THE LAW SOCIETY
OF NEW SOUTH WALES

Our ref: ELCSC:JvdPsh090922

9 September 2022

Dr James Popple
Chief Executive Officer
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By email: matthew.wood@lawcouncil.asn.au

Dear Dr Popple,

Quality of Care Amendment (Restrictive Practices) Principles 2022

Thank you for the opportunity to contribute to a Law Council submission on the exposure draft *Quality of Care Amendment (Restrictive Practices) Principles 2022* (**Exposure Draft**). The Law Society's Elder Law, Capacity & Succession Committee contributed to this submission.

We note that, pursuant to the recent amendments to the *Aged Care Act 1997* (Cth) (**Act**), the Exposure Draft amends the *Quality of Care Principles 2014* (Cth) to provide a hierarchy of substitute decision-makers which will determine who may consent to the use of restrictive practices with respect to an aged care recipient who lacks capacity to consent themselves, and which applies in the absence of a specific state or territory consent regime.

As a general comment, we have significant concerns that the Principles bring a range of uncertainties and impracticalities to the process for consenting to restrictive practices, which expose the recipient of care to risk of harm and the provider to risk of liability (despite the immunity provisions in the Act).

In our view, the proposed hierarchy for determining a restrictive practices substitute decision-maker (hierarchy) has substantial flaws.

We understand the term restrictive practices authority to refer to a natural person or body (such as the NSW Trustee and Guardian) who is authorised to give consent to restrictive practices by a court or tribunal in the relevant state or territory. We consider it appropriate that such a person or body is placed first in the hierarchy.

However, we do not support the provision in Item 1, clause (d) in Column 2 in the Table to s 5B (**Table**), which proposes that where there are two or more restrictive practices authorities and the state or territory law does not provide for "the order of precedence of the restrictive practices authorities", the elder of those individuals is deemed to be the restrictive practices authority. The elder person will not necessarily be the most appropriate decision-maker as regards the best interests of the care recipient. Moreover, the rationale for mandating that there be only one person who can act as the restrictive practices decision-maker is unclear. Item 1, clause (d) in Column 2 to the Table appears to purport to override orders made by the Supreme Court of NSW or NCAT appointing two or more individuals to act as guardian for the

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care recipient, with authority to consent to the use of restrictive practices, on a joint or several basis. This is likely to lead to uncertainty and confusion.

We note that in NSW, Item 1, cl (c)(iii) in Column 2 of the Table would be superfluous, as s 16(3) of the Guardianship Act does not permit NCAT to make a guardianship order and to appoint the NSW Trustee and Guardian and an individual as "joint guardians".

We do not support the inclusion of Items (3), (4) and (5) of the Table which provide that the decision-maker may be a partner with whom the care recipient has a close continuing relationship, a relative or friend who was a carer for the care recipient, and a relative or friend with a personal interest in the care recipient's welfare on an unpaid basis.

There are several difficulties with these provisions.

First, they would operate to automatically appoint a person who falls within Items (3), (4) and (5) as the restrictive practices decision-maker (assuming there is no person above that person in the hierarchy), irrespective of the views of the care recipient, or whether the person has been found by a court or tribunal to be unsuitable to act as guardian for the care recipient. A court or tribunal may have made adverse findings about a person who falls within Items (3), (4) and (5), for example, that they had perpetrated elder abuse against the care recipient, or were unsuitable to act as guardian for the care recipient for some other reason.

Second, the Table provides no guidance on who is to determine whether the person said to fall within Items (3), (4) or (5) satisfies the pre-condition for appointment specified by the Table nor how any dispute between parties is to be resolved. For example, there may be a factual dispute about whether a former spouse or carer has a "close and continuing relationship" with the care recipient (Items 3 and 4), whether the proposed relative or friend has a "close and continuing relationship" with the care recipient, or whether that person is the eldest relative or friend with such a relationship with the care recipient.

Third, in practice the provisions would operate to impose an onus on the provider's staff to make these assessments, which may be difficult and which may expose the provider to undue risk.

In our view, it is appropriate to place a restrictive practices nominee second in the hierarchy. However, our reading of s 5A is that a restrictive practices nominee is defined as a person who has been nominated by the care recipient (at a time when they have capacity), in writing in accordance with the section, specifically to consent to restrictive practices, and has accepted that appointment. This would seem to ignore the role of an enduring guardian appointed by the care recipient under the relevant state or territory legislation where the appointing instrument includes a restrictive practices function. In our view, where state or territory legislation provides for such an appointment (as it does in NSW), and where the enduring guardian has accepted the appointment, that person should constitute the restrictive practices nominee. In those circumstances, the performance of the restrictive practices function would be subject to the oversight of the relevant state or territory tribunal, so that an application could be made to the tribunal to review the enduring guardian appointment if there were concerns about its misuse.

We note that the Principles are generally intended to operate only to the extent that there are no specific state and territory provisions in place. If it is intended that an enduring guardian appointed under state or territory legislation would be the restrictive practices nominee, this is not clear in the Exposure Draft.

Subsection 5A(4) appears to make provision for decision-making where more than one person is appointed in writing under the Principles. Again, this would seem to override state or territory

provisions for joint or several decision-making where more than one enduring guardian is appointed. If the subsection is intended to apply to nominees under the Principles, we suggest there should be provision for either joint or several nominees. In many cases a nominee may be more confident accepting the nomination if they are not the sole nominee. Where joint nominees disagree, an application could be made to the tribunal to resolve the matter.

As an interim measure, we do not object to the inclusion of a medical treatment authority in the hierarchy of restrictive practices substitute decision-maker. We acknowledge that consenting to medical treatment raises different considerations to consenting to restrictive practices. In the experience of practitioners, medical treatment is most often required for short discrete periods, whereas restrictive practices are often required on an ongoing basis, particularly as regards persons with disability. Additionally, restrictive practices can have a more significant impact on the recipient's personal liberty, dignity and autonomy. However, on balance, the fact that the medical treatment authority has judicial oversight confers a degree of confidence in the suitability to consent to restrictive practices.

We do not support proposed s 15GC, which imposes responsibilities relating to nominations made under s 5A on the provider. It would be unreasonable to require the provider to ensure a care recipient nominating a substitute decision-maker is not subject to coercion or duress, given that in practice it would often be difficult for staff at a facility to identify or assess such behaviours. It would also be impractical to impose a duty to assist the care recipient to notify the nominee and provide a copy of the nomination. Our experience is that the many care recipients, particularly at the stage where restrictive practices are being contemplated, will have impaired capacity, and it is unreasonable to expect a provider to undertake such role if the care recipient's capacity is in question. In our view, this is unsatisfactory as an interim arrangement.

If you have any further questions in relation to this letter, please contact Sue Hunt, Principal Policy Lawyer on (02) 9926 0218 or by email: sue.hunt@lawsociety.com.au.

Yours sincerely,

Joanne van der Plaat
President