How will the requirement for “informed consent” in the new *Aged Care Act 2024* inform the process of the use of restrictive practices in the Aged Care Sector? What are the repercussions on the State and Commonwealth systems and how might they be prevented?

By Daniel Moore

INTRODUCTION

On 12th September 2024 the Commonwealth Government introduced the *Aged Care Bill 2024* to Parliament in recognition of significant gaps within the Australian aged care system. The Bill was passed on 25th November 2024 and will become the new *Aged Care Act 2024 (‘the Act’ or ‘AC Act’)* as of 1st July 2025.[1] Through passage of the Act, the Albanese labour government aims to address the recommendations made by the *Royal Commission into Aged Care Quality and Safety (‘The Commission’)*.[2] By doing so, the intention of the Act is to deliver improvements to benefit Australians in aged care, including a tougher regulatory model, strengthen Quality Standards and a Statement of Rights to ensure elderly people and their needs are at the centre of the aged care system.[3]

For those individuals receiving aged care services, the legislation confirms the requirement for “informed consent” to be given to the use of a restrictive practice.[4] In line with recommendations made by the Commission, the Act also stipulates when a substitute decision-maker may give informed consent for the use of a restrictive practice when that individual lacks capacity to provide that consent.[5] There is a potential that residential aged facilities will rely on a state appointed Guardian as the only reliable substitute decision-maker to give consent under the provisions of the new Act. The State system is underprepared to face a mass increase of resource burden in this sector, thus a full investigation on how this requirement will impact the South Australian and Commonwealth systems is required. This

[1] Department of Health and Aged Care, ‘New Aged Care Act’, *Our Work* (Web Page) <https://www.health.gov.au/our-work/aged-care-act>.
[2] Commonwealth, Royal Commission into Aged Care Quality and Safety, *Final Report* (2021), vol 1.
[3] Department of Health and Aged Care, ‘Historic aged care reform passes parliament’, *Minister Wells’ Media* (Web Page) <https://www.health.gov.au/ministers/the-hon-anika-wells-mp/media/historic-aged-care-reform-passes-parliament>.
[4] *Aged Care Act 2024* (Cth), s 18(1)(f).
[5] Ibid, s 18(2).

paper aims to explore the parameter of capacity to give consent in aged care, who are the appropriate substitute decision makers who can give informed consent for the use of a restrictive practice under the new system and in what form it may be given.

BACKGROUND

Restrictive Practices in Aged Care

A restrictive practice in relation to an individual has been defined under s 17 of the Act to mean "any practice or intervention that has the effect of restricting the rights or freedom of movement of that induvial."[6] The use of a restrictive practice in aged care intersects with human rights in a substantial manner. As it involves balancing the safety and wellbeing of individuals with their rights to autonomy, dignity and freedom from inhumane treatment. In application to individuals in aged care, the articles under the UN Convention on the Rights of Persons with Disabilities *('CRPD')* should be recognized as a primary guiding principle in this area of law.[7] A human rights-based approach to restrictive practices in aged care is supported by the Commission's effort to minimise the use of restrictive practices.[8] The Coalition has supported this approach by placing stronger controls over the use of restrictive practices in aged care, to ensure they are effective in upholding the rights of older Australians as a last resort.[9]

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[6] Ibid, s 17(1).
[7] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, [2008] ATS 12 (entered into force 16 August 2008).
[8] Commonwealth, Royal Commission into Aged Care Quality and Safety, 'Minimising restrictive practices', *Safety and Care* (Web Page) <https://www.agedcarequality.gov.au/older-australians/safety-care/minimising-restrictive-practices>.
[9] Department of Health and Aged Care, 'Restrictive practices in aged care – a last resort', *Providing Aged Care Services* (Web Page) <https://www.health.gov.au/topics/aged-care/providing-aged-care-services/training-and-guidance/restrictive-practices-in-aged-care-a-last-resort>.

The *Office of the Public Advocate ('OPA')* specifically categorises restrictive practices. Those are; chemical restraint involving medication that changes someone's behaviour; environmental restraint involving restricting access to items; and mechanical restraint involving a device that restricts someone's movement for behavioural purposes.[10] In implementation, the use of restrictive practices exists on a broad spectrum and is prevalent in residential aged care facilities. Some examples include but are not limited to psychotropic medications, locking away certain items such as cutlery, bed rails, restrictive clothing or straps to prevent specific bodily movements, seclusion and detention.[11]

Supported Decision-making in South Australia

In South Australia, there are several pathways which allow for a substitute decision-maker to approve for the use of a restrictive practice on an individual who lacks decision-making capacity.[12] A *substitute decision-maker* appointed under an Advance Care Directive may give consent, however an Advance Care Directive can only be made by the individual to whom it applies when they still have capacity. Further, there is clause under s 10(g) of the *Advance Care Directive Act 2013* which may limit this power, it states a substitute decision-maker "must not, as far as is reasonably practicable, restrict the basic rights and freedoms of the person".[13] Another option, a *person responsible* under the *Consent to Medical Treatment and Palliative Care Act 1995* may provide consent in relation to the administration of medical

[10] Office of the Public Advocate, 'Restrictive Practices', *Guardianship* (Web Page) <https://www.opa.sa.gov.au/guardianship/restrictive-practices>.
[11] 'Restrictive practices in residential aged care', *Department of Health and Aged Care* (PDF) <https://www.health.gov.au/sites/default/files/2022-11/types-of-restrictive-practices.pdf>.
[12] Office of the Public Advocate (n 10).
[13] *Advance Care Directive Act 2013* (SA), s 10(g)

treatment to an individual with impaired decision-making capacity.[14] However, consent in that case is limited to practices which fall within the scope of "health care".[15]

Alternatively, a guardian appointed by the South Australian Civil and Administrative Tribunal ('SACAT') under the powers granted in the *Guardianship and Administration Act 1993 ('GAA Act')* may give consent to the use of a restrictive practice for an individual that has a mental incapacity.[16] The SACAT may appoint a private guardian or, in cases where no other appropriate person can by appointed, the Public Advocate as the substitute decision-maker to make decisions relating to lifestyle, accommodation and/or health.[17] The Public Advocate, as the statutory-appointed body may then delegate their authority to a delegated guardian, or a team of delegated guardians who may act in this position. A guardian appointed via a guardianship order may act as the restrictive practices substitute decision-maker except when the use of force or detention is required. This will then require an additional "Special Powers" order made by the SACAT made in conjunction with the appointment of a guardian.[18] As guardianship restricts the autonomy of an individual through an order made by the Tribunal, it should be used in cases of last resort.[19]

[14] *Consent to Medical Treatment and Palliative Care Act 1995* (SA), s 14B.
[15] *Ibid*, 14(1).
[16] *Guardianship and Administration Act 1993* (SA), s 29, s 31.
[17] 'Guardianship and the Public Advocate', *Office of The public Advocate* (PDF) <https://www.opa.sa.gov.au/documents/fact-sheets/Fact-Sheet-GUARDIANSHIP-and-THE-PUBLIC-ADVOCATE-Nov-2024.pdf>.
[18] *'GAA Act'* (n 16), s 32.
[19] Commonwealth, Australian Law Reform Commission, 'Guardianship and Financial Administration', *Elder Abuse – A National Legal Response (ALRC Report 131)* (2017).

Redefining "detention"

South Australia has the highest number of individuals under guardianship per capita than any other state.[20] The OPA has recorded that the amount of individuals under Guardianship has doubled since 30th June 2019. Contextual analysis suggests that this has come as a consequence of the case *Public Advocate vs C, B.*[21] Here, the Full Court considered whether the scope of the general guardianship powers contained in section 31 of the *Guardianship Act* extends to making an order to detain a person. The Chief Justice ruled that "the *Guardianship Act* had in fact abrogated the general law powers of a guardian contained in section 31 by creating an exclusive power for detention in section 32. As a result of this case, the Public Advocate can no longer unilaterally order the detention of those under guardianship. Instead, section 32 provides that SACAT must oversee decisions which involve the restrictions of a vulnerable person's liberty.

The rise in Guardianship orders can be attributed to the requirement that any detention practices, or any associated use of force, require a guardianship order alongside a section 32 special powers order through SACAT. Under this broadened test, the following may constitute detention: locked doors at night; passcode to enter wards; or supervision even without physical restraint. Whilst these checks and balances are essential for the protection of human rights, they place individuals under unnecessary guardianship and takes away the decision-making ability of individuals when informal arrangements may be suitable. This consequence may also come as a result of the "informed consent" requirement under the new Act.

[20] 'Public Advocate Annual Report 2023-2024', *Office of The public Advocate* (PDF, 20 June 2024) <https://www.opa.sa.gov.au/__data/assets/pdf_file/0011/1091891/OPA-Annual-Report-2023-24.pdf>.
[21] *Public Advocate v C, B* (2019) 133 SASR 353.

INTERPRETATING THE *AGED CARE ACT 2024*

The new legislation

Anika Wells, the Minister for Aged Care in her speech to the general public states the new Act will "create a range of improvements, including a tougher regulatory model that will crack down on dodgy providers doing the wrong thing."[22] Part of this "tougher regulatory model" is that the requirements for the use of restrictive practices are tied to the registration of aged care providers. This is stipulated in section 162 of the Act which states:

> "It is a condition of registration that a registered provider of a kind prescribed by the rules must comply with any requirements prescribed by the rules relating to the use of restrictive practices in relation to an individual to whom the provider is delivering funded aged care services"[23]

In addition to this part, section 18 (2) identifies that the Aged Care Rules may:

> "make provision for, or in relation to, the persons or bodies who may give informed consent to the use of a restrictive practice in relation to an individual to whom a registered provider is delivering funded aged care services if that individual lacks capacity to give that consent."

The Australian government has scheduled the public consultation on the draft Rules for February 2025.[24] Through the *Quality of Care Principles 2014 ('The Principles')* a temporary arrangement allows a hierarchy of substitute decision-makers to provide informed consent

[22] Department of Health and Aged Care (n 3).
[23] '*AC Act*' (n 4), s 162.
[24] Department of Health and Aged Care, 'Consultation on the new Aged Care Act', *Our Work* (Web Page) <https://www.health.gov.au/our-work/aged-care-act/consultation>.

under the requirement under section 18.[25] The Principles are schedule to end on 1 December 2026. They apply to State and Territory jurisdictions that do not have an explicit model to appoint a substitute decision-maker to give consent to restrictive practices and enable those jurisdictions to develop one.[26]

"Informed Consent"

As previously expressed, a requirement for aged care providers registration is that "informed consent is given to the use of a restrictive practice in relation to the individual" under section 18(1)(f).[27] Section 18(2) sets out who may give that consent "if that individual lacks capacity to give that consent."[28] Informed consent may be given its ordinary meaning, that is, the act of agreeing to allow something to happen, or to do something, with a full understanding of all the relevant facts, including risks, and available alternatives.[29] Although "informed consent" may be construed under this meaning, the test for who "lacks capacity to give that consent" is not explicitly expressed within the Act. It may be assumed that the Rules will rectify the absence in clarification on this topic. However, a court will likely infer this system to operate similarly to how consent is currently given, for the use of restrictive practices. Meaning that, consent may be given verbally or written, and a lack of capacity applies to individuals without cognitive capacity to understand what they are consenting to. This interpretation aligns the system as is consistent with the current authorisation process within the disability sector.

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[25] *Quality of Care Principles 2014* (SA), s 5B.
[26] Commonwealth, Royal Commission into Aged Care Quality and Safety, (Regulatory Bulletin 2023-22) < https://www.agedcarequality.gov.au/sites/default/files/media/rb-2023-22-regulation-of-restrictive-practices.pdf>, pg 5.
[27] '*AC Act*' (n 4), s 18(1)(f).
[28] Ibid, s 18(2).
[29] Commonwealth, Royal Commission into Aged Care Quality and Safety, (n 8).

"Persons or Bodies"

It is unsure whom or what the Rules will prescribe to be "persons or bodies who may give informed consent". However, inferences can be made from the construction of the Act. Section 27 of the Act prescribes the actions of *supporters*, but, explicitly extinguishes the power to make a decision on a behalf of an individual, therefore excluding the authority of a supporter to consent to a restrictive practice.[30] There may be some speculation that the Rules may grant supporters a position within a hierarchy similar to the Principle's to give consent to a restrictive practice, however the original drafting of the Bill also specifically repealed a role for *decision-making supporters* – making it clear the supporters explicitly cannot over-step these boundaries.

Section 28 specifically outlines the Roles of Guardians and other similar positions, providing that:

> *"A person must not do any thing on behalf of an individual that may or must be done by the individual under, or for the purposes of, this Act unless the person is a person covered by subsection (2) who is, by reason of being such a person, authorised to do the thing on behalf of the individual".*[31]

This section applies to the appointed guardian of an individual or another person "appointed by a court, tribunal, board or panel (however described) under the law of the Commonwealth, a State or Territory."[32] Therefore, the Act explicitly prescribes a state-appointed guardian as an appropriate substitute decision-maker to grant consent for the use of restrictive practice.

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[30] '*AC Act*' (n 4), s 27(c).
[31] Ibid, s 28.
[32] Ibid, s 28(2).

Unless the Rules infer otherwise, residential aged care providers are far more likely to view guardianship as the most reliable option to receive informed consent in the circumstance that an individual in aged care lacks that capacity to give it.

IMPACT OF THE ACT

Purpose of the Commonwealth

The Commonwealth has made deliberate efforts to minimise the inappropriate use of restrictive practices in aged care.[33] Whilst safeguarding may be managed by the Commission to assess aged care rights and quality standards, the legislative instrument is how the Commonwealth provides oversight to the sector. Prescribing a restrictive practice substitute decision-maker to give informed consent for an individual if they lack capacity in the Act has set a requirement on all registered aged care providers nation-wide.[34] In order to avoid inconsistency with Commonwealth legislation, States and Territory jurisdictions are required to adequately implement the requirements of the new Aged Care Act.[35]

Impact on the State System

A key concern for the state aged care sector comes from the response of aged care providers to the informed consent requirement. Noting the limitations for a substitute decision maker an advance care directive,[36] and a person responsible for matters relating to medical treatment,[37]

[33] Department of Health and Aged Care,
[34] Ibid.
[35] *Australian Constitution*, s 109.
[36] *ACD Act, (n 13)*, Division 2.
[37] *Consent Act (n 14).*

the construction of the Act may lead providers to treat guardianship appointed by the SACAT as the most reliable option to give consent when an individual lacks capacity. Considering that the requirement is tied to registration under section 162 of the Act, there has been an indication that in anticipation for the Acts commencement, providers have made push in applications for guardianship orders[38]. If an influx of applications occurs, the resource impact upon the SACAT and Public Advocate will be dire. As the Aged care sector is double the size of the disability sector, should the Act drive a higher demand for guardianship, in conjunction with rise in special powers orders (s32 for detention and the use of force) there will be considerable resource strain upon the OPA and SACAT. This will impact the effectiveness of the government bodies, and ultimately impact those individuals that require assistance in decision-making.

Impact on individuals in aged care

In the South Australian system for guardianship, section 5(c) of the Guardianship and Administration Act states:

> *"consideration must, in the case of the making or affirming of a guardianship or administration order, be given to the adequacy of existing informal arrangements for the care of the person or the management of his or her financial affairs and to the desirability of not disturbing those arrangements;"*[39]

The Public Advocate places emphasis on respecting informal arrangements for substitute decision-making if they are effective and uphold the rights of the individual who requires

[38] Fougere, Christine, 'THE EVOLVING LANDSCAPE OF RESTRICTIVE PRACTICES IN AGED CARE: WHAT IS THE ROLE OF GUARDIANSHIP?' *Guardianship Division, NSW Civil and Administrative Tribunal (NCAT)* (PDF) <https://ncat.nsw.gov.au/documents/speeches/20210312_paper_fougere_c_aged_care_role_of_gd.pdf>.
[39] *'GAA Act'* (n 16), s 5(c).

decision-making assistance. The Commonwealth's requirement for informed consent does not provide for informal decision-makers in any capacity. The hierarchy listed under the Principles may allow for a selection of restrictive practice substitute decision-makers for those with a close relationship to the individual, however, the hierarchy gives way to the systems set up by the State or Territory jurisdiction.[40] In South Australia the most reliable method is through guardianship, creating a risk of countless unnecessary appointments.

CRITIQUES OF THE MODEL FOR "INFORMED CONSENT"

Problematic Wording

The OPA's view, in regard to detention, is there is no limitation on liability that would require a special powers order under section 32 when a protected person does not express a wish to be somewhere else other than where they are being held.[41] For example, if a resident in aged care is being held in a dementia ward with restricted access, yet does not have an expression of a wish to be elsewhere, they are not being detained as there has not been a restriction on their will. This same principle can be applied to a requirement of informed consent for the use of any restrictive practice for an individual in aged care. After all, if an individual has given consent, how can there be a restriction of their rights and liberty, when they have freely chosen to forfeit those rights.

Commonly, in the Aged Care sector, a substitute decision-maker or guardian, usually a family member, gives consent to the use of restrictive practice on behalf of the individual.

[40] *The Principles* (n 25), s 5B.
[41] Office of The public Advocate (n 20).

This may place family members in a position where they do not have the clinical skills, understanding or feel apprehensive to withhold consent in fear of jeopardising the individuals placement within the care of an aged care provider.[42] Further, consent for the use of a restrictive practice should only be given on a person's behalf on the condition that that person would have consented to it themselves. The function of consent is problematic as it does not fit within the scope of how a restrictive practice operates and is supposed to operate only as a last resort whilst prioritising the safety of the individual and others.

Comparison to the Disability Sector

Whilst the Aged Care sector relies upon the requirement of consent for the use of a restrictive practice on an individual, the disability sector operates under a scheme of authorisation. This scheme operates under Part 6A of the South Australian *Disability Inclusion Act 2018 ('DI Act')*[43] in consistency with the requirements under the Commonwealth *NDIS (Restrictive Practices and Behaviour Support) Rules 2018*.[44] The State Act grants authority to the Restrictive Practices Authorisation Unit, a government body which sits within the Department of Human Services (DHS). It provides for specified officers to authorise the use of a restrictive practise on an individual receiving services upon the application of a registered NDIS provider. This system allows for a regulated government body to carry out an independent investigation before determining whether to grant authorisation to a regulated

[42] The Public Advocate, 'Submission on Aged Care Bill' *OPA QLD* (PDF, 2024) <https://www.justice.qld.gov.au/__data/assets/pdf_file/0005/816161/opa-qld-submission-aged-care-bill.pdf#:~:text=I%20write%20to%20make%20a%20submission%20on,rights%20of%20adults%20with%20impaired%20decision%2Dmaking%20ability.>
[43] *Disability Inclusion Act 2018*, Part 6A.
[44] *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018*, (Cth) s 9.

restrictive practice.[45] This process is successful in safeguarding individuals with disabilities and allows for the appropriate reporting and safeguarding that the consent model lacks.[46]

Authorisation vs Consent

As it operates in the disability sector, authorisation for the use of restrictive practice cannot operate in the same context as consent. The authorisation scheme functions outside the scope of the wishes of the individual or a substitute decision-maker. This is affirmed in section 23M(5) of the *DI Act* which states "To avoid doubt, restrictive practices may be used in relation to a prescribed person—without the consent of the prescribed person."[47] Additionally, the prohibition of "detention" under section 23(c) of the *DI Act* means that any practice that curtails detention cannot be authorised under this scheme and falls within the scope of section 32 special powers provisions of the *GA Act*. Authorisation does not operate the same as the requirement for consent under the Aged Care Act and therefore cannot be directly translated into the scheme.

OPTIONS FOR REFORM

Following the success of the scheme applied to NDIS participants, one reform possibility is to expand the parameters of the *DI Act* to include aged care. This would implement a process to grant "informed consent" for individuals receiving aged care services under the restrictive

[45] Department of Health and Aged Care, (n 9).
[46] NDIS Quality and Safeguards Commission, 'Regulated Restrictive Practices Guide', (PDF, Version 1.1, October 2020) <https://www.ndiscommission.gov.au/sites/default/files/2024-09/regulated-restrictive-practice-guide-rrp-20200_0.pdf>.
[47] *DI Act* (n 43), s 23.

practice's authorisation scheme. To function effectively a required amendment to the Act will need to facilitate a parallel system of "consent" alongside the operation of "authorisation".

Another option would be implementing a system to allow the SACAT to administer limited guardianship orders to the Public Advocate. This would primarily function by granting consent to a restrictive practice under the Act, then delegating the Public Advocates power to the restrictive practice authorisation scheme.[48] This would allow for the DHS to utilise its specialist knowledge to oversee the granting of consent, whilst still fulfilling the administrative role of a guardian. However, this will not effectively address the concern regarding the increase of guardian applications and burden on the SACAT and OPA.

Victoria has opted to create its own *Aged Care Restrictive Practices (Substitute Decisionmaker) Act 2024* to appropriately address and implement a measure to allow for a substitute decisionmaker to give consent to a restrictive practice without the requirement of guardianship. Whilst the Victorian Act aims to address the pressure on the VCAT and Victorian Public Advocate, it raises concerns about potential misuse and lack of oversight as restrictive practice may be too easily approved.[49] To balance these risks, stronger safeguards and clear guidelines will be necessary if South Australia were to create its own independent legislation on this issue.

[48] Ibid.
[49] *Aged Care Restrictive Practices (Substitute Decisionmaker) Act 2024* (Vic), s 17-19.

CONCLUSION

The *Aged Care Act 2024* aims to address the lack of regulations of restrictive practices in the aged care sector by confirming the requirement of informed consent. Whilst this Commonwealth reform aligns with human rights principles and aims to enhance protections for Australians in aged care, it presents challenges when applied to the South Australian system. Specifically, the requirement will likely promote a reliance on state-appointed guardians as the appropriate restrictive practice substitute decision-maker, leading to surges in guardianship orders, placing strain on the SACAT and the OPA. This increases the risk of unnecessary guardianship appointments, potentially restricting individuals' autonomy in aged care where informal arrangements may be more appropriate for those who lack capacity to give consent. To mitigate these repercussions, the South Australian system must utilise the processes in place and make appropriate adjustments in legislation whilst maintaining the aim to respond to a rise in guardianship applications to alleviate the burden on State systems, in anticipation of the Rules.

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Bibliography

Advance Care Directive Act 2013 (SA).

Aged Care Act 2024 (Cth).

Aged Care Restrictive Practices (Substitute Decisionmaker) Act 2024 (Vic), s 17-19.

Commonwealth, Australian Law Reform Commission, 'Guardianship and Financial Administration', *Elder Abuse – A National Legal Response (ALRC Report 131)* (2017).

Commonwealth, Royal Commission into Aged Care Quality and Safety, *Final Report* (2021), vol 1.

Consent to Medical Treatment and Palliative Care Act 1995 (SA).

Commonwealth, Royal Commission into Aged Care Quality and Safety, 'Minimising restrictive practices', *Safety and Care* (Web Page) <https://www.agedcarequality.gov.au/older-australians/safety-care/minimising-restrictive-practices>.

Commonwealth, Royal Commission into Aged Care Quality and Safety, (Regulatory Bulletin 2023-22) < https://www.agedcarequality.gov.au/sites/default/files/media/rb-2023-22-regulation-of-restrictive-practices.pdf>, pg 5.

Convention on the Rights of Persons with Disabilities, opened for signature 30 March 2007, [2008] ATS 12 (entered into force 16 August 2008).

Department of Health and Aged Care, 'Consultation on the new Aged Care Act', *Our Work* (Web Page) <https://www.health.gov.au/our-work/aged-care-act/consultation>.

Department of Health and Aged Care, 'New Aged Care Act', *Our Work* (Web Page) <https://www.health.gov.au/our-work/aged-care-act>

Department of Health and Aged Care, 'Historic aged care reform passes parliament', *Minister Wells' Media* (Web Page) <https://www.health.gov.au/ministers/the-hon-anika-wells-mp/media/historic-aged-care-reform-passes-parliament>.

Department of Health and Aged Care, 'Restrictive practices in aged care – a last resort', *Providing Aged Care Services* (Web Page) <https://www.health.gov.au/topics/aged-care/providing-aged-care-services/training-and-guidance/restrictive-practices-in-aged-care-a-last-resort>.

Fougere, Christine, 'THE EVOLVING LANDSCAPE OF RESTRICTIVE PRACTICES IN AGED CARE: WHAT IS THE ROLE OF GUARDIANSHIP?' *Guardianship Division, NSW Civil and Administrative Tribunal (NCAT)* (PDF) <https://ncat.nsw.gov.au/documents/speeches/20210312_paper_fougere_c_aged_care_role_of_gd.pdf>.

'Guardianship and the Public Advocate', *Office of The public Advocate* (PDF) <https://www.opa.sa.gov.au/documents/fact-sheets/Fact-Sheet-GUARDIANSHIP-and-THE-PUBLIC-ADVOCATE-Nov-2024.pdf>.

National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018, (Cth) s 9.

NDIS Quality and Safeguards Commission, 'Regulated Restrictive Practices Guide', (PDF, Version 1.1, October 2020) <https://www.ndiscommission.gov.au/sites/default/files/2024-09/regulated-restrictive-practice-guide-rrp-20200_0.pdf>.

Office of the Public Advocate, 'Restrictive Practices', *Guardianship* (Web Page) <https://www.opa.sa.gov.au/guardianship/restrictive-practices>.

'Public Advocate Annual Report 2023-2024', *Office of The public Advocate* (PDF, 20 June 2024) <https://www.opa.sa.gov.au/__data/assets/pdf_file/0011/1091891/OPA-Annual-Report-2023-24.pdf>.

Public Advocate v C, B (2019) 133 SASR 353.

Quality of Care Principles 2014 (SA).

'Restrictive practices in residential aged care', *Department of Health and Aged Care* (PDF) <https://www.health.gov.au/sites/default/files/2022-11/types-of-restrictive-practices.pdf>.

The Public Advocate, 'Submission on Aged Care Bill' *OPA QLD* (PDF, 2024) <https://www.justice.qld.gov.au/__data/assets/pdf_file/0005/816161/opa-qld-submission-aged-care-bill.pdf#:~:text=I%20write%20to%20make%20a%20submission%20on,rights%20of%20adults%20with%20impaired%20decision%2Dmaking%20ability.>

[1] *National Disability Insurance Scheme (Restrictive*