Realising choice and control through supported decision-making

Submission on the NDIS Support for Decision Making Consultation (September 2021)

Victoria Legal Aid

Acknowledgement of Country

This submission was written on the land of the Wurundjeri and Boon Wurrung people of the Kulin Nation.

We acknowledge and pay our respects to Aboriginal and Torres Strait Islander peoples and Traditional Custodians throughout Victoria, including Elders past and present.

We also acknowledge the strength and resilience of all First Nations people whose social and emotional wellbeing continues to be negatively affected by discrimination, racism, child removal and other devastating ongoing effects of colonisation.

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Executive summary

Victoria Legal Aid (**VLA**) welcomes the opportunity to engage with the National Disability Insurance Agency (**NDIA**) in response to the National Disability Insurance Scheme (**NDIS**) support for decision making consultation paper (**consultation paper**).

We welcome the vision of the consultation paper to realise the intentions of the United Nations Convention on the Rights of Persons with Disability for people accessing, or eligible to access, the NDIS. The Convention promotes the rights to dignity, individual autonomy, freedom to make our own choices, and support for decision-making. These human rights also underpin the *National Disability Insurance Scheme Act* 2013 (Cth) (**NDIS Act**) and notions of 'choice' and 'control'.

VLA is an independent statutory agency responsible for providing information, advice and assistance in response to a broad range of legal problems across Victoria. VLA is the largest provider of legal services to people with disability in Victoria. In 2019–20, we provided assistance to over 88,000 clients and 25% – over 22,000 people – disclosed having a disability or experiencing a mental health issue.[1]

VLA's Independent Mental Health Advocacy (**IMHA**) non-legal advocates assist people receiving or at risk of compulsory mental health treatment to make decisions and have as much say as possible about their assessment, treatment, and recovery. IMHA provides services over the phone through an intake line and advocates attend every public mental health service in Victoria to advocate, promote human rights and supported decision-making and support self-advocacy. In 2019–20, IMHA delivered 12,623 advocacy and self-advocacy services and 22,338 information and referral services.

In addition to promoting supported decision-making through its service provision, IMHA has:

- Developed a **supported decision-making training package**, which has been rolled out across all designated mental health services in Victoria. This training was co-designed with people with a lived experience of mental health issues, to address the low levels of understanding of supported decision-making amongst mental health clinicians.
- Co-produced a suite of resources about **rights, supported decision-making, and self-advocacy** for people that are subject to compulsory treatment.[2]
- Co-designed a '**Self-advocacy for the NDIS**' training program and resources for NDIS service providers and other mental health professionals to build the capacity of people to self-advocate at any stage of the NDIS process, under the psychosocial disability stream.[3]

[1] See Victoria Legal Aid, *Annual Report 2019–20* (2020) (available at: https://www.legalaid.vic.gov.au/about-us/our-organisation/annual-report) (**VLA Annual Report**). This includes clients seen by a private practitioner duty lawyer. Unique clients are individual clients who accessed one or more of Victoria Legal Aid's legal services. This does not include people for whom a client-lawyer relationship was not formed, who received telephone, website or in-person information at court or at public counters or participated in community legal education—we do not create an individual client record for these people. This client count also does not include people assisted by our Independent Mental Health Advocacy or Independent Family Advocacy and Support services. We note that, because this figure relies on clients disclosing their disability or mental health issue at the time of receiving legal assistance, the actual number of clients with disability is likely to be significantly higher. We also note that, because of the way our data is collected and recorded, we are not able to accurately separate out mental health from other disability.

[2] See, eg, Independent Mental Health Advocacy, *Speaking Up For Your Rights*, self-advocacy video and resources (available at: https://www.imha.vic.gov.au/know-your-rights/speaking-up-for-your-rights).

[3] See, eg, Independent Mental Health Advocacy, *Self-advocacy for the NDIS*, Workbook (available at: https://www.imha.vic.gov.au/know-your-rights/self-advocacy-for-ndis). Other materials and resources are available via an online Training Hub and we could arrange for these to be shared with the NDIA if that would be of interest.

IMHA has embedded lived experience into its model by employing a Senior Consumer Consultant, creating the Speaking from Experience consumer advisory group and recently employing an NDIS Lived Experience Consultant. These roles and mechanisms ensure that IMHA service provision is informed by lived experience.

In addition, VLA's specialist mental health and disability lawyers promote and enable supported decision-making by assisting people facing compulsory mental health treatment and people with cognitive disability subject to guardianship and administration orders and supervision orders to understand their rights and options and put forward their views. This work includes presenting clients' views in proceedings related to the imposition of substitute decision-making orders, including in the Mental Health Tribunal, the Victorian Civil and Administration Tribunal and courts. This often includes consideration about the role of NDIS supports in maximising the person's autonomy and minimising restriction.

Together with other legal aid commissions across Australia, our Economic and Social Rights program is also funded by the Department of Social Services to provide legal representation in NDIS matters on review at the Administrative Appeals Tribunal.

It is through this work, and this lived experience expertise, that we see:

- The benefits of supported decision-making for people's rights, autonomy and wellbeing.
- What works well when designing and implementing a service model that promotes supported decision-making.
- What works well when designing and delivering training modules focussed on supported decision-making and on self-advocacy for the NDIS.
- How crucial it is that services, training, resources and evaluation are co-designed and co-produced with people with lived experience of disability, including people who experience mental health issues or identify as having a disability, First Nations people, people from culturally and linguistically diverse backgrounds, members of the LGBTQI+ community, young people, and older people.
- The role for access to independent non-legal advocacy and to legal assistance in embedding supported decision-making because these services help people to understand and exercise their rights.
- The challenges converting a policy or legislation that introduces supported decision-making into real changes for consumers on the ground. In particular, we have seen that the *Mental Health Act* 2014 (Vic) (**Victorian Mental Health Act**) has not effectively embedded supported decision-making as intended because of the absence of mechanisms to drive cultural change, including education, resourcing, lived experience leadership and oversight and accountability.[4]

Each of these points is discussed in more detail throughout this submission.

We would welcome the opportunity to share this experience, both of our lived experience experts and our services, with the NDIA as you move toward a model of supported decision-making for people who are eligible for or using the NDIS.

[4] See, Victoria Legal Aid, *Act for Change: A Mental Health and Wellbeing Act that realises the vision for change* (August 2021) (available at: https://www.legalaid.vic.gov.au/about-us/news/new-mental-health-and-wellbeing-act-must-bring-about-cultural-change) (**Act for Change**).

Seven recommendations to effectively embed supported decision-making in the NDIS

We make the following seven recommendations to strengthen the policy framework and to ensure effective implementation of the proposed NDIS support for decision-making policy:

1. **Get the foundations right**. The policy should reiterate core concepts that are fundamental to supported decision-making: the starting assumption is that the person has capacity (or capability) to make their own decisions, and it is the person's choice whether they want support with decisions or not; and the best people to help with decision-making are those that the person chooses. Even where a substitute decision-maker, such as a plan nominee, is in place, they should be required to act on the basis of the person's will and preferences as much as possible, rather than on the basis of the person's perceived best interests.
2. **Learn from, adapt and expand models that work**. Where there are proven supported decision-making service models and training in operation, these models should be learned from, adapted and expanded – for example, the Independent Mental Health Advocacy service model that promotes supported decision-making and embeds lived experience leadership, as well as IMHA's co-designed and co-produced training modules on supported decision-making and NDIS self-advocacy. Consideration should be given to the benefits of rolling out the NDIS self-advocacy training module nationally.
3. **Embed co-production and co-design**. All development of NDIS supported decision-making policies, guidelines, education and training, information provision, and resources, should follow a co-production or co-design process with people accessing, or likely to access, the NDIS. People directly affected should be involved in the co-design of the indicators of success, and the person's views on whether they have been supported to make their own decisions should be central to measuring outcomes.
4. **Diverse voices and intersectionality**. Any co-production or co-design process should ensure the active involvement of diverse communities, including people who experience mental health issues or identify as having a disability, First Nations people, people from culturally and linguistically diverse backgrounds, LGBTQI+ community members, people with different socioeconomic backgrounds, young people and older people. These processes should also account for intersectionality, as different aspects of a person's identity can subject them to overlapping forms of discrimination.
5. **Delivery of training and resources**. All information, resources and training must be provided in a culturally and socially appropriate way, including the provision of translated information, accessible versions, and in a diverse range of media formats, including videos with Auslan interpreters.
6. **Independent non-legal advocacy and legal assistance**. Recognise, and invest in, access to independent non-legal advocacy and legal assistance as key mechanisms for embedding supported decision-making through supporting people to understand and exercise their rights (including in relation to appeals in the Administrative Appeals Tribunal). This should include investment in Aboriginal Community Controlled Organisations to be partners in the delivery of these services.

7. **Embedding changes in practice**. To make sure the NDIS supported decision-making policy has a real impact for people who receive NDIS supports, thought and resourcing will need to be invested in leadership, education and resources, oversight and accountability, which are all necessary to support and embed cultural change.

A note on language

Throughout our submission we refer to people accessing the NDIS, or consumers of mental health services, as 'people', except where we must clearly delineate between service providers and service users. In these instances, we will use the term 'consumer' as traditionally used in the mental health sector, however, we will broaden the definition to include all people with a disability as follows:

A consumer refers to a person with a direct experience of mental health issues or disability, and who has received, is receiving, or is seeking mental health or disability services from a mental health or disability service provider, including the NDIS.[5]

1. What supported decision-making can look like in practice

This part addresses consultation questions 1, 2 and 3.[6]

VLA provides legal and non-legal advocacy support to people receiving compulsory treatment under the Victorian Mental Health Act through its Mental Health and Disability Law and Independent Mental Health Advocacy (**IMHA**) programs. Our experience primarily relates to the legislative mechanisms in the Victorian Mental Health Act designed to enable supported decision-making. This experience is particularly relevant to this consultation paper as many people on orders under the Victorian Mental Health Act have a diagnosis of psychosocial disability and may be eligible to access the NDIS.

The Productivity Commission Inquiry into Disability Care and Support estimated that the proportion of people eligible for the NDIS under the psychosocial disability stream is 13.8%, however in 2019 the actual proportion was lower at 9.6%.[7] Psychosocial disability continues to make up a relatively small percentage of people accessing the NDIS. The experience of psychosocial disability can present barriers to accessing the NDIS and engaging with what can be a complex and stressful process to apply or re-apply.[8] However, IMHA and the Mental Health and Disability Law program have been able to engage this group successfully through our supported decision-making models.

This work promoting supported decision-making is informed by lived experience co-production and co-design and places the person at the centre of the supported decision-making process.

[5] Definition adapted from Department of Health & Human Services, State Government of Victoria, *'Mental Health – Working with Consumers and Carers'* (available at: https://www2.health.vic.gov.au/mental-health/working-with-consumers-and-carers).
[6] Consultation questions: 1. How can we help people with disability to make decisions for themselves? 2. Who are the best people to help you (or a person with disability) to make decisions? 3. What should they do to help with decision making?
[7] See National Disability Insurance Agency, 'People with a psychosocial disability in the NDIS; (30 June 2019) (available at: https://data.ndis.gov.au/reports-and-analyses/participant-groups/people-psychosocial-disability) 5.
[8] Hancock, N., Gye, B., Digolis, C., Smith-Merry, J., Borilovic, J. & De Vries, J., Commonwealth Mental Health Programs Monitoring Project: Tracking transitions of people from PIR, PHaMs and D2DL into the NDIS. Final report. The University of Sydney & Community Mental Health Australia, Sydney, 2019, 2 (available at: https://cmha.org.au/wp-content/uploads/2019/10/CMHA-and-University-of-Sydney-NDIS-Transitions-Final-Report_September-2019.pdf).

More information about what this model looks like in practice is set out below.

Independent Mental Health Advocacy: A model for supporting people to exercise choice and control

IMHA supports people who are receiving, or at risk of receiving, compulsory mental health treatment to make decisions and have as much say as possible about their assessment, treatment and recovery. IMHA was set up as an integral part of realising the reforms and vision of the Victorian Mental Health Act, in particular those related to supported decision-making.

IMHA delivers representational advocacy using a supported decision-making paradigm, which takes the form of information provision, discussion of pros and cons of options available, individual advocacy, coaching to self-advocate, referrals, and community education. The model applies a recovery approach and incorporates empowerment principles to support people's ability to self-advocate.

The IMHA advocacy model provides a structure for realising the goals outlined in the consultation paper for people to be actively involved in making decisions about their lives, exercising real choice and control, and supporting development of capacity (or capability) to make decisions.[9] It does this by:

- Placing the person at the centre of the process
- Exploring the person's concerns and issues from their point of view
- Exploring the person's preferences and providing all options available to the person, not just those someone else might think are in the person's 'best interest'
- Actively involving the person in planning for advocacy or self-advocacy and respecting their decisions about how, when and to who the advocacy will be carried out
- Actively involving the person in identifying opportunities, barriers, enablers, supports and resources needed to carry out the advocacy, ensuring that these are identified from the person's point of view
- Reviewing and debriefing with the person after the episode of advocacy so that they can further develop their capacity (or capability) to advocate for themselves and make their own decisions.

From the above we can see that the model IMHA uses for advocacy employs many important elements of supported decision-making, by exploring concerns, issues, options, and outcomes from the person's perspective in order for them to make decisions about a course of action. We propose

[9] The goals of the policy set out in the consultation paper are: 1. Increase opportunities for you and future participants to: a) be actively involved in making decisions about your life, and b) exercise real choice and control; 2. Support the development of your capability in making decisions (and helping you to explore and make those decisions); 3. Build the capacity of decision supporters, agency staff and partners to recognise and enable the will and preference of participants; 4. Strengthening a support for decision making approach in the appointment of nominees.

that the act of advocacy itself is also an essential part of supported decision-making, as it is essentially the implementation stage of decision-making.

In an independent evaluation conducted by RMIT university, it was found that as a result of contact with IMHA, people identified an improvement in their self-advocacy skills, an increased sense of having their views and preferences respected, a greater sense of control over treatment and recovery, and generally felt they had received less restrictive treatment.[10]

Access to IMHA is entirely voluntary – it is the person's choice whether they want support with decisions or not. It is important that the NDIA recognises that the best people to help with decision-making are those who the person chooses. This may be someone in a professional role such as an advocate, but could also be friends, family members, kinship communities, community leaders, peer groups, and a diverse range of other relationships and contacts depending on the individual.

Our IMHA NDIS Lived Experience Consultant highlighted this point:

> *"It is important to think about different points of view when making decisions about who you choose to support you to make decisions. When thinking about the support you would like it's important to not only think about whether the person knows you well enough, the most important thing is that they must have a really good understanding of your worldview. So, what does that mean?*
>
> *When we talk about a person's worldview, we are talking about how they construct meaning, the thoughts, beliefs and actions that influence what they think and why they think that way.*
>
> *Why is this important? The way in which you see yourself and the world around you may be different from the lens or way another person sees you and the world. Problems can arise when people who have different worldviews are unwilling to accept the views of others and vice versa. Or when someone thinks they know what's best for someone else instead of advocating for what they actually want."*

We encourage the NDIA to consider some of the strengths in the IMHA services promoting supported decision-making when designing the NDIA's supported decision-making policy and implementation.

[10] See Maylea, Chris; Alvarez-Vasquez, Susan; Dale, Matthew; Hill, Nicholas; Johnson, Brendan; Martin, Jennifer; Thomas, Stuart & Weller, Penelope (2019) *Evaluation of the Independent Mental Health Advocacy Service (IMHA),* Melbourne: Social and Global Studies Centre, RMIT University 24 (available at: imha-rmit-evaluation-of-the-independent-mental-health-advocacy-service-03-2019.pdf) (**IMHA Evaluation Report**).

2. Moving away from 'best interests' decision-making

This part addresses consultation question 6.[11]

The NDIA's support for decision-making policy should clearly start with the assumption that the person has capacity (or capability) to make their own decisions, but that support to make decisions is available if the person wants it, and then provide support only where this is what the person wants.

In our view, some of the language used throughout the consultation paper implies an assumption that people with a disability are not able to make their own decisions,[12] or that the decisions they do make are somehow less valid than for people without a disability.

We reiterate the importance of being clear that every person has the right to make their own decisions, but also may seek support for decision-making throughout their life, and it is no different for people accessing the NDIS.

Our IMHA NDIS Lived Experience Consultant highlighted this point:

> *Making our own decisions is a fundamental human right, something that everyone in our society should be able to do because it is one of the few ways in which we can exercise choice and control over our lives. It's something that most people take for granted.*
>
> *Unfortunately, many people living with mental distress and disability have found themselves in positions where other people have made decisions for them or where their decision-making ability has been withheld or taken away.*
>
> *Imagine what that would be like to have the right to make your own decisions taken away, denied, or you'd never been given the opportunity to develop decision-making skills in the first place, if this has been your experience then what support would you need to start making your own decisions?"*

In a supported decision-making approach, the person has the final say, both in the decision itself and in the process of deciding.[13] The below diagram outlines a continuum of decision-making, with substitute decision-making at one end, and independent decision-making at the other. As discussed above, IMHA sits clearly in the middle position where people are able to make their own decisions and are provided with the support identified by them to do so.

[11] Consultation questions: 6. What should decision supporters know about so they can help people with disability make decisions?
[12] Examples include references to 'real decision making', 'mak(ing) decisions that are in your best interest', the need for decision-making 'practice', and 'natural capacity' for decision making.
[13] MB Simmons and PM Gooding, 'Spot the Difference: Shared Decision-Making and Supported Decision-Making in Mental Health' [2017] *Irish Journal of Psychological Medicine* 1.

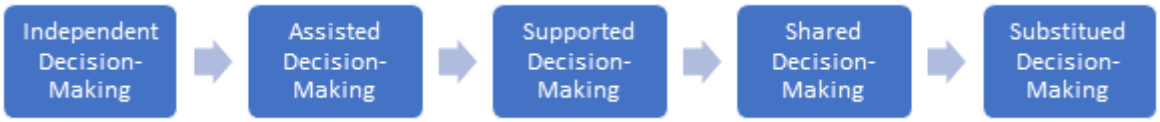

Figure 2 – A Continuum of Decision-Making[14]

VLA supports the NDIA's proposal to conceptualise supported decision-making along a continuum, however we recommend some amendments to the continuum presented in the consultation paper. The use of terms such as 'low-autonomy' and 'high-autonomy' in regard to decision-making is not in line with a strengths-based approach. We recommend instead adapting the above continuum for decision-making, which focusses on what support the person wants or needs, rather than on a perceived deficit in capacity or autonomy.

We also recommend that the policy includes a definition of supported decision-making that recognises that decision-making happens on a continuum. Through our work with people receiving compulsory treatment and decision-makers, we have found it necessary to define supported decision-making in comparison to other types of decision-making to reduce conflation between approaches. For example, we have often experienced decision-makers believing they are operating under a supported approach, when actually it would be more accurately described as a shared approach. It is critical that decision-supporters do not assume people cannot make independent decisions.

We recommend considering the following definitions:

- **Substitute Decision-making:** This is where someone makes a decision on behalf of someone else. This may be because a formal substitute decision maker has been put in place or it may happen informally because of assumptions that a person needs someone to make a decision for them. While some formal substitute decision-makers are required to act on the basis of the person's will and preferences, they are predominantly required act on the basis of the perceived best interests of the person.[15]
- **Shared Decision-making:** Decisions are made jointly between a person and another person. There is no primary decision-maker as such, discussion and consideration are given to both people's preferences. However, shared decision-making approaches must consider potential power dynamics between people. If one person holds more power than the other, such as in a carer dynamic, or service provider context, then the decision-making process may technically be more substituted than shared.[16]
- **Supported Decision-making:** This decision-making model places the person being supported in the front of the decision-making process; they are the primary decision-maker. There is an emphasis on the ability of the person to make their own decisions, when supported appropriately to do so. There is a focus on what assistance the person needs or

[14] Wanda Bennetts et al, 'The 'Tricky Dance' of Advocacy: A Study of Non-Legal Mental Health Advocacy' (2018) 2018(24) *International Journal of Mental Health and Capacity Law* 12.
[15] See, eg, Australian Law Reform Commission, 'Equality, Capacity, and Disability in Commonwealth Laws (ALRC Report 124) – Supported and Substitute decision-making', 18 September 2014 (available at: https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-alrc-report-124/2-conceptual-landscape-the-context-for-reform-2/supported-and-substitute-decision-making/).
[16] Hoffmann, T.C., Légaré, F., Simmons, M.B., McNamara K., McCaffery, K., Trevena, L.J., Hudson, B., Glasziou, P.B., & Del Mar, C.B., Shared decision making: what do clinicians need to know and why should they bother?, *Med J Aust* 2014; 201 (1) 35–9 (available at: https://www.mja.com.au/journal/2014/201/1/shared-decision-making-what-do-clinicians-need-know-and-why-should-they-bother).

wants, rather than on deficits in decision-making. There is an emphasis on what the person decides for themselves, rather than what others determine is in their best interests.[17]

While substitute decision-making involves someone making a decision on behalf of someone else, it is important that substitute decision-makers are guided by what the person wants as much as possible. This is now a requirement of guardianship and administration law in Victoria, requiring substitute decision-makers to act in accordance with the will and preferences of the represented person and only override this if it is necessary to prevent serious harm.[18]

As stated by the Office of the Public Advocate (**OPA**), Victoria's public guardian, "the expression 'best interests' no longer has a place in any of the law relating to substituted or supported decision making and is considered paternalistic."[19]

This should be the approach required of all substitute decision-makers, including plan nominees. Also, substitute decision-making should only happen once a supported decision-making process has been undertaken to determine the person's ability to make the decision for themselves, assist them to express their will and preferences and support them as much as possible to make the decision for themselves. Substitute decision-making should only be used for those decisions that the person cannot make themselves with support. Processes should be in place to record the supported decision-making process and to audit decision making processes to ensure that substitute decision-making is only used where the person is unable to make the decision for themselves with support. The authority of formal substitute decision-makers should be clearly defined to reflect this.

OPA has set out principles for how decision-making should be performed in the case of guardianship, which provides a good basis for NDIS supported decision-making policy for plan-nominees:[20]

- *The represented person with a disability who requires support to make decisions should be provided with practicable and appropriate support to enable the person, as far as practicable in the circumstances, to:*
    - *make and participate in decisions affecting them*
    - *express their will and preferences*
    - *develop their decision-making capacity.*
- *The will and preferences of the represented person should direct, as far as practicable, decisions you make for them as guardian.*
- *You should exercise your powers as guardian in a way which is the least restrictive of the ability of the represented person to decide and act as is possible in the circumstances.* [21]

[17] Adapted from Australian Law Reform Commission, 'Equality, Capacity, and Disability in Commonwealth Laws (ALRC Report 124) – Supported and Substitute decision-making' (18 September 2014) (available at: https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-alrc-report-124/2-conceptual-landscape-the-context-for-reform-2/supported-and-substitute-decision-making/).

[18] *Guardianship and Administration Act* 2019 (Vic) s 9(1).

[19] Office of the Public Advocate, 'Supported Decision-Making in Victoria' (October 2020) 18 (available at: https://www.publicadvocate.vic.gov.au/resource/file?id=31).

[20] We also note that the provisions in the NDIS Act relating to the appointment, recognition and authority of child representatives and plan nominees do not provide certainty. They should be reviewed, to ensure that people with disability, their representatives, and the NDIA, are all clear on supported decision-making arrangements under the Act. We do not address this issue in detail in this submission, understanding it not to be within scope for this review process, but flag it for the NDIA's attention.

[21] Office of the Public Advocate, 'Guardianship Guide: A guide for guardians appointed under the Guardianship and Administration Act 2019' (March 2020) 9 (available at: https://www.publicadvocate.vic.gov.au/joomlatools-files/docman-files/booklet/Guardianship_Guide.pdf).

This is in line with national decision-making principles developed by the Australian Law Reform Commission in 2014 to guide the development of new laws, policies and practice,[22] as referenced in the consultation paper.

We propose the NDIA support for decision-making policy step away from notions of best interests and employ a human rights approach to decision-making even when substitute arrangements are in place.

Recommendation 1: Get the foundations right

The policy should reiterate core concepts that are fundamental to supported decision-making: the starting assumption is that the person has capacity (or capability) to make their own decisions, and it is the person's choice whether they want support with decisions or not; and the best people to help with decision-making are those that the person chooses. Even where a substitute decision-maker, such as a plan nominee, is in place, they should be required to act on the basis of the person's will and preferences as much as possible, rather than on the basis of the person's perceived best interests.

3. Models that work – education and training to embed change

This part addresses consultation questions 4 and 5.[23]

Education, training and resources will be essential for translating the NDIS support for decision-making policy into meaningful changes in practice for decision-supporters, NDIA staff and partners and for people accessing the NDIS.

Ensuring that this training is developed in collaboration with people with a lived experience of the NDIS will result in better training outcomes as it is through lived experience that we can understand how to put supported decision-making into practice. Training should also be co-delivered with trainers who have a lived experience of the NDIS and are able to use this experience in training delivery.

Following are two examples of training that IMHA provides in the supported decision-making and self-advocacy space that we would welcome the opportunity to share and discuss in more detail with the NDIA so they can be drawn on in your work.

3.1 IMHA Supported Decision-Making Training

Informed by people receiving compulsory mental health treatment and recognising low levels of understanding of supported decision-making among mental health clinicians, IMHA's supported decision-making training modules have played a role in improving the on-the-ground focus on rights and recovery in compulsory mental health in Victoria. It is an example of the kind of initiative and investment required to translate well-intentioned legislation, policies or guidelines into meaningful change for people through participation in decisions about their treatment, discharge planning, risk assessment, or recovery.

[22] Office of the Public Advocate, 'Supported Decision-Making in Victoria' (October 2020) (available at: https://www.publicadvocate.vic.gov.au/resource/file?id=31).
[23] Consultation questions: 4. How can they get better at helping? 5. How can we make sure the right people are helping? For example: that they are building the capacity of the person with disability; that they are considering what the person with disability wants.

IMHA training significantly increases mental health staff's understanding of supported decision-making and confidence to integrate it into their services

IMHA's training about supported decision-making under the Victorian Mental Health Act has been rolled out to all designated mental health services in Victoria. More than 50 sessions have been carried out across the State.

Outcomes reported from training participants demonstrate:

- 85% report an increase in knowledge of supported decision-making.
- 85% report an increase in knowledge of how to put supported decision-making into practice.
- 80% report an increase in understanding of the benefits of supported decision-making.

Although the training is specifically aimed at supported decision-making in the mental health context, the main concepts are easily adapted for use in the NDIS context. We propose the following key elements from IMHA's training be considered for future training on NDIS supported decision-making policies or guidelines:

- **Providing a comparison:** Provide definitions of supported decision-making in comparison to other types of decision-making as this reduces confusion for decision supporters as well as potential 'slippage' along the supported decision-making continuum (refer to Figure 2 – A Continuum of Decision-Making).
- **Policy and guidelines explanation:** Provide practical explanations of the proposed policies and guidelines and how they promote supported decision-making.
- **Key principles:** Outline the importance of the following key principles of supported decision-making:
  - Capacity (or capability) is decision specific.
  - People have the right to make decisions involving a degree of risk.
  - Steps should be taken to build a person's capacity (or capability) to make their own decisions.
  - Capacity (or capability) does not mean the person needs to make a 'sensible', 'rational' or 'well-reasoned' decision, as this is not the standard applied to everyone in the community. We should avoid discriminatory application of assessments of capacity, as more should not be expected of people with a disability than those in the general population.[24]
- **Practical application:** Provide an opportunity for training participants to put supported decision-making into practice by working through a case study and identifying how they could support the person to make the decision they want to make, including how to build the

[24] See *PBU v Mental Health Tribunal* [2018] VSC 564 (1 November 2018): Justice Bell ruled that people experiencing mental health issues should face the same standard as all other people when their capacity to consent is assessed and said: 'The issue is closely connected with the need to respect the human rights of persons with mental disability by avoiding discriminatory application of the capacity test. More should not be expected of them, explicitly or implicitly, than ordinary patients (at [173]) … When respect is afforded to the choice of the person to consent to or refuse medical treatment, the person is recognised for who they are' (at [199]).

person's capacity to make the decision, and how you might support the person to overcome any identified barriers to implementing the decision. Below is a sample case study scenario used in IMHA's training.

Sample case study scenario: Nandi

Nandi is a 28-year-old woman who lives with her dog. Nandi would like to explore the option of taking her medication orally instead of by depot injection, as she doesn't like having injections. Nandi has a diagnosis of schizo-affective disorder and has been accessing mental health services for two years. Following a three week stay on an inpatient ward, Nandi is discharged on a four-month community treatment order. Nandi is finding that having to attend the clinic every 2 weeks is interfering with her ability to work. Nandi usually sleeps in the daytime as she works in the evening. When Nandi meets with her psychiatrist, she is sympathetic and listens to her concerns, however she tells Nandi she believes she would be better off having the depot, as the reason she had to go to hospital in the first place was because she forgot to take her medication.

Nandi explains to her doctor that this was because she was dealing with a lot of stress in her life at that point, and things are much more settled now. Nandi is enjoying her work as a chef and has started going to a peer support group which is helping her manage her mental health better. Also, she was managing her oral medication on a voluntary basis for over a year before she was admitted to hospital.

Questions:

1. What decision would the person like to make?
2. What steps could you take to support the person to make the decision?
3. Discuss informed consent and how to build the person's capacity to make the decision.
4. What barriers can you identify to implementing the decision? How might you support the person to overcome these?

The IMHA training also uses the below resource from the World Health Organisation on supporting people to make decisions, which would be useful in the NDIS context.

Supported Decision-Making Checklist[25]

Provide relevant information:

- Does the person have all the relevant information they need to make a particular decision?
- Have they been given information on all the alternatives?

[25] World Health Organisation, 'Supported decision-making and advance planning'. WHO Quality Rights Specialized training. Course guide. Geneva: World Health Organization (2019) 53 (available at: https://apps.who.int/iris/rest/bitstreams/1258874/retrieve).

Communicate in an appropriate way:

- Explain or present the information in a way that is easier for the person to understand (for example, by using modified language or visual aids)
- Explore different methods of communication if required, including non-verbal communication

Ascertain if anyone else can support communication:

- Explore if the person would like assistance from another person for communication, for example a family member, friend, support worker, interpreter, speech and language therapist, or advocate

Make the person feel at ease:

- Identify if there are particular times of day when the person prefers to communicate and receive information
- Identify if there are particular locations where the person may feel more at ease
- Ascertain whether the decision could be put off to see whether the person can make the decision at a later time when circumstances are right for them

Support the person:

- Ascertain if the person would like anyone else to support them to make choices or express a view

3.2 IMHA Self-Advocacy for the NDIS Training

The IMHA Self-Advocacy for the NDIS training package and associated resources were co-designed with people with a psychosocial disability accessing or considering accessing the NDIS, and carers.

The resources built upon IMHA's Self-Advocacy model, which was co-produced, as described above. The model assists people to explore what their concerns, issues, options, and outcomes are, thus supporting them to make a decision and decide on a course of action.

Step	Actions
1. Identify the problem	• Write down the issue – what do you want to change? • Who is the decision-maker? Who do you need to talk to in order to resolve your concern?
2. Know your rights	• What resources and who could help? A resource might be a factsheet, video, or a conversation with a support person • Your rights - learn about your rights and write them below
3. Think about solutions	• Write down your ideal solution - you may want to talk with a peer, family, staff or an advocate about your options • Your [possible] alternative solutions

	• What will a successful outcome look like to you?
4. Make a Plan	• How will you express your views (e.g. meeting, call, email)? Do what feels most comfortable to you • To who and when? • Who may support (e.g. friends, family, staff member, advocate)? • What are the next steps if you don't achieve your goal?
5. Enact the Plan	• [Here you may want to write your notes about what happens during the meeting]
6. Review	• What happened? • What went well? • What didn't go well? • What would you do the same and/or different next time? • What would you like to do now – next steps?

The initial pilot project saw the co-design of the Self-Advocacy for the NDIS workbook,[26] as well as workshops for people on self-advocacy in the NDIS space. Fifty-six workshops were facilitated by peer and carer support workers, and the outcomes of this phase of the project were:

- Carer, family and other supporters had increased understanding of self-advocacy and self-determination, consistent with the NDIS principles and practice.
- People with a psychosocial disability had increased knowledge and confidence to advocate for their own needs within the NDIS.

Following the success of the pilot, a train-the-trainer model was delivered to peer support workers, NDIS service providers and other mental health professionals. Almost 200 (198) people have attended this training to date. Through this training, attendees are equipped with the knowledge and skills necessary to either train their colleagues in the model, or to deliver workshops to people eligible for, or accessing, the NDIS. The outcomes of this phase of the project were:

- Increased knowledge and confidence of training attendees to facilitate self-advocacy for the NDIS sessions for people with a psychosocial disability to build their capacity to advocate for their own needs within the NDIS and with other mainstream services.
- Increased knowledge and confidence of training attendees to train their colleagues to deliver self-advocacy for the NDIS sessions for people with a psychosocial disability to build their capacity to advocate for their own needs within the NDIS and with other mainstream services.

Every training session was co-facilitated with people with lived experience of the NDIS, mental health or mental distress. Feedback was overwhelmingly positive with the majority of training attendees reporting that lived experience co-facilitation was valuable. Qualitative feedback further confirmed the

[26] Independent Mental Health Advocacy, 'Self-advocacy for the NDIS (Mental Health) Resource Booklet' (August 2019) (available at: https://www.imha.vic.gov.au/know-your-rights/self-advocacy-for-ndis).

value of lived experience co-facilitation, with attendees reporting that the first hand lived experience they provided of the NDIS process was of value for their learning outcomes.

As the training migrated to an online environment due to COVID-19, it became much more accessible, with large numbers of regional and rural areas of Victoria attending the training. There were also attendees from Queensland, New South Wales, South Australia, Western Australia, and the Northern Territory, which demonstrated that the model is applicable nationwide. We recommend that consideration be given to the benefits of this training model being rolled out nationally to assist with the NDIA's goal of promoting supported decision-making.

One peer support worker who attended the training providing the following feedback:

> *"Just wanted to say a huge thank you to everyone who contributed to the Self-Advocacy for the NDIS training and resources because now I'm going to have NDIS. Something I thought for years I wasn't eligible for, or once realising I was, was too scared to apply for! Also, my psychiatrist will now be helping others who attend her clinic apply for NDIS. Now that she knows the process is actually not that hard with having the templates as guidance."*

Recommendation 2: Learn from, adapt and expand models that work

Where there are proven supported decision-making service models and training in operation, these models should be learned from, adapted and expanded – for example, the Independent Mental Health Advocacy service model that promotes supported decision-making and embeds lived experience leadership, as well as IMHA's co-designed and co-produced training modules on supported decision-making and NDIS self-advocacy. Consideration should be given to the benefits of rolling out the NDIS self-advocacy training module nationally.

4. The crucial role of co-design and co-production

This part addresses consultation questions 1, 9 and 11.[27]

4.1 Consumer leadership, co-design and co-production

We acknowledge the substantial work and expertise of the Independent Advisory Council in bringing about this policy and proposal for change.[28]

We welcome many of the proposed next steps set out in Appendix C of the consultation paper, but we observe that there is no clear outline of how people eligible for, or accessing, the NDIS will be involved in these processes. Throughout this submission, we have outlined models that have worked well to support people to make their own decisions. One thing they have in common is that they were all either co-designed or co-produced with people with lived experience.

We use this definition of co-production and co-design:

> *'Co-design engages end-users in the design of products or services so they will better serve their intended purpose. It is not possible to engage in robust co-production without also engaging in co-design. Planning, designing and producing services with people that have experience of the problem or service, rather than with people that are removed from the problem, means the final solution is more likely to meet the users' needs. Co-production raises the bar for working with consumers, shifting from seeking involvement or participation after an agenda has already been set, to seeking consumer leadership from the outset so that consumers are engaged in the initial thinking and priority-setting processes.*[29]

Our IMHA NDIS Lived Experience Consultant provides further insight into the value of co-production and co-design for supported decision-making in the NDIS context:

"The only way to develop a supported decision-making process that meets the needs of NDIS participants is to do so in partnership with people accessing the scheme. We know that people with a lived experience provide real world examples of how they would like to be supported, and how to offer supported decision-making in a way that best suits the people who will benefit from it.

By drawing on lived experience through co-production or co-design, we can determine how to provide a more compassionate way of engaging with and working with people who experience mental distress or identify as having a disability,

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[27] Consultation questions: 1. Who are the best people to help you (or a person with disability) to make decisions? 9. Are there different things to consider for people with different disabilities or cultural backgrounds? 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. 11. How can we help reduce undue influence?

[28] See, eg, Independent Advisory Council to the NDIS (2019), *Support for Decision Making in the NDIS* (available at: Support+for+decision+making+in+the+NDIS+-+July+2019.pdf (squarespace.com)).

[29] Roper, C., Grey, F., & Cadogan, E. 'Co-production: Putting Principles into practice in mental health contexts' (2018) 2 (available at: https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0007/3392215/Coproduction_putting-principles-into-practice.pdf).

because people with a lived experience can connect in ways that people who don't have that 'shared understanding' cannot."

From the outset, consumer leadership and co-production has been central to IMHA, and people with lived experience of the mental health system advised on IMHA's development, including co-production of IMHA's program logic and evaluation framework. Consumers are part of IMHA's work, and they are also part of its workforce. VLA employs a Senior Consumer Consultant to oversee and promote consumer leadership, and two-thirds of IMHA's advocacy workforce identify as having a lived experience of mental health issues.

Established in 2016, VLA's Speaking from Experience advisory group is made up of people who have lived experience of mental health issues and the public mental health system. IMHA's Senior Consumer Consultant supports Speaking from Experience to inform service design, delivery and evaluation for IMHA and across VLA. The Senior Consumer Consultant and Speaking from Experience have also contributed to policy development, participated in staff recruitment panels, and developed accessible resources for consumers across our legal and non-legal advocacy services.[30]

IMHA's supported decision-making and Self-Advocacy for the NDIS training and associated resources were either co-produced or co-designed with people who access the mental health system and NDIS, respectively. The success of the training and resources is linked to how they were developed, and importantly who they were developed with.

VLA is working toward embedding consumer leadership in its organisational culture, including the establishment of an advisory group for VLA's Independent Family Advocacy Support (**IFAS**) service, which began in January 2019 and consists of people with lived experience of the child protection system. The IFAS Lived Experience Consultant guides the work of the consumer advisory group in advising VLA on its work with people who have contact with the child protection system.

Through this work, VLA sees the value of consumer leadership and the depth and diversity of expertise it provides in shaping services and reform.[31] Recently, IMHA has further committed to consumer leadership by employing a NDIS Lived Experience Consultant, to ensure that lived experience is central to the Self-Advocacy for the NDIS project resources.

We recommend that all supported decision-making policies and guidelines, education and training, information provision, and resources, follow a co-production or co-design process in order for them to truly realise supported decision-making for people eligible for, or accessing, the NDIS.

We also propose that:

- The indicators of success highlighted in the consultation paper should be expanded to include measures from the consumer's perspective.
- The consumer's views on whether or not they have been supported to make their own decisions are made central to the proposed policy and subsequent outcomes.

[30] See also: Roper, Cath; Grey, Flick, and Cagodan, Emma. (5 April 2018) *Co-Production: Putting principles into practice in mental health contexts* (5 April 2018) (available at: https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0007/3392215/Coproduction_putting-principles-into-practice.pdf); Bennetts, Wanda; Cross, Wendy, and Bloomer, Melissa, 'Understanding consumer participation in mental health: Issues of power and change' (2011) 20(3) *International Journal of Mental Health Nursing*, 155–64, 2.
[31] For more information, see Act for Change, above n 4.

4.2 Diverse leadership to promote cultural safety and trauma-informed practices

By following co-production or co-design processes, the NDIA should gain lived experience insight into how to realise supported decision-making for people with a diverse range of disabilities, as well as other experiences of diversity such as cultural background, gender identity and sexual orientation, socioeconomic status, and for First Nations peoples.

In relation to First Nations people with disability, we reiterate the importance of partnerships with Aboriginal Community Controlled Organisations to design policies and deliver services. These expert, culturally safe organisations should be resourced to do this work. Working with these organisations and co-designing and co-producing policies and resources with First Nations people with disability is crucial for building cultural competency across the NDIA and NDIS service providers, as well as for making the NDIS accessible and culturally safe. Feedback we have received from Aboriginal Community Controlled Organisations we have worked with includes:

- The role of supporting decision-making for First Nations community needs to be broadened, as often this is not just one or two people within a family unit, but rather shared across family units and/or communities. There needs to be a more nuanced approach to what constitutes a 'family unit', and who are the typical supporters. For example, it is not only a mother as carer for a child, it could be cousins as carers for an aunty.
- There is evidence that First Nations communities have successfully supported people with disability using a community approach over time, and we can and should learn from this.
- There should be recognition of the appropriateness of language used by the NDIA, for example, terms such as 'disability' and 'mental health' may not translate into language. Even if they are able to be translated, these terms may carry stigma for First Nations communities, which may contribute to reluctance to apply for the NDIS.
- There needs to be consideration of Women's Business, and Men's Business, and how service providers respect and work with these structures. There needs to be cultural competency training for service providers

We also observe that the life stages outlined in the consultation paper lack consideration of cultural and social factors. For example, there is an assumption that young people aged 13 – 17 will have family as their main support for decision-making, when this is not the reality for many young people in out of home care. Further, the model outlined for life stages appears to follow an individualistic cultural transition in terms of decision-making, that does not take into account, for example, the importance of kinship and community for First Nations peoples.

We recommend that co-design and co-production of the NDIS supported decision-making policy ensure active involvement from people who experience mental distress or identify as having a disability, First Nations people, people from culturally and linguistically diverse backgrounds, the LGBTQI+ community, young people, and older people.

It is also important that any co-design or co-production process account for intersectionality as different aspects of a person's identity can subject them to overlapping forms of discrimination. Culturally and socially appropriate resources and training for people must be provided, as well as

translated information, accessible versions, and provision in a variety of media formats, such as video with Auslan interpreters.

4.3 Preventing undue influence

We welcome the NDIA considering undue influence and propose that to reduce this the NDIA must consider that decision supports will be different for each individual and may also change over time. It is essential that NDIA policies consider that service providers have power over people accessing their services, just as informal supports such as carers or family members may also hold power over people with disability.

In some cases, due to family violence and other forms of abuse, families, and carers, may not be appropriate people to assist with decision-making. For example, a person who accessed IMHA informed us that despite disclosing that her partner was using her mental health issues and medication as part of his control and abuse and that she did not want him involved in her care, he continued to be provided with information and asked to monitor her medication compliance. Legislation and systems must recognise these dynamics and risks and ensure services do not provide an avenue to facilitate abuse.[32]

A member of Speaking from Experience explained it in this way:

> *There needs to be a nuanced understanding of the role of families. It is a support role, not an authority role. Sometimes there is abuse in family relationships, but this isn't disclosed to clinicians. How do you support people to identify what they want, including who their support people are and what role they want those people to play? There needs to be a clearer way of thinking about family and boundaries.*

Recommendation 3: Embed co-production and co-design

All development of NDIS supported decision-making policies, guidelines, education and training, information provision, and resources, should follow a co-production or co-design process with people accessing, or likely to access, the NDIS. People directly affected should be involved in the co-design of the indicators of success, and the person's views on whether they have been supported to make their own decisions should be central to measuring outcomes.

[32] See, eg Victoria Legal Aid, Submission to the Royal Commission into Victoria's Mental Health System – *Roads to Recovery: Building a Better System for Victorians Experiencing Mental Health Issues* (July 2019) 9 (**Roads to Recovery**) part 4.4 discussing the need for understanding of family violence and mental health across both systems (available at: <https://www.legalaid.vic.gov.au/law-reform/building-better-justice-system/access-to-justice-for-people-with-mental-illness-and-disability/roads-to-recovery-building-better-system-for-people-experiencing-mental-health-issues-in-victoria). See also Victoria Legal Aid (2020) *Paving the roads to recovery: Building a better system for people experiencing mental health issues in Victoria*, part 3 discussing the availability and safety of services, including trauma informed care and family violence (available at: vla-rcvmhs-paving-roads-to-recovery-june-2020.pdf) (**Paving the roads to recovery**). Recommendation 6 in Paving the roads to recovery: 'The Department of Health and Human Services should require and fund mental health services to develop policies to ensure family violence risk screening is undertaken as part of the intake process within the mental health system (e.g. risk identification, referrals to family violence services for safety planning)'.

Recommendation 4: Diverse voices and intersectionality

Any co-production or co-design process should ensure the active involvement of diverse communities, including people who experience mental health issues or identify as having a disability, First Nations people, people from culturally and linguistically diverse backgrounds, LGBTQI+ community members, people with different socioeconomic backgrounds, young people and older people. These processes should also account for intersectionality, as different aspects of a person's identity can subject them to overlapping forms of discrimination.

Recommendation 5: Delivery of training and resources

All information, resources and training must be provided in a culturally and socially appropriate way, including the provision of translated information, accessible versions, and in a diverse range of media formats, including videos with Auslan interpreters.

5. Access to independent advocacy and legal assistance

This part addresses consultation questions 6, 7, 12 and 13.[33]

The Royal Commission into Victoria's Mental Health System found that non-legal advocacy is highly valued by consumers, providing important support to promote the rights of consumers and the principles of the Victorian Mental Health Act.[34]

The IMHA non-legal advocacy service, how it works and its role in promoting supported decision-making is discussed in parts 1 and 3 above.

As mentioned above, our Mental Health and Disability Law and Economic and Social Rights programs also provide legal assistance to people accessing, or eligible to access the NDIS. Examples of what this work involves includes:

- Assisting people to understand their legal matter
- Making people aware of their rights in relation to appeal options
- Liaising with the other parties, including treating teams, NDIS service providers and the NDIA
- Referring people so their needs can be holistically met, including to IMHA or for assistance with other legal issues
- Accessing information in a way people can understand, for example, using interpreters and explanations of reports with people who cannot read

[33] Consultation questions: 6. What should decision supporters know about so they can help people with disability make decisions? 7. 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. Conflict of interest is when a person or organisation takes advantage of their position for personal or corporate benefit. 12. How can we help reduce conflict of interest? 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. 13. How can we help reduce undue influence?

[34] Royal Commission into Victoria's Mental Health System Final Report, Volume 4, 'The fundamentals for Enduring Reform' (February 2021) 396 (available at: https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/03/RCVMHS_FinalReport_Vol4_Accessible.pdf) (**Royal Commission Final Report volume 4**).

- Exploring options based on a person's preferences
- In some matters, providing representation at the court or tribunal to put forward the person's case.

Through this work, we see that legal assistance is a crucial ingredient for supported decision-making, allowing people to access information about their rights and better understand their options in order to make decisions. In this way, access to legal assistance is a key mechanism for embedding supported decision-making as it supports people to understand and exercise their rights. This is particularly important for people who are less able to navigate the complex NDIS access process independently, resulting in significant inequity. Advocacy and legal assistance can play a vital role in addressing this.

The provision of legal advice and representation is also a necessary mechanism for supported decision-making at the appeals stage of the NDIS process, as it provides people information about their rights and options needed for them to make decisions and participate in matters before the Administrative Appeals Tribunal.

In addition to improving individual outcomes for people and increasing their ability to engage with decisions and processes that affect them, lawyers and advocates have a role to play in identifying and addressing systemic issues that are apparent through high volume work with clients and consumers. In this way, these services play a crucial part in oversight, including as part of introducing changes to systems, practices and culture.

Recommendation 6: Independent non-legal advocacy and legal assistance

Recognise, and invest in, access to independent non-legal advocacy and legal assistance as key mechanisms for embedding supported decision-making through supporting people to understand and exercise their rights (including in relation to appeals in the Administrative Appeals Tribunal). This should include investment in Aboriginal Community Controlled Organisations to be partners in the delivery of these services.

6. Moving beyond policy to changes in practice

We welcome the proposed next steps outlined in Appendix C of the consultation paper and recommend that the NDIA consider some further lessons from the experience in Victoria where efforts to embed supported decision-making in the 2014 Victorian Mental Health Act led to limited changes in practice on the ground.

Through our work and the experiences of consumers, we have seen that the legislative mechanisms in the Victorian Mental Health Act have not delivered the cultural change they promised,[35] including those regarding supported decision-making. The Royal Commission into Victoria's Mental Health System identified that '[e]nsuring that … changes are implemented in practices, culture and approaches to treatment, care and support will require significant support for the mental health

[35] Act for Change, above n 4, 44.

workforce'.[36] The Royal Commission identified further that 'the effectiveness of the legal reforms will depend on how well the new laws are implemented and applied in practice',[37] so 'it is essential that training and education is provided on an ongoing basis'.[38]

The Victorian Royal Commission also found:

> *There is currently limited oversight and no public reporting on how mental health services are complying with the principles of the Mental Health Act or with its practical requirements such as seeking informed consent, presuming capacity, supporting consumers to make decisions, providing statements of rights or providing treatment consistent with a person's advance statement.*[39]

This demonstrates the need for the NDIA to consider accountability and oversight when implementing supported decision-making.

We also note that the introduction of the NDIS resulted in a decrease in support services for some people with disability, either because they were found not to be eligible for the NDIS or because they were unable to secure the supports they were funded in their NDIS packages to receive as a result of market failure or thin markets.[40] There is concern that as resourcing is already an issue for NDIS service providers, the introduction of supported decision-making guidelines may have poor uptake. The NDIA must consider this and ensure adequate resourcing for staff and providers to be able to implement the policy, as well as resource education and training independently of service providers, as discussed in part 3 above.

We encourage the NDIA and NDIS providers to learn from the experiences in Victoria and ensure adequate workforce leadership, resourcing and education and accountability in order to implement the changes in culture and practice necessary to embed supported decision-making.

Recommendation 7: Embedding changes in practice

To make sure the NDIS supported decision-making policy has a real impact for people who receive NDIS supports, thought and resourcing will need to be invested in leadership, education and resources, oversight and accountability, which are all necessary to support and embed cultural change.

[36] Royal Commission Final Report volume 4, above n 34, 42.
[37] Ibid 46.
[38] Ibid.
[39] Ibid 407.
[40] See, eg, Victoria Legal Aid, *Ten Stories of NDIS 'Thin Markets': Reforming the NDIS to meet people's needs*, submission to the Department of Social Services and the National Disability Insurance Agency's NDIS 'Thin Markets' Project (June 2019).

Annexure: Our clients

During 2019–20 Victoria Legal Aid assisted 88,662 unique clients, including those seen by a private practitioner duty lawyer.