Our ref MJP:EM

Date 26 August 2021

BY EMAIL TO: agencypolicy@ndis.gov.au

National Disability Insurance Agency (NDIA)

GPO Box 700

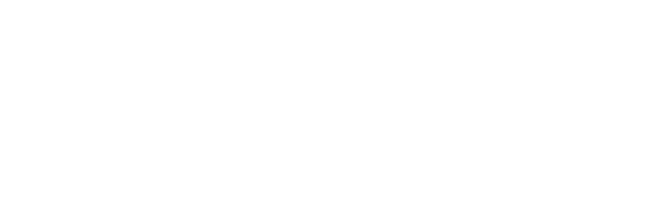
Canberra ACT 2601

Dear Colleagues,

**First Lawyers Pty Ltd**

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# Re: Response to Consultation Paper: Supporting you to make your own decisions (the Paper)

Autonomy First Lawyers appreciates the opportunity to respond to the Paper.

Since April 2020, the firm in co-operation with MQ Health, has not only operated the Capacity and Capability Clinic located at Macquarie University Hospital but also operated as a private client focused medico legal professional practice with particular expertise in empowering vulnerable decision makers including those with diagnosed and undiagnosed disabilities and using Supported Decision Making methodologies to carry out this work.

We are increasingly being asked to advise and represent National Disability Insurance Scheme (NDIS) participants, their families and supporters. This experience is reflected in this submission.

In our work we have established multi-disciplinary professional practice settings that combine the professional disciplines of clinical neuropsychology, law, financial services advice, disability advocacy and allied health practice to deliver decision making support and other complementary services to our clients, their supporters and associated communities.

We recognise and are challenged by the differing requirements on professional practice imposed by the rights-based decision-making approaches in Commonwealth Legislation, the best interests focused requirements in Australian Consumer Law and State based legislation dealing with various forms of legal personal representation.

Operating non-medical, multi-disciplinary practice settings has also taught us about the confusing impact on professional practice standards and quality assurance processes that is caused by the differing client competence evaluation requirements imposed on Australian legal practitioners from that imposed on non-

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legal professional disciplines. Harmonising these differences is in our opinion essential if a consistent implementation for Supported Decision Making is to be achieved across the disciplines and service providers who are necessary to support the social and economic engagement of NDIS participants in their communities.

In our experience, great mischief is created by the unwarranted assumption of decision-making capacity and ability. The lack of a person’s ability to advocate their best interests contributes to a lack of values alignment between a person and their carers. In our experience this often results in disempowerment of an individual and the emergence of abusive conduct in their support network.

Both our experience to date and our consideration of the paper results in our submission focusing on the following issues in addition to answering the formal consultation questions:

1. An absence within the policy framework described in the Paper of any commitment to the implementation of the National Decision Making Principles as a normative framework in the operation of the NDIA and its relationship with NDIS participants..
2. An absence within the policy framework described in the Paper, of the role of the ethics of care and the ethics of ageing in co-ordinating the development of cognitive responsive services and professional practices. Such an approach in our opinion will strengthen the decision-making capacity and ability of NDIS participants, their supporters and representatives and improve the advocacy of their best interests by NDIS participants.
3. A lack of professional training and practices validated uniformly across professional disciplines in:
   1. the evaluation of the cognitive ability of clients, and
   2. the delivery of cognitive responsive advice and services that aligns to the will and preferences of the person under care.

Responsiveness to a person’s decision-making ability (cognition) needs to be a consistent feature of interviewing, onboarding and normal operations across professional disciplines and commercial operations in the community if the will and preference of a person is to be given appropriate support and safeguarding.

1. A lack of professional training and practices across professional disciplines in understanding undueinfluence and its interaction with client decision making vulnerability when supported decision making goes wrong.
2. The role of informal supports and supporters as facilitators of abusive conduct in the community.
3. The impact of the failure to translate the cognition responsiveness initiatives in the health system to broader community sectors[[1]](#footnote-1).
4. A lack of appreciation of the unsuitability of service brokerage business models to the delivery of consultation led professional practice models.
5. The impact of a lack of appreciation of the mischief done by the unwarranted assumptions of unrestricted decision-making capacity illustrated by this quote:

‘*I’m an accountant not a doctor. If the client sounds rational and reasonable that is generally all I am concerned about*’. [[2]](#footnote-2)

The lack of appreciation of a person’s social façade as a factor masking their decision-making ability and the efficacy of any consent sought from them is in our experience a substantial factor in facilitating abusive conduct in the community.

Our focus as a law practice engaged to optimising the abilities of our clients and mitigate the impact of their vulnerability, is to work to resolve these challenges and seek support from other aligned professionals, government and community members in achieving these goals.

We acknowledge the assistance of our colleagues including Professor Carmelle Peisah (UNSW Ageing Futures

Institute and Capacity Australia), Sarah Judd Lam and Madeleine Gearside (Carers NSW), Megan Frost (Relationships Australia NSW), Michael Fox (Society of Trust and Estate Practitioners), April Creed and Rebecca Glover (ExSitu) and Petrina Coventry (GPex and SAMRI).

We are happy to speak further to this submission. For further information please contact the writer.

Yours sincerely,

**Autonomy First Lawyers Pty Ltd**



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**NATIONAL DECISION-MAKING PRINCIPLES ADOPTED AS A NORMATIVE FRAMEWORK**

These principles were established by the Australian Law Reform Commission in its 2014 report about Equality, Capacity and Disability in Commonwealth Laws (the Report) and are summarised as the right of a person:

1. To make decisions
2. To receive support for decision making
3. To have their will and preference supported, subject to
4. Their will and preference being appropriately safeguarded.

In our experience, the application of these principles as a normative framework for client engagement and the delivery of both care and professional services results in an improved outcome for clients that mitigates the following problems described at page 7 of the Paper:

1. Disempowerment of the person concerned
2. Inconsistency of supports and uniformity of client experience across the disciplines and services that may be engaged to the resolution of decisions and situations of concern.
3. Lack of emphasis on building increased decision-making capacity or ability as a service outcome
4. Lack of support for particular life transitions or affairs management objectives exacerbated by lack of access to appropriate non health and medical professional and commercial services to support the will and preference of the NDIS participant.

In our experience, lack of uniform training and professional practices in values-based interviewing, decision making ability evaluation and cognition responsiveness across professions assures the observed result at page 8 of the Paper that:

**NDIS staff and partners have different levels of understanding about support for decision making practices and how best to support participants with decision making.**

This also leads to a lack of understanding of the increased vulnerability of a person to undue influence as their cognition is compromised. The CEPAR research brief about cognitive ageing and decline released in 20183 highlighted the significant cohort of the population with mild cognitive impairments that increases their susceptibility to undue influence and abuse. This includes those NDIS participants with cognitive disabilities. This cohort is significantly larger than the population cohort affected by dementia.

Recognition of the significance of mild cognitive impairment on the ability of participants to give informed consent to the specification and operation of NDIS plans is needed first, if the role and function of an NDIS

3 https://www.cepar.edu.au/resources-videos/research-briefs/cognitive-ageing-and-decline-insights-recent-research at p.3-5.

plan nominee is to be made subject to the will and preference of the NDIS participant to whom they are accountable.

Autonomy First Lawyers have developed professional practice resources and training that addresses these concerns and is partnering with a range of complementary professionals to apply this learning across a range of service settings.

The recognition of multi-disciplinary practice and associated multi-disciplinary focused business models will in our opinion be vital to the development of the next generation of professional practices that will provide efficient and cost-effective services to help optimise the decision-making ability of all Australians including those with a disability.

We submit that by the Australian community, taking on board the National Decision-Making Principles as a normative framework for professional and commercial client engagement and practice, we necessarily shift focus from compensating for the disability of a person to the need to respond to any vulnerability in their decision making and work to optimise their abilities using appropriate supports and safeguards. Carers have an essential role to be engaged as inherently inclusive resources to this work.

The necessary shift in professional practice mindset to support this shift only occurs reliably where there is an organizational commitment to practicing both the ethics of care[[3]](#footnote-3) and the ethics of ageing[[4]](#footnote-4) as a core attribute of the functioning of the organisation. This requires deeper engagement between the NDIA, the Quality and Safeguards Commission and professional societies in order to occur.

The evolution of professional practice in dealing with the rights of the disabled needs to embrace the ethics of ageing and respond to the following statement:

“The ethics of ageing is a field of normative enquiry encompassing *ethical issues facing a person in her situation as an ageing person*.”

This can often be started by simply asking first: **“what does my younger self owe my older self”** and then responding appropriately to the answer.

**IMPLEMENTING THE ETHICS OF CARE AND THE ETHICS OF AGEING**

The Report naturally is focused on introducing the proposed decision-making principles into Commonwealth legislation and ignores the relevance of Supported Decision Making to guiding the day to day conduct of people involved in the administration of the legal, business, financial and social affairs of members of our national community.

The traditional ethical framework of the professions is focused on either the attributes of the professional or the qualifying attributes of a person to be the client of a professional. In our view, the Professional Standards Councils should be engaged in leading the establishment of a unified ethical framework for professionals engaged in dealing with the ageing of clients. All such professionals need to be bound to serve the interests of competent clients able to give proper and lawful instructions. This is simply and extension of what is required by lawyers nationally by the national Solicitors Conduct Rules to obey6:

*“A Client’s lawful, proper and competent instructions”*

This approach is consistent with the shift to a rights-based decision-making approach in general society, deemphasises the disability of a client and promotes a strengths based practice in dealing with people generally in society.

Supported Decision Making if used in this fashion, then becomes the general method by which a person’s constraints and limits of decision making can be ascertained and then used to shape the limits for supports and safeguards that are aligned to the will and preference of the person concerned and as needed, their substitute decision maker.

Supported Decision Making is not just an alternative to conventional substitute decision making arrangements. It needs. Also to be a method of operation of the administration of a person’s affairs that fosters formal and informal arrangement for the care of a person that inherently tends to mitigate the risk of abusive conduct and promotesthe efficacy of administering a person’s affairs consistently with their stated or appropriately imputed will, preference and values.

This approach is also consistent with the approach to Social Inclusion in Commonwealth Government policy as summarised by the Australian Human Rights Commission in its presentation titled **Social Inclusion and Human Rights in Australia7** in which the following observation was made**:**

1. Solicitors Conduct Rules 2015 r.8 for NSW see https://legislation.nsw.gov.au/view/html/inforce/current/sl-20150244#sec.8 .
2. Accessed at https://humanrights.gov.au/about/news/speeches/social-inclusion-and-human-rights-australia on 22

August 2021

*Inclusive society is defined as a society for all, in which every individual has an active role to play. Such a society is based on fundamental values of equity, equality, social justice, and human rights and freedoms, as well as on the principles of tolerance and embracing diversity.[7]*

We submit that for these inclusive principles to be applied to the roles of supporter (including carer and care co-ordinator) and supporting or substitute decision maker, a common ethical backplane across these roles needs to be established. Ethical principles should be constrained strictly by the boundaries of their domains of practical application.

While the law calls for a person’s decision-making capacity to be assumed, the unreasoned adoption of this assumption can in turn cause inappropriate resort to substitute decision making and the application of a substitute decision makers arbitrary belief about the best interest of the donor rather than enduring respect for their will and preference.

We have observed in our clinical and professional practice that the tension between the will and preference of a person and that of their legal personal representatives including substitute decision makers is often expressed in a range of conflict and dispute situations that could have been avoided. What is normally lacking is a stronger alignment between the processes for estate administration of a person, their will and preference and a regime of support before safeguarding in the administration of their affairs.

Implementing this is normally needs the intervention of professional leadership, intervention and support.

We agree with the general position taken by many commentators that substitute decision making without regard to the will and preference of the donor of the power should be a last resort.

The ethics of care and the ethics of ageing provide a consistent ethical backplane to the implementation of Supported Decision making in day-to-day professional practice and the administration of the affairs of any person. This focus is consistent with the social inclusion policy objectives outlined above and avoids the mischief of functional specialisation of services being delivered in an uncordinated fashion not aligned to the will and preference of the person under care.

Current difficulties with care co-ordination in delivering sub optimal supports can in many situations be resolved by establishing a carer responsibility that includes the attributes outlined above as part of the job description of care co-ordinators or plan nominees.

**PROPOSALS COMMENDED FOR CONSIDERATION**

**We commend** the ethics of care and the ethics of ageing be adapted to provide a consistent ethical framework for the operation of care co-ordination and NDIS participant representation in the operation of the NDIS.

**We commend** in the pursuit of diversity in the empowerment of decision making by vulnerable decision makers irrespective of their ability, consistency of understanding the decision-making ability of a person is achieved by:

1. appropriate training and professional support of sufficient cognitive responsive practices that result in the normal understanding of the cognitive limits or not of decision makers in dealing appropriate with professional and commercial service providers.
2. Implementation of recognition of cognitive responsive workers and workplaces as we continue to develop as a society in which rights-based decision making and the will and preference of citizens is respected and implemented as part of normal operation in of Government and Society.
3. Engagement with appropriate professional societies to develop consistent processes and practices for the delivery of cognitive responsive workplaces and workers that have to understand why they should accept and assume the decision-making ability of a person with whom they are dealing.
4. Support for aligned academic research in the validation of tools and practices in. operation such as those being examined by Professor Adam Steen of Deakin University in which our firm is involved.

**We commend** the achievement of these objectives by measure of the efficacy of practices and processes that deliver outcomes consistent with the following objectives for each plan participant:

* + *Learn (e.g. participate in education and training);*
  + *Work (e.g. participate in employment, unpaid or voluntary work including family and carer responsibilities);*
  + *Engage (e.g. connect with people, use local services and participate in local, cultural, civic and recreational activities); and*
  + *Have a voice (influence decisions that affect them).*

**We commend** the role of professionals in building the decision-making capacity and ability of NDIS participants be recognised in the operation of NDIS.

**We commend** the decision-making ability capacity building roles of professionals and service providers be distinguished from any roles they may have in individual advocacy for a person (including NDIS participants) in the operation of NDIS.

**We commend** the recognition of estates practice as a multi-disciplinary field of practice that is represented by the Society of Trust and Estate Practitioners and optimised for the development and delivery of relevant professional practices and standards that responds to this submission.

**CONSULTATION QUESTION REPLY**

**How can we help people with disability to make decisions for themselves?**

By facilitating their connection to appropriate supports and safeguards for the implementation of their will and preference or as appropriate, the advocacy and protection of their best interests by themselves or necessary substitute decision makers. Lack of availability of decision-making processes that support and protect the will and preference of a person under care facilitate the emergence of undue influence and abusive conduct in the community.

We need to increase the availability of programs and service that mitigate the emergence of undue influence and abuse. This can start by deployment of training and organizational development services that recognise the emergence and availability of cognitive responsive workplaces, workers and services,

**Who are the best people help you (or a person with disability) to make decisions? (We call them decision supporters)**

This will depend on the cause of concern requiring decision. Decision supporters can include:

1. Professionals delivering as needed consulting, advice or transactional support service
2. Commercial goods and service providers
3. Legal Personal Representatives
4. Person’s responsible as recognised in the relevant State legislation. For example in NSW see (http://classic.austlii.edu.au/au/legis/nsw/consol\_act/ga1987136/s33a.html ):
   1. the person's guardian, if any, but only if the order or instrument appointing the guardian provides for the guardian to exercise the function of giving consent to the carrying out of medical or dental treatment on the person,
   2. the spouse of the person, if any, if:
      1. the relationship between the person and the spouse is close and continuing, and
      2. the spouse is not a person under guardianship,
   3. a person who has the care of the person,
   4. a close friend or relative of the person.

Carers are in turn defined in NSW by the Carers (Recognition) Act 2010 s.5 that provides:

1. For the purposes of this Act, a person is a ***carer*** if the person is an individual who provides ongoing personal care, support and assistance to any other individual who needs it because that other individual:
   1. is a person with disability within the meaning of the *Disability Inclusion Act 2014*, or
   2. has a medical condition (including a terminal or chronic illness), or
   3. has a mental illness, or (d) is frail and aged.
2. Despite subsection (1), a person is not a carer for the purposes of this Act in respect of care, support and assistance that the person provides:
   1. under a contract of service or a contract for the provision of services, or
   2. in the course of doing voluntary work for a charitable, welfare or community organisation, or
   3. as part of the requirements of a course of education or training.
3. To avoid doubt, a person is not a carer of another person for the purposes of this Act merely because the person:
   1. is the spouse or de facto partner of the person, or
   2. is the parent, guardian, child or other relative of the other person, or (c) lives with the other person.

Counterpart definitions in all jurisdictions should be adopted and harmonised for the purpose of NDIS operation.

**What should they do to help with decision making?**

This will be always context specific to the cause, concern and cognition of the person under care.

Processes for the accountability of the provider of goods or services to the decision maker or the person for whom they are caring are needed that do not require resort to formal legal processes.

Care in contracting in the first place needs to be facilitated by the establishment of better contracting and service provision processes that are cognitive responsive.

**How can they get better at helping?**

By responding to the extent of cognitive ability of the person and respecting their will, preference and values.

**How can we make sure the right people are helping? For example:**

That they are building the capacity of the person with disability.

By having an appropriate outcomes-based framework for assessment and evidencing service outcomes.

See for example the inclusion outcomes referenced above.

As a state level, adopting the relevant Human Services Outcomes framework established in State jurisdictions such as NSW. See for example:

https://www.facs.nsw.gov.au/resources/human-services-outcomes-framework

That they are considering what the person with disability wants.

By appropriate documentation of the will and preference of the person at the commencement of the engagement and holding the goods or service provider accountable for the delivery of this outcome.

By facilitating the enforcement of Australian Consumer Law and its regime for the recognition of special disadvantage in supporting the decision making rights of those with a disability and mitigating the impact of special disadvantage on the decision making processes of a person.

By facilitating the recognition of the disconnect between cognitive ability and disability.

By facilitating processes and practices for the early intervention of supporters who can constructively deal with the cognitive decline of a person.

**What should decision supporters know about so they can help people with disability make decisions?**

This will always be context specific. Normally they need to know:

1. The values, will, preference and objectives of the person
2. Any constraints on the decision-making ability or adequate reasons to assume decision making ability for the cause or concern at hand.

**Can you tell us about a time when someone helped you (or a person with disability) to make a big decision? What worked well? What could have been better?**

Client confidentiality prevents this disclosure in open forum. Subject to confidentiality and client permission, we are happy to detail exemplar cases from our clinical and professional experience.

**What is the best way to support people with disability to make decisions about their NDIS plan?**

**This includes decisions about using or changing their plan.**

By broadening the criteria against which the plan is assessed having regard to the social inclusion objectives and Human Services Outcomes outlined in this submission.

By establishing cognitive responsive skills in the plan assessor so that the voice of the NDIS participant can be given appropriate inclusion in the plan compilation or review process. The NDIS planning process needs to be underpinned by a fiduciary obligation to the NDIS participant.

**Are there different things to consider for people with different disabilities or cultural backgrounds?**

Yes, but those considerations will always be context specific. Appropriate research and publishing the experience of recognisably good practice needs to occur.

**Conflict of interest is when a person or organisation takes advantage of their position for personal or corporate benefit.**

How can we help reduce conflict of interest?

By recognising and facilitating the resolution of the inherent conflict of interest between NDIS service providers and NDIS participants.

By adopting a formal conflict transaction management regime for plan nominees and service providers similar to that present in Queensland that applies to Powers of Attorney.

Facilitating values alignment between a person and their representatives or supporters through appropriate processes to be followed at the start of a representation or support relationship.

Facilitating initiatives that establish cognitive responsiveness in goods and service providers as a desirable element of the community.

Promoting in public education the special disadvantage regime in Australian Consumer Law and how this relates to protecting the interests of the vulnerable.

Promoting in public education the links and balances between freedom of contract and being able to assume responsibility for your actions. In this context Supported Decision Making remains a powerful protector of the will and preference ovf a person provided any undue influence factors can be neutralised by the available supports.

Helping to mitigate the mischief of the tendency for families and supporters to compensate for cognitive deterioration by provision of informal supports that disempowers the voice of the person under care.

Promoting the provision of formal processes to appoint supporters in State personal representation legislation. This gives our society a means for early intervention to respond to cognitive deterioration and decline in decision making independence and improve our compliance with our UN Human Rights System obligations.

**Undue influence is when a support person makes the person being supported do something they don’t want to do by making them feel scared, by being mean or by threatening or lying to them.**

How can we help reduce undue influence?

This requires training and support for people and their supporters in community as well as better professional training and practices in dealing with informed consent and mitigating undue influence and abusive conduct in society.

Functional specialisation is the commercial and professional sectors has dramatically reduced thew availability of consulted led professionals who are adapted and committed to dealing with the estate administration support requirements of Australians as they age, irrespective of their ability.

Initiatives such as the criminalisation of Elder abuse in the Australian Capital Territory and the passing of Human Rights legislation in States such as Queensland and Supported Decision Making legislation in South Australia and Victoria are signals to the shift occurring in the social compact that defines Australia.

Harmonising these developments can be accelerated by focusing on evolving the delivery of Commonwealth programs such as the NDIS as cognitive responsive programs that also serve as agents to mitigate undue influence and abusive conduct in dealing with the interests of NDIS participants and their supporters.

**What are your concerns (if any) around people with disability being more involved in making decisions for themselves?**

The risk of cognitive deterioration of a person making them vulnerable to undue influence and abuse and reducing their ability to advocate their own best interests.

The lack of application of the law relating to knowledge and approval to the normal operation of the NDIS.

The lack of appreciation of the extent to which an NDIS participant is at special disadvantage as understood by Australian Consumer Law and the existence of reliable processes to compensate for that disadvantage in the administration of their NDIS plan.

The lack of a decision support and carer responsibility in the definition of the role of an NDIS plan nominee.

Broad recognition of reliable processes to evaluate the demonstrated decision making ability of clients.

The need for reliable processes to distinguish about distinguishing disability form decision making ability.

The need to mitigate the inappropriate use of the legal assumption of capacity.

The need to promote and distinguish the ability of a person to competently advocate their best interest form the need of a person to need decision making support by the further detailing of these three foundational use cases:

1. Let me do it (just give me the information I need)
2. Help me do it (by whatever means necessary or appropriate)
3. Do it for me (delegation as appropriate)

**What else could we do to help people with disability to make decisions for themselves? Is there anything missing?**

This is context specific and remains a work in progress. Appropriate action based research is needed to be aligned to relevant professional practices implementing cognitive responsive practice. This research is needed is needed to quantify the efficacy of solution provision that is cognitive responsive that promotes the capacity of disabled people to advocate their best interests and draw on decision making supports and safeguards for the protection of those interests.

Recognition and partnership with the initiatives currently underway at Deakin university, UNSW, Wollongong University and University of SA and University of Adelaide, The Society of Trust and Estate Practitioners and the Financial Planning Association.

**Do you have any feedback on our proposed actions in Appendix C of this paper?**

Without an adequate ethical backplane for goods and service providers and training that facilitates consistent response to the cognitive ability of the relevant decision makers, the aspiration and outcomes described in this consultation paper are, in our opinion doomed to failure.

Australia is already obliged to develop as a rights-based society for decision making. The change in the social compact that defines Australia is e=inexorably changing. Care must be taken to use multi-disciplinary approaches where necessary in order to synthesise these influences into the operations of programs such as NDIS.

Decision making capacity and thus the ability of a person to give informed consent to contracts and the provision of goods and services must in this rights-based world be seen as a relative and not binary concept.

We must as a society evolve appropriate constraint around the traditional legal precepts of the assumption of legal capacity and “let the buyer beware” as elements that define the social compact of our society.

**Support for Decision Making consultation submission**

**Name:** Autonomy First Lawyers (NSW)

**Date and time submitted:** 8/26/2021 3:41:00 AM

# How can we help people with disability make decisions for themselves?

* Resources: No
* Information: No
* Decision Guides: No
* Having a person help: No
* Other: No

# Who are the best people to help you (or a person with a disability) to make decisions?

* Family: No
* Friends: No
* Peer Support Networks: No
* Mentors: No
* Coordinators: No
* LAC: No
* NDIA Partners: No
* Advocates: No
* Service Providers: No
* Other: No

# What should they do to help with decision-making?

No answer recorded

# How can they get better at helping?

* Getting to know the participant well: No
* Doing some training on decision support: No
* By having resources and information about providing decision support: No
* Other: No

# How can we make sure the right people are helping?

* They are chosen by the NDIS Participant as a decision supporter: No
* They value the rights of people to make decisions with support: No
* They are a registered provider: No
* They enable the participant to take risks: No
* Other: No

# What should decision supporters know about so they can better help people with disability make decisions?

* Guidelines for decision supporters: No
* Scenarios or Examples: No
* Information Sessions: No
* Support Networks: No
* Other: No

# Can you tell us about a time when someone helped you (or a person with disability) to make a big decision?

No answer recorded

## **What worked well?**

No answer recorded

## **What could have been better?**

No answer recorded

# What is the best way to support people with disability to make decisions about their NDIS plan?

* Practice: No
* Peer Support Networks: No
* Information and Resources: No
* Guidance Tools: No
* Not Sure: No
* Other: No

# Are there different things to consider for people with different disabilities or cultural backgrounds?

**An intellectual disability:** No

**A disability that impacts how they think, a cognitive impairment:** No

**A psychosocial disability:** No

**A disability that impacts their ability to communicate:** No

**From a CALD community:** No

**From an Aboriginal or Torres Strait Islander Community:** No

**From the LGBTIQA community:** No

# How can we help reduce conflict of interest?

No response recorded

# How can we help reduce undue influence?

No response recorded

# What are your concerns (if any) around people with disability being more involved in making decisions for themselves?

No response recorded

# What else could we do to help people with disability to make decisions for themselves? Is there anything missing?

No response recorded

# Do you have any feedback on our proposed actions in Appendix C of the paper?

No response recorded

1. https://www.safetyandquality.gov.au/sites/default/files/migrated/Draft-Handbook\_Consultation\_Improving-Care-for-

   People-with-Cognitive-Impairment-in-Acute-Care.pdf [↑](#footnote-ref-1)
2. ALETA GOOLEY & ANOR V BRETT GOOLEY [2021] NSWSC 56 [↑](#footnote-ref-2)
3. https://ethics.org.au/ethics-explainer-ethics-of-care/ [↑](#footnote-ref-3)
4. https://jme.bmj.com/content/medethics/44/2/128.full.pdf and particularly page 128 of this article. [↑](#footnote-ref-4)