11. Health and National Disability Insurance Scheme

Contents

Summary

11.1 This chapter considers two discrete issues: the role of health professionals in identifying and responding to elder abuse; and the potential interaction between elder abuse and the National Disability Insurance Scheme (NDIS).

11.2 Health professionals play an important role in identifying and responding to elder abuse. As frontline service providers, they have regular contact with older people. However, health professionals may often only have a small window of opportunity to assist. This may be due to an older person's reluctance to discuss the abuse or neglect they are suffering, or due to limited opportunities to seek assistance. It is therefore important that health professionals are able to take advantage of any opportunity to assist, for example by relying on multidisciplinary approaches and integrated models of care to provide coordinated support and assistance for an older person suffering abuse or neglect. Health-justice partnerships in particular may have great potential in responding to elder abuse.

11.3 There are barriers that may limit a health professional's ability to assist in identifying and responding to elder abuse. These include difficulty detecting elder abuse, limited knowledge of and access to appropriate referral pathways, and concerns that responding to elder abuse might result in a breach of privacy laws. These barriers may be addressed in a number of ways, including, for example, by:

- providing training that focuses on issues such as better recognition of elder abuse and the interaction between the role of health professionals and privacy laws;
- developing improved referral pathways; and
- adopting multidisciplinary responses to elder abuse.

11.4 While the ALRC does not make specific recommendations in this chapter, the discussion that follows should inform the development of initiatives relating to training and referral pathways under the National Plan as they apply to health professionals.

11.5 As the NDIS continues to roll out, concerns about abuse or substandard care under the NDIS, as well as the potential for quality and safeguarding mechanisms to assist in combating elder abuse, may increase. However, the ALRC considers that it is too early to determine whether the scheme is an avenue for elder abuse or test whether there are effective safeguards against elder abuse in place. Therefore, the ALRC does not make any recommendations in relation the NDIS at this time.

Health professionals

11.6 Since most elderly people trust them, medical practitioners, nurses, pharmacists and other health professionals are often in an ideal position to identify elder abuse.[1] Such professionals are also well placed to identify risks and signs of abuse as part of their clinical assessment.[2] In 2014–15, people aged between 65 and 74 years accounted for 28.8 million unreferred GP visits. People aged 85 years and over accounted for 6.2 million visits.[3] In a joint submission, cohealth and Justice Connect Seniors Law stated that, 'in relation to any legal problem, not just elder abuse, nearly 30% of people will initially seek the advice of a doctor or another trusted health professional or welfare adviser'.[4]

11.7 However, stakeholders identified the following issues as key factors which may affect a health professional's capacity to recognise and respond to elder abuse:

- difficulties detecting elder abuse, particularly where the signs are subtle;
- limited knowledge of, and access to, referral pathways and available services; and
- concerns that disclosing information about elder abuse to other service providers, police or a government agency might result in a contravention of privacy laws.[5]

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1 A Almogue et al, 'Attitudes and Knowledge of Medical and Nursing Staff toward Elder Abuse' (2010) 51 *Archives of Gerontology and Geriatrics* 86, 86.

2 Australian Medical Association, *AMA Position Statement on Care of Older People 1998—amended 2000 and 2011* (2011) [28]. See, eg, cohealth and Justice Connect Seniors Law, *Submission 179*.

3 Australian Institute of Health and Welfare (Cth), 'Older Australia at a Glance' (2016).

4 cohealth and Justice Connect Seniors Law, *Submission 179*.

5 See, eg, MIGA, *Submission 258*; cohealth and Justice Connect Seniors Law, *Submission 179*; Seniors Rights Service, *Submission 169*; Speech Pathology Australia, *Submission 168*; Australian Nursing & Midwifery Federation, *Submission 163*; UnitingCare Australia, *Submission 162*; National Seniors Australia, *Submission 154*; Australian Association of Social Workers, *Submission 153*; Australian College of Nursing, *Submission 147*; MIGA, *Submission 119*. cohealth and Justice Connect Seniors Law also recognised that language barriers, and other factors such as increased isolation and limited engagement with mainstream services, make engagement with older people from culturally and linguistically diverse backgrounds more complex. It recommended greater coordination and integration of community workers from culturally and linguistically diverse communities in the delivery of health services: cohealth and Justice Connect Seniors Law, *Submission 179*. Such initiatives could be coordinated through the National Plan discussed in ch 3.

Training

11.8 Many stakeholders emphasised the need for additional training to assist health professionals better recognise that an older patient might be experiencing, or at risk of, elder abuse, and provide an appropriate response.[6] The ALRC agrees, and considers that additional training for health professionals should be an important initiative under the proposed National Plan.[7] Such training could build on existing training, and be focused on providing health professionals with the tools to identify elder abuse, and information on appropriate referral pathways. It might address issues such as ensuring older people from culturally and linguistically diverse backgrounds are provided 'appropriate language support to facilitate accurate communication', and raise awareness among health professionals about the potential concerns relating to the accuracy of the interpreting, confidentiality and potential conflicts of interest arising from the use of family and friends as interpreters.[8]

11.9 Existing training materials for general practitioners include specific guidance on elder abuse in the Clinical Guidelines published by the Royal Australasian College of General Practitioners (RACGP). This sets out risk factors, and includes a discussion of possible signs and symptoms of elder abuse, guidance on management, and a case study.[9] The RACGP has also made available a webinar on elder abuse as well as video case studies to assist GPs.[10]

11.10 The family violence GP toolkit prepared by Women's Legal Service NSW is an illustrative example of how information can be made readily available to health professionals. The toolkit is short, succinct and easy to understand. It discusses a range of matters, including how to discuss the issue with a patient, safety planning, and referrals. Further, specific guidance is provided about the interaction between family violence provisions and immigration laws to allay fears of 'partner visa' applicants

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6 See, eg, Seniors Rights Victoria, *Submission 383*; St Vincent's Health Australia, *Submission 345*; cohealth and Justice Connect Seniors Law, *Submission 179*; Seniors Rights Service, *Submission 169*; Speech Pathology Australia, *Submission 168*; Australian Nursing & Midwifery Federation, *Submission 163*; UnitingCare Australia, *Submission 162*; National Seniors Australia, *Submission 154*; Australian Association of Social Workers, *Submission 153*; Australian College of Nursing, *Submission 147*; Capacity Australia, *Submission 134*; S Kurrle, *Submission 121*; MIGA, *Submission 119*; Leading Age Services Australia, *Submission 104*; Aged and Community Services Australia, *Submission 102*; H Vidler, *Submission 12*.

7 The NSW Legislative Council also recognised the importance of additional training for health professionals, and recommended that the NSW Department of Family and Community Services and Ministry of Health 'develop and fund a comprehensive plan addressing the training needs of service providers, to enable better identification of and responses to abuse': Legislative Council General Purpose Standing Committee No 2, Parliament of New South Wales, *Elder Abuse in New South Wales* (2016) rec 5. See ch 3 of this Report for a discussion of the need for training to assist frontline staff and professionals in recognising and responding to elder abuse.

8 Federation of Ethnic Communities' Councils of Australia, *Submission 89*.

9 Royal Australasian College of General Practitioners, 'Clinical Guidelines—Abuse and Violence: Working with Our Patients in General Practice' (February 2014) 10.1.

10 Royal Australasian College of General Practitioners, *Elder Abuse—Recognise, Respond and Explore Risk* <www.racgp.org.au/education/courses/elder-abuse-webinar/>; Royal Australasian College of General Practitioners, *Elder Abuse* <www.racgp.org.au/education/courses/elder-abuse/>.

from culturally and linguistically diverse backgrounds. It is available both in hard copy and as a downloadable document.[11]

Referral pathways and integrated care models

11.11 Stakeholders raised the need for appropriate referral pathways and better information sharing.[12] The Australian Medical Association, in a submission to the NSW Legislative Council's inquiry into Elder Abuse (NSW Elder Abuse Inquiry), raised a related issue: medical practitioners need to spend 'significant non face-to-face time' to 'coordinate an appropriate continuum of referrals and services for patients experiencing abuse'.[13] The ALRC supports the call for better information sharing and clearer referral pathways to assist health professionals. This may be achieved in a number of ways.

11.12 NSW has developed 'a streamlined and integrated approach to victim safety assessment, referrals and service coordination of domestic violence' called 'It Stops Here: Safer Pathway' (Safer Pathway).[14] It is an example of how tools might be developed to assist health professionals and other service providers to more easily recognise and respond to elder abuse. Safer Pathway seeks to streamline referral pathways to secure the safety of victims of domestic and family violence. Once fully implemented:

- service providers, including health professionals, will have access to an assessment tool to guide the identification of risks of intimate partner violence;
- the health professional can make a referral via the electronic Central Referral Point if a risk is identified;[15] and
- the electronic system allocates a case to a Local Coordination Point. At the Local Coordination Point, staff undertake a comprehensive threat assessment and coordinate access to relevant local services:
    - if a person is considered to be at serious threat, a 'Safety Action Meeting' will be convened that brings together government and non-government agencies to coordinate an integrated response;
    - if there is no serious threat, the victim is referred to domestic and family violence specialists and other services for ongoing support and assistance.[16]

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11 Women's Legal Service NSW, 'A Toolkit for GPs in NSW' (2013).

12 See, eg, Seniors Rights Victoria, *Submission 383*; St Vincent's Health Australia, *Submission 345*; Justice Connect, *Submission 182*; cohealth and Justice Connect Seniors Law, *Submission 179*; Caxton Legal Centre, *Submission 174*; Seniors Rights Service, *Submission 169*.

13 Australian Medical Association, Submission No 73 to General Purpose Standing Committee No 2, NSW Legislative Council, *Inquiry into Elder Abuse* (November 2015).

14 Ministry of Health (NSW) and Women NSW, *Safer Pathway* <http://domesticviolence.nsw.gov.au/__data/assets/file/0019/301555/it-stops-here-safer-pathway-factsheet.pdf>.

15 The Central Referral Point is an electronic referral mechanism used to coordinate access to other services.

16 NSW Government, *Safer Pathway Service Delivery Map*.

11.13 Stakeholders also emphasised the potential for multidisciplinary approaches to improve referrals between health professionals and other service providers and better respond to elder abuse.[17] For example, many stakeholders were supportive of the development of health-justice partnerships and other integrated care models to implement a multidisciplinary approach.[18] Health-justice partnerships rely on utilising pro bono legal resources to embed legal services in a health service. Key elements are:

- locating a lawyer at a health service or hospital;
- integrating the lawyer as part of the health service;
- secondary consultations with the lawyers; and
- training health professionals on legal issues.[19]

11.14 Evidence suggests that older people are reluctant to come forward about elder abuse for a number of reasons, including shame and fear.[20] An older person may be reluctant to repeat their concerns numerous times to different professionals. They may also be unable to seek legal assistance discreetly. These concerns may be magnified in smaller rural and regional communities, where an older person may face greater fears of discovery.

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17 See, eg, National Older Persons Legal Services Network, *Submission 180*; cohealth and Justice Connect Seniors Law, *Submission 179*; Seniors Rights Service, *Submission 169*; Speech Pathology Australia, *Submission 168*; Carers Australia, *Submission 157*; ADA Australia, *Submission 150*; Office of the Public Advocate (Qld), *Submission 149*; Townsville Community Legal Service Inc, *Submission 141*; Legal Aid NSW, *Submission 137*; Older Women's Network NSW, *Submission 136*; S Goegan, *Submission 115*; Leading Age Services Australia, *Submission 104*; Office of the Public Advocate (Vic), *Submission 95*; Alzheimer's Australia, *Submission 80*; Law Council of Australia, *Submission 61*; Legal Aid ACT, *Submission 58*.

18 See, eg, National Legal Aid, *Submission 192*; Commissioner for Senior Victorians, *Submission 187*; Hume Riverina CLS, *Submission 186*; Justice Connect, *Submission 182*; National Older Persons Legal Services Network, *Submission 180*; cohealth and Justice Connect Seniors Law, *Submission 179*; Caxton Legal Centre, *Submission 174*; Seniors Rights Victoria, *Submission 171*; Seniors Rights Service, *Submission 169*; People with Disability Australia, *Submission 167*; Australian Nursing & Midwifery Federation, *Submission 163*; Carers Australia, *Submission 157*; National Seniors Australia, *Submission 154*; ADA Australia, *Submission 150*; Townsville Community Legal Service Inc, *Submission 141*; Legal Aid NSW, *Submission 140*; Older Women's Network NSW, *Submission 136*; Capacity Australia, *Submission 134*; Legal Services Commission SA, *Submission 128*; S Kurrle, *Submission 121*; North Australian Aboriginal Legal Service, *Submission 116*; S Goegan, *Submission 115*; Macarthur Legal Centre, *Submission 110*; Aged and Community Services Australia, *Submission 102*; Office of the Public Advocate (Vic), *Submission 95*; Northern Territory Anti-Discrimination Commission, *Submission 93*; Law Council of Australia, *Submission 61*; Legal Aid ACT, *Submission 58*.

19 cohealth and Justice Connect Seniors Law, *Submission 179*.

20 See, eg, FMC Mediation and Counselling, *Submission 191*; WA Police, *Submission 190*; Office of the Public Guardian (Qld), *Submission 173*; Seniors Rights Victoria, *Submission 171*; Seniors Rights Service, *Submission 169*; United Voice, *Submission 145*; Townsville Community Legal Service Inc, *Submission 141*; ACT Disability, Aged and Carer Advocacy Service, *Submission 139*; Legal Aid NSW, *Submission 137*; Older Women's Network NSW, *Submission 136*; Capacity Australia, *Submission 134*; University of Melbourne and Multicultural Centre for Women's Health, *Submission 129*; National LGBTI Health Alliance, *Submission 116*; S Goegan, *Submission 115*; Protecting Seniors Wealth, *Submission 111*; Aged and Community Services Australia, *Submission 102*; Australian Research Network on Law and Ageing, *Submission 90*; Alzheimer's Australia, *Submission 80*; E Cotterell, *Submission 77*; National Ageing Research Institute and Australian Association of Gerontology, *Submission 65*; Law Council of Australia, *Submission 61*; Cochrane Public Health Group, *Submission 54*; Ethnic Communities' Council of Victoria Inc, *Submission 52*; University of Newcastle Legal Centre, *Submission 44*.

11.15 Professor Lynette Joubert and Sonia Posenelli suggest that 'the "window of opportunity" for responding to aged abuse in a health service is brief'.[21] Health-justice partnerships have great potential to use this window effectively because they can build on the trust developed between health professionals and older patients, and can provide legal advice and assistance discreetly and conveniently. In a health-justice partnership, the health professional can confer with a lawyer to determine appropriate pathways for referrals.[22] With the consent of their patient, the health professional could also brief a lawyer of the older person's concerns and organise for a lawyer to discreetly speak with the older person either as part of a medical appointment, or in a separate consultation.[23] An integrated care model which incorporates legal practitioners into a health practice may reduce the number of separate appointments and interactions required to seek assistance.

11.16 The case study of Ms Li, provided by cohealth and Justice Connect Seniors Law, is illustrative. Ms Li was receiving physiotherapy treatment following a stroke, when she raised concerns about pressure from her husband to access her superannuation funds and savings to make mortgage payments on a house bought in his name. Her husband was very controlling, did not allow her to go out on her own, and managed the family finances. He had been physically and verbally abusive. Due to her complex health needs, there was limited scope for Ms Li to live independently of her husband. The police had taken out an intervention order which permitted him to remain in the house, but prohibited family violence. Ms Li wished to prepare a will and protect her interest in the family home. She was concerned that her husband may become violent if he heard of her plans. Ms Li's care coordinator organised, with Ms Li's consent, for a health-justice partnership lawyer to attend her next physiotherapy appointment, who advised Ms Li on preparing a will and checked on Mr Li's ongoing compliance with the intervention order. The lawyer arranged for specialist pro bono lawyers to prepare a will and attend the next physiotherapy appointment, where Ms Li signed the will and binding death nomination form for her superannuation. The pro bono lawyers agreed to store the will at their offices so Ms Li's husband would not find it.[24]

11.17 Surveys of medico-legal partnerships in the United States of America have shown that they provide financial benefits to clients, improve their health and well-being, and increase the knowledge and confidence of health professionals.[25] In Australia, an evaluation of a health-justice partnership established in Victoria between

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21 Lynette Joubert and Sonia Posenelli, above n 20, 712.

22 MIGA cautioned that a health-justice partnership must develop appropriate protocols and guidance about the role of the lawyer in the partnership, and explore how the partnership interacts with a health professional's duties: MIGA, *Submission 258*.

23 However, MIGA noted that some patients may be reticent to engage with a health service featuring on-site lawyers: Ibid.

24 cohealth and Justice Connect Seniors Law, *Submission 179*.

25 National Center for Medical-Legal Partnership, 'Making the Case for MLPs: A Review of the Evidence' (February 2013) 3.

Inner Melbourne Community Legal and the Royal Women's Hospital Victoria aimed at addressing family violence made similar findings.[26]

11.18 A number of other health-justice partnerships focused on assisting older people are being trialled, or under development.[27] These partnerships appear promising, and states and territories could potentially consider supporting their expansion.

Privacy and confidentiality

11.19 A common theme in submissions was that health professionals may be reluctant to report elder abuse or discuss it with other professionals because of concerns about confidentiality and compliance with privacy laws.[28] Some stakeholders submitted that privacy laws may need to be amended to clarify that health professionals can report instances of elder abuse to the police.[29] Stakeholders also submitted that reports or referrals to other public authorities with an investigative role should be exempt from privacy laws.[30]

11.20 However, as the Office of the Australian Information Commissioner noted, while privacy laws are 'often named as a barrier to sharing or accessing personal information', upon closer examination, this is usually not the case.[31] The privacy and confidentiality of health information is governed by Commonwealth, state and territory legislation and the equitable duty of confidence. Exemptions allowing the use and disclosure of health information under state and territory legislation are similar to the exemptions set out in the Australian Privacy Principles.[32]

11.21 Although it is generally prohibited to disclose a person's sensitive personal information without their consent, there are exceptions where, among other things:

- the person would 'reasonably expect' the disclosure, and the disclosure is 'directly related' to the primary purpose for which the information was collected (secondary purpose exception);[33]
- the disclosure is authorised by or under an Australian law or a court or tribunal order (authorised by law exception);[34]

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26 University of Melbourne, 'Acting on the Warning Signs Evaluation: Final Report' (August 2014) 1–5.

27 Examples include partnerships between Justice Connect and cohealth, Senior Rights Victoria and Footscray Hospital, Justice Connect and St Vincent's Hospital, Townsville Community Legal Services and Townsville Hospital, and Justice Connect and Caulfield Hospital.

28 ` MIGA, *Submission 258*; Seniors Rights Service, *Submission 169*; cohealth and Justice Connect Seniors Law, *Submission 179*; Australian Association of Social Workers, *Submission 153*; Australian College of Nursing, *Submission 147*; Legal Aid NSW, *Submission 140*; Older Women's Network NSW, *Submission 136*.

29 See, eg, Seniors Rights Service, *Submission 169*; Australian College of Nursing, *Submission 147*.

30 See, eg, Seniors Rights Service, *Submission 169*; Australian College of Nursing, *Submission 147*; Legal Aid NSW, *Submission 140*; Older Women's Network NSW, *Submission 136*.

31 Office of the Australian Information Commissioner, *Submission 132*.

32 This chapter discusses the provisions in the Australian Privacy Principles, but broadly similar exemptions are also available under relevant state and territory privacy laws.

33 *Privacy Act 1988* (Cth) sch 1 cl 6.2(a).

34 Ibid sch 1 cl 6.2(b).

- the disclosure is required to prevent a serious (or in some jurisdictions 'serious and imminent') threat to the life, health or safety of a person, and it is unreasonable or impracticable to obtain the patient's consent (serious threat exception);[35] or
- the disclosure is 'reasonably necessary for an activity related to law enforcement (law enforcement exception).[36]

11.22 Under the secondary purpose exception, a health professional may, in some circumstances, be able to confer with and discuss an older person's situation with other service providers to assist an older person to address elder abuse. To rely on this exception, the health professional will need to establish clear expectations with the patient, so the patient understands how their information might be used and to whom it might be disclosed.[37] An open discussion with the older patient about a care plan can establish reasonable expectations about what services may be included as part of a multidisciplinary response to elder abuse.

11.23 A health professional may be able to report elder abuse to police or a public authority under a number of existing exemptions to Commonwealth, state and territory privacy laws. Where a common law duty of care owed by an organisation would require that a health professional report elder abuse, the disclosure would be exempt under the 'authorised by law' exception, as the definition of 'Australian law' includes a rule of common law or equity.[38]

11.24 Under the serious threat exception, if there is a threat to the life, physical or mental health or safety of an older person, and it is potentially life threatening, or could cause other serious injury or illness, a health professional may, without consent, disclose information to relevant authorities in circumstances where it would be unreasonable or impracticable to get the older person's consent prior to disclosure.

11.25 Under the 'law enforcement exception', a health professional may report elder abuse to the police, but not to other state and territory bodies such as the public advocate or public guardian. An enforcement body is relevantly defined to mean a state or territory police force or other state or territory body with the power to conduct criminal investigations or inquiries, or impose penalties or sanctions.[39] An enforcement related activity is defined to include the prevention, detection and investigation of criminal offences.[40]

11.26 The ALRC considers that existing exemptions in privacy laws, the proposed establishment of protocols to guide health professionals on when they should refer abuse to adult safeguarding agencies,[41] and the recommended immunity for reports to

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35 Ibid s 16A, sch 1 cl 6.2(c).
36 Ibid sch 1 cl 6.2(e).
37 Office of the Australian Information Commissioner (Cth), *Draft Business Resource: Using and Disclosing Patients' Health Information* (2015).
38 *Privacy Act 1988* (Cth) s 6; Office of the Australian Information Commissioner, *Submission 132*.
39 *Australian Privacy Principles Guidelines* (March 2015) B.70.
40 Ibid B.71.
41 Rec 14–8.

such agencies,[42] are sufficient protection for health professionals seeking to disclose concerns about elder abuse to other service providers or a government agency.

11.27 Some submissions noted that health professionals may be reluctant to speak about the patient's situation to relatives or significant others without an enduring power of attorney. This is seen to be of particular concern where the person exercising the enduring power of attorney is perpetrating the abuse.[43] However, existing exemptions under the *My Health Records Act 2012* (Cth) and the Australian Privacy Principles allow health professionals to disclose information to persons other than someone exercising an enduring power of attorney or other enduring document.

11.28 Under the *My Health Records Act 2012* (Cth), a health professional may disclose information in a healthcare recipient's health record if it is 'necessary to lessen or prevent a serious threat to an individual's life, health or safety', and it would be unreasonable or impracticable to gain the health care recipient's consent.[44]

11.29 Under the Australian Privacy Principles, where the patient is unable to 'communicate consent', disclosure is permitted to a responsible person where necessary for appropriate care and treatment, or for compassionate reasons.[45] Such disclosure is not permitted where it is contrary to a patient's wishes expressed before they became unable to communicate consent, or contrary to wishes the health professional is or could reasonably be expected to be aware of.

11.30 'Responsible persons' for this purpose include:

- parents, children or siblings;
- spouses or de facto partners;
- an individual's relative, where the relative is over 18 and part of the household;
- a guardian;
- a person exercising an enduring power of attorney, exercisable in relation to decisions about a patient's health;
- a person who has an intimate personal relationship with the patient; or
- a person nominated as an emergency contact.[46]

11.31 If a health professional is concerned that an older person with impaired decision-making ability is being abused by someone exercising an enduring power of attorney or by another appointed decision maker, the health professional can apply to the relevant

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42 Health professionals who make a report of elder abuse to an adult safeguarding agency in good faith and on reasonable suspicion, should not be civilly or criminally liable, including under privacy laws. Health professionals would also not be considered to have breached standards of professional conduct under this recommendation: rec 14–7.

43 See, eg, Australian College of Nursing, *Submission 147*.

44 *My Health Records Act 2012* (Cth) s 64.

45 *Privacy Act 1988* (Cth) s 16B, sch 1 cl 6.2(d).

46 *Privacy Act 1988* (Cth) s 6AA.

state or territory civil and administrative tribunal for a guardian or financial administrator to be appointed or replaced.[47]

11.32 The ALRC considers that concerns about potential breaches of confidentiality and privacy are best addressed by incorporating information and guidance on privacy laws and confidentiality into the training discussed above. This could include detailed guidance on exemptions to privacy laws and how they may apply to a health professional presented with an older person experiencing, or at risk of experiencing, elder abuse. It might also include an in-depth exploration of the circumstances in which a health professional may disclose information to family and friends.

The National Disability Insurance Scheme

11.33 The NDIS supports people with a 'permanent and significant disability'.[48] Although a person must be under the age of 65 years at the time they seek to become a participant in the NDIS,[49] if a person is already in the NDIS when they turn 65, they may elect to remain in the NDIS or enter the aged care framework.[50]

11.34 Participants can access individualised plans for the delivery of 'reasonable and necessary supports to participate in economic and social life.[51] The National Disability Insurance Agency (NDIA) works with a participant to develop a plan. It considers the extent to which families, carers and informal networks may reasonably be expected to assist.[52] However, risks to the participant's well-being, and the impact on a participant's level of independence will be taken into account in evaluating whether informal carers may reasonably be relied upon.[53]

11.35 Some stakeholders expressed preliminary concerns about the potential for abuse and substandard care under the NDIS.[54] However, others noted that at this early stage

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47 Ch 5 discusses a suite of recommendations targeted at reducing instances of elder abuse by a person exercising an enduring power of attorney by improving the understanding of both attorneys and third parties dealing with attorneys. Ch 10 discusses recommendations targeted at reducing instances of elder abuse by a person appointed as a guardian or financial administrator.

48 *National Disability Insurance Scheme Act 2013* (Cth) s 24.

49 Ibid s 22(1)(a).

50 Ibid s 29(1)(b). As people can expect to live longer 'disability-free', and the proportion of people with disability who are older increases, the number of people eligible to remain in the NDIS is likely to drop. According to the Australian Institute of Health and Welfare, 'men aged 65 in 2012 could expect to live 8.7 additional years disability-free' and a further 6.7 years 'without severe or profound core activity limitation'. Women in the same age cohort 'could expect 9.5 additional years disability-free' and a further 6.7 years 'without severe or profound core activity limitation': Australian Institute of Health and Welfare, 'Aboriginal and Torres Strait Islander People with Disability: Wellbeing, Participation and Support' (May 2011) 237. People with a disability who are over 65 years of age are increasing as a proportion of all people with a disability. In 1981, 10% of all Australians with disability were aged under 15 years and 31% were 65 years or older; in 2009, 7% of the population with disability were aged 0–14 years and 39% were 65 years or over: Australian Institute of Health and Welfare, *Australia's Welfare 2011, Cat No AUS 412* (2011) 12

51 *National Disability Insurance Scheme Act 2013 2013* (Cth) s 8(c).

52 Ibid s 34(1)(e).

53 *National Disability Insurance Scheme (Supports for Participants) Rules 2013* (Cth) rule 3.4(b)(i).

54 Office of the Public Guardian (Qld), *Submission 173*; NSW Ombudsman, *Submission 160*; Office of the Public Advocate (Vic), *Submission 95*; Law Council of Australia, *Submission 61*; Legal Aid NSW, *Submission 137*.

of the rollout of the NDIS, they have had limited experience with the scheme.[55] Legal Aid NSW and the Law Council of Australia noted that 'it is not aware of any elder abuse being experienced by participants in the NDIS'.[56]

11.36 In December 2016, a comprehensive quality and safeguarding framework was introduced. It includes safeguards targeted at individuals participating in the NDIS (participants), the NDIS workforce, and NDIS providers, and incorporates preventative and corrective mechanisms.[57]

11.37 Key safeguards for participants include:

- conducting a formal risk assessment during the plan development process, that will be used to identify those 'who may be most at risk of abuse, violence, neglect and exploitation';[58]
- calibrating the level of support provided to the person's personal circumstances. A participant who is identified as vulnerable to exploitation or abuse will have access to a 'support coordinator' to help implement a 'participant plan';[59]
- ongoing monitoring and evaluation, including through regular plan review;[60] and
- Commonwealth funded individual and systemic advocacy services.[61]

11.38 These are supported by a number of systemic safeguards, including:

- a risk-based nationally consistent screening of NDIS workers, reliant on a variety of sources of information, including police checks and evidence of workplace misconduct that 'comes to light through complaints and serious incident reporting';[62]
- limits on the use of restrictive practices, including prohibitions on certain practices, the establishment of requirements that must be met before a restrictive practice can be used, and the introduction of a NDIS Senior Practitioner with the power, among other things, to review 'serious incident reports involving the unplanned or unapproved use of a restrictive practice';[63]

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55 Office of the Public Guardian (Qld), *Submission 173*; Seniors Rights Victoria, *Submission 171*; Public Trustee of Queensland, *Submission 98*; Office of the Public Advocate (Vic), *Submission 95*; Federation of Ethnic Communities' Councils of Australia, *Submission 89*; Law Council of Australia, *Submission 61*.

56 Legal Aid NSW, *Submission 137*.

57 Department of Social Services (Cth), *NDIS Quality and Safeguarding Framework* (2016) 13–14. These are underpinned by initiatives to strengthen the capabilities of individuals, the workforce and providers: Ibid.

58 Department of Social Services (Cth), *NDIS Quality and Safeguarding Framework* (2016) 31.

59 Ibid 30. A support coordinator works 'intensively with participants to shortlist and investigate suitable providers, choose preferred providers, create an agreement with the providers, and to move to a different provider if required': Ibid 32.

60 Department of Social Services (Cth), *NDIS Quality and Safeguarding Framework* (2016) 32–33.

61 Ibid 35.

62 Ibid 61–62.

63 Ibid 73–74.

- a requirement for all providers and workers to comply with an NDIS code of conduct;
- a requirement for providers delivering higher-risk supports, or supporting participants at heightened risk to undergo quality assurance certification. Certification will involve audits against practice standards, and usually will be conducted every three years. Providers with a history of serious non-compliance may be audited more frequently. An auditor will be required to notify the NDIS registrar of 'major non-compliance' issues;[64]
- the establishment of an NDIS registrar with responsibility to monitor compliance with the NDIS code of conduct and provider quality and competency standards; and
- the establishment of a NDIS Complaints Commissioner whose main focus 'will be on complaints suggesting that an individual worker or provider has breached the NDIS code of conduct'.[65] People are also able to raise broader issues about service quality, abuse and neglect with the Commissioner. This allows the Commissioner 'to identify emerging issues in the NDIS market and make recommendations to government'.[66]

11.39 The ALRC considers that it is too early to determine whether the scheme is an avenue for elder abuse, or test whether there are effective safeguards against elder abuse in place.

64 Ibid 87.
65 Ibid 46.
66 Ibid 46–7.