the needs of people who do not meet eligibility for the NDIS within the aged care system.

Further, the NDIS must fund the disability support needs of its participants who need residential care in the aged care system.

The list of funded aged care services will be included in subordinate legislation. There is currently no visibility in relation to the services that will be included in that list. We understand the Department proposes that the service list will initially comprise all the types of aged services that are currently funded by the Commonwealth. It will be subsequently updated to facilitate commencement of the new Support at Home program in 2025.

For example, current aged care programs do not include any dedicated funding for high-cost assistive technology. In 2019, the Department commissioned the Australian Health Care Associates to undertake a review of Assistive Technology Programs in Australia. The review found:

> Stakeholders frequently cited inequities between the aged care, health and disability sectors as a major challenge within the AT landscape, with age seen as a major cause of inequity. For example, a consumer aged 65 years or older is ineligible for NDIS support if they were not an NDIS recipient before the age of 65. This consumer is less likely to have their AT needs met than a consumer with the same condition who is aged 64 and is eligible for NDIS funding for the rest of their lives. This was seen

> as creating a two-tiered system, with older people who must rely on the aged care system for AT often missing out.[65]

Evidence also exists from a more recent research report that the average spend on assistive technology and home modifications per person per year for NDIS participants was $2,500, compared with $51 per person per year for aged care recipients.[66]

High and low-cost assistive technology and home modifications must be included in the list of funded supports to be developed under the Bill to ensure this gap is addressed properly.

The assessment tool for aged care services must enable an individual to identify whether they have a disability and capture all relevant disability-related support needs as appropriate.

AFDO further urges the Committee to ensure the Department is required to undertake extensive consultation and listen to, and consider, the needs of all users of the aged care system, including people with disability and their representative organisations in developing the service. Also, the Bill must include a mechanism that ensures legislative oversight over the development of the service list.

9. Statutory duty of care

The Aged Care Royal Commission recommended a statutory duty of care for aged care providers[67]. The Exposure Draft of the Bill contained criminal and civil penalties for providers guilty of serious breaches of their duty of care, as well as provisions for compensation for users of aged care services who suffer harm as a result[68].

The negotiations between the Government and the Opposition resulted in the removal of these criminal sanctions for breaches of provider duty of care from the Bill. The duty of care in the Bill now only includes a civil penalty for providers.[69]

The Aged Care Royal Commission's recommended duty of care mirrored that of the work health and safety legislation. Removing criminal sanctions will mean providers will face lesser penalties for breaches of their duty of care to their clients and residents than they face in relation to their workers.

The Bill must include a statutory duty of care for aged care providers consistent with the Aged Care Royal Commission's recommendation, that mirrors the duty of care for employers in work health and safety legislation and creates civil and criminal liability for any breaches of that duty of care.

Endnotes

[1] Aged Care Bill 2024, clause 5(a), accessed 17 September 2024, retrieved from https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bId=r7238

[2] United Nations Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 6 (1995), paragraph 10, adopted at the thirteenth session (39th meeting) of the Committee, on 8 December 1995 (contained as an annex to Document E/1996/22) reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 34 (2003), accessed 17 September 2024, retrieved from https://www.globalhealthrights.org/wp-content/uploads/2013/10/CESCR-General-Comment-No.-6-The-Economic-Social-and-Cultural-Rights-of-Older-Persons.pdf

[3] Convention on the Rights of Peoples with Disabilities, article 25(b) (on the right to health services); article 28(2)(b)(on the right to access to social protection and poverty reduction programs)

[4] ibid., article 13(1)

[5] ibid., article 16(2)

[6] UN General Assembly adopted resolution 46/91, accessed 17 September 2024, retrieved from https://www.ohchr.org/en/instruments-mechanisms/instruments/united-nations-principles-older-persons

[7] Note 1, clause 5(b)

[8] ibid., paragraph 252(2)(c)

[9] Royal Commission into Aged Care Quality and Safety (2021) Final report - List of recommendations, accessed 16 September 2024, retrieved from https://www.royalcommission.gov.au/system/files/2021-03/final-report-recommendations.pdf

[10] Note 1, clause 5(c)

[11] ibid., paragraph 23(1)(a)

[12] Australian Law Reform Commission, Equality, Capacity and Disability in Commonwealth Laws (ALRC Report 124), tabled in Parliament 14 November 2014, accessed 16 September 2024, retrieved from https://www.alrc.gov.au/news/equality-capacity-and-disability-in-commonwealth-laws-alrc-report/

[13] ibid., recommendation 3.1, accessed 16 September 2024, retrieved from https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-alrc-report-124/3-national-decision-making-principles-2/national-decision-making-principles-2/

[14] Bigby, C., Carney, T., Then, S-N., Wiesel, I., Sinclair, C., Douglas, J., & Duffy, J., (2023). Diversity, dignity, equity and best practice: a framework for supported decision-making. Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, accessed 17 September 2024, retrieved from https://disability.royalcommission.gov.au/publications/diversity-dignity-equity-and-best-practice-framework-supported-decision-making

[15] Note 1, clause 8(6)

[16] ibid., clause 7

[17] ibid., paragraph 5(b)(ii)

[18] ibid., paragraph 23(2)(a)

[19] ibid., paragraph 23(3)(b)

[20] ibid., paragraph 23(3)(d)

[21] ibid., clause 23(7)

[22] ibid., clause 24(1)

[23] ibid., clause 24(2)

[24] Royal Commission into Aged Care Quality and Safety, Final Report: Care, Dignity and Respect: Volume 3A, p. 20, accessed 8 October 2024, retrieved from https://www.royalcommission.gov.au/system/files/2021-03/final-report-volume-3a.pdf

[25] Note 1, clause 25(1) and paragraph 25(2)(a)

[26] ibid., clause 25(10)

[27] Note 9

[28] Special Rapporteur on the Rights of Persons with Disabilities, Access to rights-based support for persons with disabilities, (2017) accessed 16 October 2024, retrieved from https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/436/64/PDF/G1643664.pdf?OpenElement.

[29] Note 1, clause 25(11)

[30] ibid., clause 17(1)

[31] ibid., clause 17(2)

[32] ibid., paragraph 18(1)(a)

[33] ibid., paragraphs 18(1)(b)-(g)

[34] ibid., clause 18(2)

[35] ibid., clause 18(3)

[36] ibid., paragraph 18(1)(f)

[37] Note 3434

[38] Note 1, paragraph 163(2)(a)

[39] ibid., clause 162

[40] Explanatory memorandum, p. 70, accessed 22 October 2024, retrieved from https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bId=r7238

[41] https://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/national-framework-for-reducing-and-eliminating-the-use-of-restrictive-practices-in-the-disability-service-sector

[42] Spivakovsky, C., Steele, L., & Wadiwel, D. (2023). Restrictive Practices: A Pathway to Elimination. Australia: Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, accessed 17 October 2024, retrieved from https://disability.royalcommission.gov.au/publications/restrictive-practices-pathway-elimination

[43] Note 3, article 15

[44] ibid., article 16

[45] Note 9

[46] Quality of Care Amendment (Restrictive Practices) Principles 2022 (Cth).

[47] s 15GA(a)(i), (ii), (iv), (v)

[48] s 15GA(d)

[49] Note 24, p 109.

[50] https://www.health.gov.au/topics/aged-care/providing-aged-care-services/training-and-guidance/restrictive-practices-in-aged-care-a-last-resort?language=und#interim-arrangements-for-consent-to-restrictive-practices

[51] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability: Final Report, Volume 6, Enabling autonomy and access, Commonwealth of Australia, 2023, pp.512-513, accessed 24 October 2024, retrieved from https://disability.royalcommission.gov.au/publications/final-report-volume-6-enabling-autonomy-and-access

[52] ibid., p. 513

[53] Senate Standing Committee for the Scrutiny of Bills, Report Snapshot, Scrutiny Digest 13 of 2024, paragraph 1.11, p. 5; [2024] AUSStaCSBSD 201, accessed 22 October 2024, retrieved from https://www.aph.gov.au/-/media/Committees/Senate/committee/scrutiny/scrutiny_digest/2024/d13_24.pdf?la=en&hash=AA9F63001D5B699CC7C1216BA8617A66D149E664

[54] ibid., paragraph 1.12, p. 6

[55] Guardianship and Administration Act 1986 (Vic).

[56] Guardianship Act 1987 (NSW).

[57] Note 5353, paragraph 1.14, p. 6

[58] Note 1, paragraph (18(1)(a)(i)

[59] ibid., paragraph 18(1)(e)

[60] Note 5353, paragraph 1.13, p. 6

[61] Note 1, clause 163

[62] Note 40, 53p. 179

[63] Disability Act 2006 - https://www.legislation.vic.gov.au/in-force/acts/disability-act-2006/048

[64] Note 40 p. 180

[65] Australian Healthcare Associates, Review of Assistive Technology Programs in Australia Final Report, (2020), Commonwealth of Australia, p.33

[66] Layton, Natasha; Brusco, N K, The Australian assistive technology equity studies: Improving access to assistive technology for people with disability who are not eligible for the NDIS, (2022),Monash University, accessed 16 October 2024, retrieved from https://doi.org/10.26180/21113887

[67] Note 9

[68] Exposure draft – Aged Care Bill 2023, Department of Health and Aged Care, published 14 December 2023, accessed 21 October 2024, retrieved from https://www.health.gov.au/resources/publications/exposure-draft-aged-care-bill-2023?language=en

[69] Note 1, clause 179