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Dear Ministers,

Re: Exposure Draft Aged Care Bill

We refer to our letter of the 4th February 2024. We acknowledge the release of the very recent exposure draft of the Aged Care Bill (A Bill for an Act about aged care, and for related purposes.)

Our discussion on the exposure draft Bill does not replace the questions and issues raised in our previous letter, which awaits your response, and which has also been the subject of ongoing communications with the State Government and Labor MPs. What follows is a consideration of the issues arising from the architecture of the draft Bill.

1. **Incomplete regulation of Restrictive Practices in proposed Bill**

It is noted that the proposed system for regulating restrictive practices in the draft bill is incomplete. Without completion of the "rules," it is very difficult to assess the extent to which unnecessary and inappropriate use of restrictive practices will be checked. We agree with the points outlined in item 21 of the *Key Issues Paper* of the national organisations working with older people and carers - *Better protections for older people on the use of Restrictive Practices:*

> "The labelling of restrictive practices as a last resort is insufficient to protect older people and ensure that they are protected from their use."

The starting point should be a position consistent with the human rights focus namely that there be no restrictive practices. Insufficient control is exercised by the simple exhortation that such practices are a last resort, and the remainder of the mantra that, "it is used in the least restrictive form … the shortest time …necessary to prevent harm to the individual or other persons" with the additional clause missing, to be "proportional to the risk of not undertaking these practices."

2. **Rigorous control of medicines that may adversely affect functioning and quality of life**

Another suggestion in item 21 of the *Key Issues Paper* is questioned, viz:

> There needs to be clarification of the difference in using anti-psychotic medicines to treat mental health conditions and/or psychiatric symptoms that may manifest in dementia, and its use as a restrictive practice. When used appropriately for diagnosed mental illnesses, antipsychotic medications can benefit people. However, where they are inappropriately used as a chemical restraint, they can cause significant harm.

The dichotomy in the use of antipsychotic medications, for 'diagnosed mental illnesses' and as a restrictive practice, is questioned in the light of the *21st March 2022, Joint Statement on the Inappropriate Use of Psychotropic Medicines to Manage the Behaviours of People with Disability and Older People,* by the Aged Care Quality and Safety Commission (ACQSC), the NDIS Quality and Safeguards Commission (NDIS Commission) and the Australian Commission on Safety and Quality in Health Care (ACSQHC). The Commissions noted that whilst there was "*little evidence that psychotropic medicines are effective for managing behaviours of concern" there was "evidence that psychotropic medicines can diminish the wellbeing and quality of life of older people and people with disability."* These adverse outcomes can impact on quality of life and human rights of those individuals by increasing risk of falls, weight gain, hypertension and diabetes, by adversely affecting the person's ability to swallow, and by increasing the risk of aspiration pneumonia and other respiratory complications. Accordingly, we support the broad classification of medicines that may impact on a person's cognitive and physical capacity, as needing to be subject to rigorous review and assessment when prescribed for a person receiving aged care. We are very mindful of the extent to which an older

person experiencing cognitive decline may be significantly impacted by a range of medications both physically and mentally including onset of disorientation and delirium. Accordingly, we strongly disagree that a medical practitioner's assessment and "consent" should remove any matter from the definition of a restrictive practice requiring review via an authorisation process.

3. Informed Consent

The notion of "informed consent" in the present "interim arrangements," and continuing in the draft bill, as the mechanism for regulating restrictive practices, is nonsensical and should not be a foundation principle to exercise control over restrictive practices.

We note the exposure draft bill makes clear that restrictive practices may only occur "to the extent that it is necessary and in proportion to the risk of harm to the individual or other persons" s17(1)(d) and by "informed consent" given to the use of a restrictive practice in relation to the individual. S17(1)(f) The way this "informed consent" may operate is to be outlined in rules to "make provision for, or in relation to, the persons or bodies who may give informed consent to the use of a restrictive practice … if that individual lacks capacity to give that consent" s17(2) We assume the existing "interim arrangements for consent" are back in focus along with the role of the States. We note and applaud the change in s27(2) that a representative cannot give consent to a restrictive practice. It is less clear about the role of the guardian in s28.

Reference to the concept of "informed consent" continues to be problematic and somewhat nonsensical without

1. a clear explanation of how a consent may be "informed," including how it may be freely given, with the recipient and/or family in the hands of the provider delivering the services, and
2. clarification of the confusion surrounding the meaning of "consent" versus "authorisation" and "court ordered decisions."

4. Rules and Penalties

The Rules in s413 do not specify how a scheme may operate and so the referral to the rules in s106 is the only link. The scope of the Rules is, however, limited in their scope by the provision that the rules "may not create an offense or civil penalty" or provide for "entry, search or seizure."

Elsewhere in the proposed Bill there are sanctions against the providers but remain unspecified for restrictive practices other than the statement in s106 that the provider "must comply with any requirements prescribed by the rules relating to the use of restrictive practices." How may this be adjudicated with proper rigour given the vague permission given to restrictive practices "necessary in an emergency" referred to in s 27(3)

An understanding arising in guardianship law, mental health legislation and operation of NDIS in South Australia, would indicate that only State laws, court orders or an authorisation system, may restrict a person's freedoms outside the criminal justice system.

We note the Statement of Rights and Statement of Principles. We assume that these rights and principles are intended to underpin the operation of the aged care system by informing how:

a) the services are delivered by providers, and
b) the activities and operation of the various statutory entities will regulate, administer, monitor and enforce system requirements.

By definition, restrictive practices are at variance to an individual's rights. We wonder about the Statement of Rights of the individual and the provision of s21(3) asserting that the "rights and duties" specified are not "enforceable by proceedings in a court or tribunal." Our concern is the unintended consequence of giving the provider extra comfort that actions that conceivably, at present constitute a criminal act, may be given some protection under this provision. It would be interesting to see what a court may make of the situation. This provision continues recent amendments to the present act where a protection from criminal liability was inserted in the legislation. On the 5th August 2022, the Aged Care and Other Legislation Amendment (Royal Commission Response) Bill 2022 was passed which included "immunity from civil or criminal liability in relation to the use of a restrictive practice in certain circumstances." The Minister at the time explained that it was a necessary adjunct to the "interim

consent arrangements" in place until amendments were undertaken to State and Territory laws. Criticism was raised at the time by a number of groups, including Australian Lawyers Alliance, that this immunity for aged care providers would strip elders of legal rights.

5. **Interplay between Commonwealth regulation and quality control of Providers and the States regulation of Restrictive Practices**

The essential interplay between the role of the Commonwealth regulating providers and the State role arising from guardianship and associated matters, indicates the States are the only jurisdiction presently able to regulate restrictive practices. By a robust and forensically reviewed system of authorisation, State regulation to restrict the use of restrictive practices, offers the best hope that such practices will truly be a last resort and proportionate to the risk of harm to the individual or others. As stated in the letter of 4th February, a State system of authorisation must contain the following elements:

- featuring a very robust and independent modus operandi,
- challenging the necessity of restrictive practices,
- pointing to alternatives,
- ensuring conflicts of interest are not allowed to operate,
- ensuring appeal rights are fully supported enabling individuals, their families, friends, approved visitors, advocacy bodies, and a nominated entity etc, to challenge any decision to authorise restrictive practices and therefore to further guarantee human rights of individuals are upheld, and
- forensically monitoring and examining the outcomes of the authorisation system checking the numbers to ensure in each case the use of restrictive practices is indeed necessary, unavoidable and the very last resort.

The SA NDIS system of authorisation contains Commonwealth behaviour support practitioners and behaviour support plans, State authorised program officers who are employees of the provider, and the State senior authorising officer. The success of such a system needs to be evaluated for its effectiveness in ensuring that restrictive practices are always meeting the 'last resort mantra' and the six elements listed above. We look forward to a review of its operation to see if as it is presently constituted it is meeting the 'last resort mantra'. The sort of questions to uncover the efficacy of the authorisation process as it is presently constituted in the NDIS should address a range of issues including those framed in the questions below. If the model proves to be OK, it should be determined whether further refinement will enhance its success and more successfully address issues including those contained in the following questions:

> Even with the existence of the best possible guidelines, quality care principles, and education and training, would not the level of resourcing and financial self-interest of providers also potentially intervene in restrictive practice considerations?
>
> Do institutions recognise, understand and accept that the manner of structuring and delivering care may exacerbate or trigger the necessity to use restrictive practices?
>
> Are care management approaches and manner of service delivery carefully considered and tailored for each individual to mitigate or avoid the need to use restrictive practices?
>
> Does the structuring and cost effectiveness of the delivery of care services in institutional settings, or by agency care providers, sometimes dictate or override the vigorous hunt for alternative strategies to care management that are free from restrictive practices?

A disaster, and a shirking of State responsibility, would be the development of a sub-optimal system that allowed restrictive practices without the most rigorous assessment of alternatives, and which did not operate to fully support the paradigm shift described above.

What remains clear is the likely need for a dual harmonised system, with the Commonwealth responsible for the best possible aged care system via its regulation of the providers, and with the States via its laws ensuring the human rights of its citizens in aged care facilities are protected.

6. **Delays!**

The Commonwealth's actions in trying to implement a system providing a human rights focus for aged care service delivery, without realising at the same time harmonisation with mechanisms that only the States can provide, will result in a sub-optimal system of human rights protections. We agree with the authors of the Key Issues Paper that "older people have waited too long for their rights to be upheld" and that "Albanese Government committed to the Act's commencement in this term as one of its key election pillars." Where we disagree, is a new aged care act implemented by the Commonwealth in (say) July of this year, that does not contain the above six elements implemented under State law, will still constitute a failure of the Commonwealth following the recommendations of the Royal Commission. One cannot talk about a human rights focus if restrictive practices are not also rigorously controlled. If the Commonwealth does not secure a system guaranteeing the human rights protections of aged care residents, by harmonising legislation with State laws, an incomplete system will constitute a breach of its promise. Recommendation 17 of the Royal Commission, amendments to the present Act since the Royal Commission, and the "interim consent arrangements," in place until the States amend their laws or by 1st December, have all been pointed to in our ongoing argument with the South Australian Government that the wording has always indicated the need for appropriate State laws to complement the Commonwealth's regulation and licencing of providers. We have sought clarification since the Royal Commission on what the State is doing without success. Without any indication otherwise, it is our suspicion that despite the Commonwealth's statements for the need for state amending legislation and our contention that an authorisation system is required to regulate and therefore control restrictive practices, the State is continuing to sit back waiting for the Commonwealth to complete each step. It has chosen to take no action even though action by the SA government can occur and is required to implement the robust and independent system of authorisation. We look forward to being surprised in this Parliamentary year. Otherwise, the State Government will face its final year before an election not doing all it can for older South Australians.

In the meantime, tens of thousands of residents have passed through South Australia's aged care residential facilities without maximum protections for their human rights. There has been sufficient time for the States and Federal Government to prioritise harmonising their laws in protecting this very vulnerable group of citizens in the final chapter of their life. Whilst we hold the State Government responsible for the absence of these protections being developed, which was in no way prevented by the actions and programme of the Commonwealth to date, the Commonwealth must still accept without appropriate State law there will be further 'interim consent arrangements' that will mean an effective human rights-based system in the aged care sector will still not have been delivered

Yours sincerely,

Professor Richard Bruggemann
Disability advocate, SA Senior Australian of the Year 2021

JOHN DARLEY
Hon John Darley OAM, Former MLC

Ted Lee
17 February 2024

cc. South Australian Attorney-General and Chief of Staff to the Attorney-General