Capacity Australia

Submission

to the

Law Reform Commission of New South Wales

on the

Anti-Discrimination Act 1977 (NSW)

August 2025

What is Capacity Australia?

Capacity Australia (capacityaustralia.org.au) is a-not-for-profit organisation with charity (DGR) status. Our board is comprised of people with substantial expertise and experience in law, medicine (principally psychiatry), and other relevant fields (including social work, psychology and occupational therapy). We are committed to supporting the human rights of people with decision-making disability.

How do we do this?

We provide research, advocacy, and education services about capacity (decision-making ability).

These services are provided to medical, allied health, legal, financial, and community sectors across Australia and internationally.[1] Our mission is to ensure that the human rights of people with decision-making disability are protected: i.e., that such people make the decisions that they are capable of making, while safeguarding them against undue influence and abuse.

We are guided, in particular, by the United Nations *Convention on the Rights of Persons with Disabilities* (**CRPD**), to which Australia was an original signatory.[2]

Our special focus is on older people. Indeed, our mission extends to combating ageism. We are a founding member of ROPA (Rights of Older Persons Australia), comprising Australian civil society organisations, individual supporters and advocates, who publicly call for a specific United Nations Convention on the human rights of older persons.[3] We also have specialist expertise concerning the issues of ageing and retirement in the professions, particularly medicine and allied healthcare.

[1] See, for example, O'Neill N., Peisah C. (2021) Capacity and the law. 4th Edition Australasian Legal Information Institute (AustLII) Communities http://austlii.community/wiki/Books/CapacityAndTheLaw/.

[2] United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (2012). http://www.un.org/disabilities/convention/conventionfull.shtml.

[3] See www.rightsofolderpersons.org.au. The United Nations Principles for Older Persons (1991) does not have the legal status of a convention.

General statement of our position

We welcome the fact that the Commission has been tasked with reviewing the *Anti-Discrimination Act 1977* (NSW) (**ADA**).

We share the views of many – including the Attorney-General in July 2023, the Hon Michael Daley MP, whose remarks are quoted at para 1.8 of the Consultation Paper – that a review of this kind is much needed and long overdue due to the outdated nature of the ADA.

Our approach in this submission has been to confine ourselves to areas within our specialised knowledge and experience, which extends to ageing, disability, aged care and human rights. We do not claim specialist expertise in the ADA, though we can call upon considerable expertise in the law of evidence and statutory interpretation, and, more generally, in the conduct of civil litigation.[4] Thus, certain topics and specific questions posed in the Consultation Paper will not be addressed by us.

For convenience, we will set out the topics and specific questions that we have chosen to address, adopting the numbering and language used in the Consultation Paper.

3. Tests for discrimination

General comments as regards questions 3.1-3.7

Capacity Australia acknowledges the issues, and shares many of the concerns, which are discussed by the Commission at pp. 21-39 of the Consultation Paper.

[4] One of our board members, Roy Williams, is an Adjunct Senior Lecturer at the University of Sydney, teaching (since 2018) Evidence and Civil and Criminal Procedure. He is also a Teaching Fellow at the University of New South Wales, and a former litigation partner at Allens.

We accept that the law cannot always be simple or straightforward, if it is also to be just. We consider, for example, that there are good arguments for retaining in the ADA the two discrete categories of "direct discrimination" and "indirect discrimination". Even so, the existing definitions of those terms are excessively and unnecessarily complicated. We also consider that the burden of proof is unduly weighted against complainants.

These challenges are difficult for anyone to overcome, even trained lawyers. But the problems are exacerbated for people with disability, a class of people whom the ADA is intended to protect.

This is disempowering. As a practical matter, more so than is usual (and perhaps, to an extent, inevitable), it puts opportunities for seeking redress under the ADA in the control of lawyers rather than complainants. That is so at both the complaint and litigation stages. At least at the complaint stage, it ought to be possible for a layperson or a person with a cognitive disability with due support to conduct a matter at the Commission without the need to retain a lawyer, or, if so chosen, to instruct a lawyer competently understanding the matters at hand.

There are wider access to justice and human rights issues at stake here.[5] As the Commission has noted at para 2.20 of the Consultation Paper, Article 5(1) of the CRPD refers not only to the right to "equal protection of the law", but to the right to "equal **benefit** of the law" (our emphasis). The latter right requires States Parties to take positive actions, such as by providing reasonable accommodation, and ensuring accessibility.

With these considerations in mind, we support simplifying the definitions in the ADA and (in some respects) changing the burden of proof.

Question 3.1: Direct discrimination

Could the test for direct discrimination be improved or simplified? If so, how?

The short answer is "Yes". The test needs to be simplified.

[5] Mitchell W, Byrnes A, Bergman A, Peisah C. (2021) The Human Right to Justice for Older Persons With Mental Health Conditions. American Journal Geriatric Psychiatry.; 29(10):1027-1032.

In our view, for the reasons outlined in paras 3.16-3.24 of the Consultation Paper, the "comparator" test should be replaced by an "unfavourable treatment" test. We favour the simpler version of this test in s 8(1) of the *Equal Opportunity Act 2010* (Vic), which asks if the complainant was treated unfavourably **because** they have a given protected attribute. (For the reasons explained in our answer to Question 3.8, we would have reservations about adopting the more complex test in s 8(2) of the *Discrimination Act 1991* (ACT).)

An "unfavourable treatment" test would, thus, contain a causation element. In our answer to Question 3.6 we address the vital issue of the burden of proof.

Question 3.2: The comparative disproportionate impact test

Should the comparative disproportionate impact test for indirect discrimination be replaced? If so, what should replace it?

The short answer is "Yes". For all the reasons outlined in para 3.45 of the Consultation Paper, the test needs to be replaced.

In our opinion, a suitable replacement would be a "disadvantage" test of the sort contained in ss 8(3)-(4) of the *Discrimination Act 1991* (ACT). We note that recent reviews in Western Australia and Queensland have recommended replacing the comparative disproportionate impact test with a disadvantage test.

Question 3.3: Indirect discrimination and inability to comply

What are your views on the "not able to comply" part of the indirect discrimination test? Should this part of the test be removed? Why or why not?

In our opinion, for the reasons outlined in para 3.51 of the Consultation Paper, this part of the existing test is unnecessary and should be removed.

As noted at para 3.54 of the Consultation Paper, the issue does not arise if a "disadvantage" test were to be introduced. The "disadvantage" test does not require the complainant to prove that they are unable to comply with a requirement or condition.

Question 3.4: Indirect discrimination and the reasonableness standard

(1) Should the reasonableness standard be part of the test for indirect discrimination? If not, what should replace it?

We agree with the arguments against a "proportionality" test advanced in 2022 by the Queensland Human Rights Commission (referred to in para 3.65 of the Consultation Paper). Wherever possible, such complex and onerous tests should be avoided.

It follows that we support the retention of a reasonableness standard. Some such standard seems to us unavoidable.

In general – and subject to what we say below in relation to specification of the factors to be considered in determining reasonableness, the burden of proof, and a positive duty to prevent discrimination – we consider that a reasonableness standard is the simplest and fairest way to deal with alleged (indirect) discrimination. Other than in exceptional circumstances, it is a preferable approach to the enactment of piecemeal exceptions.

(2) Should the ADA set out the factors to be considered in determining reasonableness? Why or why not? If so, what should they be?

Notwithstanding our support for a reasonableness standard, we share some of the concerns alluded to at para 3.57 of the Consultation Paper.

To address such concerns, we support the Victorian approach (outlined in para 3.60 of the Consultation Paper) of enacting a non-exclusive list of specific factors that must be considered. This is, of course, a commonly used technique in legislation: cf., for example, s 5B(2) of the *Civil Liability Act 2002* (NSW); s 138(3) of the *Evidence Act 1995* (NSW).

Comments on systemic discrimination

At paragraph 3.66 of the Consultation Paper, the Commission has raised a most important issue about which we wish to comment at a little length:

> *The reasonableness standard does not address systemic discrimination. Whether a requirement is reasonable is measured at a particular point in time and for a specific group. But some argue that a failure to change systemic barriers or practices should itself be considered a form of discrimination.*

These words are especially pertinent when applied to systemic discrimination associated with **ageism**. Ageism encompasses stereotypes (beliefs), prejudice (emotional responses), and discrimination (behaviour) based on age – usually, old age.[6]

It is well known that Australia, along with the rest of the world, is experiencing a "pandemic" of ageism.[7] A national survey undertaken in 2021 by the Australian Human Rights Commission found that 64% of older Australians reported experiencing ageism in the previous five years.[8]

Ageism is especially ubiquitous across **healthcare services**. In that context, the consequences can be dire.

It is well established globally that systemic mechanisms drive less favourable treatment of older people in healthcare settings, leading to significantly worse health outcomes across 11 health domains including: (i) denied access to health care and treatments; (ii) exclusion from health research; (iii) devalued lives (as assessed by age-rationing of social resources); (iv) lack of work opportunities; (v) reduced longevity, (vi) poor quality of life and well-being; (vii) poor social relationships; (viii) risky health behaviours, (ix) mental illness; (x) cognitive impairment and (xi) physical

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[6] Iversen TN, Larsen L, Solem PE. A conceptual analysis of ageism. Nordic Psychology, 2009; 61(3): 4–22; Ayalon L, Tesch-Römer C. Contemporary perspectives on ageism. 2018. Cham, Switzerland: Springer; 2018; World Health Organization, Global Report on Ageism 2021. Available at www.who.int/teams/social-determinants-of-health/demographic-change-and-healthy-ageing/combatting-ageism/global-report-on-ageism.

[7] Chang E-S, Kannoth S, Levy S, Wang S-Y, Lee JE, Levy BR. Global reach of ageism on older persons' health: A systematic review PLoS One, 2020: 15(1): e0220857; North MS, Fiske ST. Modern attitudes toward older adults in the aging world: a cross-cultural meta-analysis. Psychol Bull. 2015;141(5):993–1021.; Officer A, Thiyagarajan JA, Schneiders ML, Nash, P., & de la Fuente-Núñez, V. Ageism, healthy life expectancy and population ageing: How are they related? International Journal of Environmental Research and Public Health, 2020; 17(9): 3159.

[8] Australian Human Rights Commission What's age got to do with it? A snapshot of ageism across the Australian lifespan September 2021 https://humanrights.gov.au/our-work/age-discrimination/publications/whats-age-got-do-it-2021

illness. In summary, older people are under-informed, under-diagnosed and under-treated.[9] [10]

These kinds of ageism are perpetrated by service providers in all health disciplines, regardless of stage or training: medical students, physicians, physicians-in-training, nurses and social workers.[11]

Equal access to the highest quality of healthcare is enshrined as a human right in Article 25 of the CRPD.[12] Thus, the dire consequences of ageism for Australians gives enormous power to the argument (noted at para 3.66 of the Consultation Paper) that "a failure to change systemic barriers or practices should itself be considered a form of discrimination".

Capacity Australia has extensive expertise in this area, ranging from having undertaken empirical research in Australian public hospitals,[13] to making

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[9] Chang E-S, Kannoth S, Levy S, Wang S-Y, Lee JE, Levy BR. Global reach of ageism on older persons' health: A systematic review PLoS One, 2020: 15(1): e0220857

[10] Markham S. Professional Ageism : The Impact of Ageism among Research and Healthcare Professionals on Older Patients: A Systematic ReviewA thesis in fulfilment of the requirements for the degree of Master of Science (Research) 2020: UNSW. Available at ps://unsworks.unsw.edu.au/entities/publication/55269675-cb92-4947-8682-9facd474a88e/full. Wyman MF, Shiovitz-Ezra S, Bengel J. Ageism in the health care system: providers, patients, and systems. In: Ayalon L, Tesch-R¨omer C, eds. Contemporary Perspectives on Ageism. Vol 19. Cham, Switzerland: Springer; 2018: 193–212; Buttigieg SC, Ilinca S, de Sao Jose JM, Larsson AT. Researching ageism in health-care and long term care. In: Ayalon L, Tesch-R¨omer C, eds. Contemporary Perspectives on Ageism. Vol 19. Cham, Switzerland: Springer; 2018: 493–515.

[11] Chrisler JC, Barney A, Palatino B. Ageism can be hazardous to women's health: ageism, sexism, and stereotypes of older women in the healthcare system. J Soc Issues. 2016;72(1):86–104; Ben-Harush A, Shiovitz-Ezra S, Doron I, Alon S, Leibovitz A, Golander H, Haron Y, Ayalon L. Ageism among physicians, nurses, and social workers: findings from a qualitative study. Eur J Ageing. 2016 Jun 28;14(1):39-48. Higashi RT, Tillack AA, Steinman M, Harper M, Johnston CB. Elder care as "frustrating" and "boring": understanding the persistence of negative attitudes toward older patients among physicians-in-training. J Aging Stud. 2012;26(4):476–483. Jeyasingam N, McLean L, Mitchell L, Wand APF. Attitudes to ageing amongst health care professionals: a qualitative systematic review. Eur Geriatr Med. 2023 Oct;14(5):889-908.Reuben DB, Tschann JM, Croughan-Minihane M. (1995) Attitudes of beginning medical students toward older persons: a five-campus study. The University of California Academic Geriatric Resource Program Student Survey Research Group. *J Am Geriatr Soc*. 1995;43(12):1430-1436.;Kusumastuti S. When Contact Is Not Enough: Affecting First Year Medical Students' Image towards Older Persons. *PLoS One*. 2017;12(1):e0169977. Wilson MAG, Kurrle S; Wilson I. (2018) Understanding Australian medical student attitudes towards older people. Australas J Ageing.2018; 37(2):93-98.

[12] Peisah C, Sheppard A, de Mendonça Lima C, Ayalon L. Banerjee D, Rabheru K, (2023) Right to health and access to health services Response to the call from the of WPA-SOAP and IPA response to the call from the UN-OHCHR rapporteur for the 13th session of the OEWG.

[13] Mujuru C, Peisah C. Beyond error: A qualitative study of human factors in serious adverse events. *J Healthc Risk Manag*. 2024; 44: 7–13.

submissions on the issue to the Office High Commissioner Human Rights (OHCHR) United Nations (UN).[14] Part of our global mission is to address ageism.

Another neglected form of systemic discrimination is ***mentalism***, that is, discrimination based on having the attribute of mental illness or cognitive impairment. As with ageism, Capacity Australia has long been committed to raising awareness about mentalism throughout world.[15]

We will address mentalism further in our answers to Questions 4.3 and 5.1-5.2.

We will address both ageism and mentalism further in our answers to Questions 6.4 and 11.3, regarding the provision of goods and services and possible imposition of a positive duty to avoid or reduce discrimination.

If it were thought by the Commission to be useful, we would be happy to provide further information to the Commission about ageism and/or mentalism.

Question 3.5: Indirect discrimination based on a characteristic

Should the prohibition on indirect discrimination extend to characteristics that people with protected attributes either generally have or are assumed to have?

Our answer is an emphatic "Yes", for the reason stated in 2022 by the Law Reform Commission of Western Australia: it should never be lawful to discriminate based on attributes or characteristics (cf. para 3.70 of the Consultation Paper). Countering stereotypes is essential because they can be so insidious.

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[14] Ayalon L, Peisah C, de Mendonça Lima, C, Verbeek, H, Rabheru K. (2021) Ageism and the state of older people with mental conditions during the pandemic and beyond: Manifestations, etiology, consequences, and future directions". Response to the call by the Independent Expert on the human rights of older persons, Office High Commissioner Human Rights (OHCHR) United Nations (UN) to inform the Expert's report to the 48th session of the Human Rights Council, UN. https://www.ohchr.org/_layouts/15/WopiFrame.aspx?sourcedoc=/Documents/Issues/OlderPersons/AgeismAgeDiscrimination/Submissions/NGOs/IPA-and-WPA.pdf&action=default&DefaultItemOpen=1; and Peisah C, Sheppard A, de Mendonça Lima C, Ayalon L. Banerjee D, Rabheru K, (2023) Right to health and access to health services Response to the call from the of WPA-SOAP and IPA response to the call from the UN-OHCHR rapporteur for the 13th session of the OEWG.

[15] Peisah C, de Mendonça Lima C, Verbeek H, Rabheru K IPA and WPA-SOAP joint statement on the rights of older persons with mental health conditions and psychosocial disabilities. Int Psychogeriatr. 2021 May 12:1-5. Ayalon L, Peisah C, Lima CM, Verbeek H, Rabheru K. (2021) Ageism and the State of Older People With Mental Conditions During the Pandemic and Beyond: Manifestations, Etiology, Consequences, and Future Directions. Am J Geriatr Psychiatry. 29(10):995-999.

Question 3.6: Proving discrimination

General comments

In our opinion, one of the two most consequential reforms[16] that could be made to the ADA would be regarding the burden of proof (i.e., in some situations, shifting the burden from the complainant to the respondent).

Further below, we have answered specific questions posed by the Commission about the burden of proof, but here we offer three short general remarks.

First, shifting the burden of proof in civil (and even criminal) proceedings is far from unprecedented.

Second, in our view, shifting the burden of proof as regards claims of discrimination under the ADA would assist many complainants in obtaining redress for **valid** complaints that, as things stand, and by no fault of their own, they are not able to prove (at least not without the assistance of expensive lawyers). We agree with the points made at paras 3.74-3.76 of the Consultation Paper.

Third, given appropriate publicity about any such changes to the ADA, potential respondents in all the relevant areas of life might be motivated properly to educate themselves about the ADA, and to put in place appropriate decision-making and other mechanisms to reduce the risk of contraventions of it. At the least, after a complaint, respondents would be forced to examine their practices. Deficiencies would soon become obvious.

(1) Should the ADA require respondents to prove any aspects of the direct discrimination test? If so, which aspects?

The short answer is “Yes”, as regards the causation part of the test (under either the existing test or our preferred alternative, an “unfavourable treatment” test).

The model in ss 351 and 361 of the *Fair Work Act 2009* (Cth), outlined at para 3.78 of the Consultation Paper, would not be unsatisfactory.

[16] The other is the imposition of a positive duty to avoid or reduce unlawful conduct: see Question 11

However, we support going a step further, along the lines recently adopted in Queensland and applicable in the UK (see para 3.80 and 3.81 of the Consultation Paper).

In substance, this approach would create a rebuttable presumption of causation. If adopted – given the deplorable nature of direct discrimination – it might even be desirable to set out in the ADA factors that a respondent would **not** be permitted to rely upon in rebutting the presumption: cf. s97A of the *Evidence Act 1995* (NSW).

(2) Should the ADA require respondents to prove any aspects of the indirect discrimination test? If so, which aspects?

In our view, a respondent should bear the burden of proving that a requirement or condition is reasonable – as is already the case in other parts of Australia (cf. para 3.82 of the Consultation Paper).

If this approach were adopted in the ADA, along with the other changes that we have argued for above, the complainant would have to prove that:

- they have an attribute protected by the ADA, and
- they have received unfavourable treatment from the respondent

The respondent would then have to prove that the unfavourable treatment was reasonable in the circumstances.

Question 3.7: Direct and indirect discrimination

(1) How should the relationship between different types of discrimination be recognised?

(2) Should the ADA retain the distinction between direct and indirect discrimination? Why or why not?

In our opinion, the distinction between direct and indirect discrimination should be retained. We do not favour a single definition.

Direct discrimination is more to be deplored than indirect discrimination. Respondents found to have committed it should be so identified. The victim of direct discrimination should be vindicated and compensated accordingly.

An (imperfect) analogy might be drawn with the law of homicide. Almost all common law jurisdictions, including New South Wales, retain the distinction between murder and manslaughter. They are different things.

We have no difficulty with the suggestion that the ADA should acknowledge that direct and indirect discrimination can overlap.

Question 3.8: Intersectional discrimination

(1) Should the ADA protect against intersectional discrimination? Why or why not?

Our short answer is a qualified "No".

Of course, we acknowledge the potential for intersectional discrimination – the existence for some individuals of what might be termed double, triple or even quadruple jeopardy.[17] In our experience, the protected attributes of (older) age and disability often intersect.

Our concern is that intersectionality is a complex phenomenon. At least where age and disability are concerned, the **combined** effects of multiple attributes on an individual are always peculiar to that individual. Assessing them on an empirical psychosocial scientific basis is no easy task.

We fear that a legislative attempt to protect against intersectional discrimination may introduce more complexity than is necessary, when one of the prime aims of any amendment of the ADA should be to **reduce** complexity.

Furthermore, we are not persuaded of the existence of significant numbers of potential complainants who would fail in a claim under the ADA based on a single

[17] Peisah C O'Neill N, Brodaty H. (2011) Mental Health and Human Rights in the elderly In Dudley, M., Derrick Silove, D., Gale F. (eds.) Mental health and human rights, Oxford University Press

protected attribute but succeed on intersectionality. If that could be clearly demonstrated, our views could well change.

Question 3.9: Intended future discrimination

Should the tests for discrimination capture intended future discrimination? Why or why not?

Our short answer is a firm "Yes". As in other jurisdictions (cf. para 3.102 of the Consultation Paper), it should be possible for the ADA to be used to prevent discrimination from occurring in the first place, perhaps based on mandatory training within organisations. Persons should not be subjected to discrimination if it is preventable.

4. Discrimination: protected attributes

Question 4.1: Age discrimination

(1) What changes, if any, should be made to the way the ADA expresses and defines the protected attribute of "age"?
(2) What changes, if any, should be made to the age-related exceptions?

We have no difficulty with the current definition of "age", and we support the concept of separate protection in the ADA against compulsory retirement due to age.

We do, however, have concerns about the **scope** of the protection against compulsory retirement. At present, it is "all or nothing". There should be more exceptions, but those exceptions should be better targeted.

The provisions in the ADA about compulsory retirement need to be updated, consistent with prevailing scientific understanding of age-related neurodegenerative diseases, professional capacity,[18] professional impairment, and contemporary

[18] O'Neill N., Peisah C. (2021) Chapter 18 Professional Capacity. Capacity and the law. 4th Edition Australasian Legal Information Institute (AustLII) Communities http://austlii.community/wiki/Books/CapacityAndTheLaw/.

community expectations concerning the safeguarding of users of services, especially professional services, against undue risk.

This issue extends way beyond judges, and the few other responsible office holders currently covered by exceptions in the ADA (cf. para 4.12 of the Consultation Paper).

Many other service providers may put the public at serious risk if they continue to practice into old age when they are no longer capable – political and business leaders, doctors, barristers, solicitors, engineers, operators of machinery and public transport, to name just a few. It seems anomalous to single out judges for compulsory retirement.[19]

On the other hand, in our view, compulsory retirement is an overly blunt form of exception. Some judges could continue to serve well beyond the current compulsory retirement age. The premature loss of their expertise is unnecessary.

Capacity Australia recommends a more nuanced approach, perhaps based on the approach taken in the ADA with respect to drivers' licences (see para 4.14 of the Consultation Paper). In other words, this issue might be better dealt with by mandated age-based **assessment** of people in a range of specified offices and occupations, rather than mandated retirement.

As we have said, given Capacity Australia's expertise,[20] we would be happy to provide further advice on this issue.

Question 4.3: Disability discrimination

(1) What changes, if any, should be made to the way the ADA expresses and defines the protected attribute of "disability"?

In our opinion, the current definition is outdated and inadequate. In particular, it does not refer **in terms** to cognitive impairment or mental illness

[19] We appreciate that, as regards certain occupations (e.g., airline pilots), some private employers impose their own compulsory retirement age.
[20] Peisah et al. (2018) International Consensus Group on Health Screening (Cognitive and Physical) for doctors over 70 in response to a call from the Medical Board of Australia.

It is true, as the Commission says at para 4.32 of the Consultation Paper, that "although it does not use these terms, the ADA's definition is broad enough to include a range of conditions including … cognitive impairment [and] mental illness".

Nevertheless, we are firmly of the view that these terms should be explicitly used. Given the prevalence in the Australian community of "mentalism" (see our comments above on systemic discrimination), and the more general failure to understand or detect cognitive impairment, resulting in "invisibility" of people living with cognitive or mental disorders, the non-use of these terms in such a vital piece of legislation as the ADA is a kind of collusion.

We suggest that the definition of "disability" be aligned with Article 1 of the CRPD, which is quoted at para 4.42 of the Consultation Paper:

> *Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.*

As the Commission points out at para 4.42, another advantage of the CRPD definition is that it represents a **combination** of both the "medical" and "social" models of disability.

Capacity Australia accepts that any adequate definition of disability must include a social aspect. But we firmly reject an exclusively social model. With great respect, it is imperative that the Commission understands that the correct conceptualisation of disability is **biopsychosocial**, incorporating both social and medical models. To ignore the medical model of disability and rely solely on the social model is one-eyed and reductionistic, inconsistent with contemporary scientific evidence that many causes of disability are indeed due to "deficit[s], abnormalit[ies] or medical problem[s] requiring a cure". Obvious examples of causes of disability that require treatment, and potentially a "cure," are Parkinsons' disease and Alzheimer's disease.

We note that Article 25 of the CRPD requires State Parties to recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.

Capacity Australia also endorses the definition proposed in the preliminary submission of Dementia Australia (*Preliminary Submission PAD17*, 5):

> *Disability is any impairment, including a physical, mental, intellectual, cognitive, neurological, learning, communication, or sensory impairment, or a functional limitation whether permanent, temporary, or episodic in nature*

Question 4.9: Extending existing protections

(1) Should the ADA protect people against discrimination based on any protected attribute they have had in the past or may have in the future?

We note that the ADA protects against discrimination based on someone's past or future disability. We thoroughly approve of this, but see no good reason why such protection should not be extended to other attributes, including **age**.

5. Discrimination: potential new protected attributes

Question 5.1: Guiding principles
What principles should guide decisions about what, if any, new attributes should be added to the ADA?

Question 5.2: Potential new attributes
(1) Should any protected attributes be added to the prohibition on discrimination in the ADA? If so, which what should be added and why?
(2) How should each of the new attributes that you have identified above be defined and expressed?
(3) If any of new attributes were to be added to the ADA, would any new attribute specific exceptions be required?

We have argued in response to Question 4.3 that major changes should be made to the way the ADA expresses and defines the protected attribute of "disability". One of our main concerns with the current definition is its elliptical treatment of mental illness and cognitive impairment.

If the definition of “disability” were changed in the way we have suggested with a more explicit and inclusive definition (e.g., in line with the CRPD definition), then we accept there would strictly be no need to create any new protected attribute of, say, “mental illness”.

A possible alternative – we accept it might be novel to New South Wales – would be to create two separate (non-overlapping) protected attributes: (1) physical disability and (2) mental/cognitive disability.

One advantage of such an approach might be to highlight the insidious reality of discrimination based on mental illness and cognitive impairment. In our experience, such discrimination is not nearly so well understood by the general public as is discrimination based on more “obvious” forms of physical disability such as, say, quadriplegia.

We support the introduction of a new protected attribute of “irrelevant health record”, for the reasons outlined at paras 5.44-5.48 of the Consultation Paper.

6. Discrimination: Areas of public life

Question 6.1: Discrimination at work — coverage

(1) Should the definition of employment include voluntary workers? Why or why not?

Our short answer is “Yes”, for the reasons discussed at paras 6.11-6.13 of the Consultation Paper.

Voluntary work is crucial to society and must not be discouraged. We would add that voluntary work is also crucial to the mental health of many of the older people who (disproportionately) undertake it.

(3) Should local government members be protected from age discrimination while performing work in their official capacity? Why or why not?

While there is no good reason arbitrarily to exclude voluntary workers, or local government members acting in their official capacity, from protection from all forms

of discrimination (including age discrimination), the fact remains that at least some such service providers may put the public at serious risk if they continue to work into old age when they are no longer capable of doing so. See our answer to Question 4.1.

In short, the question arises whether there should be mandatory age-based **assessment** of people in a range of specified offices and occupations (which potentially puts the public at risk) paid or unpaid, official or unofficial.

Question 6.2: Discrimination in work — exceptions

What changes, if any, should be made to the exceptions to discrimination in work?

In our view, the exceptions in respect of discrimination by **small businesses** and by **small partnerships** should be removed. We agree with the views expressed by the Commission in 1999. These entities provide significant employment opportunities, not least for older people and those with disabilities.

We also support removal of the exception in respect of disability discrimination if the disability relates to **addiction to a prohibited drug**. The reasons outlined at para 6.32 of the Consultation Paper seem to us to be strong.

Question 6.4: The provision of goods and services — coverage

What changes, if any, should be made to the definition and coverage of the protected area of "the provision of goods and services"?

Question 6.6: The provision of goods and services – exceptions

What changes, if any, should be made to the exceptions to sex, age and disability discrimination in relation to the provision of goods and services?

As we said in our answer to Question 3.4, we agree with the view (noted at para 3.66 of the Consultation Paper), that a failure to change **systemic** barriers or practices should itself be considered a form of discrimination.

It can be powerfully argued that so-called “care poverty and unmet needs” in older people,[21] is discriminatory. Likewise, care poverty and unmet needs in persons with mental illness.

In our opinion, the systemic failure to provide any (or any adequate) aged care services, or any (or any adequate) mental health services, is – and should be under the ADA – a form of discrimination.

Of course, difficult questions arise as to whose duty it should be to provide such services, and to whom. From a drafting perspective, we have not thought through all the implications. It may well be that such issues are best dealt with by the imposition of a positive duty to prevent unlawful conduct (with consequential changes elsewhere) – see our answer to Question 11.3.

In any event, we consider that these issues must be addressed if Australia, and specifically New South Wales in this context, are to meet obligations under the CRPD.

Question 8.1(2): Vilification – protected attributes

Should the ADA protect against vilification based on a wider range of attributes? If so, which attributes should be covered and how should these be defined?

Our short answer is “Yes”. We note (para 8.55 of the Consultation Paper) that while the ADA prohibits **discrimination** based on age and disability, it does not protect against vilification on either of these grounds. This is plainly anomalous, especially as other jurisdictions in Australia do protect against vilification on those grounds (cf. para 8.62).

Having said that, we accept that the appropriate definition of vilification is a vexed one. Up to a point, concerns about freedom of expression are legitimate.

[21] Hill, T, Cortis, N, Hamilton M, Peisah C.. (2024) From rationing to rights: measuring unmet care needs to transform aged care systems Ch 4. in Kröger, T, Brimblecombe, N, Rodrigues R, Rummery K. Care Poverty and unmet Needs. Policy Press. Wylie

Question 9.7: Attribute-based harassment

If the ADA was to prohibit attribute-based harassment, which attributes and areas should it cover?

We note that harassing a person based on a protected attribute is not currently prohibited under the ADA (para 9.78 of the Consultation Paper). In our opinion, this is a serious lacuna.

As the Commission notes at para 9.80, not all attribute-based harassment meets the threshold of discrimination or vilification.

We support the approach in the Northern Territory (cf. para 9.89). The same attributes and the same areas of life that are protected from discrimination should also be protected from harassment.

All that said, we accept that there are legitimate grounds for a relatively narrow definition of harassment. The conduct in question might be confined to threats, abuse, insults, or taunts, as in Western Australia (cf. para 9.84)

Question 11.3: A positive duty to prevent or eliminate unlawful conduct

(1) Should the ADA include a duty to take reasonable and proportionate measures to prevent or eliminate unlawful conduct? Why or why not?

Our short answer is an emphatic “Yes”. Many discrimination laws in Australia already impose such a duty, and not to do so in the ADA is anomalous.

In any event, imposing such a duty would be a highly desirable step, for all the reasons outlined at para 11.65 of the Consultation Paper.

As we have said (see our answer to Question 4.3 above), at Capacity Australia we are especially concerned about systemic discrimination. It seems to us that imposing such a duty is likely to be the best way to tackle that scourge effectively.

(2) If so: (a) What should duty holders be required to do to comply with the duty? (b) What types of unlawful conduct should the duty cover? (c) Who

should the duty holders be? (d) What attributes and areas should the duty apply to?

As to (a), duty holders should be required to take "reasonable and proportionate" steps to prevent or eliminate unlawful conduct. The Victorian approach outlined in para 11.73 of the Consultation Paper seems to us a sensible one. It requires meaningful action, but the requirements are tailored to the circumstances of the duty holder.

We suggest, in addition, that the ADA should specify (in a non-exclusive list) certain types of steps that duty holders are required to consider taking – these would be steps of the sort listed in para 11.72 of the Consultation Paper (training, targets, record-keeping, action plans, etc.).

We also suggest that the ADA should require in terms that duty holders consider any relevant rules, regulations or standards applicable to that duty holder, using their current accountability frameworks, which should be updated in line with changes to the ADA to include ADA- based standards. Thus, for example, providers of health care services would be obliged to consider such standards added to the Australian National Safety and Quality Health Service (NSQHS) standards and Accreditation process; providers of aged care services would be obliged to consider such standards added to the Aged Care Quality and Safety Commission (ACQSC) standards and Accreditation process.

As to (b) and (d), we urge uniformity to the greatest extent possible. Ideally (though we do not profess expertise in relation to some protected attributes), any positive duty should apply to:

- all forms of prohibited conduct
- all protected attributes
- all areas of life in which prohibited conduct is prohibited

Finally, as regards (c), we consider that the duty should apply to anyone with an obligation not to engage in discrimination, vilification or harassment. The duty should extend to anyone conducting a business or undertaking, including corporations, government departments and agencies, sole traders, and not-for-profit organisations.