Quality of Care Amendment (Restrictive Practices) Principles 2022 [F2022L01548][1]

Purpose	This legislative instrument amends the Quality of Care Principles 2014 to authorise certain individuals or bodies to provide informed consent to the use of a restrictive practice in relation to a care recipient
Portfolio	Health and Aged care
Authorising legislation	*Aged Care Act 1997*
Last day to disallow	15 sitting days after tabling (tabled in the House of Representatives on 1 December 2022 and in the Senate on 6 February 2023). Notice of motion to disallow must be given by 21 March 2023 in the House and 29 March 2023 in the Senate[2]
Rights	Rights of persons with disabilities; equal recognition before the law; equality and non-discrimination; access to justice; effective remedy

1.1 The committee requested a response from the minister in relation to the legislative instrument in *Report 1 of 2023*.[3]

Consent to the use of restrictive practices in aged care

1.2 This legislative instrument amends the Quality of Care Principles 2014 (Quality of Care Principles) to specify a hierarchy of persons who can give consent on behalf of persons in aged care to the use of restrictive practices, if the care recipient is assessed to lack capacity to give consent. Restrictive practices include physical, environmental, mechanical or chemical restraints or seclusion[4] (such as the use of restraining chairs, bed rails, locked doors or medications for the purpose of sedation). The instrument specifies who is classified as a 'restrictive practices substitute decision-maker'.

1 This entry can be cited as: Parliamentary Joint Committee on Human Rights, Quality of Care Amendment (Restrictive Practices) Principles 2022 [F2022L01548], *Report 3 of 2023 – Quality of Care Amendment (Restrictive Practices) Principles 2022*; [2023] AUPJCHR 27.

2 In the event of any change to the Senate or House's sitting days, the last day for the notice would change accordingly.

3 Parliamentary Joint Committee on Human Rights, *Report 1 of 2023* (8 February 2023), pp. 53–60.

4 See Quality of Care Principles 2014, section 15E.

1.3 Under the instrument, the priority for who can give consent is an individual or body appointed under a relevant state or territory law (where the care recipient lives) who can give consent to a restrictive practice.[5] If no such person or body has been appointed and there is no clear mechanism for appointing such a person or body, or an application has been made but there is a significant delay in deciding the appointment, then the following persons or bodies can give consent in hierarchical order:[6]

(a) a restrictive practices nominee – being an individual or group of individuals nominated in writing by the care recipient while they still had capacity;

(b) the care recipient's partner with whom they have a close continuing relationship;

(c) a previous unpaid carer, who is a relative or friend of the care recipient with whom they have a close continuing relationship and who has a personal unpaid interest in the care recipient's welfare (and if more than one, the eldest relative or friend);

(d) the care recipient's relative or friend with whom they have a close continuing relationship and who has a personal unpaid interest in the care recipient's welfare (and if more than one, the eldest relative or friend); or

(e) a medical treatment authority, being a person or body appointed in writing under state or territory law as one that can give consent to the provision of medical treatment to the care recipient.

1.4 All of those who could consent on the care recipients' behalf have to themselves have the capacity to consent and have agreed in writing to act as a restrictive practices substitute decision-maker.

1.5 The *Aged Care Act 1997* provides that if a restrictive practice is used on a person in aged care who is assessed to lack capacity to give informed consent to its use, an approved provider or anyone who uses the restrictive practice is not subject to any criminal or civil liability for its use, if informed consent was given by a person or body specified in delegated legislation.[7] This instrument provides that the persons or bodies listed in the instrument are specified for the purposes of this immunity.

---

5 See Quality of Care Amendment (Restrictive Practices) Principles 2022, Schedule 1, item 3, subsection 5B(1).

6 Quality of Care Amendment (Restrictive Practices) Principles 2022, Schedule 1, item 3, subsection 5B(2) and table.

7 *Aged Care Act 1997*, section 54–11.

1.6 Prior to the introduction of this instrument, the Quality of Care Principles only specified as a restrictive practices substitute decision-maker a person or body authorised under state or territory law to give consent to the use of restrictive practices.[8] This instrument is intended to address 'unexpected outcomes' as in many jurisdictions it is unclear if the relevant state or territory laws can provide the necessary authorisation. To this end, this instrument is intended to introduce interim arrangements to allow time for state and territory governments to make amendments to their consent and guardianship laws.[9] As such, the amendments last for two years, and then will revert back to provide that consent can be given only as authorised as per state and territory laws.[10]

Summary of initial assessment

Preliminary international human rights legal advice

Rights of persons with disability; equal recognition before the law; equality and non-discrimination; access to justice; effective remedy

1.7 Setting out who can consent to the use of restrictive practices on behalf of a care recipient engages and may promote and limit a number of human rights, as set out by the committee in previous report entries.[11] In particular, specifying who can consent on another person's behalf when that person is assessed to lack capacity to give consent, engages and limits the rights of persons with disabilities, including the right of persons with disabilities to consent to medical treatment.[12]

1.8 Article 12 of the Convention on the Rights of Persons with Disabilities provides that in all measures that relate to the exercise of legal capacity, there should be appropriate and effective safeguards to prevent abuse. Such safeguards must ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by an independent and impartial body.[13] The United Nations (UN) Committee on the Rights of Persons with Disabilities has confirmed that there can be no derogation from article 12, which describes the

---

8 See Quality of Care Principles 2014, section 4A definition of 'restrictive practices substitute decision-maker' (as in force before 1 December 2022).

9 Explanatory statement to the Quality of Care Amendment (Restrictive Practices) Principles 2022, pp. 2–3.

10 Quality of Care Amendment (Restrictive Practices) Principles 2022, Schedule 3.

11 See most recently Parliamentary Joint Committee on Human Rights, *Report 10 of 2021* (25 August 2021) pp. 63–90.

12 The committee has previously commented on this, see most recently Parliamentary Joint Committee on Human Rights, *Report 1 of 2022* (9 February 2022) pp. 23–39.

13 Convention on the Rights of Persons with Disabilities, article 12(4). See also article 17.

content of the general right to equality before the law under the International Covenant on Civil and Political Rights.[14] In other words, 'there are no permissible circumstances under international human rights law in which this right may be limited'.[15] While not all aged care recipients are people with disability, those who are assessed to lack capacity are invariably those with cognitive impairment and thus, in effect, the measure exclusively applies to people with disability. Enabling a substitute decision-maker to consent to the use of a restrictive practice on behalf of a care recipient would therefore engage the rights of persons with disability.[16]

1.9 The UN Committee on the Rights of Persons with Disabilities has stated that substitute decision-making should be replaced by supported decision-making.[17] Supports may include peer support, advocacy, assistance with communication or advance planning, whereby a person can state their will and preferences in advance should they be unable to do so at a later point in time. The Committee on the Rights of Persons with Disabilities has noted that 'where, after significant efforts have been made, it is not practicable to determine the will and preferences of an individual, the "best interpretation of will and preferences" must replace the "best interests" determinations'.[18] States are also required to create appropriate and effective safeguards for the exercise of legal capacity to protect persons with disabilities from abuse.[19]

14 Committee on the Rights of Persons with Disabilities, *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [1], [5].

15 Committee on the Rights of Persons with Disabilities, *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [5].

16 The Committee on the Rights of Persons with Disabilities has made clear that practices that deny the right of people with disabilities to legal capacity in a discriminatory manner, such as substitute decision-making regimes, must be 'abolished in order to ensure that full legal capacity is restored to persons with disabilities on an equal basis with others': *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [7]. For a discussion of the academic debate regarding the interpretation and application of article 12, particularly in relation to substitute decision-making, see e.g. Bernadette McSherry and Lisa Waddington, 'Treat with care: the right to informed consent for medical treatment of persons with mental impairments in Australia', *Australian Journal of Human Rights* (2017) vol. 23, issue no. 1, pp. 109–129.

17 Committee on the Rights of Persons with Disabilities, *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [15]–[16], [21]. The features of a supported decision-making regime are detailed in paragraph [29].

18 Committee on the Rights of Persons with Disabilities, *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [21].

19 Committee on the Rights of Persons with Disabilities, *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [20]; Convention on the Rights of Persons with Disabilities, article 12(4).

1.10 In addition, the Convention on the Rights of Persons with Disabilities requires health professionals to provide care of the same quality to persons with disabilities as to others including on the basis of free and informed consent.[20] It also provides persons with disabilities must be protected from all forms of exploitation, violence and abuse.[21]

Rights of persons with disabilities to equality and non-discrimination, access to justice and effective remedy

1.11 In addition, this instrument, in specifying persons who may consent for the purposes of granting immunity from all civil and criminal liability to those who rely on that consent, engages and may limit the rights of persons with disabilities to equal recognition before the law, equality and non-discrimination, and access to justice and has implications for the right to an effective remedy.[22] The committee considered the immunity provision in 2022 when it was introduced as an amendment to the *Aged Care Act 1997* and concluded that it did not appear to be compatible with the above listed rights.[23] This instrument, in specifying the persons who may give consent, to ensure the immunity applies, raises the same concerns.

Committee's initial view

1.12 The committee noted that setting out who can consent to the use of restrictive practices on behalf of an aged care recipient engages and may promote and limit a number of human rights. In particular, the committee considered this may limit the rights of persons with disabilities. Further, specifying persons who may consent for the purposes of granting immunity from all civil and criminal liability to those who rely on that consent, engages and may limit the rights of persons with disabilities to equal recognition before the law, equality and non-discrimination, and access to justice and has implications for the right to an effective remedy. The committee sought the minister's advice in relation to:

(a) what guidance has been provided to aged care providers to assist them in assessing if a care recipient lacks capacity to give consent (and so when it is, or is not, appropriate to rely on the consent arrangements in the instrument);

(b) what guidance has been provided to aged care providers to enable them to determine if the law in their state or territory allows for the

20 Convention on the Rights of Persons with Disabilities, article 25(d).

21 Convention on the Rights of Persons with Disabilities, article 16.

22 International Covenant on Civil and Political Rights, articles 2 and 26; Convention on the Rights of Persons with Disabilities, articles 5, 12 and 13.

23 Parliamentary Joint Committee on Human Rights, *Report 1 of 2022* (9 February 2022) pp. 23–39.

appointment of an individual or body to give consent to the use of restrictive practices;

(c) who determines whether there is a 'clear mechanism for appointing' a person under the state and territory laws, or what is a 'significant delay' in deciding an application for appointment under the state or territory laws;

(d) who is authorised to give consent under the instrument if an application for an appointment to consent to the use of restrictive practices has been made under state or territory law but not yet determined, but there is no significant delay in deciding the application (yet no one is yet appointed);

(e) are all the state and territory laws that allow for the appointment of an individual or body to give consent to the use of restrictive practices consistent with the Convention on the Rights of Persons with Disabilities. If not, what is the Commonwealth, as the signatory to the Convention, doing to ensure the use of restrictive practices in aged care is compatible with human rights (now, and in two years when the instrument reverts back to provide that consent will only be as set out in state and territory law);

(f) why does the instrument not require that restrictive practices substitute decision-makers must have a duty to seek to ascertain the wishes of the care recipient and, where possible, act in a manner consistent with their will and preferences;

(g) will substitute decision-makers as specified in this instrument have the necessary skills and expertise to be able to properly give informed consent to the use of restrictive practices;

(h) do all states and territories have laws that allow for a medical treatment authority to be appointed in writing, and if not, what can aged care providers do to seek consent;

(i) since this instrument came into force how many notifications in aged care facilities across the Commonwealth have been made specifying that restrictive practices have been used without consent (organised per jurisdiction); and

(j) how is specifying persons as those who may give consent for the purposes of granting immunity from all civil and criminal liability consistent with the rights of persons with disabilities to equal recognition before the law, equality and non-discrimination, access to justice and the right to an effective remedy.

1.13 The full initial analysis is set out in *Report 1 of 2023*.

Minister's response[24]

1.14 The minister advised:

> The Department of Health and Aged Care (Department) has advised that the Principles strengthen existing legislative consent requirements for the use of restrictive practices. Existing restrictive practice legislation provides significant safeguards, having strict requirements to only use restrictive practices: as a last resort; to prevent harm; only to the extent necessary; only in proportion to the risk of harm to the care recipient and others; in the least restrictive form and for the shortest time necessary to prevent harm to the care recipient and others. The necessity and effectiveness of any use of a restrictive practice must also be regularly monitored, reviewed and documented.
>
> The Principles seek to resolve issues raised by some jurisdictions where there is a question about whether a person other than the care recipient is able to consent to the use of a restrictive practice, which is leaving care recipients at risk of not receiving the care they require and/or being at risk of harm. The Principles are not intended to override state and territory laws. Where state and territory laws exist to appoint a Restrictive Practices Substitute Decision Maker (RPSDM), the Principles provide that they should be relied on. The Principles are intended as an interim arrangement until state and territory guardianship and consent laws can be amended, or until 1 December 2024.
>
> Individuals with a disability who are under 65 years and participants of the National Disability Insurance Scheme (NDIS) will have their own arrangements for consent for the use of Restrictive Practice under the NDIS legislation. People with a disability over 65 in residential aged care will be afforded the protections and safeguards under the Principles. The NDIS and aged care legislation reflect the specific needs of their users.
>
> (a) what guidance has been provided to aged care providers to assist them in assessing if a care recipient lacks capacity to give consent and so when it is or is not appropriate to rely on the consent arrangements in the instrument;
>
> The Aged Care Quality and Safety Commission (Commission) has a suite of resources available, including training, to support approved providers in meeting their obligations under the *Aged Care Act 1997* including the use of restrictive practices and informed consent. Guidance is also available from other sources including Capacity Australia, Dementia Australia and Dementia Services Australia.
>
> When assessing whether a care recipient lacks capacity to consent, approved providers rely on guidance such as a care recipient's cognitive

24 The minister's response to the committee's inquiries was received on 24 February 2023. This is an extract of the response. The response is available in full on the committee's website.

assessment, the provider's clinical governance framework, and consultation with the care recipient and/or their representative.

(b) what guidance has been provided to aged care providers to enable them to determine if the law in their state or territory allows for the appointment of an individual or body to give consent to the use of restrictive practices;

The Department continues to engage with states and territories on the use of restrictive practices and laws regarding the appointment of a RPSDM. State and territory agencies are best placed to provide advice to service providers or members of the community who may need to access guardianship tribunals in each jurisdiction for appointments of a RPSDM. The Department has advised that states and territories are aware of the Principles' sunsetting date on 1 December 2024 and are collaborating to work towards a longer term solution through the establishment of a national working group facilitated by the Department. This group is also looking at sharing communication products and resources. The Commission has a critical role in sector engagement and education. In reviewing services they seek evidence of actions taken to minimise the use of restrictive practices, and where used, ensures it complies with legislation including that appropriate consent has been obtained. This will include whether the provider can demonstrate that they have done everything possible to determine whether the relevant state or territory has a 'clear mechanism for appointing' a RPSDM before using the Principles.

(c) who determines whether there is a 'clear mechanism for appointing' a person under the state and territory laws or what is a 'significant delay' in deciding an application for appointment under the state or territory laws;

Approved providers should contact the relevant state or territory body for advice on laws regarding the appointment of a RPSDM under the state and territory law in their jurisdiction. The relevant state or territory body is best placed to provide advice on current laws for that jurisdiction.

The Department are engaging with states and territories and will continue to collaborate with jurisdictions to support them to assist the sector in understanding what is considered a significant delay in their jurisdiction.

The Department has advised me there is no specific timeframe that is to be considered a 'significant delay' and it will depend on the circumstances of each situation. The intention is to ensure informed consent can be given when there is a significant delay by a tribunal or similar decision-making body, recognising the time it may take for state and territory bodies to decide applications. However, a 'significant delay' is more likely to be considered months or years rather than days or weeks. The relevant state or territory body may also provide advice on standard timeframes for seeking a decision from the relevant tribunal or decision-making body.

(d) who is authorised to give consent under the instrument if an application for an appointment to consent to the use of restrictive practices has been made under state or territory law but not yet determined, but there is no significant delay in deciding the application (yet no one is yet appointed);

In the scenario described above, an approved provider cannot use a restrictive practice in relation to a care recipient who does not have the capacity to consent until such appointment has been made under the relevant state or territory law.

However, a restrictive practice can be used without consent (including where a RPSDM has not yet been appointed) in an emergency through existing legislation (see section 15FA of the Quality of Care Principles 2014). This ensures approved providers can appropriately and rapidly respond to an emergency to protect a people in their care or other persons from immediate harm. The approved provider has additional reporting obligations where a restrictive practice is used in an emergency. An emergency is a serious or dangerous situation that is unanticipated or unforeseen and that requires immediate action. If a provider uses a restrictive practice in an emergency, the provider must, as soon as practicable after the restrictive practice starts to be used, inform the RPSDM about the use of the restrictive practice, and ensure the use is appropriately documented in the care and services plan. During an emergency, providers must still ensure the least restrictive form of a restrictive practice is being used and for the shortest period possible.

(e) are all the state and territory laws that allow for the appointment of an individual or body to give consent to the use of restrictive practices consistent with the Convention on the Rights of Persons with Disabilities. If not what is the Commonwealth, as the signatory to the Convention, doing to ensure the use of restrictive practices in aged care is compatible with human rights now and in two years when the instrument reverts back to provide that consent will only be as set out in state and territory law;

The Department has advised me that it is a matter for states and territories to ensure that their laws, including their laws that allow for the appointment of a person or body to give consent to the use of a restrictive practice, is consistent with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

Given the Commonwealth's role in the aged care sector and the fact it is a signatory to the UNCRPD the Department on behalf of the Commonwealth is continuing to encourage states and territories ensure their legislation is consistent with the UNCRPD. This is being done through existing forums and engagement including a National Working Group on restrictive practices established to discuss each state and territory government's legislative framework for substitute decision making in a residential aged care context and encourage amendment where required.

(f) why does the instrument not require that restrictive practices substitute decision-makers must have a duty to seek to ascertain the wishes of the care recipient and, where possible, act in a manner consistent with their will and preferences;

The Principles only apply where the care recipient lacks capacity to provide consent to the use of a restrictive practice and there is no relevant state or territory law to appoint a RPSDM. The Department has advised me that the Aged Care Act does not allow for subordinate legislation to prescribe obligations on other persons beyond the approved provider. The Principles clarify that for items two to four of the hierarchy the RPSDM has a personal interest in the care recipient's welfare on an unpaid basis, and with whom the care recipient has a close continuing relationship.

(g) will substitute decision-makers as specified in this instrument have the necessary skills and expertise to be able to properly give informed consent to the use of restrictive practices;

The skills and expertise of each RPSDM will vary. In providing consent to the use of a restrictive practice for the consent to be valid it must be informed, voluntary, current and specific, and provided by an individual who has the requisite capacity to understand and communicate their consent.

Consent is informed when the RPSDM is provided sufficient information about the decision before giving their consent. In the context of restrictive practices, this means that generally a care recipient or RPSDM should be provided with accurate and relevant information from the approved provider regarding:
• the proposed restrictive practice, including whether it involves medication or an intervention
• the reason for the use of the proposed restrictive practice
• best practice alternative strategies that have been used with the care recipient before the restrictive practice was proposed
• any alternative options available to them (including not taking or using the medication or intervention)
• the risks and benefits of the use of the restrictive practice and any alternative options.

When the use of chemical restraint is being considered, additional safeguards are required under the legislation in the form of:
• a medical practitioner or nurse practitioner has assessed the care recipient as requiring the restraint; and
• a medical practitioner or nurse practitioner has prescribed medication for the purpose of using the chemical restraint; and
• the assessment is recorded in the care and services plan for the care recipient.

The care recipient or RPSDM should have the opportunity to review and ask questions about the use of any restrictive practice and given sufficient time to do so.

The approved provider should be satisfied that the care recipient or RPSDM has the requisite capacity to understand the decision and to communicate their decision. The care recipient or RPSDM must be able to come to a considered and independent decision, free from duress or coercion.

If effective consent has not been obtained by the approved provider, the approved provider will not have the benefit of the immunity provision set out in section 54-11 of the *Aged Care Act 1997*.

(h) do all states and territories have laws that allow for a medical treatment authority to be appointed in writing, and if not, what can aged care providers do to seek consent;

It is only in the event that a care recipient is receiving aged care in a state or territory without an explicit legal avenue to appoint a RPSDM, and the care recipient has no family or friends (i. e. unable to use items one to four of the Principles), that a medical treatment authority for the care recipient can act as the RPSDM as the last resort. If a medical treatment authority is not in place for the care recipient, the provider will be required to apply to the relevant court or tribunal to have a person or body, appointed as the medical treatment authority for example a public guardian.

In the rare event that a medical treatment authority is the only eligible item in the hierarchy, Table 1 in the Principles Explanatory Statement sets out information on the medical treatment authority arrangements for each state and territory at the time of registration of the instrument. As this was a point in time reflection of state and territory laws, approved providers should either contact or review information provided by the relevant state or territory body to confirm the relevant medical treatment authority. The relevant state or territory body is best placed to provide advice on the current medical treatment authority.

(i) since this instrument came into force how many notifications in aged care facilities across the Commonwealth have been made specifying that restrictive practices have been used without consent (organised per jurisdiction); and

The mandatory reporting of the inappropriate use of restrictive practices occurs through the Serious Incident Response Scheme (SIRS) managed by the Commission as the Regulator. Given the short period of time since the commencement of the legislation this data is not yet publicly available. The Commission will publish data on the number of incidents on the inappropriate use of restrictive practices in its next Sector Performance Report due later this month. The publicly available data is not broken down by state or territory or notes which incidents were due to a lack of consent.

(j) how is specifying persons as those who may give consent for the purposes of granting immunity from all civil and criminal liability consistent with the rights of persons with disabilities to equal recognition before the law, equality and non-discrimination, access to justice and the right to an effective remedy.

I understand and appreciate community concern regarding the rights of older people and the use of restricted practises in residential aged care. Significant checks and balances were enacted to ensure the immunity provision only protects approved providers in very limited circumstances. The immunity does not prevent approved providers or their staff from potentially being charged with a criminal offence or a civil claim being brought in negligence where the use of the restrictive practice was not in accordance with the legislative requirements.

The intention in using an immunity provision is to ensure approved providers in jurisdictions without appropriate legal consent laws who rely on informed consent given through the Principles are not criminally or civilly liable under state and territory laws. This will instil confidence in approved providers to rely on the Principles without fear of prosecution, provided they follow all of the strict legislative requirements. Without assurances that they will not be prosecuted for using the Principles, approved providers may choose not to use restrictive practices when they are a necessary last resort to protect the aged care recipient. This could result in harm to the care recipient and others. This also aims to close the gap that currently exists in some jurisdictions and ensure, where necessary, restrictive practices can be used to protect care recipients and others, including those with a disability.

The immunity only applies where consent was given by a person or body in the hierarchy who may not be authorised by state or territory law and the restrictive practice is used in accordance with all relevant legislative requirements. This includes requirements to only use restrictive practices: as a last resort; to prevent harm; only to the extent necessary; only in proportion to the risk of harm to the care recipient and others; in the least restrictive form and for the shortest time necessary to prevent harm to the care recipient others. The necessity and effectiveness of any use of a restrictive practice must also be regularly monitored, reviewed and documented.

These amendments necessarily have to take into account the rights of the care recipient the subject of a restrictive practice as well as the rights of other care recipients and persons, including those with disability. This is consistent with the UNCRPD.

Concluding comments

International human rights legal advice

Rights of persons with disability; equal recognition before the law; equality and non-discrimination; access to justice; effective remedy

1.15 The instrument provides that the model for consent set out in state and territory legislation applies first in the hierarchy of consent, and that in two years' time consent requirements will revert to being solely governed by state and territory law. The minister advised that it is a matter for states and territories to ensure that their laws, including their laws that allow for the appointment of a person or body to give consent to the use of a restrictive practice, are consistent with the United Nations (UN) Convention on the Rights of Persons with Disabilities (although the Commonwealth is 'encouraging' states and territories to comply). However, it is noted that it is the federal government, as the signatory to the Convention, that is responsible for compliance with the Convention. Moreover, the role of this committee is to assess whether Commonwealth legislation is compatible with international human rights law[25] – and if Commonwealth legislation defers to state and territory legislation this may mean, depending on the rights compatibility of the state and territory legislation, that the Commonwealth legislation cannot be said to comply.

1.16 The minister was asked what guidance has been provided to aged care providers to assist them in assessing if a care recipient lacks capacity to give consent and so when it is, or is not, appropriate to rely on the consent arrangements in the instrument. The minister advised that the Aged Care Quality and Safety Commission has a suite of resources available, including in relation to informed consent, and guidance is available from a range of non-government organisations. However, no information was provided as to precisely what guidance aged care providers follow when determining whether a person in aged care lacks capacity to consent. The minister indicated that guidance may include a care recipient's cognitive assessment. However, it is noted that if a person's cognitive impairment was used as justification for denying legal capacity, such an approach risks being incompatible with article 12 of the Convention on the Rights of Persons with Disabilities. The UN Committee on the Rights of Persons with Disabilities has made clear that 'perceived or actual deficits in

25 See *Human Rights (Parliamentary Scrutiny) Act 2011*.

mental capacity must not be used as justification for denying legal capacity'.[26] The UN Committee has further noted that denial of legal capacity often results in further violations of human rights, such as the right to liberty and security of the person, as a person may be deprived of their liberty or subjected to other restraints on the basis of actual or perceived impairment.[27] In light of this jurisprudence, in order to be compatible with the rights of persons with disabilities, aged care providers would need to support care recipients to exercise their legal capacity, rather than undertake a cognitive assessment that leads to the denial of their legal capacity. Where such capacity assessments do occur, questions remain as to whether aged care providers are fully assessing a person's capacity in each instance before seeking consent by substitute decision-makers for the use of restrictive practices.

1.17 It is also not clear if there is clarity for providers as to who can give consent once they have determined that a person lacks capacity. The hierarchy in the instrument of those who can consent requires providers to first consider whether there is an individual or body appointed under a relevant state or territory law (where the care recipient lives) who can give consent to a restrictive practice. In response to how providers will determine this, the minister advised that state and territory agencies are best placed to provide advice to service providers who may need to access guardianship tribunals, and that approved providers should contact the relevant state or territory body for advice on laws in their jurisdiction. Noting the Commonwealth's limited role in this, it is difficult to assess whether providers are being given sufficient information to adequately determine appropriate consent arrangements.

---

26 Committee on the Rights of Persons with Disabilities, *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [13]. At [15] the Committee criticised the common approaches taken by States parties to assess capacity and deny legal capacity accordingly, including on 'on the basis of the diagnosis of an impairment (status approach), or where a person makes a decision that is considered to have negative consequences (outcome approach), or where a person's decision-making skills are considered to be deficient (functional approach)…In all of those approaches, a person's disability and/or decision-making skills are taken as legitimate grounds for denying his or her legal capacity and lowering his or her status as a person before the law. Article 12 does not permit such discriminatory denial of legal capacity, but, rather, requires that support be provided in the exercise of legal capacity'.

27 UN Committee on the Rights of Persons with Disabilities, *Guidelines on the right to liberty and security of persons with disabilities*, A/72/55 (2017) [12], where the Committee stated that 'States parties should refrain from the denial of the legal capacity of persons with disabilities and their detention in institutions against their will, either without the free and informed consent of the persons concerned or with the consent of a substitute decision maker, as that practice constitutes arbitrary deprivation of liberty and violates articles 12 and 14 of the Convention'. The Committee further noted that even where there are other reasons for detention, such as a risk of harm to themselves or others, detention in such circumstances would still be discriminatory and amount to arbitrary deprivation of liberty: [6]–[7], [13]–[15].

1.18 Further, the minister advised that where an application has been made for an appointment to consent to the use of a restrictive practice under state or territory laws but before the appointment has been determined, if there is no 'significant delay' in deciding the application, the provider cannot use the consent arrangements in the instrument. This may be for a period of months or years (as noted by the minister above as to what might constitute a 'significant delay'). In such instances the minister advised that a restrictive practice can be used without consent in an emergency through existing legislation. However, in non-emergency situations it is not clear if providers in such cases are not using restrictive practices, or if they are using such practices, but without consent, and choosing to make an incident notification. The minister advised that no data is yet publicly available on how many notifications in aged care facilities across the Commonwealth have been made specifying that restrictive practices have been used without consent.

1.19 The initial analysis noted that there is no requirement on persons in the list in the instrument who can give consent, be they nominees, partners, carers, relatives or friends, to seek to determine the will and preferences of the aged care recipient in consenting to the use of the restrictive practice. It also noted that it is not clear that partners, friends or relatives would have the necessary skills or expertise needed to question the use of restrictive practices.

1.20 In relation to why the instrument does not require substitute decision-makers to seek to ascertain the wishes of the care recipient and, where possible, act in a manner consistent with their will and preferences, the minister stated that the *Aged Care Act 1997* does not allow for subordinate legislation to prescribe obligations on other persons beyond the approved provider. This raises the question, as raised by the committee when the primary legislation was amended to empower the making of this delegated legislation,[28] as to why the Act does not require consideration of such matters. When the legislation was amended in 2022 the then minister acknowledged that supported decision-making was a best practice approach but that enabling the Quality of Care Principles 2014 to set out who may be a substitute decision-maker is an interim solution to give time to the states and territories to address limitations in their laws.[29] However, as stated at this time, and as remains applicable now, this substitute decision-making model, even if an interim solution, appears contrary to the requirements in article 12 of the Convention on the Rights of Persons with Disabilities,

28 See Parliamentary Joint Committee on Human Rights, *Report 1 of 2022* (9 February 2022) pp. 23–39.

29 See minister's response in Parliamentary Joint Committee on Human Rights, *Report 1 of 2022* (9 February 2022) at p. 30.

as set out above.[30] In particular, the UN Committee on the Rights of Persons with Disabilities has, on a number of occasions, recommended that:

> States parties abolish in law and in practice the deprivation of legal capacity on the basis of impairment, and introduce supported decision-making schemes; ensure that persons with disabilities have access to individualized support that fully respects their autonomy, will and preferences, and that it is provided on the basis of the free and informed consent of the person concerned and, when applicable, with due recourse to the "best interpretation of will and preferences" test, in line with the Committee's general comment No. 1 (2014) on equal recognition before the law.[31]

1.21 Further, as noted above, it remains unclear if the processes in each state and territory are themselves compatible with the rights of persons with disabilities.

1.22 In relation to whether substitute decision-makers as specified in this instrument have the necessary skills and expertise to be able to properly give informed consent to the use of restrictive practices, the minister advised that the skills and expertise of each substitute decision-maker will vary. The minister advised that consent will be informed when the substitute decision-maker is provided with sufficient information about the decision before giving their consent, and that 'generally' a care recipient or substitute decision-maker 'should' be provided with accurate and relevant information from the approved provider regarding the proposed restrictive practice. The list of matters the minister sets out that a substitute decision-maker should receive prior to granting consent (including reasons for the use of the restrictive practice, alternative strategies previously used, any alternative options, and the risks and benefits of its use) may serve as a something of a safeguard. However, it is not clear if such matters are required as a matter of law to be provided to substitute decision-makers and if, in practice, they are provided. Further, noting the variation in the skills and expertise of any substitute decision-maker it is also not clear

30 It is noted that Australia has made an interpretive declaration in relation to article 12, which most relevantly states, 'Australia declares its understanding that the Convention allows for fully supported or substituted decision-making arrangements, which provide for decisions to be made on behalf of a person, only where such arrangements are necessary, as a last resort and subject to safeguards'. The Australian Government has stated that it does not propose to withdraw this declaration and it does not purport to exclude or modify the legal effects of the Convention, but clarify Australia's understanding: see Committee on the Rights of Persons with Disabilities, *Combined second and third periodic reports submitted by Australia under article 35 of the Convention, due in 2018*, CRPD/C/AUS/2-3 (2019) [15]. The Committee on the Rights of Persons with Disabilities has recommended that Australia urgently withdraw this declaration: see Committee on the Rights of Persons with Disabilities, *Concluding observations on the combined second and third periodic reports of Australia*, CRPD/C/AUS/CO/2-3 (2019) [5], [6], [63].

31 UN Committee on the Rights of Persons with Disabilities, *Report on the Rights of Persons with Disabilities,* A/72/55 (2017) [34].

that all persons granting such consent would be able to adequately weigh up the risks and benefits of the proposal put to them.

1.23 The Queensland Public Advocate, Dr John Chesterman, has also raised with the committee concerns he has regarding the adequacy of the skills and expertise of any substitute decision-maker. Dr Chesterman considers the current authorisation model for the use of aged care restrictive practices to be deeply flawed and extraordinary complex,[32] observing that:

> Substitute decision-makers will typically be in the invidious position of making a restrictive practices decision having just been told that the person in question is at risk to themselves or others…Few people called on to make such a decision will have sufficient expertise, or indeed confidence, to push back and withhold consent.[33]

1.24 Having regard to such concerns, it is important that any substitute decision-maker is subject to regular monitoring and oversight so as to ensure that any consent provided is informed and specific to the restrictive practice proposed.[34]

1.25 Some questions also remain as to whether this instrument will ensure a substitute decision-maker will always be available in all states and territories. It is noted, for example, that in Victoria it is unclear if a guardian can be appointed if they are not required to make medical treatment decisions but only decisions regarding the use of restrictive practices.[35] In relation to medical treatment authorities, the minister advised that the explanatory statement set out a 'point in time' reflection of state and territory laws, and that approved providers should either contact or review information provided by the relevant state or territory body to confirm the relevant

32 Letter from Dr John Chesterman, Queensland Public Advocate to Mr Burns MP, Chair of the Parliamentary Joint Committee on Human Rights, 14 February 2023.

33 Dr John Chesterman, Queensland Public Advocate, 'Are we regulating or regularising aged care restrictive practices?' *Australian Ageing Agenda*, 14 December 2022.

34 This may include 'uniform and mandatory monitoring and reporting requirements (for instance through the offices of the Chief Psychiatrist and Senior Practitioner in the various states and territories)'. See Yvette Maker and Bernadette McSherry, 'Regulating restraint use in mental health and aged care settings: Lessons from the Oakden scandal', *Alternative Law Journal*, 44(1), 2019, p. 35.

35 See *JIN (Guardianship)* [2023] VCAT 152 (17 February 2023). In this case an aged care facility had made an application to the Victorian Civil and Administrative Tribunal for a guardianship order for a resident, 'JIN', to 'make medical decisions and treatment'. The Public Advocate was appointed as guardian but applied for a rehearing on the basis that there was a lack of any medical treatment decisions to be made on behalf of JIN; rather it appeared the true purpose in seeking the appointment of a guardian was to authorise restrictive practices (chemical restraint). VCAT ultimately found that JIN did have capacity to give consent so overturned the guardianship order. Because of this, the decision-maker did not make a finding on whether it would be contrary to the general principles of the *Guardianship and Administration Act 2019* (Vic) to appoint a guardian with authority to make medical treatment decisions purely to create an aged care restrictive practices decision maker, leaving this matter undecided.

medical treatment authority. This suggests the matter may remain unclear in some states and territories.

1.26 In conclusion, noting the significance of the rights that are engaged by enabling substitute decision-makers to consent to the use of restrictive practices on persons in aged care, and the vulnerability of those affected by the measure, it is essential to ensure that this instrument does not set out a process that could risk being incompatible with the rights of persons with disabilities, and the prohibition on cruel, inhuman or degrading treatment or the rights to liberty, privacy or health. While this instrument does not itself provide legislative authority for the use of restrictive practices,[36] it arguably facilitates the use of restrictive practices by allowing a substitute decision-maker to consent to their use, irrespective of the will and preferences of the care recipient to whom the practices would apply. This concern was raised with the committee by Dr Chesterman, who stated that the amendments made by this instrument effectively render the restrictive practices authorisation requirements 'almost meaningless'. He noted the amendments 'will do nothing to drive down restrictive practice usage; they merely make the authorisation of restrictive practices easier'.[37] If this were the case, this raises serious human rights concerns, noting Australia's obligation to minimise, and ultimately eliminate, the use of restrictive practices.[38]

1.27 The use of restrictive practices themselves raise serious human rights concerns, noting the clear position under international human rights law that such practices are not consistent with multiple human rights, including the prohibition of torture and ill-treatment.[39] It is acknowledged that there are important safeguards around the use of restrictive practices that now apply in legislation. However, in relation to the issue of substituted consent, as much depends on unknown safeguards in state and territory legislation, and as there is no requirement to provide for

---

36 Quality of Care Principles (2014), section 15F provides that an approved provider may use a restrictive practice in relation to a care recipient in circumstances where the requirements set out in Division 3 of the Principles are satisfied. The specific requirements are set out in section 15FA.

37 Dr John Chesterman, Queensland Public Advocate, 'Are we regulating or regularising aged care restrictive practices?' *Australian Ageing Agenda*, 14 December 2022.

38 Committee on the Rights of Persons with Disabilities, *Concluding observations on the combined second and third periodic reports of Australia*, CRPD/C/AUS/CO/2-3 (2019) [30(b)].

39 UN Committee on the Rights of Persons with Disabilities, *Guidelines on the right to liberty and security of persons with disabilities*, A/72/55 (2017) [12]. The Committee called on States parties to 'to protect the security and personal integrity of persons with disabilities who are deprived of their liberty, including by eliminating the use of forced treatment, seclusion and various methods of restraint in medical facilities, including physical, chemical and mechanical restraints. The Committee has found that those practices are not consistent with the prohibition of torture and other cruel, inhuman or degrading treatment or punishment of persons with disabilities, pursuant to article 15 of the Convention'.

supported, rather than substitute, decision-making, this instrument does not appear to be compatible with the rights of persons with disability.

1.28 Finally, this instrument provides that the persons or bodies listed in the instrument are specified for the purposes of immunity from civil and criminal liability. The minister advised that this listing will instil confidence in approved providers to rely on the Principles without fear of prosecution, provided they follow all of the legislative requirements. The minister advised that the immunity does not prevent approved providers or their staff from potentially being charged with a criminal offence or a civil claim being brought in negligence where the use of the restrictive practice was not in accordance with the legislative requirements. However, if the restrictive practice was used in accordance with legislative requirements, but nonetheless the care recipient or their family wanted to commence civil action in relation to the use of the restrictive practices, the amendments to the legislation[40] mean they would be unable to, as providers and their staff are immune from any civil or criminal liability in relation to the use of the practice, once the consent is given. The measure thus differentially treats care recipients on the basis of disability by only granting immunity from liability for the use of a restrictive practice on a person who is deemed to lack capacity to consent, whereas those care recipients who are deemed to have capacity to consent are afforded greater protection under the law. In this way, the measure limits the right to both equality *before* the law and equality *under* the law.[41] This differential treatment limits the rights of persons with disabilities to be treated equally and the right to effective access to justice for persons with disabilities on an equal basis with others. Furthermore, by denying care recipients who are deemed to lack capacity the ability to pursue a remedy for any violation of their human rights arising from the use of restrictive practices, the measure has implications on the right to an effective remedy. This instrument in listing the persons from whom informed consent may be granted for the purposes of the immunity has the same human rights concerns as that applicable to the recent amendments to the primary legislation. As such, this instrument does not appear to be compatible with a range of human rights, particularly the rights of persons with disabilities.

---

40 Aged Care Act 1997, section 54-11 as introduced by the *Aged Care and Other Legislation Amendment (Royal Commission Response No. 2) Act 2022*.

41 Convention on the Rights of Persons with Disabilities, article 5(1). See Committee on the Rights of Persons with Disabilities, *General comment No. 6 (2018) on equality and non-discrimination* (2018) at [14] where the Committee explained: '"Equality under the law" is unique to the Convention. It refers to the possibility to engage in legal relationships. While equality before the law refers to the right to be protected by the law, equality under the law refers to the right to use the law for personal benefit. Persons with disabilities have the right to be effectively protected and to positively engage…Thus, the recognition that all persons with disabilities are equal under the law means that there should be no laws that allow for specific denial, restriction or limitation of the rights of persons with disabilities, and that disability should be mainstreamed in all legislation and policies'.

Committee view

1.29 The committee thanks the minister for this response. The committee notes that the use of restrictive practices on persons in aged care raises significant human rights issues, as previously considered by the committee, particularly in its 2019 inquiry into restrictive practices legislation.[42] Significant safeguards have been introduced in recent years in response to these human rights concerns that seek to ensure that restrictive practices are only used: as a last resort; to prevent harm; only to the extent necessary; only in proportion to the risk of harm to the care recipient and others; in the least restrictive form and for the shortest time necessary. These greatly assist in the compatibility of the use of restrictive practices. However, given the potential significant interference with the rights of extremely vulnerable people in aged care, it is essential that the safeguards that apply are effective in practice and sufficiently robust to ensure the use of restrictive practices does not amount to cruel, inhuman or degrading treatment, an arbitrary deprivation of liberty or an arbitrary interference with privacy. Further, for those in aged care with a disability, such as persons with cognitive impairment, it is essential that the rights under the Convention on the Rights of Persons with Disabilities are respected. Measures relating to the exercise of legal capacity must respect the rights, will and preferences of the person, be free of conflict of interest and undue influence, be proportional and tailored to the person's circumstances, apply for the shortest time possible and be subject to regular review by an independent and impartial body.[43]

1.30 The committee acknowledges the minister's advice that this instrument seeks to resolve issues raised by some jurisdictions about who can consent to the use of a restrictive practice, is not intended to override state and territory laws and is intended as an interim arrangement until state and territory guardianship and consent laws can be amended, or until 1 December 2024. The committee also notes the advice provided by the Department of Health and Aged Care that 'it is a matter for states and territories to ensure that their laws, including their laws that allow for the appointment of a person or body to give consent to the use of a restrictive practice, is consistent with the United Nations Convention on the Rights of Persons with Disabilities'. The committee welcomes the advice that the Department, on behalf of the Commonwealth, is continuing to encourage states and territories to ensure their legislation is consistent with the Convention.

1.31 However, the committee notes that it is the Commonwealth, as the nation state, that is answerable at the international level for any failure to fulfil the obligations in the core human rights treaties, whether this is the result of the acts or

42 Parliamentary Joint Committee on Human Rights, *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (13 November 2019). See also most recently Parliamentary Joint Committee on Human Rights, *Report 1 of 2022* (9 February 2022) pp. 23–39.

43 Convention on the Rights of Persons with Disabilities, article 12(4). See also article 17.

omissions of the Commonwealth, or of a state or territory. The committee further notes that its mandate is to assess the compatibility of Commonwealth legislation with Australia's international human rights obligations, and as such this committee is required to consider whether the consent arrangements for the use of restrictive practices are compatible with these human rights. However, as much of the detail is left to the states and territories, it is difficult for the committee to fully assess this – a problem that becomes even greater in December 2024 when the instrument reverts the consent arrangements to be those solely applicable under state and territory law.

1.32 The committee is also concerned that the consent arrangements in this instrument are highly complex and much depends on aged care providers understanding the complex hierarchy and understanding the interplay between this legislation and relevant state and territory laws. The committee thanks the Queensland Public Advocate, Dr John Chesterman, who provided a private briefing to the committee in relation to his concerns with this instrument, and more broadly with whether consent is the best model to use in the context of restrictive practices.[44]

1.33 Noting the significance of the rights that are limited by enabling substitute decision-makers to consent to the use of restrictive practices on persons in aged care and the vulnerability of those affected by the measure, the committee considers it is essential to ensure that this instrument does not set out a process that could risk being incompatible with human rights.

1.34 The committee considers this instrument risks being incompatible with a range of human rights, particularly the rights of persons with disability, noting that there is no requirement to provide for supported, rather than substitute, decision-making; much depends on unknown safeguards in state and territory legislation; there is some uncertainty for providers as to the applicable law in their jurisdiction; and there is a broad-ranging immunity from liability. The committee also notes that there may be a risk that in simplifying consent arrangements, this instrument has the effect of facilitating the use of restrictive practices, which is inconsistent with Australia's obligation to minimise, and ultimately eliminate, the use of restrictive practices.

1.35 The committee considers its concerns regarding the use of restrictive practices generally,[45] as well as the substituted decision-making model for consent to the use of restrictive practices in aged care, are broader than what is set out in this instrument.

---

44 Private briefing on 8 March 2023. See also Dr John Chesterman, Queensland Public Advocate, 'Are we regulating or regularising aged care restrictive practices?' *Australian Ageing Agenda*, 14 December 2022.

45 As outlined in previous reports, e.g. Parliamentary Joint Committee on Human Rights, National Disability Insurance Scheme (Restrictive Practice and Behaviour Support) Rules 2018 [F2018L00632], *Reports 7 of 2018* (14 August 2018); *9 of 2018* (11 September 2018); and *13 of 2018* (4 December 2018); *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 Report* (13 November 2019).

As such, the committee considers steps should continue to be taken towards implementing more substantial reforms with respect to the broader legislative scheme in which this instrument operates, particularly replacing substitute decision-making with supported decision-making. The committee also notes concerns, such as those raised by Dr Chesterman, with the consent model in the context of restrictive practices. In light of these concerns, the committee considers that further consideration should also be given to whether the consent model to the use of restrictive practices is the best approach to protect the rights of aged care residents.

Suggested action

1.36 The committee considers the legislative instrument may be somewhat clarified if it were amended to:

(a) set out a process of who may give informed consent in the event that an application has been made to appoint a person to give consent but there is a significant delay in deciding the application; and

(b) define what constitutes a 'significant delay' and explain when there is no 'clear mechanism for appointing such an individual or body under the law of the State or Territory'.[46]

1.37 The committee recommends that the minister and Department of Health and Ageing undertake extensive consultation with relevant stakeholders to consider whether:

(a) there is sufficient and nationally consistent guidance readily available to aged care providers and workers to support them in undertaking an assessment of whether an aged care resident has the capacity to provide informed consent;

(b) the model of seeking consent to the use of all forms of restrictive practices, that do not relate to medical treatment, is the most appropriate way to protect residents' rights, and whether it would be more appropriate to differentiate between different forms of restraint (such as in the NDIS rules);

(c) the issue of who may provide informed consent is best left to the states and territories, or whether there would be benefit in the Commonwealth adopting a uniform 'best practice' approach to this issue;

46 See paragraphs 5B(2)(b)(i) and (ii) of the Quality of Care Principles 20114 (as inserted by this instrument).

(d) whether all state and territory legislation on the issue of who can provide informed consent is compliant with the UN Convention on the Rights of Persons with Disabilities; and

(e) there is effective oversight and monitoring of substitute decision-makers.

1.38 The committee considers the issue of substituted consent to the use of restrictive practices in aged care raises significant human rights and policy concerns that are broader than the issues raised in this legislative instrument. It considers it would be useful to have a broad ranging inquiry to consider the issues raised by this committee and others. The Parliament may wish to consider referring this issue to a relevant policy committee to consider this important matter further.

1.39 The committee recommends that the statement of compatibility be updated to reflect the information provided by the minister.

1.40 The committee draws these human rights concerns to the attention of the minister and the Parliament.

Mr Josh Burns MP

Chair