The Law Society OF NEW SOUTH WALES

Our ref: ELCS/HRC/IIC:RMsb100426

10 April 2026

Dr James Popple
Chief Executive Officer
Law Council of Australia
PO Box 5350
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By e-mail: janina.richert@lawcouncil.au; adam.fletcher@lawcouncil.au

Dear Dr Popple,

DEVELOPMENT OF AN INTERNATIONAL LEGALLY BINDING INSTRUMENT ON THE HUMAN RIGHTS OF OLDER PERSONS

The Law Society is grateful for the opportunity to inform the Law Council's submission to the consultation by the United Nations Office of the High Commissioner for Human Rights' (**OHCHR**) Intergovernmental Working Group (**IGWG**) regarding the development of an international legally binding instrument on the promotion and protection of the human rights of older persons. The Law Society's Elder Law, Capacity and Succession, Indigenous Issues and Human Rights Committees contributed to this submission.

The Law Society supports the development of a Convention on the Rights of Older Persons (**Convention**). We suggest that the standards prescribed by the United Nations Principles for Older Persons, which emphasise independence, participation, care, self-fulfilment and dignity would also form important foundational pillars of the Convention.[1] Further, we support grounding the Convention by reference to the rights and freedoms contained in the Universal Declaration of Human Rights and the following international instruments:

- International Covenant on Civil and Political Rights;
- International Covenant on Economic, Social and Cultural Rights;
- International Convention on the Elimination of All Forms of Racial Discrimination;
- United Nations Convention on the Rights of Persons with Disabilities (**CRPD**);
- United Nations Declaration on the Rights of Indigenous Peoples;
- Convention on the Elimination of All Forms of Discrimination against Women (**CEDAW**); and
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.[2]

[1] United Nations Human Rights Office of the High Commissioner, *United Nations Principles for Older Persons*, OHCHR, United Nations, 1991.
[2] See as follows: *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976); *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 999 UNTS 3 (entered into force 3 January 1976), *International Convention on the Elimination of All Forms of Racial Discrimination*, opened for signature 1965, 660 UNTS 195 (entered into force 1965), *United Nations Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, A/RES/61/106 (entered into force 3 May 2008), *United Nations Declaration on the Rights of Indigenous Peoples*, GA Res 61/295, UN Doc A/RES/61/295 (2 October 2007); *Convention on the Elimination of All Forms of Discrimination Against Women*, opened for signature 20 November 1989, (entry into force 2 September 1990*), Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 10 December 1948, 1465 UNTS 85 (entered into force 26 June 1987).

We suggest that this approach would help to situate the Convention within the existing international human rights landscape and appropriately recognise the compounded challenges faced by older people with a range of protected attributes.

As noted in our submission in 2020 to the Law Council, we consider that older persons face unique challenges which are not fully accounted for within the current international human rights framework.[3] The United Nation's Open-ended Working Group on Ageing identified gaps which span across and intersect with various political and social, economic and cultural rights found in relevant international instruments. These include the issues of equality and non-discrimination; violence, neglect and abuse; autonomy and independence; access to justice; and the right to work.[4]

The establishment of a convention is only one measure in the broader legal architecture to promote, protect and recognise the rights of older persons. Such instruments are nevertheless important for their promotion of globally recognised normative standards. They also can be used to strengthen the case for domestic law reform. We note, for example, that advocacy in relation to the development of state and Commonwealth anti-discrimination and human rights laws are regularly supported by reference to unifying international instruments to which Australia is a signatory such as CEDAW and CRPD.

Definition of 'older persons'

Older persons are a diverse group within society. We suggest that it is important for the IGWG, to the extent that it is not already alive to this issue, to appreciate the particular vulnerabilities of certain groups in terms of physical and mental health problems, which impact their life expectancy. In Australia, for example, there is a higher mortality rate and lower life expectancy of Aboriginal and Torres Strait Islander people.[5] As a result, it may be that simply defining older people by age alone (e.g., persons over 65) fails to be an inclusive definition across different populations within countries like Australia, as well as globally.

Current and emerging issues in relation to the rights of older persons in Australia

Given that this is a global consultation process, we consider that it may be most helpful for any submission made by the Law Council to reference current and emerging areas in the Australian context which raise issues that could inform the Convention, particularly in respect of addressing gaps in existing rights for older persons where further normative development is required. In this respect, we draw your attention to the following issues of relevance arising for our members in the context of legal practice:

Participation in decision-making processes

In our view, it is critical that the Convention emphasise older peoples' participation in all decision-making processes, including, but not limited to, healthcare, housing and employment.

We note that participation in decision-making processes can intersect with the concept of supported decision-making, which is addressed in the CRPD to which Australia became a signatory in 2009. We refer to our recent submission to the NSW Parliamentary Committee on Ageing and Disability's inquiry on this issue (attached),

[3] The Law Society of New South Wales, 'Proposed Convention on the Rights of Older Persons', letter to the Law Council of Australia dated 11 March 2020.
[4] United Nations, Report of the Open-Ended Intergovernmental Working Group on Transnational Corporations and Other Business Enterprises with Respect to Human Rights, UN Doc A/AC.278/2024/2 (2024) [20].
[5] Australian Bureau of Statistics, *Aboriginal and Torres Strait Islander Life Expectancy, 2020–2022* (29 November 2023): https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/aboriginal-and-torres-strait-islander-life-expectancy/latest-release.

which noted our preference for the introduction of a legislative framework in NSW for supported decision-making with a focus on enabling people to exercise their autonomy, including with respect to legal decision making.

We recognise that substitute decision-making arrangements are sometimes necessary as a last resort. We suggest the Convention should address the situation where an older person lacks capacity, including legal capacity, to undertake certain tasks e.g., to sign a contract to enter an aged care facility. In this case, the right to substitute decision-making when required within a reasonable timeframe is appropriate.

The Convention would therefore need to give expression to the concept of supported decision-making and, in limited circumstances, substitute decision making. At the same time, we consider that it should clearly acknowledge that the simple fact of a person being 'older' or of having a diagnosis of a neurological disorder such as dementia in and of itself should not diminish the person's agency to participate in decision-making processes (i.e., there must always be a baseline presumption of autonomy and legal capacity). While rights to autonomy may present with some risk to a person, for example in relation to their health or finances, we suggest that it is important for the Convention to foreground dignity of risk, a concept that is increasingly well-recognised, for example in relation to persons with disabilities.[6]

Further, we note that it would be important for the Convention to cover both decision-making by older people about their own lives as well as a wider concept of social decision-making, including the ability to participate in civil and political life.

Protecting against elder abuse

We suggest that the Convention should directly address the right of older people to live a life free of physical, psychological, financial and sexual abuse and any other form of exploitation. We note that elder abuse often occurs within intimate or familial relationships where there is an expectation of trust which is undermined. It may be useful to draw the IGWG's attention to the Australian Government's *National Plan to End the Abuse and Mistreatment of Older People 2026-2036*.[7] This document contains key focus areas, including whole-of-community awareness, education and engagement, improved laws and systems and capacity building, which could usefully inform discussion on the contents of the Convention.

Ensuring the safety and wellbeing of older persons receiving care

The Royal Commission in Aged Care Quality and Safety drew attention to abusive practices within the aged care system, including physical abuse, sexual abuse and the use of restrictive practices, which were not effectively prevented by the existing regulatory and reporting environment.[8] We suggest that it would be essential for the Convention to foreground the safety, integrity, health and wellbeing of older persons receiving care in light of the prevalence of abuse and neglect.

Given the vulnerabilities of persons receiving care (whether that be through relatives, at home, in a hospital, or in a residential care facility), the Convention should emphasise the following rights recommended by the Royal Commission (in the context of its recommendations around the principles to underpin the development of a new legislative regime for aged care):

- the right to freedom from degrading or inhumane treatment, or any form of abuse.
- the right to liberty, freedom of movement, and freedom from restraint.

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[6] NSW Department of Communities and Justice, "Dignity of risk": https://dcj.nsw.gov.au/resources/capacity-toolkit/decision-making-and-capacity-module/chapter-4-risk-is-part-of-decision-making/dignity-of-risk.html#:~:text=His%20family%20noticed%20that%20he,which%20involves%20risk%20from%20them.
[7] Australian Attorney-General's Department, *National Plan to End the Abuse and Mistreatment of Older People 2026-2036*: https://www.ag.gov.au/sites/default/files/2026-03/national-plan-to-end-abuse-mistreatment-of-older-people-2026-2036.PDF.
[8] See Royal Commission into Aged Care Quality and Safety, *Final Report*, *Volume 2*, 26 February 2021 at [3.3.1].

- the right of autonomy and the presumption of legal capacity, and in particular the right to make decisions about their care and the quality of their lives and the right to social participation.
- the right to fair, equitable and non-discriminatory treatment in receiving care.
- the right to voice opinions and make complaints.[9]

We note that particular guidance on the right to freedom from restraint would be important, given the ongoing use of restrictive practices used in aged care contexts, including chemical and physical restraint and locked/seclusion areas. We have noted the need for this in the context of recent consultations on restrictive practices: See, for example, our 2025 submission to the NSW Department of Communities and Justice (attached), which recorded our concerns around a proposed reduction in consent requirements in respect of restrictive practices.

Ageism and discrimination

We consider that ageism and discrimination is an important issue to be foregrounded in the Convention, including in relation to workforce participation. We note, for example, the 2025 national survey of employers and human resources (**HR**) professionals conducted by the Australian HR Institute and the Australian Human Rights Commission found that one in four employers consider workers in their 50s to be 'old' and are reluctant to hire people over 50 despite skills shortages.[10] We suggest that it would be important for the Convention to take account not only of the fact of ageism and aged-based discrimination, but also its downstream impacts such as economic disadvantage, health problems, social exclusion and homelessness.

Access to safe, secure and suitable housing

It will be important to ensure that the Convention emphasises the need for older people to access safe, secure and suitable housing. While other conventions address this issue in broad terms, we consider it necessary for the Convention to address the particular risks faced by older persons experiencing or at risk of homelessness. In Australia, this risk is exacerbated for older women, on account of the high cost of housing and the wealth accumulation gap between men and women. Further, we note the concerning trend whereby elderly patients, who are ready for discharge, remain in hospitals for extensive periods of time as they are unable to access aged care facilities or at-home support.[11]

Thank you for the opportunity to comment. Questions at first instance may be directed to Sophie Bathurst, A/g Head of Commercial and Advisory Law Reform, at (02) 9926 0285 or Sophie.Bathurst@lawsociety.com.au.

Yours sincerely,

Ronan MacSweeney
President

Attachment

[9] Royal Commission into Aged Care Quality and Safety, *Final Report*, *Recommendations*, 26 February 2021, Recommendation 2(b).
[10] Australian HR Institute and the Australian Human Rights Commission, 'Older and Younger Workers – What do employers think?', July 2025.
[11] See NSW Advisory Council on Ageing (MACA), *Position Paper: Hospital Bed Blockage and Aged Care Shortages: Impact on Older People* (2025) 2, which noted that 'across NSW there were 1,158 patients in hospital waiting for a NDIS package or an aged care bed at the end of June 2024…The average patient ready for discharge spent more than 48 days in hospital when they could have been more appropriately housed in residential aged care or supported at home with home care': https://dcj.nsw.gov.au/content/dam/dcj/dcj-website/documents/community-inclusion/advisory-councils/maca/maca-hospital-bed-blockages-and-aged-care-shortagages-impact-on-older-people.docx.

The Law Society OF NEW SOUTH WALES

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19 March 2026

Mr Cameron Murphy AM
Chair, Committee on Ageing and Disability
Parliament of New South Wales
6 Macquarie Street
SYDNEY NSW 2000

By e-mail: ageingdisability@parliament.nsw.gov.au

Dear Mr Murphy,

INQUIRY INTO SUPPORTED DECISION-MAKING

Thank you for the opportunity to make a submission to the Committee on Ageing and Disability's inquiry on supported decision-making in NSW. The Law Society's Elder Law, Capacity and Succession, Indigenous Issues, and Human Rights Committees contributed to this submission.

We note this inquiry was self-referred pursuant to s 28B(1)(e) of the *Ageing and Disability Commissioner Act 2019* (NSW) (**Act**), for the Committee to conduct an inquiry into and report on supported decision-making for adults with disability and older people in NSW.

The absence of a legislative framework for supported decision-making in NSW

Supported decision-making is mandated by the United Nations Convention on the Rights of Persons with Disabilities (**CRPD**), to which Australia became a signatory in 2009.[1] As noted by Professor Cameron Stewart in a recent paper prepared for the Parliamentary Research Service (**Parliamentary Research Service Paper**):

> There are many different approaches to supported decision-making, but at its core, supported decision-making is a model that requires decision-makers to provide support to people living with dementia so that they either have the capacity to make their own decisions, or, when capacity is no longer achievable, they will have decisions that reflect their will and preferences made for them by others.[2]

While the Parliamentary Research Service Paper concerned supported decision-making for people living with dementia, the above definition is equally applicable to other cases of adults with decision-making support needs.

[1] See *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 320 (entered into force 3 May 2008) art 12.
[2] Cameron Stewart, 'Supported decision-making for people living with dementia' (Research Paper No 6, Parliamentary Library, Parliament of New South Wales, 16 October 2025) 10 ('**Parliamentary Research Paper**'): https://www.parliament.nsw.gov.au/researchpapers/Documents/Supported-decision-making-for-people-living-with-dementia-in-NSW.pdf.

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Law Council OF AUSTRALIA CONSTITUENT BODY

At the current time, there is no legislative framework for supported decision-making in NSW. The existing legislative frameworks dealing with decision-making are predominantly found in the *Guardianship Act 1987* (NSW) and the *Powers of Attorney Act 2003* (NSW). These rely on a combination of the best interests test and substituted judgment model, and do not incorporate the principles of supported decision making.[3]

We note, however, that the concept of supported decision-making has been included to some extent in NSW Government policies. For example, both the NSW Public Trustee and Guardian and the Public Guardian, in their public-facing communications to family, friends and service providers, offer resources on supported decision-making.[4] Further, the Australian Guardianship and Administration Council has published guidelines on supported decision making but, as noted in the Parliamentary Research Service Paper, these are typically not referred to in NCAT decisions on decision-making capacity as a matter of course.[5]

While policy approaches may go some way to the implementation of supported decision-making in NSW, in our view, they fall short of what is required to ensure that the will and preferences of people with decision-making support needs are consistently recognised in a way contemplated by the CRPD. As such, the Law Society considers that it would be appropriate for NSW to consider legislative responses for decision-making in NSW law.

The idea of a legislative framework for this purpose in NSW is not novel. It was canvassed in detail as part of a review by the NSW Law Reform Commission (**NSWLRC**) on the *Guardianship Act 1987* (NSW). In that review, the NSWLRC consulted on draft proposals to introduce a new Act to provide for supported decision-making and substitute decision-making, which was called the "Assisted Decision-Making Act". The new legislation was contemplated to replace the *Guardianship Act 1987* (NSW) and the enduring power of attorney provisions in the *Powers of Attorney Act 2003* (NSW) and, among other matters, included:

- Principles to guide the assessment of decision-making ability.
- Assisted decision-making arrangements and the mechanisms for putting these in place, including processes for personal appointments, court and tribunal appointments and default arrangements.
- Principles to guide supported decision-making.
- Safeguards that ensure accountability of decision-makers, including monitoring and review of orders and decisions.[6]

The recommendations of the NSWLRC were premised on the existence of the following entities: the NSW Trustee (currently called the NSW Trustee and Guardian), the Public Representative (currently called the Public Guardian), the Assisted Decision-Making Division of the NSW Civil and Administrative Tribunal (currently called the Guardianship Division), and a new entity called the Public Advocate.[7] The role of the Public Advocate would be to 'advocate for people in need of decision-making assistance, mediate decision-making disputes, provide

[3] See Parliamentary Research Paper (n 2), 6–13.
[4] See NSW Public Trustee and Guardian, Public Guardian, *Supported Decision Making* (Factsheet, April 2024): https://www.nsw.gov.au/sites/default/files/noindex/2024-06/NSW-trustee-guardian-supported-decision-making.pdf.
[5] Parliamentary Research Paper (n 2) 23. See also Australian Guardianship and Administration Council, *National Public Guardianship Guidelines* (Fourth Edition, 2025).
[6] New South Wales Law Reform Commission, *Review of the Guardianship Act 1987* (Report 145, May 2018) 25 [4.1]: https://lawreform.nsw.gov.au/documents/Current-projects/Guardianship/Report/Report%20145.pdf,
[7] Ibid xxii.

information, advice and assistance about decision-making and investigate cases of potential abuse, neglect and exploitation'.[8] In its submission to the NSWLRC, the Law Society supported the establishment of this new entity.[9]

Current considerations in relation to supported decision-making

The Law Society continues to support legislative change to embed and, to the extent necessary, formalise supported decision-making in law. We suggest that it will be important for the Committee on Ageing and Disability to build on the work already undertaken by the NSWLRC in 2018, while looking to other Australian jurisdictions, in particular Victoria, who, since that time, have enacted comprehensive changes to give expression in law to supported decision-making. Under the *Guardianship and Administration Act 2019* (Vic), for example, VCAT is empowered to make a supportive order appointing a 'supportive guardian' or 'supportive administrator' who is subject to certain duties under law.[10]

In our view, any legislative reform in NSW should also be considered in the context of the commencement of the *Aged Care Act 2024* (Cth) (**Aged Care Act**), which is intended to promote a rights-based model of aged care. We consider that alignment between the NSW and the Commonwealth regimes is important, and that any proposal for legislative change in NSW must consider interaction with the relevant Commonwealth 'supporter' provisions.

Our responses to Terms of Reference (b) to (d) are set out below.

TOR (b): Barriers to implementing models for supported decision-making across legal, financial, health, education, employment and care systems in NSW

Inconsistent legislative approaches to supported decision-making, including across NSW and Commonwealth legislation and policy

The fact that supported decision-making is not embedded in NSW law has the potential to give rise to a lack of consistent supported decision-making practices across NSW. As pointed out in the Parliamentary Research Paper, while NSW Government policies take a favourable approach to supported decision-making, this is not consistently reflected in the processes related to substituted decision-making and the application of the best interests test found in existing legislation.[11]

This barrier may be exacerbated in light of the introduction of new Commonwealth frameworks, including the Aged Care Act. This introduced a scheme for 'supporters', who are individuals registered as supporters by the System Governor, and are to act in accordance with principles of supported decision-making.[12] The function of the supporter under the Aged Care Act is to complement the role of the substitute decision-maker under state and territory regimes.[13] At the current time, however, the practical interaction between these roles remains unclear and may give rise to confusion.

[8] Ibid xxxiv.
[9] The Law Society of NSW, Submission No GA164 to The NSW Law Reform Commission, *Review of the Guardianship Act 1987* (26 February 2018): https://lawreform.nsw.gov.au/documents/Current-projects/Guardianship/Submissions%20DP/GA164.pdf.
[10] *Guardianship and Administration Act 2019* (Vic) Pt 4, Div 1.
[11] Parliamentary Research Paper (n 2).
[12] *Aged Care Act 2024* (Cth) s 6.
[13] Ibid s 33.

Barriers to implementing models for supported decision-making for the most vulnerable members of the community

As noted above, policy approaches are useful in disseminating information about supported decision-making. These may help to ensure that people requiring assistance with decision-making are supported by family and close friends in a way that recognises their right to exercise their autonomy and express their needs and preferences. Such informal arrangements, which are widespread, are an essential part of community life.

However, barriers to implementing models for supported decision-making arise for persons where family and community supports are unavailable or not working as intended. These can include vulnerable groups experiencing homelessness, addiction and mental illness, or those subject to any kind of abuse. The fact that there is no legislative framework in NSW to apply for the appointment of a supporter (as occurs in Victoria), coupled with the fact that supported decision-making as a legal concept is not embedded in the existing guardianship and administration regimes, means that these cohorts may be subject to substituted decision-making where supported decision-making would be more appropriate. While specialised community legal centres provide legal assistance to some members of this cohort in exercising their legal rights, these services are not sufficiently resourced to meet the needs of vulnerable populations.

Lack of specialised training on supported decision-making

While policy dissemination efforts help to provide information about supported decision-making, we note there is little specialised training for solicitors and other service providers to understand how to facilitate supported decision-making in line with evidence-based frameworks. We note that any changes to legislate for supported decision-making should be accompanied by broad education to all relevant stakeholders, including the aged care industry and the banking industry, to ensure that supported decision makers are able to assist the person in the way intended by the legislation.

TOR (c): The distinct experiences of and challenges faced by Aboriginal people and people from culturally and linguistically diverse backgrounds

Aboriginal and Torres Strait Islander peoples are overrepresented as the subjects of guardianship or administration orders.[14] There have long been concerns around the cultural suitability of assessment tools and diagnostic criteria to determine their decision-making capacity, particularly where there is reliance upon assessments of language, behavioural cues, stimuli or normative data which are informed by cultural bias, meaning that there may be situations where such orders are imposed where a person does in fact have decision-making capacity.[15]

At the same time, Aboriginal and Torres Strait Islander people under guardianship or administration orders are often not afforded cultural safety, and experience harm from the consequent removal from their support network, Country, and cultural support, as was highlighted in the Royal Commission into Violence Abuse, Neglect and Exploitation of People with Disability (**Disability Royal Commission**).[16]

In this context, it is essential that the framework and principles for supported decision-making are culturally safe and tailored, noting in particular cultural differences in how decisions are understood, made and communicated in First Nations communities. This is consistent with the principles for supported decision-making that the

[14] *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability: Final Report* (Final Report, September 2023) vol 4, 134–135 (*'Disability Royal Commission'*).
[15] See Human Rights and Equal Opportunity Commission, *Indigenous young people with cognitive disabilities & Australian juvenile justice systems* (Report, December 2025) 26–29.
[16] *Disability Royal Commission* (n 14) 146.

Disability Royal Commission recommended for adoption by federal, state and territory governments, including the following:

> **Principle 10 – Cultural safety**
>
> First Nations people and culturally and linguistically diverse people with disability are entitled to supported decision-making that is culturally safe, sensitive and responsive. This includes recognising the importance of maintaining a person's cultural and linguistic environment and set of values.[17]

Responding effectively to the significant and systemic barriers facing Aboriginal people with decision-making support needs requires culturally competent service design and delivery. For example, any framework should value kinship and community networks as legitimate supports, and recognise and make allowance for kinship structures specific to Aboriginal and Torres Strait Islander communities. We note that subsections 4(2)(e) and 4(3)(ii) direct the Commissioner, or any other person exercising a function under the Act, to take these matters into account for Aboriginal and Torres Strait Islander people.

To ensure that supported decision-making structures are culturally safe and appropriate, there must be co-design with Aboriginal and Torres Strait Islander communities. Crucially, cultural competence must also be integrated into all systems and services which intersect with decision making supports such as legal, health, financial and aged care services. We suggest that cultural competence and safety is best guaranteed by the inclusion of Aboriginal Community Controlled Organisations (**ACCOs**) into service design and delivery. ACCOs are trusted by, and highly connected with, Aboriginal and Torres Strait Islander communities. To do this important work, Aboriginal Community Controlled Health Organisations across urban, regional, and remote NSW must receive sustainable, long-term funding to increase the availability of culturally safe services.

Additionally, given the legal consequences of these processes, this should be complemented with commensurate funding to the Aboriginal Legal Service NSW/ACT, to enable access to culturally appropriate legal support.

We take this opportunity to note the obligations of Governments under the National Agreement on Closing the Gap, and the Targets set out in that Agreement, to address the determinants of the life expectancy gap between Aboriginal and Torres Strait Islander people and other Australians. The National Agreement recognises the need, and effectiveness, of an approach consistent with Aboriginal and Torres Strait Islander peoples' self-determination in addressing the particular challenges faced by Aboriginal and Torres Strait Islander peoples.

TOR d): the role and functions of the Ageing and Disability Commission (the Commission) in relation to supported decision-making; and e) possible changes to the functions of the Commission, including legislative amendments to the Act, to enhance supported decision-making

Current functions of the Ageing and Disability Commissioner

The functions of the Ageing and Disability Commissioner are set out in s 12 as follows:

> (a) to deal with allegations of abuse, neglect and exploitation of adults with disability and older adults, whether on the basis of a report made to the Commissioner or at the Commissioner's own initiative, including by referring matters to appropriate persons or bodies and by conducting investigations,
>
> (b) to take further action, following an investigation into an allegation of abuse, neglect or exploitation of an adult with disability or older adult, that the Commissioner considers necessary to protect the adult from abuse, neglect and exploitation, including by making an application to a court or tribunal in respect of the adult,

[17] Ibid 174.

(c) to raise awareness and educate the public about matters relating to the abuse, neglect and exploitation of adults with disability and older adults,

(d) to provide advice and general assistance to the public about matters relating to the abuse, neglect and exploitation of adults with disability and older adults, including referrals to independent advocacy services, where appropriate,

(e) to inquire into and report on systemic issues relating to the protection and promotion of the rights of adults with disability and older adults or the abuse, neglect or exploitation of adults with disability or older adults,

(f) to consult with the Board on matters relating to the abuse, neglect and exploitation of adults with disability and older adults that the Commissioner considers appropriate,

(g) to advise, and make recommendations to, the Minister, at the Commissioner's own initiative or at the request of the Minister, on matters relating to the abuse, neglect and exploitation of adults with disability and older adults,

(h) to monitor, assess and report on the New South Wales implementation of *Australia's Disability Strategy 2021–2031*.

While the Commissioner's functions are drawn broadly in terms of the way in which they encompass community prevention and responses to abuse, neglect and exploitation of adults with disability and older adults, as well as systemic investigations on these issues, there is no specific functions directed to supported decision-making.

It is arguable that the intersection between certain types of decision-making and abuse, neglect and exploitation of adults with disability and older adults, could mean that, absent legislative amendment, there is still a role for the Commissioner to play in providing guidance and education on supported decision-making in addition to that which has been produced by the NSW Public Trustee and Guardian and the Public Guardian.[18]

In our view, regardless of where the function vis-à-vis education and guidance on supported decision-making sits, it is essential that this work is coordinated so that consistent advice is given to the public on this issue. The organisation leading on this service must also be properly resourced. It would be helpful for individuals and service providers to be able to direct their questions around supported decision-making to a single source. This is especially relevant in the context of the recent implementation of the Aged Care Act, where federal frameworks of 'supporter' interact directly with the substituted decision-making functions of enduring guardians and attorneys, as well as in the context of interactions with the National Disability Insurance Scheme.

Possible changes to the functions of the Ageing and Disability Commissioner

We suggest that consideration of possible changes to the functions of the Ageing and Disability Commissioner will necessarily be informed by the nature and scope of any legislative amendments proposed for NSW i.e., whether the Commission's functions under the Act need to be expanded, or whether it would be preferable to establish a new statutory office in line with the "Public Advocate" entity proposed by the NSWLRC would, depend on the way in which any supported decision-making model is enacted in law. The adoption of a decision-making model that includes supported decision-making as a clear outcome available under legislation (similar to what is in place in other jurisdictions including Victoria), is a different outcome to changes that could be made to existing legislation to embed supported decision-making as a relevant principle in decision-making proceedings.

[18] We note the Victorian Office of Public Advocate, *Supported Decision-Making in Victoria* (Guide, October 2020) as a good example of guidance for people with a decision-making disability, and their family members, carers and friends who have been appointed, or have been asked to be, a legally appointed decision-supporter in Victoria. As noted above, however, the legal framework for supported decision-making is more mature in Victoria, meaning that this type of guidance can be provided in a more definitive manner.

TOR f) measures to ensure that substitute decision-making is an alternative approach that is employed in appropriate and limited circumstances

Article 12 of the UN CRPD, which emphasises the primacy of a person's will and preferences in decision-making, notes that '[s]upport in the exercise of legal capacity must respect the rights, will and preferences of persons with disabilities and should never amount to substitute decision-making'.[19]

In our view, the introduction of a legislative framework for supported decision-making with a focus on enabling people to exercise their legal capacity and make decisions that impact them would be the best way to ensure substituted decision-making is only considered in limited circumstances. In this respect, we suggest that the decision-making principles adopted in the *Guardianship and Administration Act 2019* (Vic) offer a useful model on how to define supported decision-making in line with a human rights approach. In particular, we draw attention to the principle require that 'the represented person's will and preferences should only be overridden if it is necessary to do so to prevent serious harm to the represented person'.[20]

We note that any legislation should set out clear procedural steps to identify when and how the supportive decision maker function is activated and when, in limited circumstances as described above, a person can override the decision of a represented person.

If you have any queries about the items above, or would like further information, please contact Mimi Lee, Policy Lawyer, on 02 9926 0174 or mimi.lee@lawsociety.com.au.

Yours sincerely,

Ronan MacSweeney
President

[19] See *Convention on the Rights of Persons with Disabilities* (n 1) art 12 [3.17].
[20] *Guardianship and Administration Act 2019* (Vic) s 9(1)(e).

THE LAW SOCIETY
OF NEW SOUTH WALES

Our ref: ELCSC/HRC:JBml030325

3 March 2025

The Policy Manager
Department of Communities and Justice
Locked Bag 5000
Paramatta NSW 2124

By email: policy@dcj.nsw.gov.au

Dear Policy Manager,

LEGISLATIVE FRAMEWORK FOR REGULATING THE USE OF RESTRICTIVE PRACTICES ON PEOPLE WITH DISABILITY

Thank you for the opportunity to provide comments on the Department of Communities and Justice (**DCJ**)'s consultation paper, *A Legislative Framework to Regulate Restrictive Practices* (**Consultation Paper**). The Law Society's Elder Law, Capacity and Succession Committee and Human Rights Committee contributed to this submission.

We are concerned that the proposed legislative framework (**Senior Practitioner framework**) departs from the current consent-based model (outlined at section 3.2.5) in the disability service provision setting, especially in respect of the removal of the requirement to obtain informed consent to the use of a restrictive practice, either from the person or by a substitute decision-maker appointed by the person, or by the NSW Supreme Court or the NSW Civil and Administrative Tribunal (**NCAT**). We suggest that the Senior Practitioner framework and the informed consent framework need not be mutually exclusive but may operate alongside each other. For example, the Senior Practitioner may offer global protections to achieve the principles proposed at section 4.3,[1] while the consent process is retained for individualised decisions about specific restrictive practices used in respect of the person.

As currently proposed, we believe the review, complaints and investigations functions of the Senior Practitioner are insufficient to protect individual rights in the absence of an informed consent mechanism and stronger oversight mechanisms. The proposed processes presuppose the knowledge and capability particular to the affected individual or known to a person with a genuine interest in their welfare, which is necessary to underpin the authorisation of the restrictive practice by the Senior Practitioner. The stringent safeguards and effective oversight mechanisms to guard against the misuse of that restrictive practice by the service provider

[1] The Consultation Paper, at section 4.3 on page 22, proposes for restrictive practices to only be used in accordance with the following principles:
- 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,
- as the least restrictive response possible to ensure the safety of the person with disability or others,
- 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.

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are also lacking. Even when the persons concerned do avail themselves of the rights to seek review or complain, there is a significant practical time delay between the application for review or complaint and the decision being handed down by the Senior Practitioner or NCAT. The inability to withhold or withdraw consent means the person would still have been subject to the use of the challenged restrictive practice in the intervening period.

If informed consent is retained alongside the proposed Senior Practitioner framework, it benefits the person to have an additional and more personal oversight of the use of the restrictive practice than can be afforded by the more distant and less personalised oversight offered by the Senior Practitioner and/or the Authorised Program Officer (**APO**). It would also provide more timely resolutions to challenges to the authorisation or use of restrictive practices than the inevitable waiting period inherent in internal or administrative review, and complaints and investigation processes.

Question 3: What issues and challenges are raised by there being different frameworks for the authorisation of restrictive practices in the disability service provision setting and the aged care setting?

We note that the Consultation Paper acknowledges the Senior Practitioner framework would not cover the aged care setting. The new *Aged Care Act 2024* (Cth), passed on 25 November 2024 and coming into effect on 1 July 2025, requires, in relation to restrictive practices, informed consent (s 18(1)(f)), and enables rules to be made to make provision for persons or bodies who may give informed consent if an individual lacks capacity to give that consent (s 18(2)). The consultation draft of the new Aged Care Rules 2025 was released recently.[2] Proposed clause 162-15(1)(f) requires:

> *Informed consent to the use of the restrictive practice, and how it is to be used (including its duration, frequency and intended outcome), has been given by:*
>
> *(i) The individual; or*
>
> (ii) *If the individual lacks the capacity to give that consent – the restrictive practices substitute decision-maker for the restrictive practice*

The existing *Quality of Care Principles 2014* (Cth) have the effect of requiring a guardian or an enduring guardian to consent to the use of restrictive practices.

We believe that the proposed framework for the disability service provision setting should be aligned with the consent requirements of the aged care framework in respect of restrictive practices. We understand that proponents of the Senior Practitioner framework contend that an advantage of the framework is that it would obviate the need to obtain consent from the person or their substitute decision maker, thereby cutting 'red tape' and streamlining decision-making convenience in respect of restrictive practices. This appears to be at odds with a person-centric model that prioritises the rights of the individual.

[2] Aged Care Rules 2025 (Cth), Consultation draft, 80: https://www.health.gov.au/sites/default/files/2025-02/new-aged-care-act-rules-consultation-release-3-provider-obligations_0.pdf.

In our view, if decisions about the use of restrictive practices in the disability sector were to be made by a single government official, such as the proposed Senior Practitioner, or their delegate, there is a risk that a "one size fits all" approach will be adopted. This could result in individuals not receiving the due attention necessary to ensure that the proposed restrictive practice is appropriate and tailored for their individual circumstances and in accordance with the principles outlined at section 4.3. We acknowledge that the APOs are intended to mitigate this risk through their knowledge of the operational environment, and we outline our concerns about the APO framework further below. We remain concerned about the risk of the overuse of restrictive practices, which was a subject of criticism by the Royal Commission into Aged Care Quality and Safety.[3]

We are concerned there may be gaps between policy intent and implementation. Even if a restrictive practice is authorised by the Senior Practitioner and/or the APO in accordance with the principles at section 4.3 and best practice, it is likely to be difficult for the Senior Practitioner and/or APO to monitor how each approved restrictive practice is implemented. We are concerned that there is no effective safeguard against a service provider implementing an authorised restrictive practice only to the extent necessary or for the shortest time possible, which are two of the principles outlined at section 4.3. Without informed consent, we query how the person or their substitute decision-maker could understand the decision to implement restrictive practices or be made aware of any misuse of restrictive practices, let alone complain or seek a review of decisions in relation to the use of a restrictive practice.

From a legislative perspective, the Senior Practitioner framework appears to be inconsistent with Part 5 of the *Guardianship Act 1987* (NSW) (**Guardianship Act**), which makes it unlawful for a health practitioner to carry out medical treatment on a "patient" (a person who is incapable of giving consent to the carrying out of medical or dental treatment) without approval of the "person responsible". At common law, a medical practitioner must obtain informed consent before carrying out medical treatment on a person: *Rogers v Whitaker* (1992) 175 CLR 479; [1992] HCA 58. A similar requirement is contained in the code of conduct governing medical practitioners in NSW: *Good medical practice: a code of conduct for doctors in Australia* at [4.5].

Part 5 of the *Guardianship Act* operates to permit a health practitioner to carry out medical and dental treatment on a person who is incapable of giving consent to the carrying out of that treatment where the consent of the "person responsible" is obtained. In the Senior Practitioner framework as it relates to the use of the restrictive practice, "chemical restraint" appears to by-pass the requirement in Part 5 of the *Guardianship Act* that a health practitioner must obtain consent to the use of "medication … for the primary purpose of influencing a person's behaviour",[4] from either the person for whom the medication is proposed, or, if they lack capacity to consent to the proposed medication, the person responsible or the NCAT". We note that the administration of antibiotics in some situations requires consent and it therefore seems inconsistent with the principles at section 4.3 for anti-psychotics to be approved as behaviour support without similar consent.

[3] Royal Commission Final Report: Care, Dignity and Respect Volume 3A, 108: https://www.royalcommission.gov.au/system/files/2021-03/final-report-volume-3a.pdf.
[4] Definition of "chemical restraint" at section 4.5.1, page 23 of the Consultation Paper.

We suggest that DCJ further considers the interaction between Part 5 of the *Guardianship Act* and the Senior Practitioner framework. We believe that informed consent is fundamental and should not be removed or replaced by the Senior Practitioner framework. Rather, consent should operate alongside the Senior Practitioner framework for individualised cases of restrictive practice use.

Question 10: Should APOs be empowered to give authorisation or provide preliminary approval?

The Consultation Paper proposes the use of an APO who is an employee of the provider with training in behaviour support. The Consultation Paper acknowledges that because the APO is employed by the provider, there may be a potential or perceived conflict of interest. However, it is suggested that this could be mitigated by: regulation of the APO; that all APO decisions be notified to the Senior Practitioner; and that all decisions by the APO be reviewable.[5] The Consultation Paper describes a partially delegated model, where the APO can solely authorise some categories of restrictive practices while others must be directly authorised by the Senior Practitioner, or a two-step model where the APO provides preliminary authorisation, which must be formally approved by the Senior Practitioner.[6] In Victoria, environmental and chemical restraints are approved by an APO alone, with the exception of a person with a psycho-social disability, which requires approval by the Senior Practitioner and an APO.[7]

In our view, the use of an APO employed by the provider who approves any restrictive practice appears contrary to the recommendation of the Royal Commission into Aged Care Quality and Safety that the use of restrictive practices in aged care must be based on an assessment by an independent expert.[8] Even with the proposed mitigations, an APO is not an independent expert and there is a direct conflict of interest. In our view, an APO is not an adequate substitute for informed consent to the use of a restrictive practice, either from the person or by a substitute decision-maker appointed by the person, or by the NSW Supreme Court or the NCAT. For these reasons we would oppose empowering an APO to give authorisation or provide preliminary approval.

Question 15: Should authorisation decisions be open to internal review and then reviewable at NCAT?

The Consultation Paper proposes that an affected person, the NDIS provider and any person who has a genuine concern for the welfare of the affected person may seek independent review of the decision to authorise or not authorise a restrictive practice. The review rights would be first to the Senior Practitioner for internal review and then to NCAT.

We assume the internal review process will be covered by the *Administrative Decisions Review Act 1997* (NSW) (**ADR Act**). The review rights available in the ADR Act are insufficient to address the concerns we have raised in this submission for several reasons.

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[5] NSW Department of Communities and Justice, *A legislative framework to regulate restrictive practices*, Consultation Paper (2024) 30.
[6] Ibid 30-31.
[7] Ibid 30.
[8] Royal Commission Final Report: Care, Dignity and Respect Volume 3A, 109: https://www.royalcommission.gov.au/system/files/2021-03/final-report-volume-3a.pdf.

First, a person or their substitute decision maker who wishes to challenge a decision made by the Senior Practitioner in relation to the authorisation of a restrictive practices may lack the ability to avail themselves of the opportunity to seek administrative review under the ADR Act. It is difficult to see how the internal review can be independent when the Senior Practitioner is reviewing their own authorisation decision. We query who the Senior Practitioner reports to, and how independence and transparency may be safeguarded in the proposed structure for internal review.

Second, it is likely that the challenged decision will have been in operation for some months by the time NCAT has completed its review of the challenged decision. Under the ADR Act, the making of an application to NCAT for administrative review of a reviewable decision does not stay or otherwise affect the operation of that decision.[9] Factoring in the time taken to conduct an internal review of the challenged decision,[10] several months may have elapsed between the making of the decision and the handing down of the NCAT decision. In the intervening period, the person may have been subject to the use of the challenged restrictive practice.

We suggest that further consideration is given to the possible risks to the person resulting from the length and possible delays in the internal and administrative review processes. The removal of consent mechanisms means the individual or their substitute decision-maker has lost the right to give, withhold or withdraw consent for the use of the restrictive practice. Without informed consent, we query how the person or their substitute decision-maker could understand the Senior Practitioner's decision to authorise restrictive practices or be made aware of any misuse of restrictive practices, let alone complain or seek a review of decisions in relation to the use of a restrictive practice. Even if they do avail themselves of the rights to review or complain, the proposed process appears to relocate the burden or 'red tape' on the individual to challenge the decision or misuse and defeats the some of the principles at section 4.3, including 'to the extent necessary' and 'for the shortest time possible', for the reasons of time delay outlined above.

The Consultation Paper discusses sanctions and potential civil and criminal remedies, but in a process that lacks oversight, except for the individual oversight by "any person who has a genuine concern for the welfare of the affected person", it may be difficult to access these sanctions and remedies, including in a timely way. We suggest further consideration is given to improve transparency and oversight, and an effective pathway to redress where warranted.

If you have any queries about the items above, or would like further information, please contact Mimi Lee, Policy Lawyer, on 02 9926 0174 or mimi.lee@lawsociety.com.au.

Yours sincerely,

Jennifer Ball

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President

[9] *Administrative Decisions Review Act 1997* (NSW) s 60.
[10] Ibid s 63.