

Reparations for Harms Experienced in Residential Aged Care

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Abstract

This paper explores the possibility of reparations for harms suffered by people in residential aged care, focusing on experiences of people with dementia. We first explain how systemic and structural harms occur within residential aged care and outline how they constitute human rights violations. Using Australia as a case study, we then consider the limitations of court-based approaches to pursuit of redress and the current absence of redress from policy responses. We then propose an expansive and multifaceted notion of redress as reparations, where governments, residential aged care operators, medical and legal professionals, and civil society engage in ongoing recognition of harms and specific actions to prevent recurrence. By drawing on the United Nations Convention on the Rights of Persons with Disabilities and the Van Boven Principles, we consider the application to aged care of the framework of access to justice and reparations for human rights violations. This framework encompasses inclusive and accessible processes to access reparations for individuals in such forms as compensation and rehabilitation, and collective reparations, including apologies and public education. In order to ensure that reparations support the prevention of further harm in aged care, the design of redress could form part of broader government strategies directed toward increasing funding and access to community-based support, care, and accommodation, and enhancing the human rights of people with dementia.

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Building on the foundational work of disability rights activists calling for reparations for people with disabilities, this paper explores the possibility of reparations for harms suffered by people in residential aged care (aged care).¹ Research indicates that people in aged care can suffer harm arising from such experiences as lack of access to medical and dental care and rehabilitation, neglect in personal care, malnutrition, social isolation, verbal abuse, and physical and sexual assault (although quality of care and support can vary between aged care facilities and countries and can depend on individuals' socioeconomic and other circumstances). People with dementia in aged care can additionally suffer harm from substituted decision-making, use of restrictive practices such as chemical restraint, forced mental health treatment, segregation in separate dementia units, and non-consensual confinement in aged care (all of which are often lawful or clinically and socially authorized by reason of disability).² These experiences in aged care can cause harms that include mental distress; deterioration in physical health, cognitive ability, and physical mobility; and sometimes even premature death. The pain, resistance, and distress that people express in response to harms they have suffered might be disbelieved or dismissed by aged care staff and police, and, for people with dementia, their responses to harm can be pathologized as part of their dementia (sometimes even resulting in further use of restrictive practices and forced mental health treatment). Indeed, former United Nations Special Rapporteur on the rights of persons with disabilities, Catalina Devandas-Aguilar, in her report on the rights of older persons with disabilities (which includes dementia), observes that many human rights violations experienced by older people with disabilities "are frequently regarded as normal and rendered invisible to Governments, deepening the circle of discrimination and exclusion of older persons with disabilities."³

Harms experienced in aged care are often not the result of isolated incidents perpetrated by aberrant staff. Rather, as has been argued elsewhere, they are systemic and structural harms because they are facilitated by and sometimes embedded

within the geography and architecture, political economy, legal and regulatory frameworks, and operation of aged care.⁴ Structural conditions— notably community stigma around ageing, disability, and dementia; lack of public funding for and access to community-based health and social care to support the changing physical, psychological, communication, and behavioral needs of people with dementia; lack of availability of alternative community-based housing when people with dementia can no longer continue living with their family; and a lack of support for unpaid carers— constrain the ability and willingness of families to support people with dementia to continue living in the community.⁵ Trust and hope that families often hold toward aged care operators to provide safe and supported environments are undermined by harms that people then suffer in aged care. Care partners and family members might have consented to the use of restrictive practices or confinement in a separate dementia unit in absence of alternative options and coercion by aged care operators. These experiences are then compounded by ineffective internal and external complaint systems and ongoing experiences of guilt and trauma for supporting the admission of their family member into aged care.⁶

This paper argues that systemic and structural harms experienced in aged care constitute human rights violations that must be acknowledged and redressed. Noting that reparations have been delivered in other contexts of institutional harm, we argue for exploration of the possibility of reparations as one way through which governments, aged care operators (including for-profit, religious, and charitable organizations), medical and legal professionals, and civil society can contribute to righting individual and collective wrongs suffered by people in aged care. In making this argument, we focus our human rights analysis on the experiences of people with dementia in aged care because, as Devandas-Aguilar has observed, people with dementia are particularly at risk of abuse in long-term care.⁷ However, the argument for reparations is intended to apply to anyone harmed in aged care. We explore how international human rights law supports an approach to reparations for people with dementia in

aged care that is additional (rather than alternative) to court-based remedies, improvements in quality of care within aged care, and increased funding and community-based support, care, and accommodation so people can avoid entering aged care. It is this broader dual approach—responding to past experiences *and* addressing future systems—that is central to the validation and healing of individuals’ suffering, as well as to the realization of equality, dignity, and justice and improved aged care systems for the collective benefit of all people.

Human rights violations experienced by people with dementia in aged care

Human rights-based activism for the rights of people with dementia, led by the nongovernmental organization Dementia Alliance International and other civil society organizations such as Human Rights Watch, has been key to shifts toward greater discussion of the need to address the systemic and structural harms of aged care.⁸ Appalling circumstances in aged care exposed during the COVID-19 pandemic have prompted increased public debate, civil society reports, and government inquiries into the operation of aged care, particularly in times of emergency, with some urging a fundamental reimagining of the future of aged care involving deinstitutionalization.⁹ There is also growing recognition within the United Nations system that dementia is a condition causing multiple cognitive and other disabilities and thus that people with dementia are people with disabilities who are entitled to rights enshrined in the Convention on the Rights of Persons with Disabilities (CRPD).¹⁰ On this basis, our analysis below focuses primarily on the CRPD.

The systemic and structural harms of aged care constitute specific human rights violations, as we have explored in our earlier research.¹¹ In brief, rights to legal capacity (article 12, CRPD), freedom from deprivation of liberty (article 14, CRPD) and personal integrity (article 17, CRPD) are violated through nonconsensual confinement and restrictive practices. The right to freedom from torture and cruel, inhuman, and degrading treatment (article 15, CRPD) is violated by the use of restric-

tive practices and nonconsensual mental health treatment. The right to freedom from violence (article 16, CRPD) is contravened by physical and sexual assaults and the use of restrictive practices. Former Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment Juan E. Méndez has observed that the use of nonconsensual mental health treatment and restrictive practices on people with disabilities could constitute torture or ill-treatment and calls on states to “impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities ... The obligation to end forced psychiatric interventions based solely on grounds of disability is of immediate application and scarce financial resources cannot justify postponement of its implementation.”¹² States are also called on to “replace forced treatment and commitment by services in the community. Such services must meet needs expressed by persons with disabilities and respect the autonomy, choices, dignity and privacy of the person concerned.”¹³

The rights to health, rehabilitation, and social participation (articles 25, 26, and 30, CRPD) are threatened by limited access to medical and dental treatment, routine neglect in personal care, and confining people in segregated dementia units in which there is little stimulation or social activities. People with dementia are denied the right to independent living and community inclusion (article 19, CRPD) by reason of lack of access to community-based support, care, and accommodation and nonconsensual admission to aged care, both of which deny people with dementia the opportunity and supports to live where they choose. The United Nations Committee on the Rights of Persons with Disabilities has emphasized that “institutionalization is discriminatory as it demonstrates a failure to create support and services in the community for persons with disabilities, who are forced to relinquish their participation in community life to receive treatment.”¹⁴ Devandas-Aguilar has observed that

while younger persons with disabilities are increasingly encouraged and provided with support to live independently, in many countries older persons with disabilities are regularly coerced to

*reside in long-term care facilities ... Many of these facilities are in fact segregated institutions, where staff exercise control over the person's daily life and make decisions about the person's care, including their placement in segregated locked wards, the administration of chemical restraints ... and the use of other physical restraints.*¹⁵

She further notes that “at the root of the segregation of older persons with disabilities in institutions lies the lack of quality support services within the community.”¹⁶

The sum effect of these violations is to subject people with dementia to detrimental treatment as compared to people in aged care without dementia and people with and without dementia in the broader community, thus violating the right to equality and nondiscrimination (article 5, CRPD). Devandas-Aguilar has called on state parties to the CRPD to “prohibit by law all forms of discrimination on the grounds of disability and age, as well as on the basis of the intersection between both grounds, and guarantee to older persons with disabilities equal and effective legal protection against discrimination on all grounds.”¹⁷

While noting that the obligation to respect and ensure human rights falls on the state (rather than nonstate actors such as corporate or charitable aged care operators or private medical professionals who are often involved in delivering aged care), the obligation of the state to protect against human rights violations clearly extends to taking steps to regulate the behavior of nonstate actors and provide remedies for violations.

In previous qualitative research with people with dementia, care partners, aged care managers, and lawyers and advocates, we explored with coauthors Ray Carr, Lyn Phillipson, and Richard Fleming the dynamics driving the enduring infringement of human rights of people with dementia in aged care. That research identified economic, cultural, and socio-legal barriers.¹⁸ Economic barriers relate to the marketization of aged care, which gives rise to the “objectification and dehumanisation of people with dementia because they become a source for extraction of profit.”¹⁹ As a result, there is a perversity in the common suggestion that systemic and

structural harms in aged care should be solved through increased funding, particularly in cases where aged care operators are wealthy charities, religious organizations, or corporate entities that are already gaining financially from aged care.²⁰ Cultural barriers relate to a lack of support for people with dementia to live in and be included in the community, coupled with stigma about dementia and discrimination toward people with dementia.²¹ At the extreme of these cultural dynamics, people with dementia can be viewed as burdens on others and as nearly dead, and therefore as violable and dispensable.²² Socio-legal dynamics relate “to the intersection of lay understandings of legal norms and everyday social practices and attitudes about people with dementia,” particularly the duty of care as requiring a focus on physical safety at the cost of people with dementia’s emotional well-being and recognition of human rights, and mental incapacity as requiring substitute decision-making and denial of autonomy of people with dementia.²³

The right to access to justice and remedy human rights violations in aged care

People with dementia have the right to access justice on an equal basis with others (article 13, CRPD). Principle 8 of the International Principles and Guidelines on Access to Justice for Persons with Disabilities provides that “persons with disabilities have the rights to report complaints and initiate legal proceedings concerning human rights violations and crimes, have their complaints investigated and be afforded effective remedies.”²⁴ Devandas-Aguilar has recognized that “access to effective remedies is critical to combating all forms of exploitation, violence or abuse against older persons with disabilities.”²⁵ The International Principles and Guidelines on Access to Justice for Persons with Disabilities also note that states should ensure that “effective remedies are in place for human rights violations, including the right to be free from disability-based discrimination and the rights to restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition.” These remedies should be “enforceable, individual-

ized and tailored to meet the needs of claimants,” “ensure that victims are protected from repeat violations of their human rights,” and “address the systemic nature of human rights violations.”²⁶ The principles provide guidance to states on how to meet their treaty obligations rather than being binding in themselves. Nevertheless, they are useful in highlighting the importance of delivering reparations to people with dementia.

Access to remedies for the nonconsensual confinement of people with disabilities has been specifically recognized as central to realizing the rights to independent living and community inclusion and to liberty and security of the person.²⁷ The Working Group on Arbitrary Detention’s Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court provide that any individual who has been arbitrarily or unlawfully detained “is guaranteed access to effective remedies and reparations capable of providing restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition.”²⁸ The principles provide specific guidance on remedies for persons with disabilities, stating that “courts ... shall comply with the State’s obligation to prohibit involuntary committal or internment on the grounds of the existence of an impairment or perceived impairment ... as well as with their obligation to design and implement de-institutionalization strategies based on the human rights model of disability.”²⁹

Two key points emerge from the above human rights analysis. First, people with dementia are entitled to nondiscriminatory treatment in terms of the care, support, and accommodation they access in aged care and the community, *and* they are entitled to equal access to justice, including remedies, in the wake of harms they suffer in aged care. Second, the human rights surveyed above indicate a dual temporal approach to responding to human rights violations experienced by people with dementia in aged care: redress to individuals for past harms arising from these violations, *and* structural reforms to enhance future funding and access to community-based support, care, and accommoda-

tion for the benefit of all people with dementia.

Political and legal inaction on past harms in aged care: Australian case study

Australian governments and justice systems have largely failed to adequately respond to past systemic and structural harms in aged care, despite extensive attention to the problem. The Commonwealth government recently held the highest-level form of inquiry into the country’s aged care system through the Royal Commission into Aged Care Quality and Safety (ACRC).³⁰ This followed 20 earlier government inquiries on aged care during the previous 20-year period, which are argued to have been largely inconsequential by reason of the legislative, regulatory, and funding landscape following the introduction of the Aged Care Act of 1997, which saw increased government funding to and growth in the private aged care sector.³¹

In its 2019 interim report titled *Neglect*, the ACRC noted that aged care residents have their “basic human rights denied. Their dignity is not respected, and their identity is ignored. It most certainly is not a full life. It is a shocking tale of neglect.”³² In its final report, the ACRC recognized that “the number of people who have experienced substandard care is inexcusably high” and that “abuse is an extreme example of substandard care and reaches into the realm of criminal behaviour.”³³ These two reports document diverse harms, including the widespread use of restrictive practices, neglect in medical and dental care, the denial of palliative care, neglect in personal care (e.g., rationing of incontinence pads), and physical and sexual assault. The ACRC acknowledged current problems with complaint processes and access to remedies for violations of quality and safety regulatory requirements and recommended legislative reform to enshrine private rights to court action for damages for those who have suffered loss and damage by reason of breaches of proposed aged care legislation.³⁴ The ACRC made no recommendations for an accessible redress scheme not requiring individual court action, nor did it make any recommendations for remedying individuals or their families for harms

that had already occurred.³⁵ Regardless, the Australian government has not acted on even the modest recommendations for future court-based redress, and, moreover, there continue to be stories in the media of systemic and structural harms in aged care, particularly the widespread use of restrictive practices and neglect in personal care.³⁶

Australian justice systems have also failed to adequately respond to past systemic and structural harms experienced by people with dementia in aged care. There are examples of people with dementia and their families seeking court-based remedies for harms experienced by *individuals* in aged care, including in the context of the current COVID-19 pandemic.³⁷ However, there are significant limitations in delivering justice for those individuals and in utilizing litigation as a method for addressing the broader *systemic* and *structural* harms of aged care.³⁸

Court action is premised on each victim-survivor or their family member having the financial and evidential burden of bringing their own litigation in order to obtain court-based remedies, even where the systemic nature of these harms might be widely established through media accounts, civil society reports, or government inquiries. Justice systems fail to adequately accommodate people's experiences of dementia, particularly by reason of rules about legal capacity and the complexity and expense of court proceedings.³⁹ Court action requires a specific plaintiff and defendant, specific acts or omissions perpetrated, and a demonstrably direct causal relationship between the acts or omissions and the injury or loss experienced by the plaintiff. Yet harms in aged care occur over long time frames, are perpetrated by multiple individuals, have complex causes, emanate from the environmental design of aged care facilities, and are supported by profit-driven models of care and state-driven regulatory, funding, and legal frameworks.⁴⁰ The quantum of any damages that are awarded through litigation will be limited because "aged care residents will inevitably be already receiving some care and support as a result of existing conditions, will have retired from work and may not suffer further significant economic

loss as a result of injury, and will have limited life expectancy."⁴¹ Court remedies can rarely address the scope and complexity of harm in aged care, nor can remedies be obtained through courts for harms arising from the legal use of restrictive practices. Court-based remedies are also limited in their capacity to address wider familial, intergenerational, and community impacts of systemic and structural harms of aged care. Limitations inherent within court-based responses can mean that rather than offering an effective remedy, these processes can create further layers of harm to people with dementia, their families, and communities.⁴² The lack of appropriate court-based redress for past harms can therefore support cycles of perpetration because, as the Committee on the Rights of Persons with Disabilities has noted, "Perpetrators may act with impunity because they perceive little risk of discovery or punishment as access to judicial remedies is severely restricted."⁴³

While the ACRC was the type of body that could have explored limitations of court-based remedies, this was not explicitly included in its terms of reference (although it is a matter arguably still within its terms of reference in being "reasonably relevant to the inquiry"). Political and judicial inaction on past systemic and structural harms in aged care can be contrasted with other examples of redress for institutional harms in Australia in relation to sexual abuse in child welfare institutions and members of the Stolen Generations.⁴⁴

Reparations: An expansive and multifaceted approach

Redress—which means to set right a wrong—is often narrowly limited to court-based remedies, as is evident in the Australian case study above. However, we propose a human rights approach to redress that extends beyond court-based remedies to also include "reparations." Here, reparations are understood as actions directed toward repairing harms. They are delivered outside of the court system in recognition of systemic injustices impacting a particular community or group of people. They are often delivered by government, being admin-

istered by bureaucrats pursuant to a particular policy or legislated scheme. Sometimes they are delivered outside of government by a particular industry or sector, organization, or professional body involved in perpetration of the harm or even by members of the wider community who have been witnesses to, bystanders to, or beneficiaries of the harms. Inquiries and reports into harms in a variety of other institutional settings, such as Indigenous children's homes, mother and baby homes, and various child welfare institutions, have recommended such measures as redress schemes, national apologies, memorials, and public education programs.⁴⁵ Redress schemes in relation to child welfare institutions now operate in a number of Western nations, including Australia, Canada, Ireland, and Sweden.⁴⁶ As a matter of human rights, notably the rights to nondiscrimination and equal access to justice, scholars, civil society, and governments should explore reparations for systemic and structural harms suffered in aged care, in the same way that such reparations have been made available to other marginalized populations.

Exploring in the context of aged care an approach to redress that includes reparations is proposed on the basis that reparations offer more expansive and multifaceted possibilities than what is attainable through courts, particularly in relation to what wrongs can be redressed, who can participate in redress, and how to enact redress. However, it is important to make two qualifications. First, we see reparations as operating in tandem with court-based remedies. Reparations should not be a substitute for access to justice through the courts. In particular, as a matter of equal access to justice, deficiencies in the court system (such as those identified in relation to Australia) must also be addressed in order to ensure that people harmed in aged care can pursue court remedies if they so choose. Second, reparations are additional to any human rights obligation on governments to take immediate action in response to harms in aged care, such as to facilitate an individual being freed from detention or facilitate the cessation of restraint or forced treatment.

The Van Boven Principles provide greater

detail on processes and forms through which to realize reparations for the harm suffered in relation to gross human rights violations. The principles, which have been adopted in resolutions by United Nations bodies, are "recommendations and do not bind States," although this "does not preclude the possibility that the resolutions, which as such are merely recommendations, reiterate principles which are binding on the basis of other sources of law."⁴⁷ They apply specifically to victims of "gross violation[s] of human rights," which include "the types of violations that affect in qualitative and quantitative terms the core rights of human beings, notably the right to life and the right to physical and moral integrity of the human person" and specifically extend to "torture or cruel, inhuman or degrading treatment or punishment;... arbitrary and prolonged detention; ... and systematic discrimination."⁴⁸ We propose that human rights violations occurring in aged care be considered "gross human rights violations," particularly by reason of systematic discrimination on the basis of age and disability inherent to segregation, detention, forced treatment, and use of restrictive practices, as well as the widespread nature of these violations.⁴⁹ While aged care might not be conventionally understood as a site of gross violations of human rights, we argue that the paradigm shift brought about by the CRPD in terms of how human rights of people with disabilities are understood necessitates a "disabling" of how the Van Boven Principles are interpreted and applied in order to extend to specific experiences of people with disabilities (much in the same way that Méndez notes that the CRPD necessitates a shift in understandings of torture and ill-treatment to include restraint and seclusion).⁵⁰ Indeed, the principles provide that their "application and interpretation ... must be consistent with international human rights law ... and be without any discrimination of any kind or on any ground, without exception," thus supporting an interpretation of "gross human rights violations" that is attentive to human rights violations under the CRPD.⁵¹

Pursuant to the Van Boven Principles, reparations can take a variety of forms. Here, we focus

on some forms that are particularly relevant to the aged care context. While there are no concrete examples of how reparative measures have applied in the specific context of aged care, there are analogous contexts of harm in medical and institutional contexts (such as nonconsensual sterilization and institutional child abuse) on which we can draw. First, there are some forms that could address the individual circumstances of people with dementia. Compensation (including for physical and emotional injury, material damages, and moral damage) can respond to physical injury and psychological impacts of the systemic and structural harms to people with dementia in aged care, as well as moral damage to individuals' trust and hope in the aged care system. Rehabilitation (for medical and psychological care) can serve to counter some physical impacts of limited access to medical and dental treatment and rehabilitation and neglect in personal care, such as helping people walk again (after being restrained to beds or chairs for long periods of time), communicate and socialize (after being denied social interaction and intellectual stimulation), develop continence (after becoming incontinent due to absence of assistance with toileting), or have remedial dental work (after their teeth have decayed due to lack of dental treatment). Compensation and rehabilitation have been utilized in other institutional contexts, including torture in police custody in the United States and sexual abuse in child welfare institutions in Australia, Ireland, and Canada.⁵² Restitution might also be useful. Restitution serves to restore the victim to their situation prior to human rights violations. Restitution can address specific financial losses associated with people with dementia and their families paying for substandard care and accommodation, and therefore go some way toward countering financial gain by aged care operators providing harmful cost-efficient and profitable care. Second, there are forms of reparations that address the structural dynamics of human rights violations in aged care. "Satisfaction," which includes truth seeking, public apologies, commemoration, and human rights training, could be useful in facilitating official

recognition of wrongfulness of past harms in aged care, opportunities for public engagement and collective accountability, and education for medical and legal professionals and aged care staff on the human rights of people with dementia. Satisfaction measures are evident in government responses to institutional child sexual abuse across Australia, Canada, and some European nations, historical eugenics sterilization of people with disabilities in the United States, and torture in police custody in the United States.⁵³ Guarantees of non-repetition might also be useful. These "comprise broad structural measures of a policy nature" and can directly connect past harms of aged care to government commitments to reform legal, regulatory, and funding systems in order to enhance funding and access to community-based support, care, and accommodation.⁵⁴

There are six potential benefits of reparations as a response to harms experienced by people with dementia in aged care. First, reparations overcome the problem whereby many harms in aged care are technically legal or otherwise not recognized as crimes. As a result, reparations are particularly useful in providing an opportunity to redress lawful and socially and clinically authorized violence against people with dementia. Second, reparations can be administered bureaucratically outside of the court system and thus overcome many limitations that people with dementia experience with court-based redress. Third, reparations can address individual *and* collective impacts and dynamics of harms in aged care.⁵⁵ This overcomes limitations of court-based processes that focus on individualized justice. Fourth, because reparations are "both backward and forward looking, in the sense that they attempt to redress past violations as well as prevent future re-occurrence," reparations can respond to individual experiences of harm in aged care *and* support the design and operation of future aged care systems.⁵⁶ In particular, reparations in the form of satisfaction can provide opportunities for understanding and learning from past harms perpetrated in aged care as a foundation for collective commitment to and action on prevention. Fifth,

while international human rights obligations might apply only to state actors, reparations for human rights violations can provide opportunities to expose the role in harm of nonstate actors, including charities, religious organizations, and corporate entities that operate aged care facilities and medical and legal professionals complicit in enabling or enacting harms in aged care (e.g., by providing legal and clinical authorization of restrictive practices).⁵⁷ Sixth, in being a “tangible expression of the addressing of harms endured by victims,” reparations can give people with dementia “sociopolitical agency” in contexts where the denial of their agency and autonomy (both sociopolitically and legally) has been central to harms that are perpetrated in aged care.⁵⁸

There are, however, potential limitations of reparations in relation to harms experienced by people in aged care. First, the effectiveness of reparations in part depends on whether they form part of a “holistic set of interventions to repair past harm and foster comprehensive implementation of rights.”⁵⁹ There is the possibility that aged care operators might exclude populations more likely to be harmed in aged care (such as people with dementia) in order to manage their risk and limit liability. Thus, if reparations for systemic and structural harms of aged care are not also accompanied by government reforms to enhance funding and access to community-based support, care, and accommodation (as we have proposed they should be), the operation of reparations might cause some people to be left unsupported in the community. Second, reparations can support “‘politics of distraction’ strategies” that enable systemic and structural harms to continue, governments and nonstate actors to avoid accountability, and aged care providers to continue receiving financial gain.⁶⁰ This might be particularly the case in relation to reparations in the form of satisfaction (such as official apologies), which can be “empty words” if “not accompanied by more tangible benefits”—such as material improvements in living standards in aged care facilities, enhanced funding and access to community-based support, care and accommodation, and legal reform to prevent restrictive

practices and substitute decision-making.⁶¹ Third, even when reparations operate outside of court systems, there can still be challenges in accessibility for marginalized groups, and financial and evidential challenges to participation.⁶² So, there are risks if reparations processes and outcomes are not tailored to the needs of people with dementia. Fourth, often reparations in the context of institutional harms are introduced once the institutions in which they were perpetrated have closed, and once there is widespread community and political recognition of those harms. Thus, it might be that reparations in the context of aged care will depend on a shift from the current institutional model of aged care, as well as community and political willingness to acknowledge these harms. This is perhaps the greatest challenge to reparations in the context of aged care, which, in many countries, is a well-established, state-sanctioned or -funded, and growing industry that many individuals and families depend on in the context of a vacuum of community-based options.

An invitation to explore redress

This paper has explored the possibility of redress for structural harms experienced by people with dementia in aged care. An international human rights framework of access to justice and reparations provides the basis for an expansive and multifaceted approach to redress pursuant to which governments, aged care operators, medical and legal professionals, and the broader community can be engaged in ongoing recognition and action in response to the physical injury, emotional harm, financial loss, and moral injury to victim-survivors, in the broader context of supporting community living and the dignity and equality of all people with dementia. Ultimately, this paper serves as the first step in what is hoped will become a lively global debate among older people, people with dementia, scholars, and civil society on the possibilities, complexities, and limitations of reparations as one potential framework to respond to systemic and structural harms in aged care.

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